

St. John's University

**St. John's Scholar**

---

Theses and Dissertations

---

2023

**THE ROLE OF TRAINING IN CLINICAL SUPERVISION ON  
CLINICIAN SUPERVISORY COMPETENCY AND SUPERVISORY  
SELF-EFFICACY**

Rachel A. Vaughn

Follow this and additional works at: [https://scholar.stjohns.edu/theses\\_dissertations](https://scholar.stjohns.edu/theses_dissertations)



Part of the [Psychology Commons](#)

---

THE ROLE OF TRAINING IN CLINICAL SUPERVISION ON CLINICIAN  
SUPERVISORY COMPETENCY AND SUPERVISORY SELF-EFFICACY

A dissertation submitted in partial fulfillment  
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

to the faculty of the

DEPARTMENT OF PSYCHOLOGY

of

ST. JOHN'S COLLEGE OF LIBERAL ARTS AND SCIENCES

at

ST. JOHN'S UNIVERSITY

New York

by

Rachel A. Vaughn

Date Submitted 04/17/2023

Date Approved 04/17/2023

---

Rachel A. Vaughn

---

Mark Terjesen, PhD

**© Copyright by Rachel A. Vaughn 2023**

**All Rights Reserved**

## ABSTRACT

### THE ROLE OF TRAINING IN CLINICAL SUPERVISION ON CLINICIAN SUPERVISORY COMPETENCY AND SUPERVISORY SELF-EFFICACY

Rachel A. Vaughn

To date, clinical supervision training in professional psychology has focused more on theoretical models for training the supervisee and has been lacking in science. This single-case study investigated the impact of participating in a clinical supervisor training program on supervisory competency and supervisory self-efficacy. Doctoral psychology graduate students participated in a three-month training program. During the training, the students participated in weekly meta-supervision sessions, received monthly opportunities for skill practice, and attended four didactic sessions. Data was collected at four time points. Rating of supervisory competency was measured by self-reports from participants using the Supervision Adherence and Guidance Evaluation (SAGE) “supervisee cycle” and rating of supervisory self-efficacy was measured using the Clinical Supervision Self-Efficacy Scale (CSSES). Additionally, the clinical faculty that facilitated the metasupervision sessions completed the “supervisor cycle” of the SAGE. Lastly, blind raters watched participant video responses submitted during the training to provide additional ratings of supervisory competency. Three visual analyses were used to examine whether a casual relation exists between participation in clinical supervision and training program. Repeated measures ANOVA examined clinically and statistically significant changes in supervisory competency determined by the SAGE and

CSSSES for each participant at each of the 4 time points. The clinical supervisor training program had a statistically significant effect on supervisory competencies and supervisory self-efficacy based on supervisory trainee ratings. Clinical faculty ratings indicated similar results regarding supervisory competencies. Blind rater observations of supervisory competency skills showed the clinical supervisor training program had a statistically significant effect in one area of supervisory competency. This has implications for professional psychologist by establishing an evidence-based model of clinical supervision training for graduate programs to consider as part of their curriculum. It will also help ensure that graduating psychologist have an opportunity to increase their supervisory competency and supervisory self-efficacy before becoming supervisors in the field. Future investigations that scientifically prove the relationship between increasing supervisor competency and client outcomes would be significant.

## ACKNOWLEDGEMENTS

This project would not have been possible without so many dedicated individuals who have provided me invaluable support. First and foremost, I would like to extend my gratitude to my mentor, Dr. Mark Terjesen, for his countless hours of guidance and belief in me throughout this process. His passion and visions made this undertaking possible, and he has always supported me, and helped me to conquer every obstacle thrown my way. Secondly, I would also like to thank my dissertation committee members, Dr. Raymond DiGiuseppe and Dr. Tamara Del Vecchio, for their insightful feedback and resourceful ideas that assisted me throughout this process. Next, I want to thank my mom for her unwavering support and faith in me. You have been my rock throughout everything. Nai, Jason, Beth, and Marinda, thank you for keeping me grounded, always making me laugh during my vent sessions, and putting a smile on my face in the times I needed it the most. To my family and friends, thank you for the encouragement to follow my dream and for always believing in me. To my cohort, I am so lucky to have been a part of such a special group of people, who I believe will continue to support each other far beyond graduate school.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
LIST OF TABLES.....	v
LIST OF FIGURES.....	vi
CHAPTER I: Introduction.....	1
Statement of the Problem.....	1
Rationale.....	3
Roles of Competency and Efficacy in Training Programs.....	3
Role of Supervision in Professional Psychology.....	4
Models of Supervision in Professional Psychology.....	6
Gaps in Clinical Supervision Research in Professional Psychology.....	9
CHAPTER II: Hypotheses.....	11
CHAPTER III: Methods.....	12
Participants.....	12
Procedure.....	12
Apparatus and Materials.....	16
Overview.....	16
Outcome Measures.....	17
CHAPTER IV: Results.....	19
Demographics .....	19
Data Analysis.....	19
CHAPTER V: Discussion.....	23
Discussion of Specific Hypotheses.....	23

Limitations.....	26
Sample.....	26
Methodological issues.....	26
Future Directions.....	27
Implications.....	29
CHAPTER VI: Application to School Psychology.....	31
Appendix A. Research Consent.....	32
Appendix B. Demographic Questionnaire.....	33
Appendix C. Recruitment Letter.....	34
Appendix D. Vignette Scripts.....	35
Appendix E. Supervision Training Questionnaire.....	40
Appendix F. SAGE Record Sheet: Supervisee Cycle.....	42
Appendix G. SAGE Record Sheet: Supervision Cycle.....	43
Appendix H. Blind Rater Training Vignettes.....	45
Appendix I. Blind Rater Recruitment letter.....	49
Appendix J. Blind Rater Research Consent.....	50
Appendix K. Clinical Supervision Self Efficacy Scale (CSSES).....	51
REFERENCES.....	62



**LIST OF TABLES**

Table 1 Means, Standard Deviations, and Repeated Measures Analyses of Variance for the Effects of Clinical Training Supervisor Program on Supervisory Competency Scores and Supervisory Self-Efficacy Scores from Supervisory Trainees and Blind Raters..... 52

Table 2 Means Scores on Measures of Supervisory Competency and Supervisory Self-Efficacy as a Function of Clinical Supervisor Training Program..... 53

Table 3 Means, Standard Deviations, and Repeated Measures Analyses of Variance for the Effects of Clinical Training Supervisor Program on Supervisory Competency Scores Based on Clinical Supervisor Ratings... 54

Table 4 Means Scores on Measures of Supervisory Competency as a Function of Clinical Supervisor Training Program Based on Clinical Supervisors Ratings..... 55

## LIST OF FIGURES

Figure 1	Mean-Scores for Clinical Supervisors Competency Ratings.....	56
Figure 2	Mean-Scores for Clinical Supervisors Competency Ratings.....	57
Figure 3	Mean-Scores for Clinical Supervisors Competency Ratings.....	58
Figure 4	Mean-Scores for Supervisory Trainee Competency Ratings.....	59
Figure 5	Mean-Scores for Blind Rater Competency Ratings.....	60
Figure 6	Mean-Scores for Supervisory Trainee Self-Efficacy Ratings.....	61

## **Chapter I**

### **Introduction**

#### **Statement of the Problem**

Clinical supervision is vital to the training and development of professional psychologists while attaining practitioner competencies (Ferreira-Correia, 2017). There is wide recognition that clinical supervision is crucial to the attainment of practitioner competencies (Holloway, 2016). To date, supervision training in broad psychology services has focused more on theoretical models for training the supervisee (Newman et al., 2019). However, more recent attention has turned to looking at training models that could increase competency of the supervisor in order to ensure effective training can be provided to the supervisee (Barrett et al., 2017). More specifically, there has been an increasing discussion around the need for an evidence-based supervisor training model in professional psychology (Ferreira-Correia, 2017; Kühne et al., 2019; Justice et al., 2018; Simon et al., 2019). That is, understanding the science to guide the practice of supervision.

Initially, it was believed that competency in providing supervision came with time and experience (Barrett et al., 2017). However, several studies have pointed out specific factors that play a role in training competent supervisors and find that more than time and experience is needed to increase supervisor competency. In a recent meta-analysis that explored theoretical models of supervisor development in applied psychology, over 50% of the training programs had no identified model (Barker & Hunsley, 2013). There appear to be a number of specific components of clinical supervision training that are deemed necessary to perform effective clinical supervision. Among these core components are

deliberate practice (e.g., practicing specific skills repeatedly while having continuous corrective feedback (Rousmaniere et al., 2017)), feedback on client progress, embody the spirit of treatment, task analysis, frequent feedback, and assessment of progress towards knowledge, skills, and attitudes (Falender & Shafranske, 2012; Southward & Pfeifer, 2019). An important point then is: if there is a need for competent supervisors to provide training for professional psychology training programs, as well as staff working with clients in the community, we need more studies to provide an evidence-based supervisor training model that results in increased supervisory competency and supervisory self-efficacy.

To ensure competency and efficacy for professional psychologist at the doctoral level, there is a need to explore and develop a specific model of training of supervisors. While the roles of psychologists are varied (Barrett et. al., 2017; Ferreira-Correia, 2017; Schoenwald et al., 2013) and as such the role of supervisor is also multi-dimensional, in this study we will focus on supervision and training for clinical interventions. More specifically, doctoral level students will be provided a training program for supervision that incorporates several factors combined from other training models including structured supervision sessions, lectures and demonstration/modeling on supervisory practices, online practice videos, and direct feedback as to supervision skill delivery. This study will include measures provided to the trainees and supervisors regarding rating of efficacy and multiple ratings of competency.

## **Rationale**

### ***Roles of Competency and Efficacy in Training Programs***

Prior to diving into specifics on the role supervision plays in professional psychology it is vital to discuss why measuring competency and efficacy of one's skills while in a training program is crucial. The American Psychological Association's (APA) ethical codes has included competence since inception and has remained present throughout all subsequent revisions (Falender & Shafranske, 2012). Competencies were defined and broken into essential components during the Competencies Conference and the Benchmark Conference (Fouad, et al. 2009; Kaslow et al., 2004). Although, it cannot be assumed that competence is acquired based on accumulation of clinical training experiences or completion of coursework (Newman & Guiney, 2019). Taking into account the responsibilities psychologists have regarding assuring client care and promoting welfare, it is crucial to have a competency-based model of training and practice, as well as an approach that clearly identifies, trains, and evaluates professional competencies (Falender, 2017; Milne, 2018).

Along with competency, it is also important to determine a supervisor in training's efficacy of skills in a training program. Self-efficacy has been defined as a set of beliefs that are linked to specific behaviors and situations that pertain to one's capabilities to produce a given outcome and is noted to be a more accurate predictor of performance success than past experience (Bandura, 1997). Self-efficacy has also been identified as playing a significant role in learning and academic outcomes, and due to the impact of this construct on learning, increasing a trainee's self-efficacy is important (Lockwood et al, 2017). While self-efficacy has been linked to multiple learning

outcomes, the research focus on the construct as it relates to professional training in clinical work is sparse. In multiple counseling graduate programs, Mullen et al. (2015) found that students' self-efficacy increased as they progressed through their graduate training, and Barden and Greene (2015) found a strong relationship between graduate students' multicultural competence and multicultural self-efficacy. While the relationship between self-efficacy and supervision skill development has not been researched to date, this study will look at supervisory self-efficacy in the development of clinical supervisory skills with the expectation of a similar relationship.

### ***Role of Supervision in Professional Psychology***

The APA has recognized supervision as a core professional competency that contributes to effective psychological service delivery and quality training (APA, 2015).

Clinical Supervision is defined as:

“an approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion referenced competence standards in keeping with evidenced-based practices and requirements of the local clinical setting” (Falender & Shafranske, 2017, p. 134).

In many graduate programs, the most intensive period of clinical training and direct feedback a psychologist may have in their careers is during graduate supervision (Southward & Pfeifer, 2019). Shockingly, many graduate programs have unavailable or limited training in supervision (Harris et al., 2018; Newman et al., 2020).

There are different levels of supervision that are provided to trainees in the field of psychology including graduate and post-graduate (ASPPB, 2020; NASP, 2020). The

APA and the Association of State and Provisional Psychology Boards (ASPPB) are two bodies that oversee the guidelines of psychology. Trainees are required to receive supervision while training in practicum, externship, and internship settings during graduate training (ASPPB, 2020; NASP, 2020). While in practicum training, a trainee, for example, must complete a minimum of two semesters of supervised professional experience, have a written training plan for each practicum experience, and obtain evaluations of their performance (NASP, 2020). Supervision is provided no less than 25 percent of the time spent in service-related activities, and majority of the supervision (75%) should be with the primary supervisor and in-person (ASPPB, 2020). Also, during graduate training, trainees receive supervision during field placements (i.e., internship and/or externship settings) (Justice et al., 2018). Depending on how many hours they are completing each week, trainees should be provided with at least two hours of supervision per week (ASPPB, 2020; NASP, 2020). To be eligible for licensure at the doctoral level, candidates must receive supervision at the post-doctoral level that consists of a minimum of 1500 hours under a primary supervisor (ASPPB, 2020).

Considering the intensity and multiple levels of supervision during psychology training, it is imperative that attempts are made to have well-trained supervisors (Stock et al., 2023). *Supervisor Competence* is the first guideline listed in APA's (2015) provision of supervision. It is important to look at the history and current proposed models of supervision in applied areas of psychology while exploring a best practice model for supervisory training and increasing competency.

### *Models of Supervision in Professional Psychology*

Training programs in professional psychology encourage evidence-based practice and supervisors play an important role in teaching trainees (Falender & Shafranske, 2014, Justice et al., 2018). Substantial literature has been devoted to clinical and counseling psychology psychotherapy-based supervision models which are grounded in theory (e.g., psychodynamic, person-centered, experiential, cognitive-behavioral, multimodal, and solution-focused models) (Pearson, 2006, Stoltenberg & McNeill, 2012). A particularly influential developmental model in the clinical and counseling psychology research for clinical supervision is the Integrative Developmental Model (IDM) (McNeill & Stoltenberg, 2016, Simon et al., 2014). This model emphasizes skill level throughout each stage of supervision and the necessity of tailoring the structure and content to the supervisee's experience (Stoltenberg, 2005, Simon et al., 2014).

A new model was proposed for training supervisors by Simon and colleagues; the Developmental, Ecological, Problem-Solving (DEP) model (Simon et al., 2019). This model integrates IDM and the Systems Approach to Supervision (SAS) models of supervision (Simon et al., 2014). In addition to IDM, the SAS model is discussed in broad professional psychology literature (Holloway, 2016). The SAS model investigates the contextual factors that impact both the content of the supervisory relationship and the process (Simon et al., 2014). In exploring the DEP model further, each component of the DEP model acts as a flexible framework that can be used for increasing competency and supervisory training. Additionally, each component of the DEP model has specific areas of focus. The Developmental component highlights supervisor role, supervisee functioning, and supervisee development. The Ecological component emphasizes



training, interventions, and systemic context. Lastly, the Problem-solving component highlights evidence-based interventions, collaborative teaming, data-based decision making, and outcome monitoring (Simon et al., 2014, Simon & Swerdlik, 2017a). Considering the foundation of this model stems from both IDM and SAS models of supervision that have been noted in literature for broad professional psychology (i.e., clinical and counseling psychology), and DEP additionally includes considerations specific to school psychology, it will be integrated into the structure/approach of the training of clinical supervisors in the present research.

Another model that will be included in the present research is evidenced-based CBT supervision (Milne, 2018; Milne & Riser, 2016). The development of this model was guided by the evidence-based clinical supervision (EBCS) framework (Milne, 2018). EBCS is a practice development philosophy that treats professional development in an integrative and systemic way (Milne, 2018). It's also based on a range of expert consensus, research activities, and relevant psychological theories which address the development of 'good supervision' through the applied science of training (Milne, 2018). Information was obtained from a systemic review of 24 articles on supervision that helped to guide the creation of the evidence-based CBT supervision model (Milne, 2009) and this model is conceptualized as a tandem model of CBT supervision (i.e., the supervisor and supervisee shape one another's learning and development, and operates as a system) (Milne, 2018). A number of different components make up the evidenced-based CBT supervision model including goal setting, maintaining an alliance, feedback and evaluation, facilitating learning, and support and guidance (Milne & Riser, 2016).

Hazel and Segler (2019) recently introduced another model in supervision training called the Vertical Model. This model, an applied form of didactic supervision training, uses a vertical structure. In other words, a field supervisor or instructor supervises a student supervisor in training, who in turn supervises one or more less advanced students in clinical practice (Curtis et al., 2016). Furthermore, the Vertical model has comparable client outcomes to practitioner-supervised students (Hazel & Segler, 2019). This approach will also be integrated into the current training program to be evaluated as part of this research.

Deliberate practice (DP) is also often used as part of the implementation of the DEP and Vertical models of supervision (Hazel & Segler, 2019; Simon et al., 2019) and is considered a core component in the implementation of supervision training (Goodyear & Rousmaniere, 2017; Hazel & Segler, 2019; Justice et al., 2018). Deliberate practice is generally defined as practicing specific skills repeatedly while having continuous corrective feedback (Rousmaniere et al., 2017). More specifically, deliberate practice in supervision highlights some essential features including assessment, expert feedback, systematic practice, and goal setting (Justice et al., 2018). The present research will additionally integrate this model into the training of clinical supervisors.

Lastly, meta-supervision is a key component to consider in clinical supervisor training (Newman, 2013) and is included in the vertical model of supervision (Hazel & Segler, 2019). Meta-supervision is defined as situations where highly experienced clinicians serve as a consultant to clinical supervisors in training (Newman, 2013). In other words, it is supervision of someone providing supervision. Including this component as part of your training procedure is considered best practice (Simon &

Swerdlik, 2017b). Finally, this component will also be integrated into the training curriculum in this research.

### **Gaps in Clinical Supervision Research in Professional Psychology**

Research varies on clinical supervision in professional psychology, with counseling and clinical psychology at the forefront (Bernard & Goodyear, 2019; Callahan & Watkins, 2018). Minimal research exists on clinical supervisory models specific to school psychology (Newman & Guiney, 2019, Stock et al., 2023). Interestingly, a recent meta-analysis that explored theoretical models of supervisor development in applied psychology noted that over 50% of the training programs had no identified model of supervision (Barker & Hunsley, 2013). In reviewing the literature that investigates models of clinical supervision, most research does not correspond to the complexities of professional practice and has been narrow in focus (Milne & Riser, 2016, Stock et al., 2023). Even though the number of articles on supervision has increased over the years, studies continue to have methodological weaknesses (i.e., poor attendance in group supervision, only one study utilized a controlled research design, etc.) (Inman et al., 2014), and do not thoroughly evaluate supervision (i.e., having an evidenced-based standardized method through direct observation to train and evaluate trainees).

As mentioned earlier, competence has been rooted in APA's ethical codes since inception (Falender & Shafranske, 2012) and consequently research has been conducted on a trainee's competency in a myriad of areas, including supervisory competencies (Falender, 2018; Falender & Shafranske, 2017; Milne, 2018; Simon & Swerdlik, 2017b). Unlike competence in clinical supervision, self-efficacy in clinical supervision only

recently has begun to be measured and is mostly seen in the literature for vocational rehabilitation (Herbert et al., 2018).

Taking into account the gaps in research when exploring models of professional psychology supervision training, it is important we attempt to obtain multiple outcome measures to show evidence of increased competency and efficacy using an integrated best practice approach (Stock et al., 2023). Integrating the supervision models of evidenced-based CBT supervision, DEP, and the Vertical Model, the current study provided a three-month training program to doctoral school psychology students to increase competency and efficacy in providing supervision. The training program included structured supervision sessions (including meta-supervision), lectures and demonstration/modeling on supervisory practices, skill practice using online videos, and direct feedback as to supervision skill delivery.

## **Chapter II**

### **Hypotheses**

Based on the work of several authors (e.g., Miller et al., 2008; Rousmaniere et al., 2017; Tracey et al., 2014) who identified training approaches that improve one's clinical competency, it was hypothesized that:

1. Supervisory trainees' supervisory competency will increase from pretest to posttest after participating in the clinical supervision training program:
  - a. based on ratings by the clinical faculty supervisors
  - b. based on self-report ratings by the supervisory trainees
2. Supervisory trainees' supervisory competency will increase from pretest to posttest after participating in the clinical supervision training program based on observational ratings of supervisory responses to recorded supervisory vignettes by experienced supervisors who will serve as blind raters.

Based on the work of Barden and Greene (2015) who identified a strong relationship between students' competence and students' self-efficacy, it was hypothesized that:

3. Supervisory trainees' supervisory self-efficacy will increase from pretest to posttest after participating in the clinical supervision training program based on ratings by supervisory trainees.

## **Chapter III**

### **Methods**

#### **Participants**

The investigation population consisted of 6 supervisory trainees at a community-based University clinical training facility located in a large Metropolitan area. Each trainee interested in participating in the research program on Clinical Supervision received a consent form (Appendix A), a brief demographic questionnaire (Appendix B) and then was asked to evaluate their perceived competency and efficacy using the scales described below in delivering clinical supervision prior to engaging in the supervision training program.

#### **Procedure**

Clinical Supervisor Training Program:

Six students enrolled in a doctoral psychology program (i.e., school psychology Psy.D) were recruited to participate in the clinical supervisor training program. Recruitment took place across 2 months beginning March 2022 and ending in April 2022. In order to participate in this study, all supervisory trainees completed a minimum of 70 credits of graduate instruction, a field-based externship, two clinic-based training practica (at least one being clinical interventions) and earned their masters (specialist degree) in psychology. This investigation required the direct recruitment of participants (see Appendix C). Participants were recruited through university email.

Training took place at the University based clinic and was conducted based on concept of distributed training/practice. Distributed training/practice refers to a more spaced-out method where you provide training in intervals over time and has been noted

to have higher success rates in retaining information; as opposed to massed training which is done less frequently and for larger periods of time (Schutte et al., 2015). The following were all components incorporated in the training:

- Supervisory trainees received one 2-hour group didactic session at the beginning of the study, and one 1-hour group didactic session each month of the three-month period on supervisor competencies. Of note, the curriculum for the didactics was adapted from curriculum provided by a current supervision credentialing program for school psychologists (Simon et al., 2019, the CBT supervision manual (Milne & Riser, 2016), and Hazel and Segler's (2019) Vertical Model:
  - a. The first 2- hour didactic consisted of topics including orientation to training, (i.e., schedule, measure due dates, etc.), defining clinical supervision and comparing it to teaching/therapy/consultation, role of supervisors, responsibilities of supervisors, theories and key principles of clinical training (i.e., DEP model, evidence-based CBT supervisory model, vertical model, & deliberate practice, professional competencies, supervisor/supervisee competencies, managing supervision, important components of a written contract, and establishing supervision goals).
  - b. The second 1-hour didactic consisted of topics including methods of supervision (e.g., modeling/demonstrating, co-therapy/case conceptualization, observation, & audio/video recording,

consulting/coaching), diversity/multicultural competency and system change, discussion of mock supervisee concern, and Skillsetter review.

- c. The third 1-hour didactic consisted of topics including evaluation, feedback, and review/discussion of a live clinical session with a client.
  - d. The fourth 1-hour didactic consisted of topics including supervision complexities (i.e., ruptures in supervision), supervisor coping strategies/techniques, and review/discussion of a live supervision session.
  - e. The didactic sessions were conducted by one of the staff supervisors at the University based clinic who is a licensed psychologist, has over 20 years of experience in training clinicians in CBT, and has written and done research on supervision and training in CBT.
- Supervisory trainees received weekly direct feedback for approximately 1.5 hours at the University based clinic on their supervisory skills through meta-supervision facilitated by the clinical faculty supervisors. Clinical faculty supervisors met criteria (i.e., licensure/registration, provided at least 70 hours of supervision to supervisees, and obtained at least 5 hours of prior supervisory training) to participate in this role. These guidelines were established using parameters provided by a current supervision credentialing program for school psychologists (Simon et al., 2019),



APA's guidelines to clinical supervision (APA, 2015), as well as supervision guidelines in the field of social work (ASWB, 2019; NASW & ASWB, 2013).

- Supervisory trainees used a platform called Skillsetter (a web-based skill building system with simulated videos) to practice acquired supervisory competencies. Terry et al. (2017) discussed using brief standardized online training vignettes to assess a trainees competency level more accurately. At each time point supervisory trainees viewed 4 pre-recorded video vignettes (Appendix D) that correspond to a preselected supervisory competency skill (questioning, prompting, demonstrating, and teaching) and included a mock clinical practica trainees supervision session where the clinical practica trainees expressed a scripted concern (e.g., client does not complete assigned homework). Of note, the four supervisory competency skills are defined operationally using definitions that are pulled directly from the SAGE. Supervisory trainees were then required to provide a video response to each of the 4 vignettes at each of the four timepoints (i.e., 16 video responses total were completed across the duration of the training program). Of note, while the four content areas were the same, each vignette differed at each time point (e.g., formulating vignette viewed at baseline differed from formulating vignette viewed at 4 weeks, and so on). Lastly, after completing each video response, supervisory trainees answered 4 feedback questions about their response to each vignette (i.e., answer 16 feedback questions total at each time

point) and received formal feedback to their responses during group didactic sessions.

Each supervisory trainee participated in meta-supervision for up to 90 minutes per week for 12 weeks, and as part of the meta-supervision supervisory trainees co-supervised approximately 4 clinical practica trainees. The clinical faculty supervisors were primarily responsible for the clinical practica trainees, as well as the clinical care of clients seen at the University based clinic. At the end of the training program (12 weeks) each supervisory trainee was asked to complete an optional questionnaire to indicate which component of training was/was not helpful in increasing their competency in providing clinical supervision. (Appendix E)

## **Apparatus and Materials**

### ***Overview***

Prior to commencement of the three-month training program, all supervisory trainees completed the supervisee rating of skill assessment and the rating of efficacy assessment described below to collect baseline data to further monitor competency in supervision during the course of the study. The primary endpoints include supervisor competency rated by the blind rater, supervisors, and supervisory trainees; and supervisor self-efficacy rated by supervisory trainees. Results from a recent study on assessing competency during clinical psychology practicum training indicated that trainees were reasonably accurate in their self-evaluation when compared to their supervisors (Hitzeman et al., 2020). As this is a pilot study, we recruited a sample of 6 participants. Due to only having 3 supervision sections available at the University based clinic where supervisory trainees can receive the meta-supervision part of the training program, as

well as the goal of having only two students receive meta-supervision in one section at a time, this study was limited to only 6 participants in the training program.

### ***Outcome Measures***

The following measures were completed at predetermined assessment periods. More details on specific timepoints and who completed each measure are described below.

Reliable and valid measures were selected and where possible measures were selected if they had been used in previous clinical trials.

1. Rating of Competency: Supervision Adherence and Guidance Evaluation (SAGE; Reiser, et al., 2018) is an observational instrument that includes 14 supervisor and supervisee competencies (behaviors) that are grouped into two major factors: The Supervision Cycle and The Supervisee Cycle. These two factors are measured using a 7-point Likert-type scale (0=Incompetent to 6=Expert+) with high internal consistency ( $\alpha = .91$ ). The Supervision Cycle and Supervisee Cycle subscales also demonstrated high internal reliability ( $\alpha = .91$  and  $\alpha = .81$ ) (Reiser et. al., 2018).
  - a. Supervisee rating of skills: The Supervisee Cycle (4 items) taken from the SAGE includes specific supervisee learning competencies and was used as a self-report instrument. These ratings were requested to be completed by the supervisory trainees at baseline, 4, 12, and 20 weeks. (Appendix F)
  - b. Supervisor rating of skill:
    - i. The Supervision Cycle (10 items) taken from the SAGE includes specific supervisor behaviors which are believed to facilitate optimal experiential learning and were requested to be completed

by clinical faculty supervisors at the University based clinic at 4, 8, and 12 weeks. (Appendix G)

- Sixteen blind raters rated 4 preselected supervisor cycle competencies taken from the SAGE (e.g., demonstrating) the supervisory trainees demonstrated throughout the three-month clinical supervisor training program at baseline, 4, 12, and 20 weeks. Blind raters of Skillsetter sessions were licensed/registered clinicians who volunteered to review a recording of supervisory responses by participants to a simulated supervisee. The same guidelines used for clinical faculty supervisors were used to select blind raters. Training was provided to the blind raters where each blind rater viewed one mock vignette (similar to the training vignettes described above) that included an example of the three rating categories prior to them rating the trainee responses (Appendix H). Blind raters were recruited through email (Appendix I) and signed a consent to participate (Appendix J).

2. Rating of Efficacy: The Clinical Supervision Self-Efficacy Scale (CSSES; 15 items) measures supervisor self-efficacy regarding completing tasks associated with clinical supervision. CSSES demonstrated reliability with a Cronbach alpha of .96 on the supervisor form ( $n=216$ ) (Landon et al., 2016). Internal consistency estimates taken at baseline indicated that items were highly correlated with one another ( $\alpha = .93$ ) (Herbert et al., 2018). This measure was used as a self-report instrument completed by the supervisory trainees at baseline, 4, 12, and 20 weeks. (Appendix K)

## Chapter IV

### Results

#### Demographics

The sample had an average age of 27.5 ( $M = 27.5, SD = 2.8$ ). One of the participants was male, and the other five were female. Three (50%) of the participants were Caucasian, while the remaining three participants were Hispanic/Latino (50%). Half (3) of the sample were certified school psychologists and had just completed their third year of a school psychology doctoral program, while the other half (3) were certified school psychologists, had completed their fourth year, were in the same doctoral program. While all had been supervised in clinical practice, none of the participants had prior supervisory training or experience. All six participants resided in the New York metropolitan area; there was no attrition as all six trainees maintained participation to the completion of the study.

#### Data Analysis

Since this is a single-case study, internal validity was controlled for using randomization of participant placement in supervisory training section. In order to examine whether a causal relation exists between participation in the clinical supervision training program and an increase in supervisory competency and supervisory self-efficacy ratings, initially, skewness and kurtosis were analyzed for all timepoints. All timepoints from all ratings of supervisory competency and supervisory self-efficacy (i.e., supervisor trainees, clinical supervisors, and blind raters) were within appropriate limits.

Next, three visual analyses features were used to examine phase data patterns across the 4 time points including (a) level, (b) trend, (c), variability across raters within

the same group (Kratochwill et al., 2010). Clinical supervisor ratings on the supervisory competencies had increased levels and trends from timepoint 1 to timepoint 3 for all competency areas (Figures 1-3). Supervisory trainee ratings on the supervisory competencies had increased levels and trends from baseline to timepoint 3, and then a slight decrease in levels and trends from timepoint 3 to timepoint 4 for all competency areas (See Figure 4). Similarly, Blind Rater ratings on supervisory competencies of Teaching and Questioning had an increase in levels and trends from baseline to timepoint 3, and then Teaching had a slight decrease in trend from timepoint 3 to timepoint 4 (See Figure 5). The Prompting competency had an increase in level and trend from timepoint 3 to timepoint 4 (See Figure 5). Contrastingly, the Demonstrating competency had a decrease in level and trend from baseline to timepoint 2, and then increase from timepoint 2 to timepoint 4 (See Figure 5). Lastly, supervisory trainee's ratings on supervisory self-efficacy had an increasing level and trend from baseline to timepoint 3, and then a slight decrease in level and trend from timepoint 3 to timepoint 4 (See Figure 6).

In addition, a repeated measures ANOVA was performed to compare the effect of the clinical supervisory training program on supervisory competency (determined by the SAGE for each participant at each of the 4 time points) based on ratings from supervisory trainees, clinical supervisors, and blind raters. In regard to supervisory trainee ratings on the SAGE, Greenhouse-Geisser results are reported for Reflecting and Experiencing, and Huynh-Feldt results are reported for Conceptualizing due to Mauchly's test indicated violations of sphericity for all competency areas, except for Planning. The clinical supervisor training program had a statistically significant effect on supervisor competencies Reflecting, Conceptualizing, Planning, and Experiencing (see Table 1).

Specifically, post hoc tests using the Bonferroni correction revealed that all the competency scores significantly increased from baseline to timepoint 3 (See Table 2). Additionally, Reflecting competency scores significantly increased from baseline to timepoint 4 by 1.67 points ( $p = .025$ ), and Planning competency scores significantly increased from baseline to timepoint 4 by 1.18 points ( $p = .005$ ). These results support hypothesis one.

Regarding clinical supervisor ratings on the SAGE (at each of the 3 time points), Greenhouse-Geisser results are reported for Formulating, Questioning, Training, and Feedback competencies, and Huynh-Feldt results are reported for Managing, Agenda-Setting, Prompting, Demonstrating, Teaching, and Evaluating due to Mauchly's test indicated violations of sphericity for all competencies. The clinical supervisory training program had a statistically significant effect on all supervisory competency areas (See Table 3) indicating similar results as the supervisory trainees that the clinical supervisory training program had a statistically significant effect. Specifically, post hoc tests using the Bonferroni correction revealed that all supervisory competency scores significantly increased from baseline and timepoint 2 and baseline to timepoint 3 (See Table 4). These results support hypothesis one.

Concerning the SAGE ratings completed by the blind raters (for each of the 4 time points), Mauchly's test indicated violations of sphericity for all competencies and the Greenhouse-Geisser results are reported. While the clinical supervisory training program did have a statistically significant effect for the supervisory competency of Teaching, it did not have a statistically significant effect for the supervisory competencies Questioning, Demonstrating, and Prompting (See Table 1). Specifically, post hoc tests

using the Bonferroni correction revealed that the supervisory competency Teaching scores significantly increased from baseline and timepoint 3 by 3.18 points ( $p = .013$ ), and significantly increased from timepoint 2 to timepoint 3 by 1.5 points ( $p = .042$ ). These results support hypothesis two.

Additionally, a repeated measures ANOVA was performed to compare the effect of the clinical supervisory training program on supervisory self-efficacy (determined by the CSSSES for each participant at each of the 4 time points) based on ratings from supervisory trainees. Mauchly's test did not indicate any violations of sphericity. The clinical supervisory training program had a statistically significant effect on supervisory self-efficacy ( $F(3,15) = 16.04, p = <.001$ ). Specifically, post hoc tests using the Bonferroni correction revealed that supervisory self-efficacy significantly increased from baseline to timepoint 3 by 11.67 points ( $p = .018$ ). These results support hypothesis three.

Lastly, in an attempt to understand the components of the training (i.e., Didactics, Metasupervision) that were most helpful to the supervisor trainees, the trainees were asked to complete an optional post-training questionnaire to indicate the parts of the training that were helpful. Out of the six supervisor trainees, three completed the optional questionnaire. These trainees indicated that the group didactics, particularly feedback on supervision skills during these didactics, were "very helpful." They also reported that having a positive relationship with the clinical supervisor and collaborating with them was "very helpful." The trainees expressed that metasupervision and the opportunity to receive feedback and support/guidance from the clinical supervisor were "extremely helpful." Only one trainee felt that using Skillsetter to practice skills during the training was "moderately helpful."



## **Chapter V**

### **Discussion**

This chapter will discuss the results of the investigation, significant findings, and implications these findings have for the field of psychology. First, the results of each hypothesis will be presented, followed by a discussion of plausible reasons for each finding. Next, the limitations of the investigation and future directions for this research are reviewed.

#### **Discussion of Specific Hypotheses**

The primary research question of this investigation sought to determine whether supervisory trainees' supervisory competency increased from pretest to posttest after participating in the clinical supervision training program based on ratings by the clinical supervisors and self-report ratings by the supervisory trainees (Hypothesis 1) and observational ratings of supervisory responses by blind raters (Hypothesis 2). Regarding the ratings from clinical supervisors and supervisory trainees, the clinical supervision training program demonstrated improvement for trainees in supervisory competency for all supervisor competency areas. All competencies had the most significant increase from baseline to timepoint 3. Considering the first timepoint was the baseline, and timepoint 3 was at the end of the training program, we would hope to see these results. These results are similar to studies that show both training components that increase competency (Miller et al., 2008; Rousmaniere et al., 2017; Tracey et al., 2014) and training programs that have identified increases in competency as an effect of training (Bennett-Levy & Beedie, 2007).

Two months after the training program ended, post training data were collected to examine the maintenance of supervisory competencies. Supervisory trainees participated in didactics monthly, practicing their skills through Skillsetter monthly and attending metasupervision weekly. It was anticipated that the individual supervisor competencies would increase with this combination of models of supervision training. Maintenance scores were only collected from supervisory trainees and blind rater observations of participants two months after the training ended. Based on both supervisory trainee and blind rater responses, none of the competency areas displayed maintenance in skills. This indicates that while trainees competency increased as the training program progressed, there were no observations of those skill being retained two months post training by the trainees self-report ratings or observations by the blind raters.

Supervisory trainees completed an optional questionnaire at the end of the training. While all the components of the clinical supervisor training program appeared to be helpful to the trainees, the most valuable part of the training was the metasupervision component. This is likely due to the supervisory trainees having the opportunity to work with clinical trainees on real client cases continuously with the support of a clinical supervisor in the room. The literature also makes this observation while discussing the importance of the vertical model (Hazel & Segler, 2019).

In contrast to the supervisor trainee and clinical supervisor results, the blind rater results varied. Regarding the Questioning, Prompting, and Demonstrating competencies, there was no significant increase in competency skills between the timepoints. However, the Teaching competency did demonstrate a significant increase in competency skills between timepoints. It's likely these scores differed between clinical supervisors and

blind raters due to the setting these skills were observed. The clinical supervisors observed these supervisory skills in a metasupervision setting, while the blind raters observed these skills through skill practice on Skillsetter that was recorded throughout the training. Rating the trainees on skills based on two different platforms/settings could have impacted the ratings. Additionally, it should be noted that the clinical faculty supervisors were not blind to the hypotheses of this study.

A secondary research question of this investigation sought to determine whether supervisory trainees' supervisory self-efficacy increased as a result of participating in the clinical supervision training program based on self-report ratings by the supervisory trainees (Hypothesis 3). All trainees' responses indicated a clinically significant increase in supervisory self-efficacy overall. When looking at these relationships further, it was found that similar to the self-report ratings of supervisory competencies, baseline and timepoint 3 presented the most significant difference. This increase is similar to what is reported in other research regarding multicultural self-efficacy and self-efficacy in general in graduate programs (Barden & Greene, 2015; Mullen et al., 2015).

Overall, while this study must be interpreted cautiously because it is a pilot program with a small sample size (and other limitations described below), its implications on graduate training are immense. There is a potential for having a standardized training program for psychology graduate students that assists in increasing supervisory competency and ensures competent supervisors are providing appropriate supervision. This could eventually be a required course embedded into the graduate program.

## **Limitations**

### ***Sample***

Due to this being a pilot study and only having three supervision sections available at a university-based clinic where supervisory trainees received the meta-supervision part of the training program, as well as the goal of having only two students receive meta-supervision in one section at a time, the study was limited to only 6 participants in the training program. A larger sample size could provide more power and more clearly determine the influence of training on supervisor competency skills and supervisory self-efficacy skills.

### ***Methodological issues***

Additionally, when training materials were distributed to the blind raters, there was no way to ensure they watched/reviewed the training material before they completed their ratings. Ensuring the blind raters completed the training would increase fidelity in completing the ratings. This could be done by having them complete and return a rating of the training video they watched to show they have completed the training. Also, by having the blind raters complete these training ratings, this would be a way to ensure interrater reliability (i.e., similarity in observation of a behavior by two or more individuals (Creswell, 2015)) by comparing their ratings/coding of the vignette. Obtaining interrater reliability is important because it can impact the validity of your results if the interrater reliability is weak (Creswell, 2015).

There was no uniform approach to metasupervision and this could be considered a limitation of the study. While efforts were attempted to have uniformity, due to attendance changes because of holidays or illnesses, having a uniform approach to

metasupervision was difficult. Also, there was an average of 9 supervision sessions attended by the trainees, and at times trainees attended over zoom video conferencing; however, three trainees attended all supervision sessions in person. Having a more uniformed standardized approach would help to ensure the training can be replicated. Additionally, having a checklist the clinical faculty filled out each session would have been ideal ensured fidelity.

Didactics were structured to be 2 hours at the beginning of the training program and then once a month for an hour during the training (four didactics total). During the final didactic training, trainees expressed it would have been helpful to have longer didactics so that there was more opportunity to review skills practiced on Skillsetter and receive more direct feedback. The initial intent was to use deliberate practice as a component of the training via the Skillsetter platform; however, there was not enough opportunity to receive direct feedback on their performance on Skillsetter. Increasing the duration of the didactics would allow for more time to develop each competency individually. Future studies can use the extended didactic time discussed prior have more opportunity to truly implement the deliberate practice approach.

### **Future Directions**

While the findings of this investigation add to our understanding of training in clinical supervision, research can be expanded upon in several ways. As such, several directions for future research were identified. As mentioned previously, the sample size impacted the type of analyses that could be run. Thus, a larger sample size could provide more power and more clearly distinguish the impact of training on supervisor

competency skills. A larger sample would also allow for greater generalization to graduate students seeking training for clinical supervision.

This study revealed the essential factors to consider about the training program curriculum and structure. Regarding structure, it is ideal to have uniformity in the metasupervision approach (vertical model) with the number of attended days, in-person vs. zoom, and how the supervisor trainee receives direct feedback during the metasupervision. Having a more uniformed standardized approach would help to ensure the training can be replicated, as well as help to identify areas that are important to focus on during clinical training. Considering trainees indicated this was the most helpful part of the training, it is beneficial to have the most standardized approach to metasupervision. Regarding the curriculum, it would have been helpful to consider extending the didactics to double the time and having more opportunities for in-person skills practice. Future investigations could look at these changes for a more standardized structure and in-depth curriculum.

A novel component to this study that warrants more discussion was the ability for supervisor trainees to practice their supervisory skills on Skillsetter. Throughout the training program, trainees practiced supervisory competencies that were acquired during the training. While deliberate practice is used in supervision models and is considered a core component of training (Goodyear & Rousmaniere, 2017; Hazel & Segler, 2019; Justice et al., 2018), there are minimal studies that use a similar online platform to practice skills in training, particularly in supervision. Skillsetter gave the participants the opportunity to practice their response an unlimited number of times before submission and had cues as to what skills were expected to be observed. This helped to ensure

trainees included all skills expected for each competency. Additionally, using this type of platform provided more opportunity to have a standardized component of skill practice included in a training program.

Interestingly, throughout the process of conducting this study, subskills began to emerge for each supervisory competency. There are at least three subskills under each of the main competency areas. For example, in looking at the supervisory competency of Questioning, there are three subskills: 1) Gather information and seek to raise the supervisee's awareness; 2) Help supervisee develop hypotheses regarding therapeutic/work problems; and 3) Help supervisee develop a range of perspectives regarding the therapeutic process and usefulness of different therapeutic techniques. Future investigations could attempt to tease out these supervisor competency subskills embedded in the SAGE to give even more information to help guide training.

Additionally, future investigations could examine the question; Does increasing supervisor competency skills ultimately impact clinical outcomes? While we can hypothesize that the answer to this would be yes, having a training program that meets the long-term goal of improving client outcomes adds even more weight to the need for a more standardized supervisor training program. Future investigations that scientifically prove the relationship between increasing supervisor competency and client outcomes would be significant.

## **Implications**

Implications to this study expands on the current literature in professional psychology. First, looking at the current literature in school psychology, Simon et al. (2019) explored the Illinois School Psychologist Association (ISPA) certificate program

that uses the DEP model as a foundation for their training. While Simon and colleagues promoted the DEP model as a best practice framework in school psychology supervision, they did not collect any participant feedback or practice data. Hazel and Segler (2019) examined training psychology students in supervision by using the vertical model as a guide for a supervision course at the University of Denver. In reviewing the methods and results, the supervisors in training gave positive comments about the efficacy of training, however there was nothing formally used to measure efficacy and overall competency (Hazel & Segler, 2019). Milne and colleagues conducted a systemic review of 11 controlled studies about supervisory training (Milne et al., 2011). While Milne et al. (2011) overall had a positive review and provided helpful conclusions to guide supervision training, only 2 out of the 11 studies were specific to counseling or psychology, and majority of the studies included were based on training of human services staff, paraprofessionals, and teachers. None of the studies showed a linear relationship between the role of training and clinical supervision. Identifying an evidence-based clinical supervision training model that can be generalized into not only broad psychology, but also other roles in health services would be substantial. This study is one step in the direction of beginning to focus on empirical evidence and an evaluation of training through research.



## **Chapter VI**

### **Application to School Psychology**

Research shows that only 15-20% of school psychologist receive formal training in supervision (NASP, 2018). The role of school psychologists often includes providing counseling services, and it is imperative to ensure that any supervision is provided by a psychologist who received formal supervisory training (Simon & Swerdlik, 2017b). Out of the research conducted on supervisory competencies, most have focused on supervisory training in the area of assessment and minimal supervisory training in the area of intervention (Newman & Guiney, 2019). Improving social emotional well-being for students is an important component of academic success (MacCann et al., 2020) and having well trained supervisors (particularly in the area of clinical interventions) helps to ensure this success.

This investigation identified that graduate students who participated in clinical supervision training reported higher levels of supervisory competency at the end of the program. Supervision is an essential component of graduate training (Ferreira-Correia, 2017). This initiative is consistent with the objectives of this investigation and the scientist-practitioner model (Huber, 2007).

## Appendix A



### **RESEARCH CONSENT**

#### **Please read, sign, and return to Rachel Vaughn**

The St. John's University Center for Psychological Services serves as a training site for graduate students. Center for Psychological Services' mission is to serve the Department of Psychology as a training site for all of its graduate student in the clinical and school psychology programs, to provide the highest quality psychological care to the local community by delivering evidence-based psychological services and carry out and facilitate a number of research projects and opportunities for students and faculty.

You are invited to participate in a research study, which aims to advance the knowledge of effective clinical supervisory training leading to increased supervisory competency and supervisory self-efficacy. Participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty. However, in order to participate in this study, you are required to complete all measures. Refusal to complete these forms will result in the termination of your participation in this study, and from the training program. There are no known risks associated with your participation in this research beyond those of everyday life.

In the event that you need any additional information regarding this research project, you may email Rachel Vaughn at [rachel.vaughn18@stjohns.edu](mailto:rachel.vaughn18@stjohns.edu). For questions about your rights as a research participant, you may contact the university's Human Subjects Review Board, St. John's University, (718) 990-1440. Your signature on this form means that you understand the information presented, and that you want to participate in the study. You understand that participation is voluntary and you may withdraw from the study at any time.

#### **Agreement to Participate**

---

Signature of trainee

---

Date

## Appendix B

### Demographic Questionnaire

1. Gender

- Female
- Male
- Transgender Female
- Transgender Male
- Non-Conforming
- Not Listed:
- Prefer Not to Answer

2. Ethnicity

- Hispanic
- White
- Black or African American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Race Not Listed: \_\_\_\_\_

3. What is your age? \_\_\_\_\_

4. Previous experience providing supervision? \_\_\_\_ Yes \_\_\_\_ No  
If yes: How many years of experience providing supervision? \_\_\_\_\_

## Appendix C



### Recruitment Letter

Are you interested in adding clinical supervision training to your CV? You are invited to participate in a research study, which aims to advance the knowledge of effective clinical supervisory training leading to increased supervisory competency and supervisory self-efficacy. To participate in this study, you must have completed a minimum of 70 credits of graduate instruction, a field-based externship, two clinic-based training practica (at least one being clinical interventions), and have earned their masters (specialist degree) in psychology. This training program will take place from June 2022 and will end August 2022.

Primary responsibilities will be:

- Co-supervise with a clinical supervisor for 90 minutes per week
- Complete 2 self-report measures at 4 timepoints
- Participate in a one 2-hour and three 50 minute didactic sessions each month (4 total)
- Complete Skillsetter online skill practice:
  - View and record video responses to 4 supervisory competency areas (approx. 1 min responses) at 4 timepoints months (16 video responses total).

If interested in participating in this study, please contact [rachel.vaughn18@stjohns.edu](mailto:rachel.vaughn18@stjohns.edu)

## Appendix D



### Vignette Scripts

#### Baseline

**1. Supervisory Skill to be Demonstrated:** Questioning

**Operation Definition:** The supervisor gathers information and seeks to raise the supervisee's awareness.

**Introduction:** This is Jason. He has been your clinical supervisee for two months now. He is about to have his 5<sup>th</sup> session with a 12-year-old client who is having trouble completing their journaling homework.

**Script:** I'm not sure how else to motivate my client. They always have excuses for why they do not have their journaling homework completed and the reason we decided on journaling for homework was due to their difficulty with self-reporting their thoughts, feelings, and actions during sessions.

**2. Supervisory Skill to be Demonstrated:** Prompting

**Operation Definition:** The supervisor reminds the supervisee about relevant material by prompting and cueing them.

**Introduction:** Jackie has been working with a 9-year-old client who is being treated for disruptive behaviors and their mother for 1 month now. The current token economy strategy that was originally effective is not working anymore.

**Script:** I have not been able to identify with the client or parent any changes that would make this strategy ineffective now, other than the client expressed they are no longer interested in any of the rewards that are being offered.

**3. Supervisory Skill to be Demonstrated:** Demonstrating

**Operation Definition:** The supervisor actively attempts to develop the supervisee's competence by demonstrating/modelling/illustrating the correct performance of a skill.

**Introduction:** This is George. You are currently supervising him, and he is about to complete an initial assessment with a newly assigned 15-year-old client. You just finished discussing the client has a history of suicidal ideations.

**Script:** I have not had the opportunity to complete a risk assessment on a client. I know what I need to ask but it would be helpful if you could show me how you would initiate the discussion around their history with suicidal ideations.

**4. Supervisory Skill to be Demonstrated: Teaching**

**Operation Definition:** The supervisor provides information about theories, facts, figures, ideas, methods, articles, etc. to the supervisee in a didactic, directive fashion.

**Introduction:** Natalie just completed an initial assessment for a 9-year-old client and is meeting with you for supervision to discuss how she will structure the first session. The assessment yielded a diagnosis of adjustment disorder, with mixed anxiety and depressed mood mostly due to a recent change in living environment after a move out of state.

**Script:** I am planning on starting the session doing rapport building by playing a game, but I'm stuck on what would be best to do next?

**Time-point 2**

**1. Supervisory Skill to be Demonstrated: Questioning**

**Operation Definition:** The supervisor gathers information and seeks to raise the supervisee's awareness.

**Introduction:** Michelle just had their first session with a new 13-year-old client and their mother. She is trying to decide what measure or measures to administer to assist with diagnosis.

**Script:** The client and his mother reported several symptoms at home and school. I'm not sure which measure or measures would be best to help determine my diagnoses. Some of the symptoms include excessive worry, irritability, verbal aggression, and occasional physical aggression.

**2. Supervisory Skill to be Demonstrated: Prompting**

**Operation Definition:** The supervisor reminds the supervisee about relevant material by prompting and cueing them.

**Introduction:** Jordon just completed the first appointment intake with a new 16-year-old client and is coming to you for supervision before he continues with the intake process.

**Script:** I think I asked enough questions to get a thorough history. I asked both the client and her mom about past treatment, medical and developmental history, current living environment, and education. Did I miss anything?

**3. Supervisory Skill to be Demonstrated: Demonstrating**

**Operation Definition:** The supervisor actively attempts to develop the supervisee's competence by demonstrating/modelling/illustrating the correct performance of a skill.

**Introduction:** Lisa has been working with an 18-year-old client for 2 months now and is about to meet with you for supervision to discuss their next session. The client experienced recent trauma and has not brought it up in session other than in the initial assessment.

**Script:** I feel I have pretty good rapport with the client and I want to attempt to bring up the topic of trauma since it happened so recently and may be contributing

to her symptoms. When I have tried to tip toe around the topic she doesn't continue in the discussion. Would you model for me a way I can approach this topic and help her feel comfortable?

**4. Supervisory Skill to be Demonstrated: Teaching**

**Operation Definition:** The supervisor provides information about theories, facts, figures, ideas, methods, articles, etc. to the supervisee in a didactic, directive fashion.

**Introduction:** Johnny recently started working with a client diagnosed with obsessive compulsive disorder.

**Script:** I have never worked with a client with this diagnosis before. Would you help me to understand the difference between obsessions and compulsions, and what treatment approach to use?

**Time-point 3**

**1. Supervisory Skill to be Demonstrated: Questioning**

**Operation Definition:** The supervisor gathers information and seeks to raise the supervisee's awareness.

**Introduction:** Neal has been working with his 15-year-old client and his parents and is meeting with you to discuss an upcoming family session.

**Script:** I have a family session coming up to discuss a difficult topic and I'm not sure how to structure the session. The client's parents reported the client will not perform certain religious practices and this causes arguments in the home, while the client reports having different beliefs than their parents.

**2. Supervisory Skill to be Demonstrated: Prompting**

**Operation Definition:** The supervisor reminds the supervisee about relevant material by prompting and cueing them.

**Introduction:** Kim just recently was assigned a new client. She is about to have her first intake session with them and is coming to you for supervision.

**Script:** I know I need to get a thorough history including medical and developmental history, living environment, social interactions, educational history, and prior treatment. Is there anything I am missing that I should also discuss for the first session?

**3. Supervisory Skill to be Demonstrated: Demonstrating**

**Operation Definition:** The supervisor actively attempts to develop the supervisee's competence by demonstrating/modelling/illustrating the correct performance of a skill.

**Introduction:** James recently started working with an 11-year-old client who was diagnosed with social anxiety during the intake process.

**Script:** I have provided psychoeducation to adults before about social anxiety, but I am having trouble conceptualizing providing psychoeducation to my 11-year-old client. Can you show me how you would provide psychoeducation to a child that age?

**4. Supervisory Skill to be Demonstrated: Teaching**

**Operation Definition:** The supervisor provides information about theories, facts, figures, ideas, methods, articles, etc. to the supervisee in a didactic, directive fashion.

**Introduction:** Tina just recently had a session with a client who was asking several personal questions.

**Script:** We were talking about my clients' parents, and they started asking me about my family and how my relationship was with my siblings. I was so caught off guard and didn't know what to say. How can I handle that better in the future?

**Time-point 4**

**1. Supervisory Skill to be Demonstrated: Questioning**

**Operation Definition:** The supervisor gathers information and seeks to raise the supervisee's awareness.

**Introduction:** Jennie has been working with a client diagnosed with OCD and is ready to begin gradual exposure.

**Script:** The client has done a great job identifying obsessions and compulsions. I am not sure exactly where to start to structure the gradual exposure.

**2. Supervisory Skill to be Demonstrated: Prompting**

**Operation Definition:** The supervisor reminds the supervisee about relevant material by prompting and cueing them.

**Introduction:** This is Bill. He has been working with a client recently and is struggling to document progress.

**Script:** From what the client is telling me in session they do not think they are improving; however, I am seeing progress. I want to present a strategy that is more concrete to the client to use to help monitor progress, as well as something I can visually show the progress.

**3. Supervisory Skill to be Demonstrated: Demonstrating**

**Operation Definition:** The supervisor actively attempts to develop the supervisee's competence by demonstrating/modelling/illustrating the correct performance of a skill.

**Introduction:** Jill just had her third session with a new client. She has just come in and informed you she had an alliance rupture.

**Script:** We were discussing the logistics of therapy and when I brought up pricing, she started making statements that I am only "in it for the money." I tried to convince her otherwise but I'm afraid now she doesn't trust me. How do I even start the next session with her?

**4. Supervisory Skill to be Demonstrated: Teaching**

**Operation Definition:** The supervisor provides information about theories, facts, figures, ideas, methods, articles, etc. to the supervisee in a didactic, directive fashion.



**Introduction:** This is Jack. He is having his final session with a 16-year-old client and is coming to you for supervision to prepare.

**Script:** I am not sure what to say for the final session. I know I want to review their progress, is there anything else I should put on my agenda?

## Appendix E



### Supervision Training Questionnaire:

**Please rate each item using the following scale:**

1= Not Helpful at all; 2= Slightly Helpful; 3=Moderately Helpful; 4= Very Helpful; 5= Extremely Helpful

1) How helpful was it to attend group didactic sessions?

1      2      3      4      5

2) How helpful was it to receive feedback on supervision skills in group didactic sessions?

1      2      3      4      5

3) How helpful was it to practice the supervision skills using the Skillsetter platform?

1      2      3      4      5

4) How helpful was it to co-supervise one or more less advanced students in clinical practice?

1      2      3      4      5

5) How helpful was it to receive feedback and evaluation from the clinical supervisor?

1      2      3      4      5

6) How helpful was it to receive support and guidance from the clinical supervisor?

1      2      3      4      5

7) How helpful was it to collaborate with the clinical supervisor to set goals for supervision sessions?

1      2      3      4      5

8) How helpful was it to have a positive alliance with the clinical supervisor?

1      2      3      4      5

Appendix F

SAGE Record Sheet:  
Supervisee Cycle

Date of supervision session: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Supervisee: \_\_\_\_\_ Assessor: \_\_\_\_\_ Date of rating: \_\_\_\_\_

**SUPERVISEE CYCLE items**

Please circle your rating:

	INCOMPETENT			COMPETENT		EXPERT	
<b>1. Reflecting</b> Supervisee summarizing & understanding subjective/private material (e.g., expressing own ideas).	0	1	2	3	4	5	6
<b>2. Conceptualizing</b> Integrating objective/public material (e.g., grasping relevant theory).	0	1	2	3	4	5	6
<b>3. Planning</b> Problem-solving; decision-making; action planning.	0	1	2	3	4	5	6
<b>4. Experiencing</b> Emotional processing (e.g., greater self-awareness).	0	1	2	3	4	5	6
<b>NOTES</b> (e.g., clarify low/high ratings).							
<b>FEEDBACK</b> (suggestions to improve competence).							

Appendix G

**SAGE Record Sheet:**  
**Supervision Cycle**

Date of supervision session: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Supervisee: \_\_\_\_\_ Assessor: \_\_\_\_\_ Date of rating: \_\_\_\_\_

*SUPERVISION CYCLE items*

Please circle your rating:

	INCOMPETENT	COMPETENT	EXPERT
<b>1. Managing</b> Supervisor leads, 'scaffolding' learning (structuring; pacing)	0 1 2	3 4	5 6
<b>2. Agenda-setting</b> Defining session objectives.	0 1 2	3 4	5 6
<b>3. Formulating</b> Analyzing; synthesizing; explaining (e.g., case reformulation)	0 1 2	3 4	5 6
<b>4. Questioning</b> Gathering information. raising awareness.	0 1 2	3 4	5 6
<b>5. Prompting</b> Reminding & cueing (e.g., rephrasing)	0 1 2	3 4	5 6
<b>6. Demonstrating</b> Modelling competence (e.g., live or video illustrations)	0 1 2	3 4	5 6

<b>7. Teaching</b> Informing; discussing; educating.	0	1	2	3	4	5	6
<b>8. Training/experimenting</b> Facilitating experiential learning (e.g., role-play)	0	1	2	3	4	5	6
<b>9. Evaluating</b> Monitoring & giving supervisee feedback.	0	1	2	3	4	5	6
<b>10. Feedback</b> Seeking feedback on Supervision; defining & addressing gaps.	0	1	2	3	4	5	6

**NOTES** (e.g., clarify low/high ratings).

---

**FEEDBACK** (suggestions to improve competence).

## Appendix H

### Blind Rater Training Vignettes

#### 1. **Supervisory Skill to be Demonstrated:** Demonstrating

**Operation Definition:** The supervisor actively attempts to develop the supervisee's competence by demonstrating/modelling/illustrating the correct performance of a skill.

**Introduction:** Carla has been working with the parents of a 14-year-old male client diagnosed with ADHD and Disruptive Behavior Disorder. She has just had the conversation with her supervisor to start behavioral parent training.

**Supervisee Script:** I can tell I have buy in from the client's mother to attempt some behavioral strategies again, but the father has already made statements about "trying all these strategies before and nothing worked" during my first session with them. Can you show me how I can approach this topic and try to get buy in from both parents?

**Incompetent Supervisor Response (Score of 0, 1, or 2):** That is a tricky situation. Let's just leave dad out of the next session. We can start with training mom and hope that it will begin to show some improvement. If client's father still wants to join, just direct most of the conversation to mom so that he's not feeling pressured to have to attempt the strategies.

**Competent Supervisor Response (Score of 3 or 4):** Great insight on your part to ask that question. This situation can be tricky. While dad has a point and we want to validate that to continue to build rapport, we also need to attempt the parent strategies again and identify which ones they have tried. Perhaps you can attempt this conversation is by saying "I can imagine it has been hard to attempt these strategies when you see they are not working, but we have to keep trying. Consistency is key. Can you tell me the parenting strategies you tried again?"

**Expert Supervisor Response (Score of 5 or 6):** It's great that you already picked up on his father mentioning that and how tricky it may be when you try to present some strategies to his parents they may have already attempted. It is important to make sure to begin by validating his parents as well as praising them for returning for support to further build rapport with the parents, then shift the conversation to discuss what strategies they have attempted and what worked and/or didn't work. How about we role play to practice, and you be dad and I'll be you to start so you can see an example of how you could say all of this. "I wanted to follow up from the last session when you mentioned trying some of these strategies and nothing worked. I can imagine that it's upsetting to hear about how these strategies can be helpful, and then put all of this energy into attempting them with no success. What can be helpful to start is to talk through the strategies you have tried so far to see if there are any others we can discuss and attempt, and it also gives

us an opportunity to look at some of the strategies you have tried and do some detective work on why they weren't effective, which can be for many reasons." Now let's switch and you practice.

**2. Supervisory Skill to be Demonstrated: Questioning**

**Operation Definition:** The supervisor gathers information and seeks to raise the supervisee's awareness of relevant material and effective strategies.

**Introduction:** Jackie has been working with a 9-year-old client's mother who is being treated for disruptive behaviors for 1 month now. The current token economy strategy that was originally effective is not working anymore.

**Supervisee Script:** I have not been able to identify with the parents any changes that would make this strategy ineffective now, other than the client expressed they are no longer interested in any of the rewards that are being offered.

**Incompetent Supervisor Response (Score of 0, 1, or 2):** Token economy is evidenced based and usually works. I think we should just stick with that strategy and eventually the client will get on board. The parents are using a sticker chart as a visual reminder, right?

**Competent Supervisor Response (Score of 3 or 4):** While token economy is an evidenced based approach, it's not always the best fit for every client. If you recall in your practicum class we just went over several different approaches that could be effective here and we can look at those parent strategies together if you have your notes today. Are you working with both the client and parents, or just the parents right now?

**Expert Supervisor Response (Score of 5 or 6):** While token economy is an evidenced based approach, it's not always the best fit for every client. If you recall in your practicum class we just went over several different approaches that could be effective here and we can look at those parent strategies together if you have your notes today. The three questions I would like for us to answer are: Is token economy the best approach?; Should we be working with the parent and child simultaneously?; and Have the client's interests changed since you first started working with them?

**3. Supervisory Skill to be Demonstrated: Prompting**

**Operation Definition:** The supervisor reminds the supervisee about relevant material by prompting and cueing them.

**Introduction:** Dan has been working with the parents of a 12-year-old female client diagnosed with ADHD and Disruptive Behavior Disorder. He has just had the conversation with his supervisor to start behavioral parent training.

**Supervisee Script:** I know I need to collect data to help track progress but I'm not sure what method to use with the parents.

**Incompetent Supervisor Response (Score of 0, 1, or 2):** I hear you that it's tough to know where to start when we need to collect data for a client and



what method to use. I think you just should get them to tally how many times the client is disruptive and then let's see what that looks like after two weeks.

**Competent Supervisor Response (Score of 3 or 4):** I hear you that it's tough to know where to start when we need to collect data for a client and what method to use. Think about what you have learned so far in your behavior therapy course. We can look through and discuss the different methods you have learned together today. Do you have any of your notes with you?

**Expert Response (Score of 5 or 6):** I hear you that it's tough to know where to start when we need to collect data for a client and what method to use. First, let's think about what you have learned so far in your behavior therapy course or in articles you may have read. It may be good for you to review and define the most problematic behavior with the parent and then consider the function of the behavior as that may drive what you actually collect to chart progress. Let's look over them together. ABC data may be best, and then depending on the data we can make a plan on how to continue to collect data for progress monitoring. Based on what you know about parent training and this family, what do you think would be a good place to start?

**4. Supervisory Skill to be Demonstrated: Teaching**

**Operation Definition:** The supervisor provides information about theories, facts, figures, ideas, methods, articles, etc. to the supervisee in a didactic, directive fashion.  
**Introduction:** Natalie just completed an initial assessment for a 9-year-old client and is meeting with you for supervision to discuss how she will structure the first session. The assessment yielded a diagnosis of adjustment disorder, with mixed anxiety and depressed mood mostly due to a recent change in living environment after a move out of state.

**Supervisee Script:** I am planning on starting the session doing rapport building by playing a game, but I'm stuck on what would be best to do next.

**Incompetent Supervisor Response (Score of 0, 1, or 2):** Just keep playing games with them for at least the first few sessions and then we'll go from there. We want to make sure they like you before we get them to do work with you.

**Competent Supervisor Response (Score of 3 or 4):** It sounds like you already know that therapeutic alliance with the client is very important and can impact client progress. That's great! Starting with something light like a game is nice for rapport building. It is also an important step to start to identify some goals with the client. Research shows that building an alliance this as early as possible helps with engagement in the therapy process.

**Expert Supervisor Response (Score of 5 or 6):** It sounds like you already know that therapeutic alliance with the client is very important and can impact client progress. Starting with something light like a game is great for rapport building. Given some of the concerns about anxiety and depression, you can also use games in a therapeutic way to start to see what emotions

they are aware of and can identify. For example, you can play candyland and name an emotion for each color, and every time someone lands on that a color they have to tell about a time they felt that emotion. Then gently you could work towards setting goals as they relate to these emotions. Identifying goals with the client has been shown to be important for clinical progress as well as provide you with a point to evaluate where they are in relation to these goals throughout therapy.

## Appendix I



### **Blind Rater Recruitment Letter**

Hello,

My name is Rachel Vaughn, and I am currently a 5<sup>th</sup> year doctoral candidate in school psychology at St. John's University. I was hoping some of you would be willing to participate in my dissertation project that focuses on training in supervision.

My project is a pilot study that investigates the role of training in clinical supervision on clinician supervisory competency and supervisory self-efficacy. Participants were required to demonstrate certain supervisory competencies in response to a simulated supervisee.

To be able to participate you would need to meet the following qualifications: 1) Licensure in psychology, 2) Have provided at least 70 hours of supervision to supervisees, and 3) obtained at least 5 hours of prior training in how to be a supervisor. This could be through a course, experience, or any continuing education.

If you are willing to participate you would be asked to watch three short videos to ensure you have an understanding of the rating scale (approx. 5 minutes) and then you will be asked to watch 6 videos in response to a simulated supervision session and asked to rate each response.

It is expected that this will take approximately 20 minutes to watch and rate all videos and step by step instructions will be provided.

As an expression of thank for you time, you will receive remuneration in the form of a \$50 gift card.

Please don't hesitate to email if you have any questions.

## Appendix J



### **Blind Rater Research Consent**

You are invited to participate in a research study, which aims to advance the knowledge of effective clinical supervisory training leading to increased supervisory competency and supervisory self-efficacy. Participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty. However, in order to participate in this study, you are required to complete all measures. Refusal to complete this form will result in the termination of your participation in this study. There are no known risks associated with your participation in this research beyond those of everyday life.

In the event that you need any additional information regarding this research project, you may email Rachel Vaughn at [rachel.vaughn18@stjohns.edu](mailto:rachel.vaughn18@stjohns.edu). For questions about your rights as a research participant, you may contact the university's Human Subjects Review Board, St. John's University, (718) 990-1440. Indicating "I do consent" below means that you understand the information presented, and that you want to participate in the study. You understand that participation is voluntary and you may withdraw from the study at any time.

## Appendix K

### Clinical Supervision Self Efficacy Scale (CSSES)

Directions: On a scale of **0 (not at all confident)** to **100 (highly confident)** record a number as to how confident you are to effectively perform each of the tasks stated below. For example, a number of 50 would indicate a moderately confident level.

Right now I feel that I can effectively...

- \_\_\_\_\_ 1. Evaluate counseling interactions with clients as part of supervision.
- \_\_\_\_\_ 2. Identify appropriate counseling interventions to promote positive client change.
- \_\_\_\_\_ 3. Teach, demonstrate, or model counseling intervention techniques.
- \_\_\_\_\_ 4. Explain the rationale behind specific counseling strategies and/or interventions.
- \_\_\_\_\_ 5. Interpret significant events in the counseling session.
- \_\_\_\_\_ 6. Provide alternative interventions and/or conceptualizations for the counselor to use.
- \_\_\_\_\_ 7. Encourage counselor brainstorming of strategies and/or interventions.
- \_\_\_\_\_ 8. Encourage counselor discussion of client problems, motivation, etc.
- \_\_\_\_\_ 9. Solicit and address the professional needs of the counselor during the session.
- \_\_\_\_\_ 10. Allow the counselor to structure the supervision session.
- \_\_\_\_\_ 11. Explore counselor feelings during a counseling session or supervision session.
- \_\_\_\_\_ 12. Explore counselor feelings concerning a specific counseling technique and/or intervention.
- \_\_\_\_\_ 13. Facilitate counselor self-exploration of confidence and/or worries in the counseling session.
- \_\_\_\_\_ 14. Help counselor define personal competencies and areas for growth.
- \_\_\_\_\_ 15. Provide opportunities for counselors to process their own affect or defenses.

**Table 1**

*Means, Standard Deviations, and Repeated Measures Analyses of Variance for the Effects of Clinical Training Supervisor Program on Supervisory Competency Scores and Supervisory Self-Efficacy Scores from Supervisory Trainees and Blind Raters*

Variable	Baseline		4-Weeks		12-Weeks		Post		<i>F</i>	$\rho$	$\eta^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Reflecting <sup>a</sup>	2.17	1.17	3.17	.753	4.33	.516	3.83	.408	12.23	<.001*	.71
Conceptualizing <sup>b</sup>	1.67	1.21	2.83	.753	4.00	.632	3.50	.548	10.00	<.001*	.67
Planning <sup>b</sup>	2.50	1.38	3.33	.816	4.50	.548	3.67	1.03	7.55	.031*	.60
Experiencing <sup>c</sup>	2.17	1.33	3.50	1.05	4.50	.837	.330	.816	11.64	<.001*	.70
Questioning <sup>d</sup>	3.17	1.47	4.00	1.67	4.00	1.27	4.17	1.33	.57	.645	.10
Prompting <sup>b</sup>	4.00	1.41	3.83	1.33	3.83	1.47	5.00	.632	1.27	.321	.02
Demonstrating <sup>e</sup>	4.17	1.47	3.50	1.64	3.83	1.60	3.67	1.63	.17	.919	.03
Teaching <sup>f</sup>	2.33	1.51	4.00	.632	5.50	.548	4.67	1.51	9.38	.005*	.65
Self-Efficacy <sup>b</sup>	53.67	18.84	65.33	15.40	77.17	10.38	74.17	10.80	16.04	<.001*	.97

*Note.* \*Significant at the  $p < 0.05$  level; <sup>a</sup>df= 2.17, 10.86; <sup>b</sup>df= 3,15; <sup>c</sup>df=1.86, 9.32; <sup>d</sup>df= 1.98, 9.89; <sup>e</sup>df= 2.14, 10.68; <sup>f</sup>df= 2.05,10.26; Competency scores are out of a total of 6 points. Self-Efficacy scores are out of a total of 100 points.

**Table 2**

*Means Scores on Measures of Supervisory Competency and Supervisory Self-Efficacy as a Function of Clinical Supervisor Training Program*

Variable	Baseline		4-Weeks		12-Weeks		Post	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Reflecting	2.17 <sup>a,b</sup>	1.17	3.17	.753	4.33 <sup>a</sup>	.516	3.83 <sup>b</sup>	.408
Conceptualizing	1.67 <sup>a</sup>	1.21	2.83	.753	4.00 <sup>a</sup>	.632	3.50	.548
Planning	2.50 <sup>a,b</sup>	1.38	3.33	.816	4.50 <sup>a</sup>	.548	3.67 <sup>b</sup>	1.03
Experiencing	2.17 <sup>a</sup>	1.33	3.50	1.05	4.50 <sup>a</sup>	.837	.330	.816
Questioning <sup>BR</sup>	3.17	1.47	4.00	1.67	4.00	1.27	4.17	1.33
Prompting <sup>BR</sup>	4.00	1.41	3.83	1.33	3.83	1.47	5.00	.632
Demonstrating <sup>BR</sup>	4.17	1.47	3.50	1.64	3.83	1.60	3.67	1.63
Teaching <sup>BR</sup>	2.33 <sup>a</sup>	1.51	4.00 <sup>b</sup>	.632	5.50 <sup>a,b</sup>	.548	4.67	1.51
Self-Efficacy	53.67 <sup>a</sup>	18.84	65.33	15.40	77.17 <sup>a</sup>	10.38	74.17	10.80

*Note.* Means in a row sharing subscripts are significantly different from each other; For all measures, higher means indicate higher competency/self-efficacy scores; BR= Blind Rater.

**Table 3**

*Means, Standard Deviations, and Repeated Measures Analyses of Variance for the Effects of Clinical Training Supervisor Program on Supervisory Competency Scores Based on Clinical Supervisors Ratings*

Variable	4-Weeks		8-Weeks		12-Weeks		<i>F</i>	$\rho$	$\eta^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Questioning <sup>a</sup>	3.33	1.03	5.17	.408	5.33	.516	19.00	.004*	.79
Prompting <sup>b</sup>	2.83	.983	4.83	.753	4.83	.983	24.00	<.001*	.83
Teaching <sup>b</sup>	3.00	.632	5.00	.632	5.33	.816	33.08	<.001*	.87
Managing <sup>b</sup>	2.67	.516	4.83	.753	5.17	.753	58.53	<.001*	.92
Agenda- Setting <sup>b</sup>	2.67	.516	4.50	.548	5.33	.516	47.86	<.001*	.91
Formulating <sup>c</sup>	2.83	.753	4.67	.516	5.17	.753	24.00	<.001*	.91
Training <sup>d</sup>	2.50	.837	4.50	.548	5.00	.894	28.64	<.001*	.85
Evaluating <sup>b</sup>	2.50	.837	4.67	.816	5.17	.753	63.82	<.001*	.93
Feedback <sup>e</sup>	2.50	.837	4.83	.408	5.33	.816	49.00	<.001*	.90
Demonstra- ting <sup>b</sup>	2.50	.837	4.83	.753	4.83	.983	49.00	<.001*	.91

*Note.* \*Significant at the  $p < 0.05$  level; <sup>a</sup>df=1.21,6.07, 10.86; <sup>b</sup>df= 2,10; <sup>c</sup>df= 1.23, 6.15; <sup>d</sup>df= 1.42, 7.11; <sup>e</sup>df= 1.47, 7.36; Competency scores are out of a total of 6 points.



**Table 4**

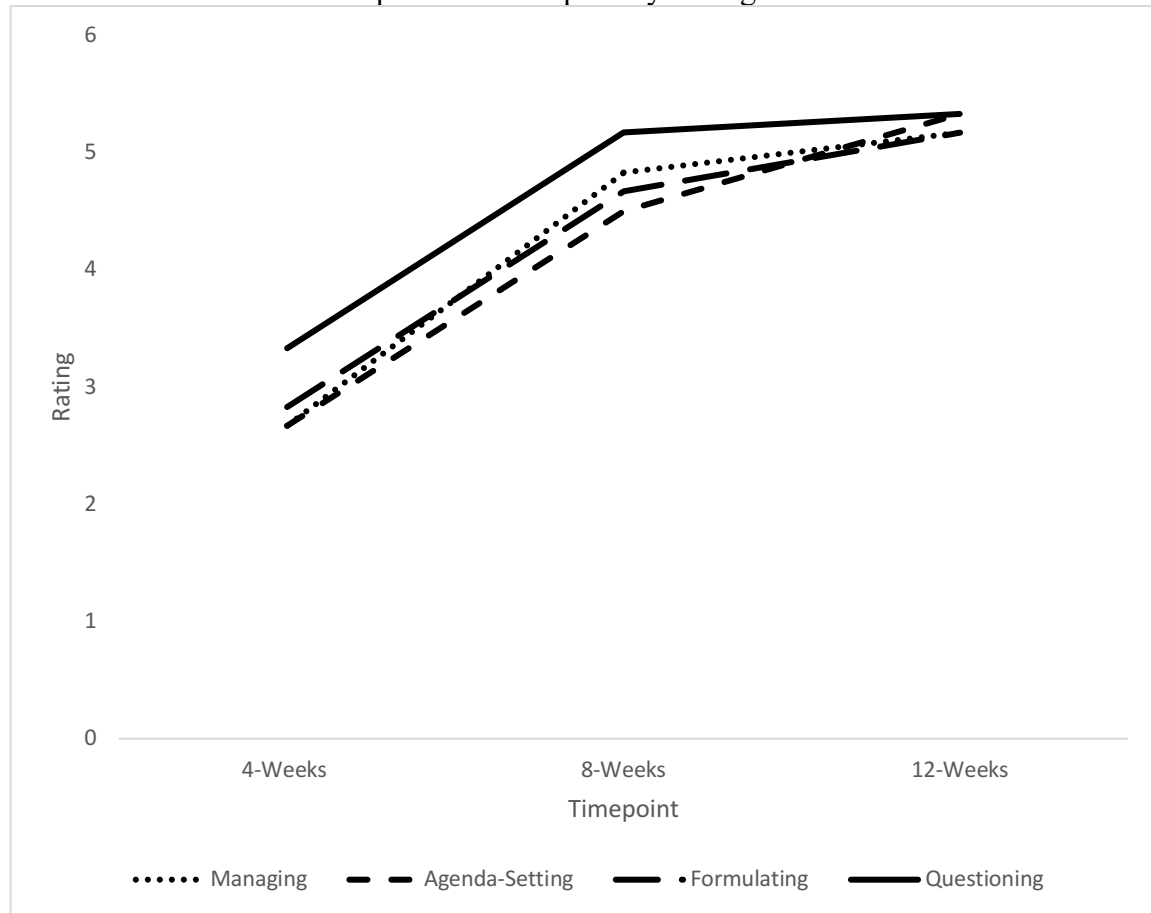
*Means Scores on Measures of Supervisory Competency as a Function of Clinical Supervisor Training Program Based on Clinical Supervisors Ratings*

Variable	4-Weeks		8-Weeks		12-Weeks	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Managing	2.67 <sup>a,b</sup>	.516	4.83 <sup>a</sup>	.753	5.17 <sup>b</sup>	.753
Agenda-Setting	2.67 <sup>a,b</sup>	.516	4.50 <sup>a</sup>	.548	5.33 <sup>b</sup>	.516
Formulating	2.83 <sup>a,b</sup>	.753	4.67 <sup>a</sup>	.516	5.17 <sup>b</sup>	.753
Training	2.50 <sup>a,b</sup>	.837	4.50 <sup>a</sup>	.548	5.00 <sup>b</sup>	.894
Evaluating	2.50 <sup>a,b</sup>	.837	4.67 <sup>a</sup>	.816	5.17 <sup>b</sup>	.753
Feedback	2.50 <sup>a,b</sup>	.837	4.83 <sup>a</sup>	.408	5.33 <sup>b</sup>	.816
Questioning	3.33 <sup>a,b</sup>	1.03	5.17 <sup>a</sup>	.408	5.33 <sup>b</sup>	.516
Prompting	2.83 <sup>a,b</sup>	.983	4.83 <sup>a</sup>	.753	4.83 <sup>b</sup>	.408
Demonstrating	2.50 <sup>a,b</sup>	.837	4.83 <sup>a</sup>	.753	4.83 <sup>b</sup>	.983
Teaching	3.00 <sup>a,b</sup>	.632	5.00 <sup>a</sup>	.632	5.33 <sup>b</sup>	.816

*Note.* Means in a row sharing subscripts are significantly different from each other. For all measures, higher means indicate higher competency scores.

**Figure 1**

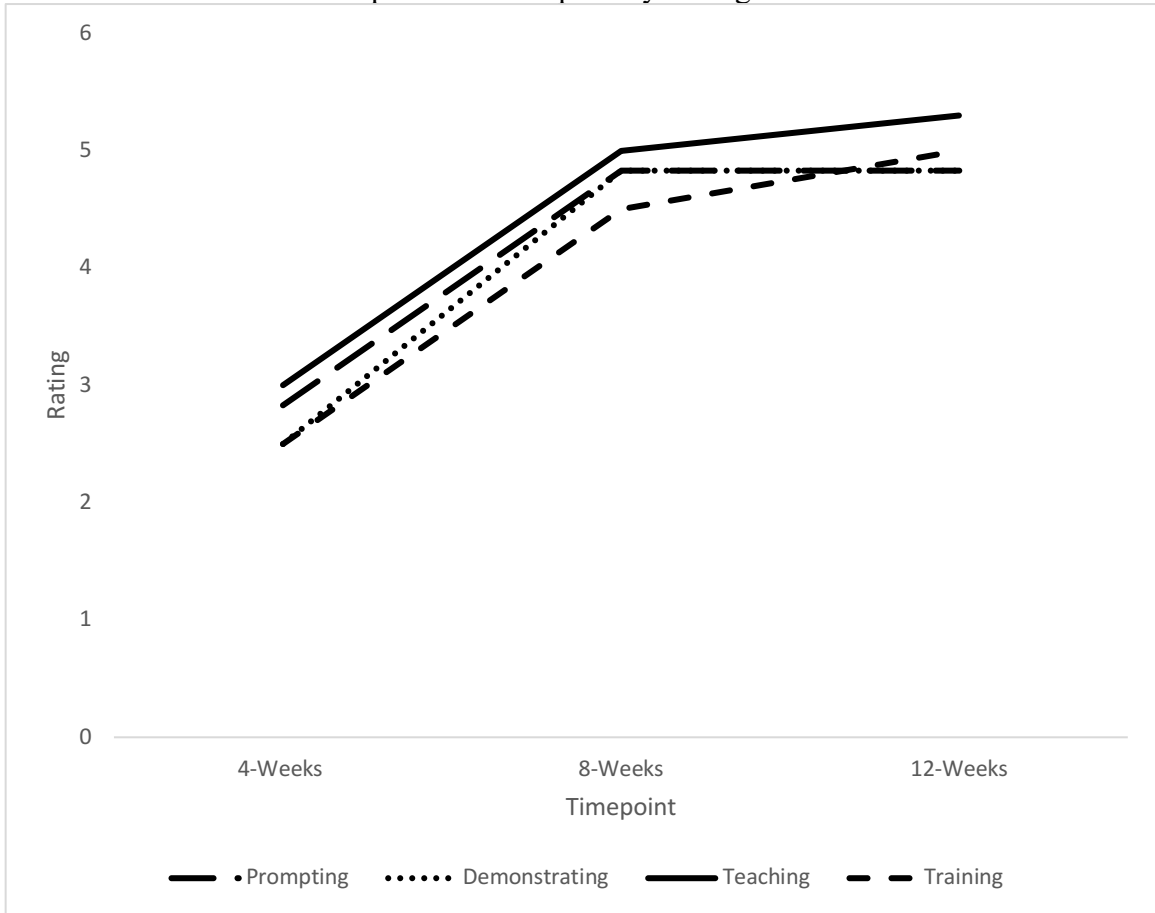
Mean-Scores for Clinical Supervisors Competency Ratings



*Note.* Managing  $R^2 = .85$ ; Agenda-Setting  $R^2 = .96$ ; Formulating  $R^2 = .90$ ; Questioning,  $R^2 = .81$

**Figure 2**

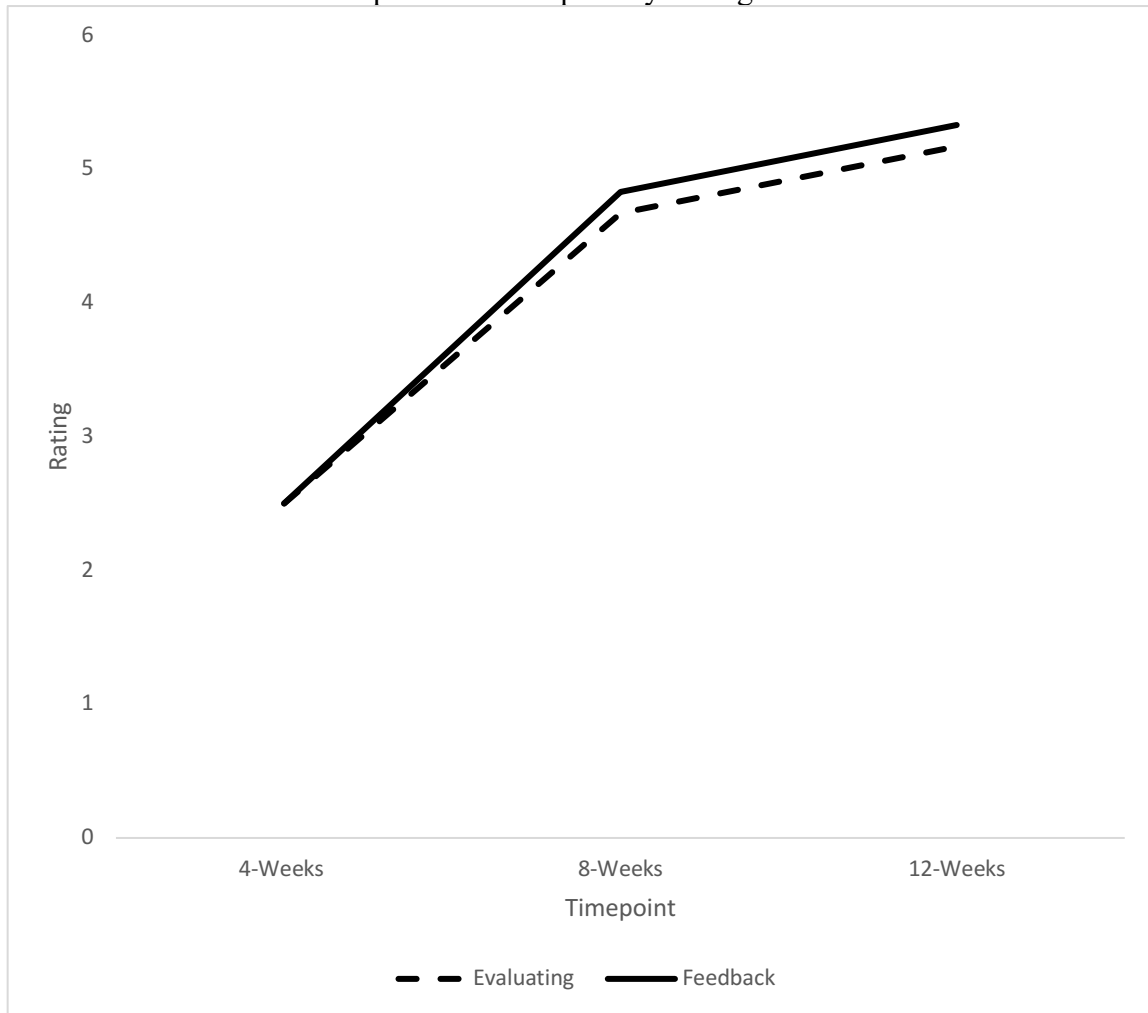
Mean-Scores for Clinical Supervisors Competency Ratings



*Note.* Prompting  $R^2 = .75$ ; Demonstrating  $R^2 = .75$ ; Teaching  $R^2 = .85$ ; Training,  $R^2 = .89$

**Figure 3**

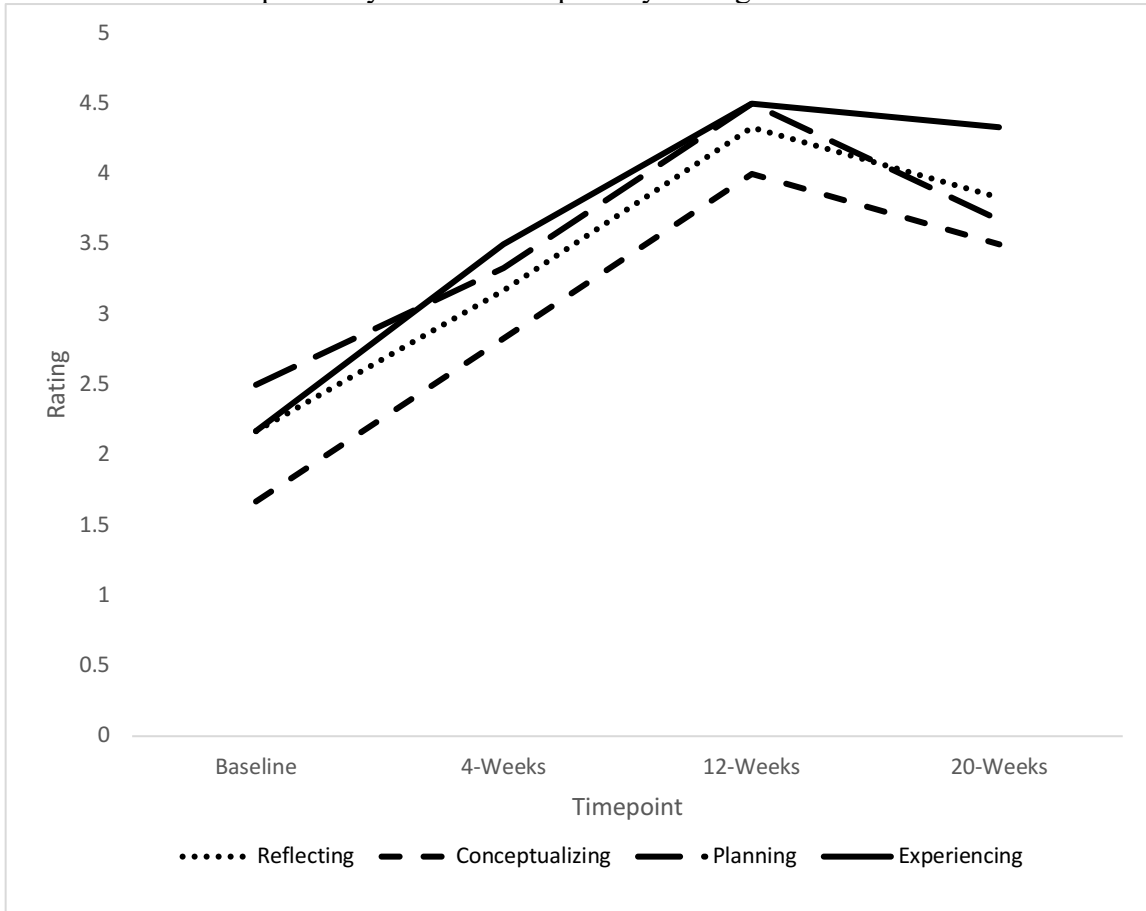
Mean-Scores for Clinical Supervisors Competency Ratings



*Note.* Evaluating  $R^2 = .88$ ; Feedback  $R^2 = .88$

**Figure 4**

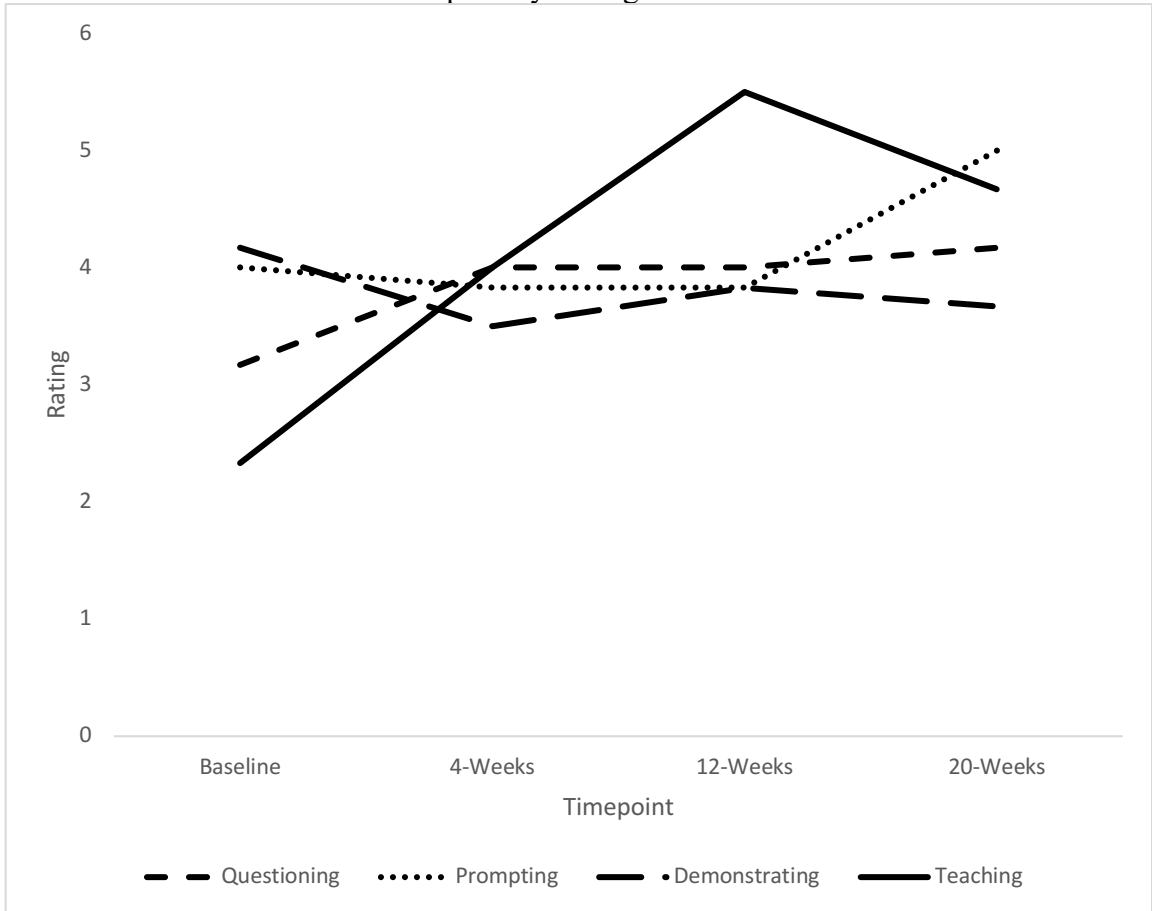
Mean-Scores for Supervisory Trainee Competency Ratings



*Note.* Reflecting  $R^2 = .72$ ; Conceptualizing  $R^2 = .73$ ; Planning  $R^2 = .53$ ; Experiencing,  $R^2 = .82$

**Figure 5**

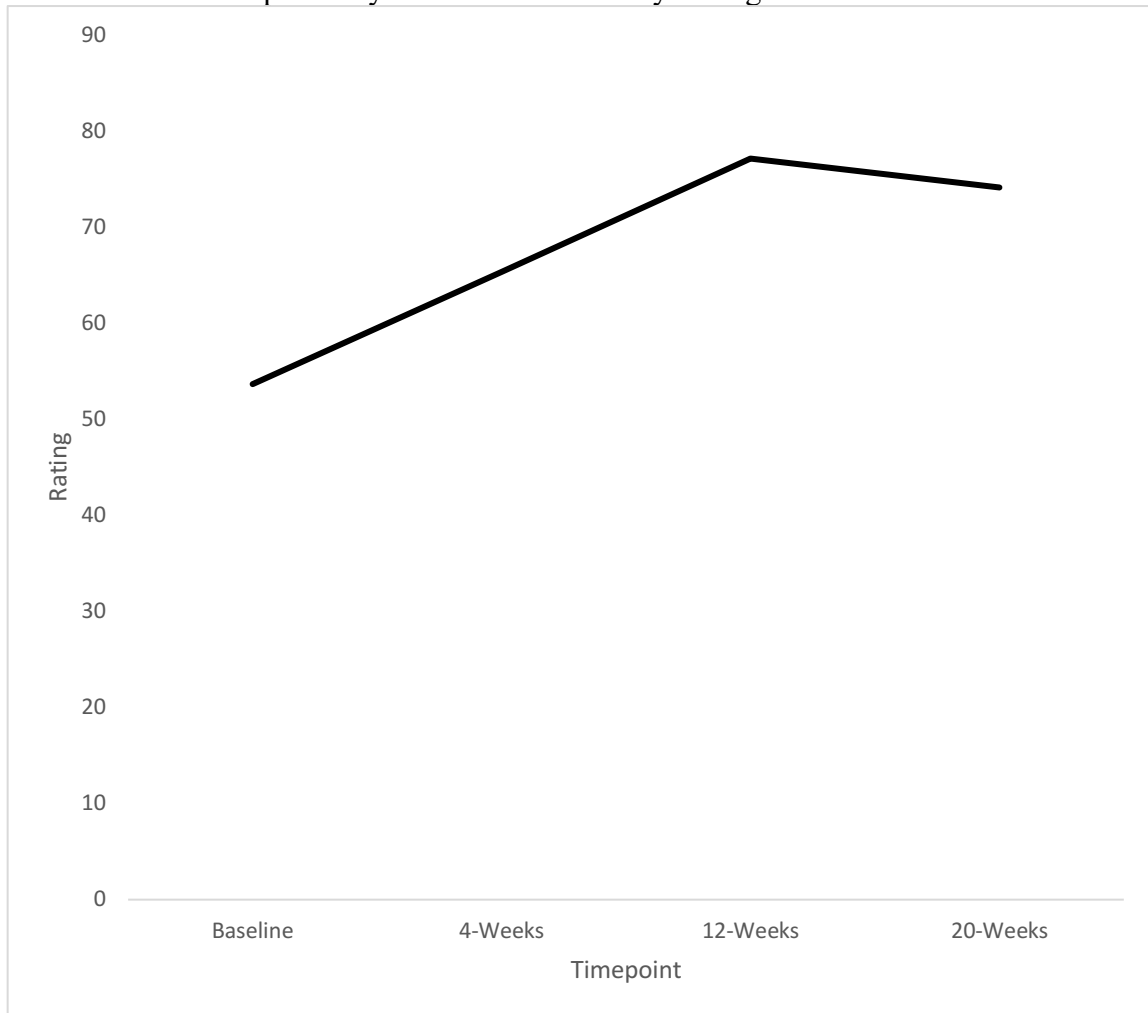
Mean-Scores for Blind Rater Competency Ratings



*Note.* Questioning  $R^2 = .74$ ; Prompting  $R^2 = .47$ ; Demonstrating  $R^2 = .28$ ; Teaching,  $R^2 = .67$

**Figure 6**

Mean-Scores for Supervisory Trainee Self-Efficacy Ratings



*Note.*  $R^2 = .81$

## References

- American Psychological Association. (2015). Guidelines for clinical supervision in health service psychology. *The American Psychologist*, 70(1), 33–46.  
<https://doi.org/10.1037/a0038112>
- Association of State and Provincial Psychology Boards. (2020). *ASPPB Supervision Guidelines*. ASPPB.
- Bandura, A. (1995). *Self-efficacy in changing societies*. Cambridge University Press.
- Barden, S. M., & Greene, J. H. (2015). An investigation of multicultural counseling competence and multicultural counseling self-efficacy for counselors-in-training. *International Journal for the Advancement of Counselling*, 37(1), 41–53.  
<https://doi.org/10.1007/s10447-014-9224-1>
- Barker, K. K., & Hunsley, J. (2013). The use of theoretical models in psychology supervisor development research from 1994 to 2010: a systematic review. *Canadian Psychology*, 54(3), 176–185.
- Barrett, C. A., Hazel, C. E., & Newman, D. S. (2017). Training confident school-based consultants: the role of course content, process, and supervision. *Training and Education in Professional Psychology*, 11(1), 41–48.  
<https://doi.org/10.1037/tep0000128>
- Bennett-Levy, J., & Beedie, A. (2007). The ups and downs of cognitive therapy training: what happens to trainees' perception of their competence during a cognitive therapy training course? *Behavioural and Cognitive Psychotherapy*, 35(1), 61–75.  
<https://doi.org/10.1017/S1352465806003110>
- Bernard, J.M., & Goodyear, R.K. (2019). *Fundamentals of clinical supervision* (6th ed.).



Pearson.

- Callahan, J. L., & Watkins, C. E. Jr. (2018). The science of training III: Supervision, competency, and internship training. *Training and Education in Professional Psychology, 12*, 245-261. <http://dx.doi.org/10.1037/tep0000208>
- Curtis, D. F., Elkins, S. R., Duran, P., & Venta, A. C. (2016). Promoting a climate of reflective practice and clinician self-efficacy in vertical supervision. *Training and Education in Professional Psychology, 10*, 133-140. doi:10.1037/tep0000121
- Falender, C. A. (2018). Clinical supervision—the missing ingredient. *American Psychologist, 73*(9), 1240–1250. <https://doi.org/10.1037/amp0000385>
- Falender, C. A., & Shafranske, E. P. (2014). Clinical Supervision and the Era of Competence. In Johnson, W. B., & Kaslow, N. J. (Eds.), *The oxford handbook of education and training in professional psychology* (pp. 290-312). Oxford University Press.
- Falender, C. A., & Shafranske, E. P. (2017). *Clinical supervision essentials series: Supervision essentials for the practice of competency-based supervision*. Washington, DC: American Psychological Association.
- Falender, C. A., & Shafranske, E. P. (2012). The importance of competency-based clinical supervision and training in the twenty-first century: why bother? *Journal of Contemporary Psychotherapy: On the Cutting Edge of Modern Developments in Psychotherapy, 42*(3), 129–137. <https://doi.org/10.1007/s10879-011-9198-9>
- Ferreira-Correia, A. (2017). Supervision in clinical neuropsychology: standards and practices. *South African Journal of Psychology, 47*(1), 60–71. <https://doi.org/10.1177/0081246316649093>

- Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., Collins, J. F. L., & 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. 1), 26. <https://doi.org/10.1037/a0015832>
- Goodenough, A. E., Hart, A. G., & Stafford, R. (2012). Regression with empirical variable selection: Description of a new method and application to ecological datasets. *Public Library of Science, 7*(3), 1-10.
- Goodyear, R.K. & Rousmaniere, T. (2017). Helping therapist to each day become a little better than they were the day before. In T. Rousmaniere, R.K. Goodyear, S.D. Miller, & B.E. Wampold (Eds.), *The cycle of excellence: Using deliberate practice to improve supervision and training* (pp.67-98). Wiley-Blackwell.
- Harris, N., Case, E., & Sheppard, H. (2018). Predoctoral internship training: Psychology intern perspectives on an internship rotation targeting supervision competency development. *The Clinical Supervisor, 37*(2), 278–297. <https://doi.org/10.1080/07325223.2017.1421110>
- Hazel, C.E. & Segler, L.J. (2019). Utilizing a vertical model to train school psychology students in supervision: Reflections and training implications. *Trainer's Forum, 36*(1), 18-27.
- Herbert, J. T., Schultz, J. C., Lei, P., & Aydemir-Döke Deniz. (2018). Effectiveness of a training program to enhance clinical supervision of state vocational rehabilitation personnel. *Rehabilitation Counseling Bulletin, 62*(1), 3–17. <https://doi.org/10.1177/0034355217725721>

- Hitzeman, C., Gonsalvez, C. J., Britt, E., & Moses, K. (2020). Clinical psychology trainees' self versus supervisor assessments of practitioner competencies. *Clinical Psychologist*, 24(1), 18–29. <https://doi.org/10.1111/cp.12183>
- Holloway, E. L. (2016). *Supervision essentials for a systems approach to supervision*. American Psychological Association. <https://doi.org/10.1037/14942-000>
- Huber, D. R. (2007). Is the scientist-practitioner model viable for school psychology practice? *The American Behavioral Scientist*, 50(6), 778-788.
- Inman, A. G., Hutman, H., Pendse, A., Devdas, L., Luu, L., Ellis, M. V., & Watkins, C. Edward. (2014). The Wiley international handbook of clinical supervision. In *Current trends concerning supervisors, supervisees, and clients in clinical supervision* (pp. 61–102). essay, John Wiley & Sons, Ltd. <https://doi.org/10.1002/9781118846360.ch4>
- Justice, N., Meredith, M. J., Newman, D. S. (2018). A deliberate framework for supervision in school psychology. *Communique*, 47(2), 8-11.
- Kaslow, N. J., Borden, K. A., Collins, F. L. J., Forrest, L., Illfelder-Kaye, J., Nelson, P. D., Rallo, J. S., Vasquez, M. J., & Willmuth, M. E. (2004). Competencies conference: future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology*, 60(7), 699–712.
- Kratochwill, T. R., Hitchcock, J., Horner, R. H., Levin, J. R., Odom, S. L., Rindskopf, D. M & Shadish, W. R. (2010). Single-case designs technical documentation. Retrieved from What Works Clearinghouse website: [http://ies.ed.gov/ncee/wwc/pdf/wwc\\_scd.pdf](http://ies.ed.gov/ncee/wwc/pdf/wwc_scd.pdf)

- Kühne, F., Maas, J., Wiesenthal, S., & Weck, F. (2019). Empirical research in clinical supervision: a systematic review and suggestions for future studies. *Bmc Psychology*, 7(1).
- Landon, T. J., Leahy, M. J., Herbert, J., Kosciulek, J., Lee, G., & Sung, C. (2016). *Perceptions of supervisory knowledge, behavior, and self-efficacy: supervisor effectiveness in performing clinical supervision and developing the supervisory relationship* (dissertation).
- Lockwood, A. B., McClure, J., Sealander, K., & Baker, C. N. (2017). Measuring school psychology trainee self-efficacy. *Psychology in the Schools*, 54(6), 655–670. <https://doi.org/10.1002/pits.22016>
- MacCann, C., Jiang, Y., Brown, L. E. R., Double, K. S., Bucich, M., & Minbashian, A. (2020). Emotional intelligence predicts academic performance: A meta-analysis. *Psychological Bulletin*, 146(2), 150–186. <https://doi.org/10.1037/bul0000219>
- McNeill, B. W., & Stoltenberg, C. D. (2016). Introduction. In B. W. McNeill & C. D. Stoltenberg, *Supervision essentials for the integrative developmental model* (pp. 3–9). American Psychological Association. <https://doi.org/10.1037/14858-001>
- Miller, S. D., Hubble, M., & Duncan, B. (2008). Supershrinks: What is the secret of their success? *Psychotherapy in Australia*, 14, 14–22.
- Milne, D. L. (2009). *Evidence-based clinical supervision: Principles and practice*. John Wiley & Sons.
- Milne, D.L. (Ed.). (2018). *Evidence-based clinical supervision: Principles and practice*. Wiley-Blackwell.

- Milne, D.L. & Reiser, R.P. (2016). A manual of evidence-based CBT supervision. Wiley-Blackwell.
- Milne, D. L., Sheikh, A. I., Pattison, S., & Wilkinson, A. (2011). Evidence-based training for clinical supervisors: a systematic review of 11 controlled studies. *The Clinical Supervisor, 30*(1), 53–71. <https://doi.org/10.1080/07325223.2011.564955>
- Mullen, P. R., Uwamahoro, O., Blount, A. J., & Lambie, G. W. (2015). Development of counseling students' self-efficacy during preparation and training. *The Professional Counselor, 5*(1), 175–184. <https://doi.org/10.15241/prm.5.1.175>
- National Association of School Psychologists. (2020). *The Professional Standards of the National Association of School Psychologists*. NASP.
- National Association of Social Workers & Association of Social Work Boards, (2013). *Best Practice Standards in Social Work Supervision*. National Association of Social Workers and Association of Social Work Boards.
- Newman, C. F. (2013). Training cognitive behavioral therapy supervisors: Didactics, simulated practice, and “meta-supervision.” *Journal of Cognitive Psychotherapy, 27*(1), 5–18. <https://doi.org/10.1891/0889-8391.27.1.5>
- Newman, D.S. & Guiney, M.C. (2019). Supervision in school psychology: Innovations in training and practice. *Trainer's Forum, 36*(1), 1-5.
- Newman, D. S., Monahan, K. L., Liu, Y., Kostelnik, C. E., Wilson, M. S., & Thies, L. (2019). The school psychology practicum: An Overview of current training and supervision practices in the United States. *Trainer's Forum, 36*(1), 28-39.

- Newman, D. S., Monahan, K. L., Liu, Y., Kostelnik, C. E., Wilson, M. S., & Thies, L. (2020). Supervision of school psychology practicum experiences: Recommendations for supervisors and supervisees. *Communique*, 48(6), 29–30.
- Pearson, Q.M. (2006). Psychotherapy-driven supervision: Integrating counseling theories into role-based supervision. *Journal of Mental Health Counseling*, 28(3), 241–252. [https://doi-org.jerome.stjohns.edu/10.17744/mehc.28.3.be1106w7yg3wvt1w-446](https://doi.org/jerome.stjohns.edu/10.17744/mehc.28.3.be1106w7yg3wvt1w-446)
- Reiser, R. P., Cliffe, T., & Milne, D. L. (2018). An improved competence rating scale for CBT supervision: Short-sage. *The Cognitive Behaviour Therapist*, 11. <https://doi.org/10.1017/S1754470X18000065>
- Rousmaniere, T., Goodyear, R. K., Miller, S. D., & Wampold, B. E. (Eds.). (2017). *The cycle of excellence: Using deliberate practice to improve supervision and training*. John Wiley & Sons.
- Schoenwald, S. K., Mehta, T. G., Frazier, S. L., & Shernoff, E. S. (2013). Clinical supervision in effectiveness and implementation research. *Clinical Psychology: Science and Practice*, 20(1), 44–59. <https://doi.org/10.1111/cpsp.12022>
- Schutte, G. M., Duhon, G. J., Solomon, B. G., Poncy, B. C., Moore, K., & Story, B. (2015). A comparative analysis of massed vs. distributed practice on basic math fact fluency growth rates. *Journal of School Psychology*, 53(2), 149–159. <https://doi.org/10.1016/j.jsp.2014.12.003>
- Simon, D. J., Cruise, T. K., Huber, B. J., Swerdlik, M. E., & Newman, D. S. (2014). Supervision in school psychology: The developmental/ecological/problem-

solving model. *Psychology in the Schools*, 51(6), 636–646.

<https://doi.org/10.1002/pits.21772>

Simon, D. J., Swerdlik, M. E., Cruise, T. K., Stein, C.J. (2019). The ISPA supervisor credentialing program: A statewide training initiative in best practices in supervision. *Trainer's Forum*, 36(1), 6-17.

Simon, D. J., & Swerdlik, M. E. (2017a). Supervision in school psychology: The Developmental, ecological, problem-solving model. Routledge.

Simon, D. J., & Swerdlik, M. E. (2017b). Teaching supervision skills to prepare and support school psychologists. *National Association of School Psychologists. Communique*, 45(7), 22–24.

Southward, M.W. & Pfeifer, B.J., (2019). Do as I say and as I do: Reflections on three methods of evidence-based clinical supervision of graduate-level trainees. *The Behavior Therapist*, 42(2), 50-53.

Stock, R., Vaughn, R. & Terjesen, M.D. (2023). Competency in Clinical Supervision in Cognitive Behavioral Therapy. In M.D. Terjesen & T. Del Vecchio *Handbook of Training and Supervision in Cognitive Behavioral Therapy*. New York: Springer.

Stoltenberg, C. D. (2005). Enhancing professional competence through developmental approaches to supervision. *American Psychologist*, 60(8), 857.

Stoltenberg, C. D., & McNeill, B. W. (2012). Supervision: Research, models, and competence. In *APA handbook of counseling psychology, Vol. 1: Theories, research, and methods*. (pp. 295-327). American Psychological Association.

Terry, J., Gonsalvez, C., & Deane, F. P. (2017). Brief online training with standardized

vignettes reduces inflated supervisor ratings of trainee practitioner competencies. *Australian Psychologist*, 52(2), 130-139.

Tracey, T. J., Wampold, B. E., Lichtenberg, J. W., & Goodyear, R. K. (2014). Expertise in psychotherapy: an elusive goal?. *The American psychologist*, 69(3), 218–229.  
<https://doi.org/10.1037/a0035099>



## Vita

Name	<i>Rachel A. Vaughn</i>
Baccalaureate Degree	<i>University of North Carolina at Greensboro, Greensboro, North Carolina Major: Social Work Minor: Psychology</i>
Date Graduated	<i>May 2007</i>
Other Degrees and Certificates	<i>Master of Science in Social Administration Case Western Reserve University, Cleveland, Ohio Social Work/Child, Youth, and Families</i>
Date Graduated	<i>August 2008</i>
	<i>Master of Science St. John's University, Jamaica New York School Psychology</i>
Date Graduated	<i>May 2021</i>