Prioritizing questions and methods for an international and interdisciplinary supervision research agenda: Suggestions by eight scholars

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Abstract:

Eight active supervision scholars provide their perspectives on priorities for advancing research in clinical supervision. Based on proposals they presented at an invited symposium held during the 11th International Interdisciplinary Conference on Clinical Supervision, the authors propose research questions around multicultural identities, supervisor expertise, supervision models, and research methods. Although neither a comprehensive nor exhaustive list of priorities, the authors hope the article encourages dialogue across disciplines and countries that expand understanding of clinical supervision practice and supervisor education.

Keywords: Clinical supervision research | multicultural supervision | expertise | supervision models | case study research | client outcomes | supervisor education and development

Articles:

Interest in clinical supervision has exploded, both globally and across the multiple mental health disciplines. This interest is evident, for example, in the statements of best practices or competencies that have been developed in a number of countries in the fields of counseling (Borders et al., 2014), social work (American Board of Examiners in Clinical Social Work, 2004; National Association of Social Workers and Association of Social Work Boards, 2013), psychology (e.g., American Psychological Association [APA], 2015; British Psychological Society, 2003; New Zealand Psychologists Board, 2010; Roth & Pilling, 2008), nursing (Cutcliffe & Sloan, 2014; Rice et al., 2007), substance abuse (U.S. Department of Health and Human Services, 2007), school psychology (Crespi & Lopez, 1998), and genetic counseling (Eubanks Higgins et al., 2013).

Most of these guidelines have been created within the past decade and stand as testament to the maturation of supervision as a specialty area of practice. The essential guidance they provide to

practitioners is grounded in increasingly robust conceptual and empirical literatures. But these literatures have remained largely separate, in siloes defined by discipline and country. One consequence has been persistent challenges in exploring the unique and universal supervision themes, issues, and processes across disciplines and countries.

From its beginnings, *The Clinical Supervisor* has had the goal of breaking down those siloes. Indeed, its earlier editors Shulman and Safyer (2003) listed cross-discipline collaboration as a core principle for their tenure. In support of this goal, they secured federal funding for an interdisciplinary and international conference on clinical supervision, which has been held annually since 2005 (http://socialwork.adelphi.edu/clinicalsupervision). A major conference goal has been to "foster discourse across disciplines" (Shulman & Safyer, 2006, p. 1).

An aspiration of the conference organizers has been to establish networks of researchers who would work together on key questions, across disciplines and countries. Therefore, for most years, these conferences have been preceded by a day of symposia or workshops that address this goal of fostering interdisciplinary discourse. The format has varied from open-ended and more focused conversations among researchers to more formal presentations on research methods (e.g., Borders & Ellis, 2014).

In advance of the 2015 supervision preconference, the first two authors invited members of an online forum created to advance supervision research to propose questions, issues, and methods they thought should be prioritized in supervision research. Forum members who could attend the conference then presented their ideas to one another at a preconference research symposium.

This article, a product of that 2015 meeting, is broadly representative of the issues raised first in the online forum discussion. The authors, eight active supervision scholars, representing three disciplines and two countries, each propose research questions or methods they believe should be prioritized for advancing supervision scholarship. It is neither an exhaustive report of ideas that were generated by the larger group of supervision scholars in their online conversations nor a consensus list. It is our hope, though, that this article will provide a starting point for what we hope might become dialogue among scholars—via the online forum and in this journal—around research that can advance understanding of clinical supervision.

We all share authorship of this article. Each of us, though, has been responsible for a particular section, summarizing the ideas presented at the conference. These individual pieces are presented next, with authors identified, followed by a few concluding comments and suggestions.

Addressing cultural identities in clinical supervision: Where are we now and where do we need to go? Heidi Hutman

Consistent with the changing demographics in the United States, supervisees and clients are becoming increasingly diverse (Inman et al., 2014). As such, understanding what constitutes multiculturally competent supervision and how supervisees with diverse cultural identities experience supervision is more important than ever before. Reflecting its importance, multidisciplinary scholarship on multicultural or cross-cultural supervision (i.e., supervision in

which the supervisees and supervisor differ in terms of one or more cultural identities) has grown and evolved over the past 20 years (Falender, Burnes, & Ellis, 2013).

Early on, researchers focused almost exclusively on race and gender in supervision. In terms of race, cross-racial supervision experiences were emphasized and, in particular, attention was given to exploring minority trainees' positive versus negative supervision experiences (Inman et al., 2014). For example, Fukuyama (1994) found that positive experiences in cross-racial supervision included the supervisor addressing cultural issues, conveying an open attitude, and providing culturally relevant resources. Alternatively, negative experiences included the supervisor lacking cultural awareness, dismissing cultural issues, providing culturally insensitive treatment recommendations, and engaging in subtle acts of racism (what we now discuss as microaggressions; Constantine & Sue, 2007).

Given the frequency with which negative events in cross-racial supervision were found to occur (Burkard et al., 2006), researchers investigated whether supervisees in racially matched dyads reported more positive outcomes. Overall, the research has yielded inconclusive results, with some studies finding that racial matching is beneficial (e.g., Goode-Cross, 2011; Hird, Tao, & Gloria, 2004), and others failing to find significant differences (e.g., Gatmon et al., 2001). Researchers have also investigated racial identity development in supervision and found that supervisees perceive supervision more positively when their supervisors surpass them (i.e., progressive dyads) or are at the same stage (parallel dyads) in their racial identity development (e.g., Bhat & Davis, 2007; Constantine, Warren, & Miville, 2005; Ladany, Brittan-Powell, & Pannu, 1997). Thus, racial identity development appears to be an important construct for understanding racial issues in supervision (Inman et al., 2014).

Early studies on gender matching in supervision also yielded mixed findings. For example, Sells, Goodyear, Lichtenberg, and Polkinghorne (1997) found no relation between gender matching and supervision structure, the supervisory working alliance, and supervisee perceptions of skill development, but they did find that it predicted supervision interactions (i.e., relationship-oriented versus task-oriented); Hicks and Cornille (1999) reported gender matching was associated with greater perceived collaboration. A collaborative relationship has been found to be essential for fostering supervisee empowerment in feminist supervision (Green & Dekkers, 2010; Prouty, 2001). Moreover, Walker, Ladany, and Pate-Carolan (2007) found that supportive gender-related events in supervision included supervisors engaging in collaborative discussions about how female supervisees' gender identity related to their professional development. Paralleling the research on racial issues in supervision, it seems that the extent to which supervisors are supportive of supervisees' gender identities is more important than gender per se.

More recently, researchers have moved beyond race and gender to focus on other cultural variables, such as sexual orientation, religion and spirituality, and international student status. Although research on these variables has lagged far behind the literature on race and gender (Inman et al., 2014), these studies constitute noteworthy advancements in facilitating a holistic understanding of multicultural supervision.

The few studies of gay, lesbian, bisexual, transgender, and queer (GLBTQ) issues in supervision suggest that supervisors tend to address sexual orientation less often than gender, race, and ethnicity (e.g., Taylor, Hernández, Deri, Rankin, & Siegel, 2006). And yet, doing so is integral to modeling affirmative clinical practice, as well as providing a space where supervisees can process institutional homophobic attitudes and understand how their sexual minority statuses relate to their professional roles (Burkard, Knox, Hess, & Schultz, 2009; Messinger, 2007; Satterly & Dyson, 2008). Similar to the research on sexual orientation, discussions about religion and spirituality have been found to occur infrequently in supervision (Gilliam & Armstrong, 2012; Gubi, 2007), in spite of their importance for both supervisees and clients (Aten, Boyer, & Tucker, 2007; Miller & Ivey, 2006). Finally, a modest, but growing, amount of research has attended to international supervisees' experiences in supervision. Like supervisees from other backgrounds, international trainees appear to benefit most when their supervisors initiate supportive discussions about cultural differences and worldviews (Mori, Inman, & Caskie, 2009; Ng & Smith, 2012; Nilsson, 2007; Nilsson & Dodds, 2006; Sangganjanavanich & Black, 2009). Thus, regardless of the cultural identity being addressed, the research collectively highlights the critical need for supervisors to engage in open dialogues about the ways in which the myriad cultural identities that the supervisor and supervisee bring to supervision influence clinical training and practice.

Although the literature addressing cultural identities in clinical supervision has witnessed considerable growth, much remains to be done. In particular, researchers should continue to examine how racial identity development relates to supervision processes and outcomes, as the extent to which the supervisor and supervisee have internalized and become aware of their own racial identities seems to be salient (Inman et al., 2014). In addition, further attention to how supervisors can be supportive of gender-related issues in supervision is needed. It is also critical for researchers to continue to attend to the influence of sexual orientation, religion and spirituality, and country of origin on supervision. Moreover, missing from the literature almost completely (see Hanks & Hill, 2015, for an exception) is a consideration of socioeconomic status or disability issues in supervision. Without being inclusive of the full range of cultural factors in supervision, a holistic understanding of multicultural supervision is precluded. Furthermore, in reality, supervisors and supervisees (and clients) have multiple identities. Thus, researchers would benefit from accounting for such intersectionality and approaching their investigations from a multidimensional perspective (Inman et al., 2014). In this way, the research in this area can have more direct implications for clinical training by providing supervisors with the knowledge needed to address cultural identities in supervision.

Multicultural supervision: Impact of multiple identities and experiences of microaggressions Catherine Y. Chang

Multicultural supervision is a complex triadic relationship among a supervisor, supervisee, and client. It involves the intersection of diverse cultural backgrounds within the relationship and discussion of relevant cultural issues in a combined effort to provide effective counseling and supervisory processes for the triad (Chang & Flowers, 2009; Chang, Hays, & Shoffner, 2003). Multicultural supervision may include the development of cultural self-exploration for the

supervisee, examination of the cultural dynamics of the counseling relationship and the supervisory relationship, and a discussion concerning the cultural biases and assumptions of traditional counseling theories and interventions (Chang & Flowers, 2009). Addressing multicultural issues in supervision facilitates ethical and effective practice with diverse clients (Ancis & Ladany, 2010).

Research in multicultural supervision continues to evolve. Two areas that warrant particular attention are those related to the intersectionality of these multiple identities and microaggressions. I will address each in turn.

Intersectionality of multiple identities

Whereas early scholarship was focused primarily on racial and gender issues, researchers are now pointing to the importance of addressing other cultural identities (e.g., sexual orientation, gender identity, religion and spirituality, international students, and socioeconomic status; see Hutman's section of this article for a summary of the literature related to cultural identities) as well as the impact of the intersectionality of these multiple identities (Falender et al., 2013; Taylor et al., 2006). All individuals have multiple identities that interact with one another. It is essential that supervisors explore how these multiple identities may influence the supervisory and counseling relationships (Chang & Flowers, 2009). In making this same argument, Grollman (2014) observed that individuals who belong to multiple stigmatized groups face greater physical and mental health challenges compared to both privileged and single-disadvantaged individuals.

Despite this call to explore the intersectionality of multiple identities, I was able to locate only a single study that has done so. Taylor and colleagues (2006) interviewed 10 ethnic minority supervisors regarding how they addressed the intersections of diversity in their clinical supervision activities. Using consensual qualitative research (CQR) methodology, three salient themes emerged from the experiences described by the ethnic minority supervisors: supervisors' initiative in integrating diversity, the impact of social location on current supervision practices, and the need for mentoring the next generation of therapists. The first theme, *supervisors' initiative in integrating diversity*, related to participants' statements that it was essential for supervisors to address issues related to multiple identities and that it was their responsibility as supervisors to initiate this dialogue. Despite this awareness, supervisors in this study also reported that they did not address issues related to sexual orientation and spirituality.

The second theme, *the impact of social location on current supervision practices*, relates to the supervisors' acknowledgment that social location (e.g., gender, race, sexual identity) impacted their supervisory process and their professional identities. For example, the participants discussed how addressing the intersection of multiple identities affected their supervisees' self-awareness, supervisees' ability to make meaning, supervisees' ability to assess their clients, and their relationships with their supervisees. The third theme, *the need for mentoring the next generation*, related to the participants' strong commitment to mentoring the next generation based on their own experiences as supervisees. This commitment involved the supervisors wanting to assist their supervisees in developing the supervisees' multiple identities.

Taylor and colleagues (2006) called for additional research focused on the development of a comprehensive model that integrates multiple identity dimensions in supervision as well as expanding their current study to include a larger sample size. Building on their call for additional research, I recommend both qualitative and quantitative research that examines the impact of discussing the intersectionality of multiple identities on both the supervision process and the counseling process. More specifically, research questions to explore in this area include the following: How does discussing the intersectionality of one's multiple identities in supervision impact the supervisory working alliance and the counseling relationship? What effective techniques are supervisors using to explore multiple identities with their supervisees? What are the relationships among supervisee and supervisor multiple identities, supervisory working alliance, and client outcome? What is the relationship between supervisor and supervisee multiple identities and multicultural counseling competence?

Microaggressions in supervision

In addition to exploring multiple identities in supervision, there has been a call to explore microaggressions in supervision (Barnes, 2011; Constantine & Sue, 2007; O'Hara, 2014). Microaggressions are the subtle verbal, behavior, or environmental indignities that denigrate, insult, or undermine the recipient (Constantine & Sue, 2007; Sue, 2010), and not only constitute a pervasive threat to interpersonal relationships but also can result in both physical and mental distress for the recipient (Helms, Nicolas, & Green, 2012; Sue et al., 2007). Microaggressions can occur when participants differ in race and culture, which often is the case in supervision (Hays & Chang, 2003; Sue et al., 2007).

I found one published study (see Constantine & Sue, 2007) and two dissertation studies that examined microaggressions in supervision (see Barnes, 2011; O'Hara, 2014). Constantine and Sue (2007) qualitatively explored Black supervisees' reports of racial microaggressions they perceived to have occurred during supervision with White supervisors. Constantine and Sue identified seven themes in the supervisees' reports. They concerned the supervisors' (a) invalidating racial and cultural issues; (b) making stereotypic assumptions about Black clients; (c) making stereotypic assumptions about Black supervisees; (d) seeming to be reluctant to give performance feedback for fear of being viewed as a racist; (e) focusing primarily on clinical weaknesses; (f) blaming clients of color for problems stemming from oppression; and (g) offering culturally insensitive treatment recommendations. Constantine and Sue (2007) concluded that microaggressions were pervasive in these supervisory relationships, that they had negative effects on the supervisory alliance and on client outcomes, and that they contributed to the supervisees' emotional frustration and disappointment.

O'Hara (2014) investigated the relationships among racial microaggressions, the supervisory working alliance, and traumatic experiences in professional counselors and counselors-in-training. Her participants include individuals who self-identified as a member of any cultural minority group. Because Helms and colleagues (2012) had reported that racial microaggressions can be triggers that prompt recipients to remember past trauma and danger, O'Hara included the Trauma Symptom Checklist (TSC-40; Elliott & Briere, 1992) to access trauma symptoms in the participants. For the purpose of this study, supervisees were instructed to only report symptoms

that developed after they had experienced microaggressions in supervision. O'Hara found that higher levels of microaggressions in supervision were related to lower quality of the supervisory working alliance and to more reported trauma symptoms; in addition, the higher reported trauma symptoms were related to lower levels of supervisory working alliance.

Whereas Constantine and Sue (2007) and O'Hara (2014) had examined supervisees' perceptions of microaggressions their supervisors had directed toward them, Barnes (2011) investigated Black supervisors' perceptions of microaggressions their White supervisees had directed toward them. To do so, Barnes adapted the Racial Microaggressions in Supervision Checklist (Constantine & Sue, 2007), which was initially developed to measure Black supervisees working with White supervisors, to create the Experiences of Black Supervisors Scale (EBSS). Like O'Hara (2014), Barnes found that supervisors who reported higher levels of perceived racial microaggressions experienced lower levels of the supervisory working alliance. Barnes found no significant relationships among perceptions of racial microaggressions and the supervisors' racial identity attitudes.

Given the pervasiveness of microaggressions and the negative impact that microaggressions have on the supervisory alliance, it is imperative that we continue to explore the impact of microaggressions on the supervisory process. For example, future researchers need to consider perspectives of both supervisors and supervisees concurrently. Furthermore, studies of supervisory relationships in which the occurrence of microaggressions were processed compared to those in which they were not would provide further information regarding the impact of microaggressions on the supervisory alliance. As well, the perspectives of supervisees from marginalized sociocultural identities (e.g., gender, gender identity, socioeconomic status, and ability status) that could make them targets for microaggressions have not yet been studied. Barnes (2011) developed the EBSS for her study with promising psychometrics. Additional validation studies of the EBSS are warranted as well as the development of additional inventories that measure microaggressions in other cultural identities. Finally, researchers will want to employ additional research designs (i.e., qualitative, quantitative, and mixed-methods designs) to investigate the presence and impact of microaggressions as they relate to the supervisory process and to client outcome.

Clearly, microaggressions and the intersectionality of multiple identities are important topics to explore in clinical supervision research. Additional research that explores the relationship between multiple identities and microaggressions will have important implications for multicultural supervision. Future researchers may assess the impact of microaggressions on the supervisory relationship between supervisors and supervisees who identify with multiple identities over the course of a supervisory relationship. Because of the complexity of investigating microaggressions, researchers may include real-time supervisory interactions through the use of videos, direct observations, and biofeedback machines to assess for the presence of microaggressions and to explore how microaggressions were processed during supervision.

Conceptualizing supervision and training through an expertise lens: Implications and research questions Rodney K. Goodyear

Programs that train mental health professionals increasingly prioritize and assess trainee learning using the competencies that disciplinary experts have identified as necessary for practice (e.g., Fouad & Grus, 2014). The development of competency statements by the various mental health professions stands as an especially important development, particularly because of the clear guidance they provide educators and supervisors (see Fouad et al., 2009). Assessing the extent to which trainees develop these competencies constitutes what Lerner and Tetlock (2001) termed "process accountability." But as important as that is, I argue here that our training of psychotherapists will be improved to the extent that we *also*impose outcome accountability demands.

I illustrate the distinction with an example from medicine: Process accountability occurs when a physician is held answerable for performing all expected procedures well, independent of whether the patient benefited as a result; outcome accountability occurs, though, when the physician is answerable for patient improvement, independent of the procedures he or she used to accomplish this outcome. Mental health professionals have assumed that the extent to which trainees either demonstrate competence or adhere to a particular treatment protocol (both instances of process accountability) will predict the extent of their success in treating clients. Although this seems intuitive, it is not supported by the evidence. Webb, DeRubeis, and Barber (2010) concluded on the basis of their meta-analytic review that the relationship between treatment outcomes and either (a) level of adherence to a treatment method or (b) rated competence in those methods were not statistically different from zero.

Therefore, I (i.e., Goodyear, 2015) argue both that the competency movement (see Rubin et al., 2007) has been important for the field *and* that it is by itself an insufficient foundation for supervision and training. Educators and supervisors would profit from drawing as well from an expertise-development framework and consider monitoring trainee progression from novices to eventual expertise using client outcomes as their criterion (see Tracey, Wampold, Goodyear, & Lichtenberg, 2015; Tracey, Wampold, Lichtenberg, & Goodyear, 2014).

The average effect size for psychotherapy is about .8 (Cohen's *d*; Wampold & Imel, 2015), which is large in social science research and contrasts with psychopharmacological treatments for depression, which are only marginally more effective than placebos (Kirsch et al., 2008). But this good news is tempered by the more sobering data that call into question how much either our training programs (see Anderson, Crowley, Himawan, Holmberg & Uhlin, 2015; Budge et al., 2013) or clinical supervision (see Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2014) account for these outcomes, and by data showing that therapists fairly quickly reach a level of proficiency beyond which they typically do not improve. In fact, one recent study shows a small deterioration of therapists' effectiveness as they gain experience (Goldberg et al., 2016)!

Yet some therapists *do* continue to develop and to reliably outperform their counterparts. Chow and colleagues (2015) concluded from their study of these high-performing therapists that they are distinguished by their willingness to engage in deliberate practice (see Ericsson, 2009). This has several implications for supervision and training that warrant implementation, though with continued research attention and monitoring.

The effectiveness of deliberate practice depends on availability of ongoing and high-quality performance feedback (Goodyear, 2014; Tracey et al., 2015; Tracey et al., 2014). This can—and should—come from both supervisors and clients. The most effective supervisor feedback is based on having directly observed the trainee's work through recordings (live supervision is less useful because the supervisee has no opportunity to watch interaction sequences and reflect on their impacts; Chow et al., 2015). In fact, the use of audio or video recordings as the basis for supervision has been codified as best practice (APA, ; Borders et al., 2014) and stands in distinction to the most frequently employed method of supervisee self-report. Supervisees deliberately withhold or distort information (Ladany, Hill, Corbett, & Nutt, 1996) and, even when not intending to do so, their reports can never fully capture the rich and nuanced interactions that occurred. One area warranting continued research attention is how supervisors can be more effective in delivering useful feedback that enhances deliberate practice, as feedback tends to become attenuated when it is difficult to give (i.e., to the supervisees who often are most in need of it; see Hoffman, Hill, Holmes, & Freitas, 2005) and in cross-racial supervisory dyads (Burkard, Knox, Clarke, Phelps, & Inman, 2014).

Client feedback is especially important to expertise development and fortunately has become readily available through measures and technologies such as Lambert's (2015) Outcome Questionnaire-45 (see Boswell, Kraus, Miller, & Lambert, 2015; Miller, Hubble, Chow, & Seidel, 2015). To use any of the many measures now available is important for both training accountability (Sparks, Kisler, Adams, & Blumen, 2011) and the feedback that is so essential to trainees' skill improvement (Reese et al., 2009). The important caveat is that this type of feedback does not suggest what in the therapy sessions is going well or poorly. Instead, it provides an “early warning system” (Tracey et al., 2014) that lets the supervisor and trainee know to examine audio or video recordings to determine what therapist-client interactions should be attended to. One priority in research, then, would be to examine ways that supervisors can effectively employ client feedback in their work.

There are at least two other implications of an expertise development perspective that warrant attention:

- If expertise develops in response to supervisor and client feedback, then, reasonably, the therapist will become increasing idiosyncratic in his or her approach. In fact, Rønnestad and Skovholt (2003) found that their sample of experienced therapists used increasingly personalized approaches over time. But one proposition I would offer for research attention is that, prior to developing this more individualized approach, the trainee should first master one particular model. This has implications for training programs, as so many are eclectic rather than focused on preparing trainees in one model. Because the models are not appreciably different from one another in their effectiveness (see Wampold & Imel, 2015), the particular model that trainees learn is unimportant.
- In the United States, once therapists are licensed in their particular profession, they no longer are required to be supervised (though this is not the case in Great Britain, Australia, and New Zealand). But expertise development is an ongoing process that does not stop at the point of licensure. Therefore, I argue for lifelong supervision for mental

health professionals in all countries. As Tracey and colleagues (2014) argued, practicing therapists do not receive the feedback that is so essential for expertise development.

If that lifelong supervision were implemented, a next step would be to develop in supervisors both an expectation for ensuring that supervision maintains a quality-improvement focus and the skills to do that. Apparently, this is not typical in at least Great Britain, as Nicholas and Goodyear (2015) found that the supervision of credentialed British psychologists most often had a supportive intent and focused rarely on skill development. Therefore, I would add the additional supervision research priorities of (a) determining how to change supervision practices for those who supervise credentialed mental health professionals, and then (b) examining their outcomes using the criterion of client change.

In short, I am proposing that supervisors, training programs, supervisees, and the broader field itself should embrace outcome accountability. Process accountability, especially when it is based on effective supervisor evalutions of the extent to which supervisees are attaining competence, is important. But expertise development requires ongoing feedback about actual client progress. This should be a lifelong learning agenda for which supervisors are prepared to assist.

Studying the expertise of clinical supervisors Gül¸ah Kemer

The preceding section spoke to an expertise framework for therapist training and supervision. This section extends that focus to supervisors themselves. Most of our knowledge about supervisors is based on research with doctoral supervisors and relatively inexperienced supervisors (e.g., Borders & Fong, 1994; Luke, Ellis, & Bernard, 2011), and very few researchers (e.g., Nelson, Barnes, Evans, & Triggiano, 2008) have examined advanced supervisors. Better understanding of expert supervisors in comparison to beginning supervisors could expand our supervision knowledge and practices.

It is an especially auspicious time to study expert or master clinical supervisors. First, since the publication of seminal articles in the 1980s (e.g., Loganbill, Hardy, & Delworth, 1982; Stoltenberg, 1981), our knowledge and practices have considerably expanded along with extensive research on clinical supervision (Borders, 2014). More recently, supervision scholars have described more complex aspects of effective supervision (e.g., Bernard & Goodyear, 2014), such as the necessity of subtle and nuanced supervision practices to meet individualized needs of supervisees (Borders, 2009). Next, supervisor development models (e.g., Hess, 1986; Watkins, 1993) published in the early 1980s through the late 1990s primarily offered descriptions of beginning rather than advanced supervisors. Supervision training was not a major focus in the premises of these early models (e.g., Stoltenberg & Delworth, 1987; Watkins, 1993). For some time now, supervision training has been required in accredited doctoral programs in several disciplines (e.g., American Psychological Association [APA], 1996, as cited in APA, 2006; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 1988). Finally, various supervision guidelines and standards have been also endorsed, such as training requirements for supervisors of counselor licensure applicants (American Counseling Association [ACA], 2010), statements of “best practices,” and guidelines for conducting supervision and training supervisors (e.g., Borders et al., 2014; Rice et al., 2007).

Thus, a growing number of professionals have devoted years to practicing, teaching, and/or researching clinical supervision as well as participating in the development of professional standards and guidelines.

In one of the few studies examining advanced supervisors (Nelson et al., 2008), an interdisciplinary group of wise supervisors reported using *reflective* (e.g., self-coaching to talk themselves through the conflict), *interpersonal* (e.g., working hard not to shame or embarrass a supervisee when giving difficult feedback), and *technical* (e.g., increasing direct observations of the supervisee to gain more information about their skills) strategies to handle conflict with their supervisees. Another interdisciplinary group of expert supervisors (Grant, Schofield, & Crawford, 2012) described *relational* (e.g., validating and normalizing the issue) and *reflective*(e.g., engaging in deep thought about supervision dynamics) interventions to manage difficulties in their supervision practices. When these interventions were ineffective, experts tried *avoidant* (e.g., withholding validation, ignoring) and *confrontive* (e.g., confronting the issue tentatively at first but then, if necessary, confronting the issue directly) interventions.

I have observed some parallels between these findings and some of the key characteristics of experts' thinking from different fields (Glaser & Chi, 1988). Experts' outstanding performances were an indication of their ability to see details beyond the obvious and a result of their commitment to practice systematically (Glaser, 1985) and deliberately (Ericsson, 2006). Thus, in my dissertation project, I examined *what* experts thought in their supervision practices and *how* their thinking was organized. Experts' supervision cognitions were organized into five areas (with subcategories) (Kemer, Borders, & Willse, 2014): *Conceptualization of Supervision and Intervening* (e.g., setting goals/agendas to plan for and manage supervision interventions), *Assessment of the Supervisee and His/Her Work* (e.g., supervisee's developmental level, skills, and professional behaviors), *Supervisory Relationship*(e.g., experts' experience of the relationship, supervisee's response/receptivity), *Supervisor Self-Assessment and Reflection* (e.g., experts' reflections on their own performances, needs, self-awareness), and *Administration and Logistics of Supervision* (e.g., documentation). In a follow-up study (Kemer, Borders, & Yel, 2015), experts also reported prioritizing their focus on some of the subcategories, mainly from the *Supervisor Self-Assessment and Reflection* and *Supervisory Relationship* areas, in their work with challenging supervisees when compared to easy supervisees.

Across these studies, particularly in challenging situations, expert supervisors' cognitions, strategies, and interventions have highlighted the importance of attending to the supervisory relationship and being highly reflective, flexible, and adapting to the developmental needs of the supervisees; being aware of their own shortcomings and contributions to the difficult situations; and being direct and confrontive when it is crucial (e.g., gatekeeping). Furthermore, experts' supervision thoughts appeared to be comprehensive, systematized, and intentional. These findings are valuable and leave us with further questions to be answered.

Expertise could be described differently in different settings and disciplines (e.g., site/field supervision, social work). However, due to the obscure nature of describing expertise (Tracey et al., 2014), first, specifying the criteria for the expert clinical supervisors of the study seems to be

critical. For example, years of experience is important, but not necessarily a proxy for expertise (Goodyear, 1997). In Nelson and colleagues' (2008) and Grant and colleagues' (2012) studies, experts were selected through peer nominations, yet nominators of experts may not be informed about the experts' performances in a detailed capacity. In both studies, interdisciplinary groups of experts from both clinical and academic settings provided rich descriptions of their experiences and strategies in the face of supervision difficulties. I am also wondering if experts from a specific discipline (e.g., counselor education) and/or a specific setting (e.g., site/agency) would have provided different and further detailed results. Trying to address these concerns, in my dissertation study (Kemer et al., 2014), I determined a set of criteria for expert supervisors from academic settings: (a) a doctoral degree in either counselor education or counseling psychology, (b) experience in teaching and supervising student counselors and/or supervisors, (c) extensive involvement in scholarly activities in supervision, and/or (d) being awarded or nominated as distinguished mentor, counselor educator, etc. I believe building concrete and objective criteria to select expert supervisors could lead us to more nuanced information regarding experts' experiences and practices, and, in return, to more informed descriptions of expert supervisors.

Second, the existing studies with experts did not involve beginning supervisors. Thus, there is a dearth of research comparing expert and beginning supervisors' unique experiences and practices. In particular, comparisons of experts' thoughts and coping strategies with those of beginning supervisors around difficult situations would be quite informative. Furthermore, in order to expand on the question of *what* expert and beginning supervisors think and do in their supervision practices, we also need examinations of *how* expert and beginning supervisors process information and make in-session decisions. Grant and colleagues (2012) used a mixed-methods qualitative approach wherein in-depth interviews regarding experts' theory and practices were followed by second interviews involving a supervision session video of the expert to examine the moment-by-moment experience and practice of the supervisor with the supervisee. Such studies not only will further our knowledge about experts' cognitive processes, but also contribute to our understandings of supervisor development.

Finally, our knowledge of experts is mostly based on self-reported data. Cross-sectional and longitudinal case studies examining what expert and beginning supervisors do in supervision and how experienced supervisors evaluate the effectiveness of expert and beginning supervisors' performances would complement our current knowledge. In short, we can only understand expertise in clinical supervision through systematic study of supervisors from different developmental levels (i.e., beginning, experienced, experts), settings (e.g., academe, site), and professional backgrounds (e.g., counselor education, social work).

Constructivist approaches to clinical supervision Douglas A. Guiffrida

For decades, psychotherapists and, by extension, clinical supervisors, have debated about how best to conduct psychotherapy. Whereas the early debates tended to pit one theoretical orientation versus another, more contemporary debates revolve around disparate ideas about the very nature of knowledge, truth, and reality. On one side of this argument are those heavily influenced by modernist ideas of truth, articulated most notably by Descartes' (1637) discourse on the scientific method. Modernists believe that effective practice can only be discovered

through rigorous scientific observation and study, which, according to modernist thought, results in the delineation of a set of universal *best practices* that outline the best approaches to use with each particular client or client issue (Mahoney, 2006).

On the other side of this issue are psychotherapists who have been influenced by pre-modernists' ideas of truth. These therapists tend to reject the best practices movement, and instead believe that the evolution of psychotherapy requires the field to authentically embrace practices associated more with the development of personal qualities of the psychotherapist (e.g., Levant, 2004; Peterson, 2004). Broadly speaking, such traditional modes of practice rely more on (a) psychotherapist intuition than established theories, and (b) reflective inquiry as a means of establishing new knowledge rather than external expertise or generalizable research. These pre-modernist ideas, once largely abandoned by practitioners in nearly all the helping professions in favor of rationality, are being bolstered recently among psychotherapy practitioners and scholars with the proliferation of research indicating that *common factors*(many of which are associated with the personal qualities of the therapist) are more important to client outcomes than theoretical orientation (Ottens & Klein, 2005; Strupp, 1978; Strupp & Anderson, 1997; Wampold, 2001).

These two competing paradigms about psychotherapy knowledge, truth, and best practice have understandably influenced the field of clinical supervision. Modernist ideas, applied to the practice of clinical supervision, require a didactic approach where the supervisor teaches, directs, and reinforces behaviors that are consistent with the supervisor's ideas about best practice, while correcting behaviors incompatible with best practice. Conversely, pre-modernist ideas applied to supervision prioritize the development of the *person of the therapist*by helping supervisees tap into their natural, ingrained helping behaviors through continually articulating and reflecting upon their own hunches and intuition rather than adhering to established forms of practice.

Rather than choosing one nature of truth over another, it is my observation that growing numbers of psychotherapists, supervisors, and scholars are, instead, recognizing the need to embrace both the modernist and pre-modernist views of therapy and are incorporating both perspectives into clinical supervision. Yet, while the complementary nature of these seemingly disparate paradigms is becoming more widely recognized in clinical practice, the field of clinical supervision lacks a comprehensive philosophical framework upon which to ground this new integrative approach. In this essay, I argue that postmodern approaches to clinical supervision, often labeled *constructivist*, provide the potential to bridge the gap that exists between modernist and pre-modernist approaches to supervision. I will also briefly outline a research agenda that will allow clinical supervision scholars to more deeply define and test constructivist approaches to supervision.

A (very) brief introduction to constructivist supervision

Constructivism has been described as an “intellectual force” in the social sciences (Neimeyer, 1995, p. 4) and its ideas have long been integrated into a wide array of psychotherapeutic approaches, including psychoanalytic, humanistic, cognitive behavioral, systemic, and multicultural approaches (D'Andrea, 2000; Hansen, 2010; Neimeyer, 1995). Yet,

despite the strong influence of constructivism in psychotherapy, constructivist ideas have only recently been applied to the practice of clinical supervision (Neimeyer, Woodward, Pickover, & Smigelsky, 2016) and only a few approaches to constructivist supervision have been offered thus far. Constructivist ideas are most evident in supervision approaches referred to as *Narrative* (e.g., Parry & Doan, 1994), *Reflective* (e.g., Neufeldt, 2007), and *Constructive* (Guiffrida, 2015; Neimeyer et al., 2016). Narrative approaches are based largely on the application of Narrative Therapy (e.g., White & Epston, 1990) to supervision, whereas reflective approaches seek to apply theories of reflective-based experiential learning (e.g., Dewey, 1933; Schön, 1995). The *Constructive* approach (Guiffrida, 2015), the most recent application of constructivist ideas to clinical supervision, is based on George Kelly's (1955) personal construct theory and the work of contemporary constructivist psychotherapists (e.g., Mahoney, 2006; Neimeyer, 1995).

Although each of these constructivist approaches differs slightly in its theoretical underpinnings and applications, they all share a common distrust in objective, knowable realities that can be generalized, and instead place a priority on understanding and validating supervisees' perceptions of reality. At the same time though, each approach (a) recognizes the contributions of established theories of human development, human change processes, and learning; and (b) encourages supervisees, to varying degrees, to critically integrate preexisting theoretical approaches and contemporary psychotherapy research into their practice. In this way, all three of these constructivist approaches to supervision seek to assist supervisees in learning and embracing both the science and art of psychotherapy and to develop expertise that combines supervisees' intuitive wisdom with established, scientific traditions.

The integration of both the intuitive and scientific basis of knowledge into the process of clinical supervision is made most explicit in the constructive approach (Guiffrida, 2015). In this approach, supervisees are continually asked by the supervisor to critically reflect upon all of their thoughts and behaviors in (and about) therapy, including attempting to understand the strengths, limitations, and possible origins of these thoughts and behaviors, in order to develop new conceptualizations of their clients' issues and their own knowledge base. However, supervisees are also continually urged to make connections between the intuitive knowledge they gain through the reflective supervision process and established theoretical approaches (including empirically supported treatments) in order to expand their clinical knowledge.

A research trajectory for constructivist supervision

As a relatively new approach to supervision, much research is needed to fully understand how to harness the power of constructivist ideas in clinical supervision. First, research is needed to clearly define constructivist supervision, including understanding differences among the various approaches that fall broadly under the constructivist heading, as well as how constructivist approaches are distinguished from other approaches such as developmental models, process models, and various psychotherapy-based models. A review of the literature revealed only a handful of conceptual writings on the topic and only one research study (Avery, 2015) that sought to empirically define the main themes consistent with constructivist principles of supervision. Although Avery's study provides a valuable first step toward understanding and

defining the approach, much more research is needed to better understand exactly what is meant by constructivist supervision.

Research is also needed to understand the process of constructivist supervision, particularly how the approach is implemented by supervisors and experienced by supervisees in varying settings. A review of the literature revealed only a few research studies that have sought to understand the perspectives of constructivist supervisors and the experiences of their supervisees (e.g., Araneda, 2015; Crocket et al., 2009; Hathaway, 2012). Although results of these studies are useful in understanding the processes involved in constructivist supervision and suggest utility of constructivist approaches to supervision in various settings (e.g., counselor education programs, mental health settings), this research has tended to utilize small case study designs which limit generalizability of the findings. Larger scale outcome studies utilizing both quantitative and qualitative methods are needed to understand the efficacy and potential limitations of constructivist approaches to supervision. Researchers should, for example, seek to understand if constructivist approaches are more effective than traditional approaches in facilitating critical self-reflection and creativity. In addition, researchers need to examine the impact of constructivist supervision on other areas of therapist skill development, as well as client outcomes.

In summary, postmodern theory provides the potential to bridge the gap that exists between modernist and pre-modernist understandings of knowledge and truth in clinical supervision. Constructivist theories of supervision provide great potential for integrating the power of these important and complementary ways of developing knowledge in the field and helping supervisees develop in ways that are both intuitive and scientific. However, much more scholarship, both conceptual and empirical, is needed to better understand how constructivist ideas can be applied to supervision.

Toward a contextual model of clinical supervision: On trans-theoretical conceptualization, integrative promise, and empirical possibility C. Edward Watkins, Jr.

An ever-expanding array of supervision models exists. Across the past several decades, longstanding psychotherapy-focused, developmental, and social process model offerings have been elaborated upon, new model offerings have been proposed, and a second generation of supervision models has even emerged within the past approximate decade alone (Bernard & Goodyear, 2014; Watkins & Milne, 2014). These models have been useful in advancing supervision understanding and informing research questions (e.g., bringing supervisee development into focus, accentuating the importance of the supervision relationship; Inman et al., 2014). We do not lack for diversity in supervision perspective. But any sort of unifying perspective has been missing: We lack for an integrative, explanatory model that can drive research across systems of supervision. As a way of beginning to address that need, I subsequently propose and briefly describe the specifics of one such explanatory model, what I label the contextual clinical supervision model (CCSM).

I contend that, just as Wampold's contextual model (Wampold & Budge, 2012; Wampold & Imel, 2015) has advanced understanding in psychotherapy, an adapted and extrapolated

contextual model can similarly advance understanding in clinical supervision by (a) providing a parsimonious framework through which the supervisee change process can be trans-theoretically conceptualized; and (b) identifying a set of common, change-inducing supervisory relationship variables and pathways that can be empirically operationalized and researched. The CCSM (Watkins, Budge, & Callahan, 2015; Watkins, Wampold, & Budge, 2015) presents a unique perspective that proposes an answer to two longstanding, interrelated supervision research questions: What are the crucial variables that contribute to making supervision work (for supervisees)? And how do those variables combine to produce desired supervision process and outcome effects? The CCSM is based on two assumptions: (a) the supervision relationship is a powerful mediator through which supervisee change occurs; and (b) both common and specific factors contribute to inducing those positive supervisee changes. Common and specific supervision factors are viewed as being inextricably and synergistically intertwined.

Common factors refer to those core elements or variables that can be found across all supervision approaches. The primary CCSM common factors are the supervisor-supervisee working alliance, real relationship, and expectations about the supervision process (see Watkins, 2012, 2015). The supervisor-supervisee working alliance consists of three components: rapport/bond, the collaboratively established goals that guide the supervision process, and the collaboratively agreed-upon tasks that stimulate pursuit of goal attainment. The real relationship refers to the supervisor-supervisee personal relationship, non-work in nature (separate from the work of the alliance), that is marked by the genuineness and realism that each party experiences in regard to the other. Expectations, which are both process and outcome in nature, give focus to the respective roles of supervisee and supervisor, the format of the supervision experience, and what each party thinks with regard to supervision's helpfulness. Specific factors or specific ingredients refer to the interventions that are used in any supervision approach, some typical examples being providing feedback, direct instruction, modeling, and stimulating self-reflection (Goodyear, 2014). Giving voice to those common and specific factors, the CCSM is fundamentally grounded in relational connection, expectations/goals, and supervisory action.

The CCSM, shown in Figure 1, emphasizes (a) the importance of initial supervisor-supervisee alliance formation (the bond) and its maintenance (where the supervisee trusts and recognizes the expertise of the supervisor); and (b) three relationship pathways by which supervisee change occurs. Those three change pathways are the following: (a) the supervisor-supervisee real relationship (involving professional belongingness, attachment, and social connection); (b) the supervisor's creating expectations about the supervision process through explanation and implementation of some form of expectation-consistent supervision (providing a framework for understanding supervision and implementing that framework); and (c) the supervisee's participation in facilitative educational actions (where experimenting and refinement beget further experimenting and refinement). The three pathways and supervisory bond are considered to converge in producing two general supervision outcomes: (a) reduction of supervisee anxiety, shame, and self-doubt; and (b) better quality of therapeutic practice (operationalized as therapist skill/competence and identity development). Arrows indicate the proposed primary impacts of the change pathways on supervision outcomes and interactive effects that exist between the outcome variables. Although perhaps being applicable across the entire spectrum of supervisee

development, the CCSM is considered to have most relevance for supervisees during the early period of therapist development. As supervisees acquire increasing conceptual/treatment skills, as their therapist identity increasingly consolidates, and as the supervisor-supervisee relationship acquires an increasingly consultative flavor, the model proposed here may accordingly become decreasingly relevant and explanatory.

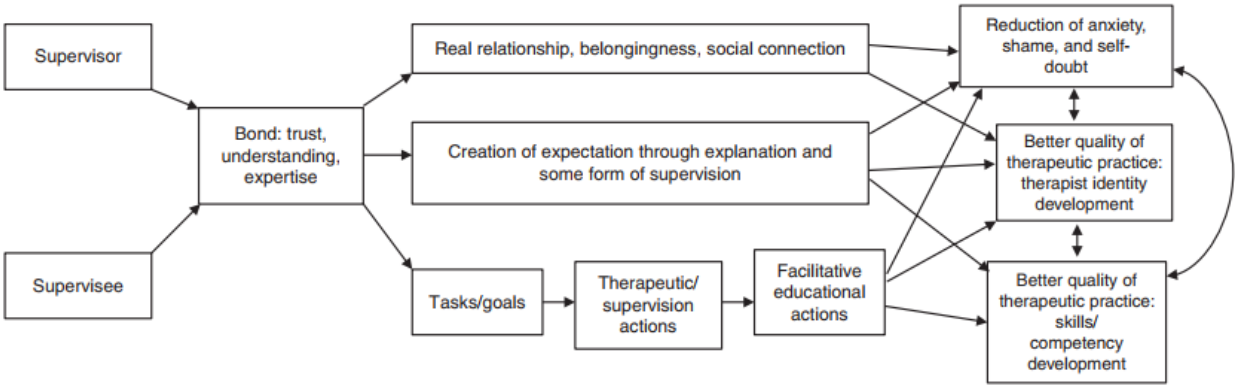

Figure 1. The Relationship in Clinical Supervision (reprinted from Watkins, Budge, & Callahan [2015] with permission of the American Psychological Association).

Expectations matter; they are accentuated in this model. Supervisors (a) provide supervisees with an adaptive educational explanation (e.g., through discussions, informed consent), giving them information about and perspective on how and why supervision works; (b) deliver a form of supervision (or program of educational intervention) that is ideally synchronized with their educational explanation; and (c) engage in an ongoing process of creating and reinforcing supervision expectations through (a) and (b). Supervisee expectations are most critically influenced by a coherent explanation *and* simultaneous supervision tasks (cf. Wampold & Budge, 2012). Each is symbiotically entwined with the other.

A few research questions suggested by the model are these:

- *Supervisory alliance*—Is the alliance bond predictive of the favorable unfolding of each change pathway and consequent supervisee outcomes?
- *Real relationship*—Does the quality of the supervisory real relationship affect therapist identity development?
- *Expectations/form of supervision*—What impact do supervisor and supervisee expectations have upon the supervision process?
- *Facilitative educational actions*—Do supervisee therapeutic/supervision actions, inspired by supervisor action and the specific ingredients, contribute to the development and/or enhancement of supervisee facilitative educational actions?
- *Component/pathway interactions*—What are the interactive effects across all pathways and outcomes? Do the directions of effect indicated in Figure 1 stand up to empirical test?

Such questions focus on why and how supervision works across systems of supervision, and I contend the CCSM is a potentially valuable heuristic perspective that can help in beginning to provide a trans-theoretical answer.

Case study research: Revealing supervision-in-action L. DiAnne Borders

Clinical supervision research and practice could be greatly enhanced by more widespread use of case study designs. Case studies seem a particularly appropriate choice at this point in clinical supervision research because, for the most part, supervision models and research to date have yielded only broad conclusions about the effective practice of supervision (e.g., that the relationship is critical). Lacking is "the kind of knowledge that practitioners need for their actual, day-to-day work with supervisees" (Ladany, Friedlander, & Nelson, 2005, p. 5)—the kind of insights that intentional, sequential, and rigorous case studies can provide. Through detailed, rich case study analyses, researchers can achieve "studies that reveal the intricacies of supervision-in-action" (Borders, 2015, p. 4), studies that, over time, can inform the pedagogy—if not the art—of clinical supervision.

Much like the clinical work supervisors oversee, clinical supervision practice is complex, contextual, nuanced, often subtle, responsive, and interactive. Supervisors must constantly adapt their approaches in light of their supervisees' responses. This is territory where case study research excels because it allows researchers to focus attention *inside the process* to reveal supervisors' *and* supervisees' behaviors, thoughts ("reflection-in-action"; Schön, 1983), and emotions while at work. Such case studies can identify key variables and processes that, with replication, can build and refine supervision knowledge and theory. Case studies also seem apt for a goal of the dialogue about research priorities presented in this article, as, with collaboration and planning, case studies can be conducted simultaneously across disciplines and internationally. Psychotherapy process researchers have illustrated this approach to theory building through systematic case studies of specific therapist techniques (e.g., immediacy), therapy events (e.g., client setbacks), client issues (e.g., social anxiety), and models and theories (assimilation model, person-centered therapy) (see Stiles, Hill, & Elliott, 2015).

Early supervision case studies illustrated the power of this research method. Doehrman's (1976) multiple case study revealed insights regarding parallel processes that still inform supervision practice today. Later, Martin, Goodyear, and Newton (1987) expanded ideas around parallel process by illustrating how a supervisor's experience with one supervisee could affect his behaviors with another supervisee. Unfortunately, such informative case studies have been published less frequently in recent years, yet systematic series of case studies are needed to build reliable, generalizable knowledge. As Martin and colleagues concluded, "it is important to replicate this and all similar case studies: Rich as these data can be, generalizations from them can be made only after replication" (p. 234).

A range of rigorous case study methods and procedures, including single and multiple case studies, are available to address clinical supervision research questions (Stake, 2005). Goals of supervision case studies can be varied, including generating pragmatic best practices knowledge, investigating tenets of a model or theory, discovering meaning in participants' experiences, and

evaluating effectiveness (cf. McLeod, 2010). Case study researchers can collect both quantitative and qualitative data (Yin, 2014); the latter can be analyzed via qualitative methods (e.g., content analysis, phenomenology, consensual qualitative research [CQR; Hill, 2012]). In addition, methods such as Interpersonal Process Recall (IPR; Kagan & Kagan, 1997) can reveal covert thoughts and feelings, and analysis of the spoken word can be accomplished through discourse analysis or conversation analysis (Fairclough, 2015; Stiles et al., 2015) and quantitative coding systems (e.g., Martin et al., 1987). In addition, a number of process measures (and a few outcome measures) are available (Borders & Ellis, 2014), although there are important limitations to consider and measures specific to the supervision context are still sorely needed.

The potential supervision topics to explore through case studies are nearly endless (and include topics proposed throughout this article). Some possibilities include microaggressions, conflict in the relationship, repair of relationship ruptures, transference and countertransference events, specific interventions (e.g., IPR), difficult evaluations, and peer feedback in group supervision. Through replication across a range of supervisors (e.g., beginning to expert), supervisees (e.g., beginning through advanced), modalities (individual and group), disciplines (e.g., social work, counseling, psychology, nursing, art therapy), and international settings, researchers can build a context-specific understanding of supervision processes. Such studies would inform supervision practice as well as supervision education for, as Gazzola, De Stefano, Thériault, and Audet (2013) so aptly stated, we need "an insider's perspective on how supervisors-in-training regularly negotiate the various demands of the supervision context as they learn to be supervisors" if we are to uncover "key learning milestones and mechanisms" (p. 19).

Certainly, other qualitative and quantitative (e.g., sequential analysis approaches, structural equation modeling, and multilevel models for longitudinal data; see Lutz & Hill, 2009; Stiles et al., 2015) methods also can contribute to our understanding of the actual conduct of supervision. But case studies are an important complement to them. For example, in an extensive qualitative study, Grant and colleagues (2012) concluded their expert supervisors used confrontation to address difficulties when relational and reflective methods were unsuccessful. A case study researcher could document that sequence and might ask, "How did these supervisors make the decision to use confrontation? What did they actually say? What emotions did they experience and how did they manage them? What were the sequential behaviors across the experts, and how did they vary by supervisee or by type of difficulty? Which were effective? What model of confrontation in supervision is suggested by these results?" Answers to these and other questions get inside and underneath the actual practice of supervision.

Just as certainly, there are hurdles to achieving systematic case studies across researchers, disciplines, and countries, such as reaching consensus on the research questions, variables and how they will be measured, and participant characteristics. This is no easy task, as even well-supported variables, such as the supervisory relationship, have been operationalized in a number of ways (Tangen & Borders, in press). If such consensus can be achieved, however, case studies offer one promising avenue for this important research goal.

Never mind the quality. . . . Feel the width: Why are there so few clinical supervision outcome studies? Edward White

A growing international research literature has accumulated, particularly over the past two decades, to show that clinical supervision has a demonstrable and positive effect on supervisees (Butterworth, Carson, Jeacock, White, & Clements, 1999). Comparatively little research has entered the public domain, however, on the effect that clinical supervision may have on patient outcomes, the so-called "acid test of good clinical supervision" (Ellis & Ladany, 1997), recently elaborated by Reiser and Milne (2014). With rare and seminal exceptions (see, for example, Kadushin, 1974; Friedlander & Ward, 1984; Shulman, 1981), the clinical supervision research literature thus far has been contained to reports of small-scale qualitative studies (Cross, Moore, Sampson, Kitch, & Ockerby, 2012), or undemanding quantitative studies (Hancox, Lynch, Happell, & Biondo, 2004), and/or those judged to be methodologically weak/flawed (Altman, 1994; Cape & Barkham, 2002; Ellis, Krengel, Ladany, & Schult, 1996; Bernard & Goodyear, 2014).

One reason so much clinical supervision research has tended to rest at the level of description, rather than elevated to the level of possible explanation, has been because large-scale clinical supervision outcomes studies have remained difficult to design, conduct, interpret, and disseminate—and difficult to fund (White & Winstanley, 2011). Such difficulties have been compounded by the dearth of scales with established international psychometric properties (Winstanley & White, 2010) and by other barriers not usually found in standard methodological texts. In combination, these hurdles may help to explain why the clinical supervision literature has become replete with documentary review articles, each of which have tended to lament the absence of creditable primary evidence, upon which the practice of clinical supervision can be confidently based (Butterworth, Bell, Jackson, & Pajnkihar, 2008). In contemporary supervision practice, therefore, it appears that less attention has been given over to priority matters of demonstrable efficacy (*quality*) in favor of, say, keeping records of occurrence and frequency of staff attendance at clinical supervision sessions (*width*).

Any attempt to deliver primary evidence will usually behoove an investigator to develop a robust funding proposal, designed to satisfy the conventional scientific requirements and be realistically possible to conduct. Such a proposal may be strengthened if the funding agency finds it to be relevant, outcomes-orientated, collaborative, interdisciplinary, strengthened by linkages at local and international levels, and around agreed priority areas of investigation. Where possible, a sympathetic set of relationships should be articulated between the importance of the clinical issue, an operational definition, a conceptual model, and a dedicated research instrument (Winstanley & White, 2014). Pragmatic trials, which can be conducted under conditions very similar to the usual care setting, may be preferred over explanatory trials, undertaken under ideal conditions to maximize success (Oxman et al., 2009).

In a systematic review of 18 outcome studies published since 1980, Wheeler and Richards (2007) conceded that, although supervision had consistently demonstrated to have some positive impacts on the supervisee, the link to improved outcome for clients was tentative and no studies in their review offered substantial evidence to support improvement in client outcomes. These findings echoed an earlier caution (Wampold & Holloway, 1997) that detection of a relation between supervision process and the patient's rating of patient change (the most distal outcome)

“would be expected to be extremely small” (p. 23). Indeed, in a recent naturalistic study, Rousmaniere and colleagues (2014) found supervisors explained less than 1% of the variance in client psychotherapy outcomes. Possible reasons for this result were discussed and, it was argued, future research on this topic would benefit from controlling for the many variables that may moderate supervisors' effects on client outcome at the levels of supervisor, supervisee, and client/patient (say, the supervisory working alliance and the influence of peers in group supervision).

Proposals that require repeated measures in a longitudinal design, where the same *individuals* are targeted at different points in time, may become vulnerable to respondent attrition and carry other attendant risks (e.g., respondent illness, holidays, job changes, secondments, absenteeism, retirements, resignations, organizational restructures). Although not without limitation, these features may be mitigated by cross-sectional designs, in which the same *variables* are tracked over time. In either event, the absence of evidence is not evidence of absence (an adage attributed to the late Carl Sagan; American astronomer, writer, and scientist). Randomized controlled trials, for example, that do not show a significant difference are often called “negative.” This term wrongly implies that a study had shown there was no difference, whereas usually all that was shown was an absence of evidence of a difference (Altman & Bland, 1995).

The stepwise development of all research proposals should give explicit consideration to address any cultural dimension (particularly indigenous conventions), and researcher roles and boundaries should be unambiguous. The gatekeeping role of a Human Research Ethics Committee (HREC) may involve arduous processes, including referral for external legal opinion; if so, these consume lead-in time so that a contingency should be factored in.

The practical conduct of any clinical supervision outcomes study may also face unexpected random events and other methodological challenges, particularly at the point of recruitment of prospective respondents. These may include, but are not limited to, a disconnect between the enthusiastic commitment to clinical supervision by senior managers in human service agencies, who are often the commissioners of such studies, and the parsimonious commitment of middle managers and their staff (White & Winstanley, 2009). That prospect may be offset by ensuring from the outset that *all* levels of management, whether within an entire organization or in a discrete administrative unit, publicly share the same positive position toward the clinical supervision research enterprise and actively support prospective study respondents to participate. Such a demonstrable commitment may emerge if the selection of a study location followed a competitive tender process (Butterworth, Bishop, & Carson, 1996). The payment of a stipend to an organization, to offset local cost consequences of an investigation, may also encourage participation and should be built into the research budget.

In multi-center clinical supervision research endeavors, some agencies may declare a preference to enter an intervention arm of a randomized controlled trial (RCT) and have a reluctance to be randomized to a control arm (in case a measurable benefit accrued in the former). In that event, they may agree to be randomized to the control arm of an RCT, if an undertaking is given by the researcher to offer the same intervention feature (given that a demonstrable benefit emerged) at the end of the trial. However, this would be an unlikely strategy for some professions in some

countries (e.g., the United States and Canada), where mandatory supervision ended at licensure and allocation to a *no supervision* control arm would be ethically unacceptable (see Goodyear & Guzzardo, 2000), as it would run counter to an obligation to protect patients/clients. In a related vein, Gonsalvez and Milne (2010) noted the observation of critics that untrained supervisors who provide supervision may be practicing outside the limits of their training and competencies, which would (potentially) place them in breach of the profession's ethical convention. Given that the extent of supervisory responsibility was ethically and morally unclear (King & Wheeler 1999), this has been termed (as recently as two decades ago) as "psychology's dirty little secret" (Hoffman, 1994, p. 25). In professions and countries where *post*-registration supervision is mandatory (e.g., psychologists in Australia), the recruitment of experienced psychologists who are already qualified for independent practice may offer a workable ethical solution (Bambling, King, Patrick, Schweitzer, & Lambert, 2006) for research purposes. For other professions in some countries, where clinical supervision is *not* a mandatory requirement (say, nursing in the United Kingdom), green field clinical supervision research sites may still be found (White & Winstanley, 2009), where *no supervision* is undertaken, and may be suitable for allocation to the control arm of an RCT.

Even when permission to access staff in a helping agency has been formally granted and respondent entry criteria have been made explicit, it may not be unusual for researchers to encounter reluctance among staff to participate in such research ventures (e.g., pressured working conditions, low morale, demotivation, and an awareness of an increasingly litigious work/research environment). Investigators should also be mindful of possible *questionnaire-completion fatigue* among staff in frequently researched settings and, if necessary, explore the issue of non-response as a function of the size and complexity of the organization (White & Brooker, 2001). These practical impediments may be revealed or obviated by early researcher-led briefing meetings with key individuals or groups at the proposed site of the investigation.

The confidentiality of individual/agency respondents can usually, although not always, be guaranteed by anonymity. For example, if a complaint is raised by a respondent during the conduct of, for example, a multi-site study, the downside of the otherwise welcome single portal entry for HREC approval may then mean a temporary suspension of data collection in *all*participant centers until the complaint has been satisfactorily resolved. The review process may delay timelines, sometimes to a significant extent.

Works that offer an interpretation of the historical development of clinical supervision are not infrequently contested (White & Winstanley, 2014) and the political context within which investigations are attempted are rarely value-free. There may also be legal embargoes to protect some relevant documents (e.g., the so-called Thirty-Year Rule in the United Kingdom and the Government Information [Public Access] Act 2009 in Australia). Final research reports may be withheld by a commissioning agency from public access, until and unless apparently sensitive material has been airbrushed, or for other hollow reasons. Where it can be reasoned that *no overriding public interest against disclosure* exists, an application for access to such research reports can be pursued under Freedom of Information legislation in many countries. A recent Australian example involved a contested six-month process before a clinical supervision research

report was released (http://www.heti.nsw.gov.au/about/public-access/heti-disclosure-log). The revelation has since allowed a community of bona fide interested parties to critically review (and form a view about) the relative strength of the research, which was later used to credential a clinical supervision publication (Health Education and Training Institute, 2014).

Substantial edits of successive draft-commissioned research reports are not uncommon, particularly if the findings run counter to the policy imperative at the time. On occasion, the final installment of a staged program of payments may be held back until the commissioner has approved the revised document and signed off on the research contract (White, 2004). Similarly, given the prevalent *publish or perish* convention in academe, investigators may find that, in some journals, eventual publication of their research may become subject to ulterior drivers (Horton, 2015), and/or to the pedantry of methodologically partisan reviewers. Yet other journals are overly prescriptive and may require manuscripts to be considerably massaged to meet their house styles. Some journals rarely publish international material, occasionally less than 2% (Dougherty, Lin, McKenna, & Seers, 2004). These features may assume an increasing importance, as clinical supervision outcomes research studies become finessed and dissemination of generalizable findings attempt to enter the public domain, with the goal of broadening an international scholarly discourse.

After the funding proposal has been written, the grant has been secured, all the access permissions have been approved, the logistics have been mastered, the random events have been accommodated, recruitment has been satisfactory, confidentiality has been maintained, roles and boundaries have remained intact, any complaint has been dealt with, and reporting and dissemination issues have been reconciled, arguably the most important stage in the research process can then ensue—the translation of findings into working practices (and, thereafter, continuously reviewed). Watkins (2011) recently identified three studies, two conducted in Australia (Bambling et al., 2006; White & Winstanley, 2010), and one in the United Kingdom (Bradshaw, Butterworth, & Mairs, 2007), that provided “the best and clearest directions for further thought about conducting future successful research in the supervision-patient outcome area” (p. 251). Future attempts should acknowledge that such investigations always will involve the study of unique human beings, operating in complex social systems. All real-life social research, therefore, is a trade-off between the substantively necessary, the methodologically convincing, the ethically defensible, the financially affordable, the practically doable, and the politically acceptable. Researchers who successfully navigate a pathway through all of these considerations may then be well placed to articulate new theoretical propositions and to test them in future research studies, to try to make incremental headway out of the “swampy lowlands” (Schön, 1983, p. 42). The design capabilities of contemporary studies are now afforded the use of bona fide clinical supervision research instruments, with established psychometric properties, to gather real data. Furthermore, an additional option also now exists for these data to be analyzed by new software, designed to tap into preexisting mathematical models (Breiman, Friedman, Olshen, & Stone, 1984), to maximize the efficacy of clinical supervision arrangements at a local level (Winstanley & White, 2014; White & Winstanley, 2014), and to measure and report their impact on nominated outcomes.

Concluding comments

Although it was not planned in advance that this would be the case, the eight sections of this article seem to comprise four clusters, each with two contributions. The first cluster concerned research on multicultural identities, with each of the two sections usefully complementing the other. The second cluster was about expertise, with one contribution arguing for expertise as a framework to guide our work with trainees and the other speaking to the importance of knowing more about what expert supervisors do and how they think. The third cluster was about supervision models that scholars and practitioners alike might explore; the first of those concerned with a constructivist position and the second with a contextual model. The fourth and last cluster concerned methods, with the first arguing the merits of using case study approaches and the second addressing some of the challenges to conducting research that examines supervision's contribution to client outcomes.

We were interested to find that Beddoe, Karvinen-Niinikosi, Ruch, and Tsui (2015) asked similar questions about research priorities of an international sample of social workers. Although some responses seemed specific to social work (e.g., “the relationship of supervision to the impacts of neo-liberalism on social work”), others (e.g., attachment processes in supervisory and clinical relationships; diversity-race, ethnicity and cross-cultural issues, learning more about supervision processes) were more consistent with the focus of our multidisciplinary group. What our article has added that Beddoe and colleagues did not was a more elaborated coverage of each of the topics, citing foundational literature and suggested next steps. Nevertheless, a more systematic approach, such as Beddoe and colleagues' Delphi study, would be an appropriate next step to build on our efforts and could reveal similar and different priorities across disciplines and countries, perhaps further encouraging interdisciplinary and cross-national research.

As we stated at in our introduction, these suggested supervision research priorities are not necessarily those that other supervision researchers would prioritize, including those from unrepresented countries and disciplines. And these research priorities certainly are not exhaustive of the possibilities. It is our hope, though, that they will stimulate reactions, which might range from an argument for different or additional priorities, or perhaps elaborations or critiques of what we have written. Either way, we will have considered this work to be successful.

References

1. Altman, D. (1994). The scandal of poor medical research. British Medical Journal, 308, 283–284.
2. Altman, D., & Bland, M. (1995). Absence of evidence is not evidence of absence. British Medical Journal, 311, 485.
3. American Board of Examiners in Clinical Social Work. (2004, October). Clinical supervision: A practice specialty of clinical social work. Salem, MA: Author.
4. American Counseling Association. (2010). Licensure requirements for professional counselors: A state-by-state report. Alexandria, VA: Author.

5. American Psychological Association. (2006). Guidelines and principles for accreditation of programs in professional psychology. Retrieved from http://www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf.

6. American Psychological Association. (2015). Guidelines for clinical supervision in health service psychology. The American Psychologist, 70(1), 33–46. 10.1037/a0038112.

7. Ancis, J., & Ladany, N. (2010). A multicultural framework for counselor supervision: Knowledge and skills. In N. Ladany & L. Bradley (Eds.), Counselor supervision (4th ed., pp. 53–95). New York, NY:Routledge.

8. Anderson, T., Crowley, M. E. J., Himawan, L., Holmberg, K., & Uhlin, B. D. (2015). Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome. Psychotherapy Research. Advance online publication. doi: 10.1080/10503307.2015.1049671.

9. Araneda, M. E. (2015). Group supervision in mental health counseling training: Experiences of supervisors and their supervisees (Unpublished doctoral dissertation). University of Rochester,Rochester, New York.

10. Aten, J. D., Boyer, M. C., & Tucker, B. T. (2007). Christian integration in clinical supervision: A conceptual framework. Journal of Psychology and Christianity, 26, 313–320.

11. Avery, E. M. H. (2015). Valuing experience: Assessing constructivist approaches to counselor supervision *(Unpublished doctoral dissertation)*. University of Rochester, Rochester, New York.

12. Bambling, M., King, R., Patrick, R., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. Psychotherapy Research, 16, 317–331.

13. Barnes, R. R. (2011). Racial microaggressions, racial identity, and working alliance in cross-racial counseling supervision relationships between Black supervisors and White supervisees *(Unpublished doctoral dissertation)*. The University of North Carolina at Greensboro, Greensboro, NC.

14. Beddoe, L., Karvinen-Niinikosi, S., Ruch, G., & Tsui, M. (2015). Towards an international consensus on a research agenda for social work supervision: Report on the first survey of a Delphi study. British Journal of Social Work. *45*. Advance online publication.

15. Bernard, J. M., & Goodyear, R. K. (2014). Fundamentals of clinical supervision (5th ed.). Boston, MA:Merrill.

16. Bhat, C. S., & Davis, T. E. (2007). Counseling supervisors' assessment of race, racial identity, and working alliance in supervisory dyads. Journal of Multicultural Counseling & Development, 35, 80–91. Retrieved from http://search.ebscohost.com.libproxy.albany.edu/login.aspx?direct = true&db = a9h&AN = 4752076&site = ehost-live.

17. Borders, L. D. (2009). Subtle messages in clinical supervision. The Clinical Supervisor, 28, 200–209.10.1080/07325220903324694.

18. Borders, L. D. (2014). “Best practices in clinical supervision”: Another step in delineating effective supervision practice. American Journal of Psychotherapy, 68, 151–162.

19. Borders, L. D. (2015). A call for breadth and depth around the science and art of clinical supervision: Inaugural editorial. The Clinical Supervisor, 34, 1–6.

20. Borders, L. D., & Ellis, M. V. (2014, June). Nuts and bolts of supervision process research: How can I get my study done?. Paper presented at the Tenth International Interdisciplinary Conference on Clinical Supervision, Garden City, NY.

21. Borders, L., & Fong, M. L. (1994). Cognitions of supervisors-in-training: An exploratory study. Counselor Education and Supervision, 33, 280–293.

22. Borders, L. D., Glosoff, H. L., Welfare, L. E., Hays, D. G., DeKruyf, L., Fernando, D. M., & Page, B. (2014).Best practices in clinical supervision: Evolution of a counseling specialty. The Clinical Supervisor, 33,26–44.

23. Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. Psychotherapy Research, 25, 6–19.

24. Bradshaw, T., Butterworth, T., & Mairs, H. (2007). Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? Journal of Psychiatric and Mental Health Nursing, 14(1), 4–12.

25. Breiman, L., Friedman, J., Olshen, R., & Stone, C. (1984). Classification and regression trees. Belmont, CA: Wadsworth.

26. British Psychological Society. (2003). Policy guidelines on supervision in the practice of clinical psychology. Leicester, England: Author.

27. Budge, S. L., Owen, J. J., Kopta, S. M., Minami, T., Hansen, M. R., & Hirsch, G. (2013). Differences among trainees in client outcomes associated with the phase model of change. Psychotherapy, 50, 150–157.

28. Burkard, A., Johnson, A. J., Madson, M. B., Pruitt, N., Contreras-Tadych, D. A., Kozlowski, J. M., … Knox,S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. Journal of Counseling Psychology, 53, 288–301. 10.1037/0022-0167.53.3.288.

29. Burkard, A. W., Knox, S., Clarke, R. D., Phelps, D. L., & Inman, A. G. (2014). Supervisors' experiences of providing difficult feedback in cross-ethnic/racial supervision. The Counseling Psychologist, 42(3),314–344. 10.1177/0011000012461157.

30. Burkard, A., Knox, S., Hess, S. A., & Schultz, J. (2009). Lesbian, gay, and bisexual supervisees' experience of LGB-affirmative and nonaffirmative supervision. Journal of Counseling Psychology, 56,176–188. 10.1037/0022-0167.56.1.176.

31. Butterworth, T., Bell, L., Jackson, C., & Pajnkihar, M. (2008). Wicked spell or magic bullet? A review of the clinical supervision literature 2001–2007. Nurse Education Today, 28, 264–272.

32. Butterworth, T., Bishop, V., & Carson, J. (1996). First steps towards evaluating clinical supervision in nursing and health visiting. 1. Theory, policy and practice development. A review. Journal of Clinical Nursing, 5, 127–132.

33. Butterworth, T., Carson, J., Jeacock, J., White, E., & Clements, A. (1999). Stress, coping, burnout and job satisfaction: Findings from the clinical supervision evaluation project. Stress Medicine, 15, 27–33.

34. Cape, J., & Barkham, M. (2002). Practice improvement methods: Conceptual base, evidence-based research, and practice-based recommendations. The British Journal of Clinical Psychology, 41, 285–307.

35. Chang, C. Y., & Flowers, L. R. (2009). Multicultural supervision competence. In L. L. Brown & J. R. Culbreth (Eds.), State of the art in clinical supervision (pp. 1–18). New York, NY: Routledge.

36. Chang, C. Y., Hays, D. G., & Shoffner, M. F. (2003). Cross-racial supervision: A developmental approach for White supervisors working with supervisees of color. The Clinical Supervisor, 22(2), 121–138.

37. Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. Psychotherapy, 52, 337–345.

38. Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among Black supervisees in cross-racial dyads. Journal of Counseling Psychology, 54, 142–153. 10.1037/0022-0167.54.2.142.

39. Constantine, M. G., Warren, A. K., & Miville, M. L. (2005). White racial identity dyadic interactions in supervision: Implications for supervisees' multicultural counseling competence. Journal of Counseling Psychology, 52, 490–496. 10.1037/00220167.52.4.490.

40. Council for Accreditation of Counseling and Related Educational Programs. (1988). 1988 CACREP accreditation manual and application. Alexandria, VA: Author.

41. Crespi, T. D., & Lopez, P. G. (1998). Practicum and internship supervision in the schools: Standards and considerations for school psychology supervisors. The Clinical Supervisor, 17(2), 113–126.

42. Crocket, K., Pentecost, M., Cresswell, R., Paice, C., Tollestrup, D., de Vries, M., & Wolfe, R. (2009).Informing supervision practice through research: A narrative inquiry. Counselling and Psychotherapy Research, 9, 101–107.

43. Cross, W., Moore, A., Sampson, T., Kitch, C., & Ockerby, C. (2012). Implementing clinical supervision for ICU outreach nurses: A case study of their journey. Australian Critical Care, 25, 263–270.

44. Cutliffe, J., & Sloan, G. (2014). Towards a consensus of a competency framework for clinical supervision in nursing: Knowledge, attitudes, and skills. The Clinical Supervisor, 33, 182–203.

45. D'Andrea, M. (2000). Postmodernism, constructivism, and multiculturalism: Three forces reshaping and expanding our thoughts about counseling. Journal of Mental Health Counseling, 22, 1–16.

46. Descartes, R. (1637). Discourse on the method of rightly conducting the reason, and seeking truth in the sciences. Retrieved from http://www.gutenberg.org/files/59/59-h/59-h.htm.

47. Dewey, J. (1933). How we think: A restatement of the relation of reflective thinking to the educational process. Lexington, MA: Heath.

48. Doehrman M. (1976). Parallel processes in supervision and psychotherapy. Bulletin of the Menninger Clinic, 40, 3–104.

49. Dougherty, M., Lin, S-Y., McKenna, H., & Seers, K. (2004). International content of high ranking nursing journals in the year 2000. Journal of Nursing Scholarship, 36, 173–179.

50. Elliott, D. M., & Briere, J. (1992). Sexual abuse trauma among professional women: Validating the Trauma Symptom Checklist-40 (TSC-40). Child Abuse and Neglect, 16, 391–398.

51. Ellis, M., Krengel, M., Ladany, N., & Schult, D. (1996). Clinical supervision research from 1981 to 1993: A methodological critique. Journal of Counseling Psychology, 43, 35–50.

52. Ellis, M., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins, Jr. (Ed.), The handbook of psychotherapy supervision (pp. 447–507). Chichester, UK: Wiley.

53. Ericsson, K. A. (2006). The influence of experience and deliberate practice on the development of superior expert performance. In K. A. Ericsson, N. Charness, P. J. Feltovich, & R. R. Hoffman (Eds.), The Cambridge handbook of expertise and expert performance (pp. 683–703). Cambridge, England:Cambridge University Press. 10.1017/CBO9780511816796.038.

54. Ericsson, K. A. (2009). Enhancing the development of professional performance: Implications from the study of deliberate practice. In K. A. Ericsson (Ed.), Development of professional expertise: Toward measurement of expert performance and design of optimal learning environments (pp. 405–431).New York, NY: Cambridge University Press.

55. Eubanks Higgins, S., McCarthy-Veach, P., McFarlane, I. M., Borders, L. D., LeRoy, B., & Callanan, N.(2013). Knowledge, characteristics, and skills of effective clinical supervisors in genetic counseling. Journal of Genetic Counseling, 22, 39–57.

56. Fairclough, N. (2015). Language and power (3rd ed.). London, England: Routledge.

57. Falender, C. A., Burnes, T. R., & Ellis, M. V. (2013). Multicultural clinical supervision and benchmarks: Empirical support informing practice and supervisor training. The Counseling Psychologist, 41, 1–20.10.1177/0011000012438417.

58. Fouad, N. A., & Grus, C. L. (2014). Competency-based education and training in professional psychology. In W. B. Johnson & N. Kaslow (Eds.), The Oxford handbook of education and training in professional psychology (pp. 105–119). Oxford University Press.

59. Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., … Crossman, R. E.(2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. Training and Education in Professional Psychology, 3(4, Suppl), S5–S26.

60. Friedlander, M., & Ward, L. (1984). Development and validation of the Supervisory Styles Inventory. Journal of Counseling Psychology, 31, 541–557.

61. Fukuyama, M. A. (1994). Critical incidents in multicultural supervision: A phenomenological approach to supervision research. Counselor Education and Supervision, 34, 142–151. 10.1002/j.1556-6978.1994.tb00321.x.

62. Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., & Rodolfa, E. (2001).Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter? Journal of Multicultural Counseling and Development, 29, 102–113. 10.1002/j.2161-1912.2001.tb00508.x.

63. Gazzola, N., De Stefano, J., Thériault, A., & Audet, C. T. (2013). Learning to be supervisors: A qualitative investigation of difficulties experienced by supervisors-in-training. The Clinical Supervisor, 32, 15–39.

64. Gilliam, T. H., & Armstrong, S. A. (2012). Spirituality and counseling supervision: Current practices of board-approved supervisors. The Clinical Supervisor, 31, 25–41. 10.1080/07325223.2012.671718.

65. Glaser, R. (1985). The nature of expertise (Occasional Paper No. 107). Columbus, OH: National Center for Research in Vocational Education. Retrieved from ERIC database. (ED261190).

66. Glaser, R., & Chi, M. T. H. (1988). Overview. In M. T. H. Chi, R. Glaser, & M. J. Farr (Eds.), The nature of expertise (pp. xv–xxviii). Hillsdale, NJ: Lawrence Erlbaum.

67. Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E.(2016). Do psychotherapists improve with time and experience? A

longitudinal analysis of outcomes in a clinical setting. Journal of Counseling Psychology, 63, 1–11.

68. Gonsalvez, C. J., & Milne, D. L. (2010). Clinical supervisor training in Australia: A review of current problems and possible solutions. Australian Psychologist, 45, 233–242.

69. Goode-Cross, D. T. (2011). “Those who learn have a responsibility to teach”: Black therapists' experiences supervising Black therapist trainees. Training and Education in Professional Psychology, 5, 73–80. 10.1037/a0023187.

70. Goodyear, R. K. (1997). Psychological expertise and the role of individual differences: An exploration of issues. Educational Psychology Review, 9, 251–265.

71. Goodyear, R. K. (2014). Supervision as pedagogy: Attending to its essential instructional and learning processes. The Clinical Supervisor, 33, 82–99.

72. Goodyear, R. K. (2015). Using accountability mechanisms more intentionally: A framework and its implications for training professional psychologists. American Psychologist, 70, 736–743.

73. Goodyear, R., & Guzzardo, C. (2000). Psychotherapy supervision and training. In S. Brown & R. Lent(Eds.), Handbook of counseling psychology (3rd ed., pp. 83–108). New York, NY: Wiley.

74. Grant, J., Schofield, M. J., & Crawford, S. (2012). Managing difficulties in supervision: Supervisors' perspectives. Journal of Counseling Psychology, 59, 528–541.

75. Green, M. S., & Dekkers, T. D. (2010). Attending to power and diversity in supervision: An exploration of supervisee learning outcomes and satisfaction with supervision. Journal of Feminist Family Therapy, 22, 293–312. 10.1080/08952833.2010.528703.

76. Grollman, E. A. (2014). Multiple disadvantaged statuses and health: The role of multiple forms of discrimination. Social Disadvantages and Health Disparities, 55(1), 3–19. 10.1177/0022146514521215.

77. Gubi, P. (2007). Exploring the supervision experience of some mainstream counsellors who integrate prayer in counselling. Counselling & Psychotherapy Research, 7, 114–121.10.1080/14733140701342544.

78. Guiffrida, D. A. (2015). Constructive clinical supervision in counseling and psychotherapy. New York, NY: Routledge.

79. Hancox, K., Lynch, L., Happell, B., & Biondo, S. (2004). An evaluation of an educational program for clinical supervision. International Journal of Mental Health Nursing, 13, 198–203.

80. Hanks, B. B., & Hill, N. R. (2015). Relational dynamics within the context of deafness: A case study of the supervision triad. Journal of Counseling & Development, 93, 299–311. 10.1002/jcad.12028.

81. Hansen, J. (2010). Consequences of the postmodernist vision: Diversity as the guiding value for the counseling profession. Journal of Counseling & Development, 88, 101–107.

82. Hathaway, A. P. (2012). Experiences of supervisors and supervisees utilizing a constructivist approach to supervision in community mental health settings *(Unpublished doctoral dissertation).* University of Rochester, Rochester, New York.

83. Hays, D. G., & Chang, C. Y. (2003). White privilege, oppression, and racial identity development: Implications for supervision. Counselor Education and Supervision, 43, 134–145.

84. Health Education and Training Institute. (2014). The Superguide: A supervision continuum for nurses and midwives. Sydney, Australia: Author.

85. Helms, J. E., Nicolas, G., & Green, C. E. (2012). Racism and ethnoviolence as trauma: Enhancing professional and research training. Traumatology, 18, 65–74. 10.1177/1534765610396728.

86. Hess, A. K. (1986). Growth in supervision: Stages of supervisee and supervisor development. The Clinical Supervisor, 4(1/2), 51–67.

87. Hicks, M. W., & Cornille, T. A. (1999). Gender, power, and relationship ethics in family therapy education. Contemporary Family Therapy, 21(1), 45–56.

88. Hill, C. E. (Ed.). (2012). Consensual qualitative research: A practical resource for investigating social science phenomena. Washington, DC: American Psychological Association.

89. Hird, J. S., Tao, K. W., & Gloria, A. M. (2004). Examining supervisors' multicultural competence in racially similar and different supervision dyads. The Clinical Supervisor, 23, 107–123.10.1300/J001v23n02_07.

90. Hoffman, L. (1994). The training of psychotherapy supervisors: A barren scape. Psychotherapy in Private Practice, 13(1), 23–42.

91. Hoffman, M. A., Hill, C. E., Holmes, S. E., & Freitas, G. F. (2005). Supervisor perspective on the process and outcome of giving easy, difficult, or no feedback to supervisees. Journal of Counseling Psychology, 52(1), 3–13. 10.1037/0022-0167.52.1.3.

92. Horton, R. (2015). Offline: What is medicine's 5 sigma? The Lancet, 385, 1380.

93. Inman, A. G., Hutman, H., Pendse, A., Devdas, L., Luu, L., & Ellis, M. V. (2014). Current trends concerning supervisors, supervisees, and clients in clinical supervision. In C. E. Watkins, Jr. & D. Milne(Eds.), Wiley international handbook of clinical supervision (pp. 61–102). Oxford, UK: Wiley.

94. Kadushin, A. (1974). Supervisee-supervisor. Social Work, 19, 288–297.

95. Kagan, H., & Kagan, N. I. (1997). Interpersonal process recall: Influencing human interaction. In C. E. Watkins, Jr. (Ed.), Handbook of psychotherapy supervision (pp. 296–309). New York, NY: Wiley.

96. Kelly, G. A. (1955). The psychology of personal constructs. New York, NY: Norton.

97. Kemer, G., Borders, L. D., & Willse, J. T. (2014). Cognitions of expert counseling supervisors in academe: A concept mapping approach. Counselor Education and Supervision, 53, 2–18.

98. Kemer, G., Borders, L. D., & Yel, N. (2015). Expert clinical supervisors' priorities when working with easy and challenging supervisees. Manuscript under review.

99. King, D., & Wheeler, S. (1999). The responsibilities of counsellor supervisors: A qualitative study. British Journal of Guidance and Counselling, 27, 215–229.

100. Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. PLOS Medicine, 5(2), e45. Retrieved from http://journals.plos.org/plosmedicine/article?id = 10.1371/journal.pmed.0050045.

101. Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). Critical events in psychotherapy supervision: An interpersonal approach. Washington, DC: American Psychological Association.

102. Ladany, N., Brittan-Powell, C. S., & Pannu, R. K. (1997). The influence of supervisory racial identity interaction and racial matching on the supervisory working alliance and supervisee multicultural competence. Counselor Education and Supervision, 36, 284–304. 10.1002/j.1556-6978.1997.tb00396.x.

103. Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. Journal of Counseling Psychology, 43, 10–24. 10.1037/0022-0167.43.1.10.

104. Lambert, M. J. (2015). Progress feedback and the OQ-system: The past and the future. Psychotherapy, 52, 381–390.

105. Lerner, J., & Tetlock, P. E. (2001). The impact of accountability on cognitive bias: Bridging individual, interpersonal, and institutional approaches to judgment and choice. In S. Schneider & J. Shanteau(Eds.), Emerging perspectives in judgment and decision-making (pp. 431–457). New York, NY:Cambridge University Press.

106. Levant, R. F. (2004). The empirically validated treatments movement: A practitioner/educator perspective. Clinical Psychology: Science and Practice, 11, 219–224.

107. Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. The Counseling Psychologist, 10(1), 3–42.

108. Luke, M. M., Ellis, M. V., & Bernard, J. M. (2011). School counselor supervisors' perceptions of the discrimination model of supervision. Counselor Education and Supervision, 50, 328–343.

109. Lutz, W., & Hill, C. E. (2009). Quantitative and qualitative methods for psychotherapy research: Introduction to special section. Psychotherapy Research, 19, 369–373.

110. Mahoney, M. J. (2006). Constructive psychotherapy: Theory and practice. New York, NY: Guilford.

111. Martin, J. S., Goodyear, R. K., & Newton, F. B. (1987). Clinical supervision: An intensive case study. Professional Psychology, 18, 225–235.

112. McLeod, J. (2010). Case study research in counselling and psychotherapy. London, UK: Sage.

113. Messinger, L. (2007). Supervision of lesbian, gay, and bisexual social work students by heterosexual field instructors: A qualitative dyad analysis. The Clinical Supervisor, 26, 195–222.10.1300/J001v26n01.13.

114. Miller, M., & Ivey, D. (2006). Spirituality, gender, and supervisory style in supervision. Contemporary Family Therapy: An International Journal, 28, 323–337. 10.1007/s10591-006-9012-0.

115. Miller, S. D., Hubble, M. A., Chow, D., & Seidel, J. (2015). Beyond measures and monitoring: Realizing the potential of feedback-informed treatment. Psychotherapy, 52, 449–457.

116. Mori, Y., Inman, A. G., & Caskie, G. I. L. (2009). Supervising international students: Relationship between acculturation, supervisor multicultural competence, cultural discussions, and supervision satisfaction. Training and Education in Professional Psychology, 3, 10–18. 10.1037/a0013072.

117. National Association of Social Workers and Association of Social Work Boards. (2013). Best practice standards in social work supervision. Retrieved from http://www.socialworkers.org/practice/naswstandards/supervisionstandards2013.pdf.

118. Neimeyer, R. A. (1995). An invitation to constructivist psychotherapies. In R. A. Neimeyer & M. J. Mahoney (Eds.), Constructivism in psychotherapy (pp. 1–10). Washington, DC: American Psychological Association.

119. Neimeyer, R. A., Woodward, M., Pickover, A., & Smigelsky, M. (2016). Questioning our questions: A constructivist technique for clinical supervision. Journal of Constructivist Psychology, 29, 100–111.

120. Nelson, M., Barnes, K. L., Evans, A. L., & Triggiano, P. J. (2008). Working with conflict in clinical supervision: Wise supervisors' perspectives. Journal of Counseling Psychology, 55, 172–184.

121. Neufeldt, S. A. (2007). Supervision strategies for the first practicum (3rd ed.). Alexandria, VA: American Counseling Association.

122. New Zealand Psychologists Board. (2010). Continuing competence programme for psychologists practising in Aotearoa New Zealand. Wellington, NZ: Author. Retrieved from http://www.psychologistsboard.org.nz/cms_show_download.php?id = 395.

123. Ng, K. M., & Smith, S. D. (2012). Training level, acculturation, role ambiguity, and multicultural discussions in training and supervising international counseling students in the United States. International Journal for the Advancement of Counselling, 34, 72–86. 10.1007/s10447-011-9130-8.

124. Nicholas, H., & Goodyear, R. K. (2015, August). When credentialed psychologists are supervisees: Reports from a British sample. Poster presented at the annual meeting of the American Psychological Association, Toronto, Canada.

125. Nilsson, J. E. (2007). International students in supervision: Course self-efficacy, stress, and cultural discussions in supervision. The Clinical Supervisor, 26, 35–47. 10.1300/J001v26n01_04.

126. Nilsson, J. E., & Dodds, A. K. (2006). A pilot phase in the development of the International Student Supervision Scale. Journal of Multicultural Counseling & Development, 34, 50–62. 10.1002/j.2161-1912.2006.tb00026.x.

127. O'Hara, C. (2014). The relationships among the experiences of racial microaggressions in supervision, traumatic experiences, and the supervisory working alliance in professional counselors, and counselors in training. (Doctoral dissertation). Georgia State University, Atlanta, Georgia. Retrieved from http://scholarworks.gsu.edu/cps_diss/102/.

128. Ottens, A. J., & Klein, J. F. (2005). Common factors: Where the soul of counseling and psychotherapy resides. Journal of Humanistic Counseling, Education and Development, 44, 32–45.

129. Oxman, A., Lombard, C., Treweek, S., Gagnier, J., Maclure, M., & Zwarenstein, M. (2009). Why we will remain pragmatists: Four problems with the impractical mechanistic framework and a better solution. Journal of Clinical Epidemiology, 62, 485–488.

130. Parry, A., & Doan, R. E. (1994). Story re-visions: Narrative therapy in the postmodern world. New York, NY: Guilford.

131. Peterson, D. R. (2004). Science, scientism, and professional responsibility. Clinical Psychology: Science and Practice, 11, 196–210.

132. Prouty, A. (2001). Experiencing feminist family therapy supervision. Journal of Feminist Family Therapy, 12, 171–203. 10.1300/J086v12n04_01.

133. Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm,R. R. (2009). Using client feedback in psychotherapy

training: An analysis of its influence on supervision and counselor self-efficacy. Training and Education in Professional Psychology, 3, 157–168.

134. Reiser, R., & Milne, D. (2014). A systematic review and reformulation of outcome evaluation in clinical supervision: Applying the fidelity framework. Training and Education in Professional Psychology, 8,149–157.

135. Rice, F., Cullen, P., McKenna, H., Kelly, B., Keeney, S., & Richey, R. (2007). Clinical supervision for mental health nurses in Northern Ireland: Formulating best practices guidelines. Journal of Psychiatric and Mental Health Nursing, 14, 516–521.

136. Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. Journal of Career Development, 30, 555–567.

137. Roth, A., & Pilling, S. (2008). A competence framework for the supervision of psychological therapies. Retrieved from https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/Supervision_of_Psychological_Therapies/Supervision_Clinicians__competences_background_paper.pdf.

138. Rousmaniere, T., Swift, J., Babins-Wagner, R., Whipple, J., & Berzins, S. (2014). Supervisor variance in psychotherapy outcome in routine practice. Psychotherapy Research. Advance online publication. Retrieved from http://dx.doi.org/10.1080/10503307.2014.963730.

139. Rubin, N. J., Bebeau, M., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S., … Kaslow, N. J. (2007).The competency movement within psychology: An historical perspective. Professional Psychology: Research and Practice, 38, 452–462. 10.1037/0735-7028.38.5.452.

140. Sangganjanavanich, V., & Black, L. L. (2009). Clinical supervision for international counselors-in-training: Implications for supervisors. Journal of Professional Counseling: Practice, Theory, and Research, 37(2), 52–65. Retrieved from http://connection.ebscohost.com/c/articles/48188420/clinical-supervision-international-counselors-in-training-implications-supervisors.

141. Satterly, B. A., & Dyson, D. (2008). Sexual minority supervision. The Clinical Supervisor, 27, 17–38.10.1080/07325220802221462.

142. Schön, D. (1983). The reflective practitioner: How professionals think in action. New York, NY: Basic Books.

143. Schön, D. A. (1995). Knowing-in-action: The new scholarship requires a new epistemology. Change: The Magazine of Higher Learning, 27(6), 27–34.

144. Sells, J. N., Goodyear, R. K., Lichtenberg, J. W., & Polkinghorne, D. E. (1997). Relationship of supervisor and trainee gender to in-session verbal behavior and

ratings of trainee skills. Journal of Counseling Psychology, 44, 406–412. 10.1037//0022-0167.44.4.406.

145. Shulman, L. (1981). Identifying, measuring and teaching helping skills. Council on Social Work Education. Ottawa, Canada: New York and the Canadian Association of Social Work.

146. Shulman, L., & Safyer, A. (2003). Editorial. The Clinical Supervisor, 21(1), 1–3.

147. Shulman, L., & Safyer, A. (2006). Introduction. The Clinical Supervisor, 24(1–2), 1–2.

148. Sparks, J. A., Kisler, T. S., Adams, J. F., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. Journal of Marital and Family Therapy, 37, 452–467.

149. Stake, R. (2005). Qualitative case studies. In N. K. Denzin & U. S. Lincoln (Eds.), The Sage handbook of qualitative research (3rd ed., pp. 443–466). Thousand Oaks, CA: Sage.

150. Stiles, W. B., Hill, C. E., & Elliott, R. (2015). Looking both ways. Psychotherapy Research, 25, 282–293.

151. Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. Journal of Counseling Psychology, 28, 59–63.

152. Stoltenberg, C. D., & Delworth, U. (1987). Supervising counselors and therapists. San Francisco, CA:Jossey-Bass.

153. Strupp, H. H. (1978). The therapist's theoretical orientation: An overrated variable. Psychotherapy: Theory, Research and Practice, 15, 314–317.

154. Strupp, H. H., & Anderson, T. (1997). On the limitations of therapy manuals. Clinical Psychology: Science and Practice, 4, 76–82.

155. Sue, D. W. (2010). Microaggressions in everyday life: Race, gender, and sexual orientation. Hoboken, NJ: Wiley.

156. Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M.(2007). Racial microaggressions in everyday life: Implications for clinical practice. American Psychologist, 62, 271–286. 10.1037/0003-066X.62.4.271.

157. Tangen, J. L., & Borders, L. D. (in press). The supervisory relationship: A conceptual and psychometric review of measures. Counselor Education and Supervision.

158. Taylor, B. A., Hernández, P., Deri, A., Rankin, P. R., & Siegel, A. (2006). Integrating diversity dimensions in supervision: Perspectives of ethnic minority AAMFT approved supervisors. The Clinical Supervisor, 25, 3–21. 10.1300/J001v25n01_02.

159. Tracey, T. J. G., Wampold, B. E., Goodyear, R. K., & Lichtenberg, J. W. (2015). Improving expertise in psychotherapy. Psychotherapy Bulletin, 50(1), 7–13.

160. Tracey, T. J. G., Wampold, B. E., Lichtenberg, J. W., & Goodyear, R. K. (2014). Expertise in psychotherapy: An elusive goal? American Psychologist, 69, 218–229. 10.1037/a0035099.

161. U.S. Department of Health and Human Services. (2007). Competencies for substance abuse treatment clinical supervisors *(TAP Series 21-A)*. Rockville, MD: Author.

162. Walker, J. A., Ladany, N., & Pate-Carolan, L. M. (2007). Gender-related events in psychotherapy supervision: Female trainee perspectives. Counselling and Psychotherapy Research, 7, 12–18.10.1080/14733140601140881.

163. Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah, NJ:Lawrence Erlbaum.

164. Wampold, B. E., & Budge, S. L. (2012). The 2011 Leona Tyler Award address: The relationship and its relationship to the common and specific factors of psychotherapy. The Counseling Psychologist, 40,601–623.

165. Wampold, B., & Holloway, E. (1997). Methodology, design, and evaluation in psychotherapy supervision research. In C. E. Watkins, Jr. (Ed.), Handbook of psychotherapy supervision (pp. 11–27).New York, NY: Wiley.

166. Wampold, B. E., & Imel, Z. E. (2015). The great psychotherapy debate: The evidence for what makes psychotherapy work (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.

167. Watkins, C. E. Jr. (1993). Development of the psychotherapy supervisor: Concepts, assumptions, and hypotheses of the supervisor complexity model. American Journal of Psychotherapy, 47, 58–74.

168. Watkins, C. E. Jr. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering 30 years of research. The Clinical Supervisor, 30(2), 1–22.

169. Watkins, C. E. Jr. (2012). On demoralization, therapist identity development, and persuasion and healing in psychotherapy supervision. Journal of Psychotherapy Integration, 22, 187–205.

170. Watkins, C. E. Jr. (2015). Extrapolating Gelso's tripartite model of the psychotherapy relationship to the psychotherapy supervision relationship: A potential common factors perspective. Journal of Psychotherapy Integration, 25, 143–157.

171. Watkins, C. E. Jr., Budge, S. L., & Callahan, J. L. (2015). Common and specific factors converging in psychotherapy supervision: A supervisory extrapolation of the Wampold/Budge psychotherapy relationship model. Journal of Psychotherapy Integration, 25, 214–235.

172. Watkins Jr. & D. Milne (Eds.). (2014). Wiley international handbook of clinical supervision. Oxford, UK:Wiley.

173. Watkins, C. E. Jr., Wampold, B. E., & Budge, S. L. (2015, August). Extrapolating the Wampold/Budge model of the psychotherapy relationship to psychotherapy supervision. Paper presented at the 123rd Annual Meeting of the American Psychological Association, Toronto, Canada.

174. Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. Journal of Consulting and Clinical Psychology, 78, 200–2011.

175. Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients: A systematic review of the literature. Counselling and Psychotherapy Research, 7(1), 54–65.

176. White, E. (2004). Making my mark. Nurse Researcher, 11(3), 77–79.

177. White, E., & Brooker, C. (2001). Community mental health nursing: A census of England and Wales. International Journal of Nursing Studies, 38, 61–70.

178. White, E., & Winstanley, J. (2009). Clinical supervision for nurses working in mental health settings in Queensland, Australia: A randomised controlled trial in progress and emerging challenges. Journal of Research in Nursing, 14, 263–276.

179. White, E., & Winstanley, J. (2010). A randomised controlled trial of clinical supervision: Selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. Journal of Research in Nursing, 15, 151–167.

180. White, E., & Winstanley, J. (2011). Clinical supervision for mental health professionals: The evidence base. Social Work and Social Sciences Review, 14(3), 77–94.

181. White, E., & Winstanley, J. (2014, November). Clinical supervision: Predicting best outcomes Research Monograph. Sydney, Australia: Osman Consulting Pty Ltd. (PDF available, free of charge, on request to edwardwhite@osmanconsulting.com.au).

182. White, M., & Epston, D. (1990). Narrative means to therapeutic ends. New York City, NY: Norton.

183. Winstanley, J., & White, E. (2010). The MCSS-26©: Revision of The Manchester Clinical Supervision Scale© using the Rasch Measurement Model. Journal of Nursing Measurement, 19, 160–178.

184. Winstanley, J., & White, E. (2014). The Manchester Clinical Supervision Scale©: MCSS-26©. In C. E. Watkins, Jr. & D. Milne (Eds.), The Wiley international handbook of clinical supervision (pp. 386–401). Chichester, UK: Wiley.

185. Yin, R. K. (2014). Case study research: Design and methods (5th ed.). Thousand Oaks, CA: Sage.

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