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Supervisee Experiences of Corrective Feedback in Clinical Supervision: A Consensual Qualitative Research Study

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SUPERVISEE EXPERIENCES OF CORRECTIVE FEEDBACK IN CLINICAL SUPERVISION: A CONSENSUAL QUALITATIVE RESEARCH STUDY

by

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ABSTRACT
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Marquette University, 2013

Clinical supervision plays an integral role in counselor development, assisting supervisees to transition from educational coursework to clinical practice. Feedback, including that which is corrective, allows supervisors to transmit knowledge to supervisees and communicate evaluations of supervisee performance. Despite the central role of feedback in clinical supervision, surprisingly little empirical attention has focused on supervisee experiences of corrective feedback in clinical supervision. This study sought to provide a deeper understanding of supervisee experiences of corrective feedback in clinical supervision. Twelve participants were interviewed regarding their experience of corrective feedback in clinical supervision during predoctoral psychology internship. Participants expected to receive corrective feedback, and they held largely positive expectations/beliefs about corrective feedback. Despite positive expectations/beliefs about corrective feedback, participants discussed corrective feedback events that went poorly and resulted in negative consequences for themselves, their clinical work, and/or the supervision relationship. Additionally, participants – including those who discussed corrective feedback events that went poorly – made changes to their clinical work, one of the goals of corrective feedback. Limitations and implications for training, practice, and research are addressed.

PREFACE

This study focuses on supervisee experiences of corrective feedback in clinical supervision. I selected this topic for two reasons. First, I am interested in supervision, having benefited enormously from the support and guidance of clinical supervisors during my training, as well as qualitative research; thus, this project presented an opportunity to blend these interests. Second, the relatively limited prior research in this area made it an appropriate topic for further study. I am hopeful this research has provided a deeper understanding of how and why corrective feedback is an important intervention in clinical supervision.

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Statement of the Problem

Supervision plays an integral role in counselor development and is widely

believed to be at the heart of training for mental health professionals (Bernard &

Goodyear, 2004; Campbell, 2006; Clark, 2005; Stoltenberg & Delworth, 1987). In fact,

some professionals view clinical supervision as critical in a successful transition from

educational coursework to clinical practice (Atkins, 1981), for supervisors provide

valuable knowledge to enhance supervisees' professional skills, allowing supervisees to

eventually function independently as mental health practitioners (Bernard & Goodyear,

2004; Loganbill, Hardy & Delworth, 1982).

One of the key components of supervision is evaluation, and it is the primary

vehicle by which supervisors impart knowledge (Bernard & Goodyear, 2009). Evaluation

provides supervisors the opportunity to monitor supervisees' work with clients, provide

clinical skills training, correct supervisee missteps, and make judgments about

supervisees' fate in their training program (Bradley & Ladany, 2001; Watkins, 1997).

The process of evaluation informs supervisees of their clinical development, strengths

and weaknesses, and effectiveness as clinicians (Bandura, 1986). Additionally, evaluation

assists supervisors in protecting the integrity of the mental health profession (Bernard &

Goodyear, 2004; Hart, 1982). Evaluation consists primarily of two components: goal

setting and feedback.

According to Bernard and Goodyear (2004), feedback is a "central activity of

clinical supervision and the core of evaluation" (p. 30). From a supervisee perspective,

previous research suggests that both positive and corrective feedback is highly correlated

with satisfaction in supervision (Lehrman-Waterman & Ladany, 2001). Given the complexities of therapy and how much it can vary from client to client, feedback from supervisor to supervisee might be the best way of transmitting knowledge to supervisees and developing competent counselors (Hoffman, Hill, Holmes, & Freitas, 2005). Yet, despite the importance of feedback and evaluation in clinical supervision and its role in supervisee development, surprisingly little is known about the process of feedback within clinical supervision. The following sections will define and clarify the terms supervision, evaluation, and feedback, provide a rationale for the proposed study, and identify the primary research questions of the proposed study.

Definition of Terms

A number of terms within the supervision, evaluation, and feedback literature are often used interchangeably, which can result in confusion and potential blurring of the distinction among these terms. Thus, for the purposes of a cogent review of the literature, it is helpful to clearly define these terms. Definitions of terms that occur frequently in this paper are outlined in the section below.

Clinical Supervision. Clinical supervision has been defined in a number of ways and can refer to a variety of settings. Common to most definitions is a more experienced professional working with a less experienced member of the same profession in an evaluative relationship that extends over time (Bernard & Goodyear, 2009; Loganbill et al., 1982). This ongoing relationship is often described as collaborative and educational, and allows the supervisee to acquire appropriate professional behavior through an examination of supervisee activities, the provision of objective feedback, modeling, and mutual problem solving (Campbell, 2006; Falender & Shafranske, 2008; Hart, 1982;

Thomas & Grimes, 2002). In the provision of mental health services, the process of supervision allows for monitoring of quality of services to clients, with supervisors serving a gatekeeping role for those wishing to enter the profession (Bernard & Goodyear, 2009; Hart, 1982).

Distinctions have been made between administrative (Copeland, 1998) and clinical supervision (Bernard & Goodyear, 2009), as well as hierarchical versus peer supervision (Benshoff & Paisley, 1996; Kottler & Hazer, 1997). The tasks performed by supervisors serve to distinguish between administrative and clinical supervision, with administrative supervisors assisting supervisees in navigating bureaucratic organizations (e.g., hospitals, universities) and clinical supervisors focusing on evaluating supervisee work in the provision of services to clients (e.g., client welfare, the therapeutic relationship, clinical interventions) (Bradley & Kottler, 2001; Holloway, 1995). Clinical supervision is the focus of this study.

For the purposes of clarity and ease of reading, clinical supervision, rather than counselor or psychotherapy supervision, was chosen as a generic term for supervision. Supervisee, rather than counselor-in-training, will be used as a generic term for those individuals who are receiving supervision from an individual with more experience in psychotherapy (i.e., supervisor), in recognition that not all supervisees are in training programs or are considered "in training." In keeping with definitions used in the literature, clinical supervision is defined as individual psychotherapy supervision that occurs between a more experienced member of the mental health profession (supervisor) and a less experienced member of the same profession (supervisee). Additionally, the terms clinical supervision and supervision will be used interchangeably. While there are

many other forms of evaluation and feedback for supervisees, including group supervision and consultation that occurs between members of the same profession who are at roughly the same developmental level (i.e., peer consultation), the focus of this investigation is individual supervision.

Evaluation. The evaluative component of supervision is widely believed to be what separates the supervision relationship from other relationships, such as the therapeutic relationship (Campbell, 2006), and evaluation has been described as the "nucleus of clinical supervision" (Bernard & Goodyear, 2009, p. 20). While the evaluative aspect of the supervision relationship can either be emphasized or ignored, evaluation is "ongoing and integral to the supervisory process as it is used to shape and direct learning" (p. 5). In light of supervisors' gatekeeping responsibilities, the clinical supervisor is continually evaluating the quality of client care provided by supervisees.

Evaluation can be either formative or summative. Formative evaluation comprises the majority of supervisors' evaluative work, and it focuses on supervisee progress and the process of professional development rather than the outcome (Bernard & Goodyear, 2009). Formative evaluation is typically an ongoing process. Examples of formative evaluation include review of supervisee audiorecordings or supervisee self-reports of sessions with clients. Summative evaluation focuses on the overall performance of the supervisee and how s/he "measures up" (p. 22). In this type of evaluation, supervisors identify larger patterns and trends in supervisee performance and compare that level of performance against criteria, oftentimes to provide performance ratings. Semester- or year-end evaluations and performance reviews are examples of summative evaluation. In order to examine the potential impact of corrective feedback on the process of

supervision, this investigation will focus on feedback that arises from formative, rather than summative, evaluation.

Feedback. Broadly defined, feedback is information that one person provides to another regarding task performance relative to a certain standard (Claiborn, Goodyear, & Horner, 2001). For the purposes of this review, feedback is generally defined as information that supervisors communicate to supervisees, unless otherwise noted (e.g., feedback within the context of the therapeutic relationship). Feedback can be categorized in several different ways, including direct or indirect, linear (i.e., one-way from supervisor to supervisee) or interactional (i.e., continuous and ongoing dialogue between supervisor and supervisee), formative (i.e., ongoing and specific) or summative (i.e., provided less regularly and more global), and positive (i.e., affirming that a supervisee is on the right path) or corrective (i.e., noting that a supervisee is off track) (Bernard & Goodyear, 2004; Claiborn et al., 2001; Dewald, 1997; Hoffman et al., 2005). Feedback can also vary by type, from immediate (e.g., bug-in-ear techniques) to delayed (e.g., videotape), and it can be delivered in a variety of ways to match supervisee level of development (e.g., more concrete, directive feedback for supervisees lower in conceptual development; more abstract, less-directive for advanced supervisees) (Norcross & Halgin, 1997; Stoltenberg & Delworth, 1987). As will become evident in chapter two, review of the literature, corrective feedback plays an important role in training for supervisees. Additionally, this type of feedback can be a source of anxiety for both supervisors and supervisees, and there is evidence to suggest that supervisors avoid this type of feedback or provide it in ways that are not helpful for supervisees. Because of the importance of corrective feedback in training and the difficulties supervisors may have

with this supervision intervention, this investigation will focus on feedback that is corrective in nature.

Rationale for the Study

A review of the supervision literature reveals a dearth of empirical investigation in the areas of evaluation and feedback within clinical supervision. Additionally, the literature identified for inclusion in the review for this study suggests that evaluation and feedback in supervision has not been the focus of recent research. This is surprising, given the integral role that supervision plays in training mental health professionals and helping supervisees bridge educational coursework and clinical practice. Furthermore, the theoretical literature on clinical supervision notes that evaluation is the primary vehicle through which supervisors share their knowledge and expertise with supervisees, and that feedback is at the core of evaluation (Bernard & Goodyear, 2004; Loganbill et al., 1982). It stands to reason, then, that failure to investigate evaluation and feedback leaves the mental health field without a clear understanding of these core processes in clinical supervision. This could potentially expose the mental health profession to questions regarding how and if supervisors are effectively training future practitioners. If little is known empirically about evaluation and feedback in supervision, how can we be sure that supervisors are effectively delivering corrective feedback to supervisees? Leaving this question unanswered opens the door to more profound questions regarding the quality of training in the mental health profession and the level of care that supervisees provide.

Much of the extant literature in the areas of evaluation and feedback in clinical supervision is qualitative in nature, likely because of the still-exploratory nature of research in these domains and the lack of psychometrically sound measures to assess

supervision, evaluation and feedback (Robiner, Fuhrman, & Ristvedt, 1993). Furthermore, a great deal of the literature, especially that which addressed feedback, has focused on supervisors' experiences in providing feedback to supervisees (Burkard, Knox, Clarke, Phelps, & Inman, 2009; Hoffman, Hill, Holmes, & Freitas, 2005; Robiner, Saltzman, Hoberman, & Schirvar, 1997). The few investigations into supervisee experiences have focused on perceptions of supervision in general, rather than focusing on the areas of evaluation and feedback (Allen, Szollos, & Williams, 1986; Magnuson, Wilcoxon, & Norem, 2000; Robiner et al., 1993). Extended further, little empirical attention has been directed to what appears to be the most troubling aspect of evaluation and supervision: corrective feedback. This leaves supervisors with a number of general guidelines for providing feedback, rather than information specific to corrective feedback, and no empirical information examining supervisee experiences, be they positive or negative, of such supervision events.

The research conducted to this point suggests that supervisors and supervisees differ in their perceptions of evaluation and feedback processes in clinical supervision. Although anxiety provoking for supervisors and supervisees, the extant literature suggests that supervisees desire corrective feedback, and they are more satisfied with supervision when supervisors provide this type of feedback. The proposed study will add to the literature on feedback and supervision by focusing on supervisee experiences of corrective feedback in clinical supervision. This qualitative study will examine the following areas: 1) supervisee experiences of corrective feedback in clinical supervision; 2) perceived effects of corrective feedback on the supervision relationship; 3) perceived

effects of corrective feedback on supervisee clinical and professional skill development; and 4) perceived effects of corrective feedback on client outcomes.

In this study, the researcher will interview predoctoral psychology interns who received corrective feedback from a licensed psychologist in the context of clinical supervision. Data will be analyzed using consensual qualitative research (CQR; Hill, Thompson, and Williams, 1997; Hill et al., 2005). Unlike many quantitative methodologies, which may neglect the unique experiences that occur within supervision, CQR highlights the individualized experiences of participants. Consensual qualitative research offers a way of analyzing data that stays true to participants' words and experiences as they naturally occur. Since research on supervisee experiences in clinical supervision is still emerging and relatively new, the discovery-oriented CQR method is an appropriate choice, as it cultivates an openness to all findings instead of only hypothesis-driven findings. Consensual qualitative research strives for detailed descriptions and an understanding of processes and individual experiences, which are missing from the current literature on supervisee experiences of corrective feedback in clinical supervision.

Conducting research that examines supervisee experiences of corrective feedback events may serve to demystify the process of providing this type of feedback to supervisees, thereby diminishing the anxiety associated with a supervisor task that highlights the evaluatory nature of supervision. Moreover, this research may stimulate consideration of how to improve the quality of supervision through improving feedback processes. At an individual level, this could stimulate supervisors to examine and refine their supervisory skills, especially in the area of corrective feedback. This supervisor

reflection on the process of feedback may lead to more effective supervision, increased supervisee satisfaction with supervision and improved training experiences, ultimately leading to more competent supervisees (who may go on to become supervisors for future generations of supervisees).

Research Questions

The primary research questions of this study are as follows:

Question 1: What are supervisees' experiences of corrective feedback from supervisors in individual clinical supervision?

- *What is the role of corrective feedback in clinical supervision?*

- *What role do supervisees play in feedback processes in clinical supervision?*

- *What have supervisees learned during their pre-internship supervision experiences about their role in shaping feedback processes?*

- *What makes corrective feedback easy or difficult for supervisees to hear?*

- *What makes corrective feedback useful for supervisees and results in change in supervisees' clinical behavior?*

This question allows for an exploration and understanding of supervisee experiences of corrective feedback in clinical supervision, the role that supervisees play in defining feedback processes in supervision, and how, if at all, early training experiences addressed the topic of corrective feedback in clinical supervision. Specifically, this question seeks to address how supervisees view the process of corrective feedback in clinical supervision. Information on what makes corrective feedback either easy or difficult to hear, what makes corrective feedback effective (i.e., results in supervisees' changing their clinical behavior), and how, if at all, early training

experiences shaped these preferences are of particular interest. As mentioned previously, the lack of empirical attention paid to supervisee experiences of corrective feedback, along with discomfort often experienced by both supervisors and supervisees regarding corrective feedback, are compelling reasons for examining this topic. By interviewing individuals who currently are or recently were predoctoral psychology interns, this researcher hopes to more fully understand supervisee beliefs and/or feelings about the process of corrective feedback in clinical supervision and how these beliefs and/or feelings emerged.

A greater understanding of supervisee experiences of corrective feedback will allow this researcher to add the current study's findings to the existing literature on supervisee experiences of corrective feedback. Previous research has suggested, for example, that although supervisees desire specific feedback that is both positive and corrective, supervisees often receive little corrective feedback and what is provided is vague (Magnuson et al., 2000). Additionally, research suggests that predoctoral psychology interns felt betrayed by supervisors and deprived of important supervision experiences if they did not receive corrective feedback (Robiner et al., 1993). Other research has suggested that the supervision relationship is an important factor for supervisors in facilitating the delivery of corrective feedback (Hoffman et al., 2005). This study aims to obtain information from the supervisees' perspective in terms of what made corrective feedback easy or difficult to receive, what makes corrective feedback helpful, what role supervisees have played in shaping the feedback process, and the influences of early clinical training (i.e., pre-internship practica) on expectations of corrective feedback.

Question 2: What are the perceived effects (on the supervisee, supervision relationship, clinical work/client outcome) of corrective feedback within clinical supervision?

Little is known about the impact that corrective feedback may have on the supervisee, the supervision relationship, and clinical work/client outcome. While research has been conducted to ascertain general supervisee preferences for feedback, most studies examining a specific feedback event have focused on supervisor, rather than supervisee, experiences of the event. In an effort to expand the empirical literature in this area, this question seeks to determine specifically how corrective feedback affects the supervisee and their perceptions of the supervision relationship and their clinical work/client outcome. Information obtained in this area may help inform the supervision literature regarding what contributes to a positive and beneficial corrective feedback experience, and what contributes to corrective feedback that is received poorly. This may demystify the topic of corrective feedback, an aspect of the supervision process that can be anxiety provoking for both supervisors and supervisees, and something that previous research suggests is desired by supervisees.

Both of these questions address the main goal of this study, which is to gain a deeper understanding of the process and outcomes associated with supervisee experiences of corrective feedback in clinical supervision in order to inform future research and practice. Upon the study's completion, this researcher hopes to provide suggestions for both supervisors and supervisees in successfully navigating corrective feedback events in clinical supervision, as well as areas for future research.

Chapter 2: Review of the Literature

Theories and Models of Clinical Supervision

Clinical supervision has been conceptualized according to a number of theories and models. This section will organize these approaches into three main categories: those based primarily on psychotherapy theories (e.g., psychodynamic supervision, cognitive supervision), models that are primarily developmental (e.g., the Integrated Development Model [IDM], process models, life span models), and social role models (e.g., Bernard's discrimination model, Holloway's Systems Approach to Supervision [SAS]). Each supervision theory/model within these three categories is briefly described, with special attention paid to how, if at all, the theory/model addresses the supervision processes of evaluation and feedback.

Supervision Grounded in Psychotherapy Theories. Theoretical approaches to psychotherapy have been extended to the provision of supervision (Bernard & Goodyear, 2009; Stoltenberg, McNeill, & Delworth, 1998), in which knowledge, theory and technique derived from a specific orientation inform treatment and provide focus for supervision (Beck, Sarnat, & Barenstein, 2008). Predominately, these conceptualizations of supervision focus on the development of skills specific to the psychotherapy theory, as well as areas of supervisee impairment in delivering effective psychotherapy (Stoltenberg et al., 1998). There are a few common elements to the following psychotherapy-based supervision models, including a focus on supervisor empathy, genuineness, warmth, trust, and positive regard, as well as a simultaneous commitment to monitoring supervisee development and client welfare (Bradley & Gould, 2001). Although not intended to be a comprehensive review of all psychotherapy-based supervision models, this section will

examine those models commonly referenced in the supervision literature, including psychoanalytic, psychodynamic, cognitive, interpersonal, client-centered, and feminist theory. Additionally, the processes of evaluation and feedback within each psychotherapy-based model are explicated for those theories that address these supervision processes.

   Psychoanalytic model of supervision. Supervision is one leg of the tripartite system of training supervisees in psychoanalytic supervision (Dewald, 1997). This tripartite system includes supervisee personal therapy, a didactic curriculum, and supervision of work with several patients by seasoned psychoanalysts. Typically, there is a different supervisor for each client with whom the supervisee is working and because supervision styles vary tremendously, this translates to the possibility of numerous styles of evaluation and feedback within a supervisee's multiple supervision relationships.

   Evaluation of supervisees is a significant function of supervisors in psychoanalytic supervision (Beck et al., 2008; Dewald, 1997). Supervisor report of supervisee skill to the psychoanalytic institute can have a significant impact on supervisee trajectory, potentially resulting in conflict; supervisors want to be liked by supervisees, while also objectively evaluating supervisee skill (Dewald, 1997). If a solid supervision alliance is not formed, the supervisor role of evaluator may be intensified for both the supervisor and supervisee. This could result in supervisee dishonesty in self-reports to supervisors of sessions with clients. One way of mitigating supervisee apprehension and promoting a strong supervision alliance might be to allow supervisees to read supervisor evaluations prior to submission to the psychoanalytic institute.

Feedback to supervisees is an extension of the evaluative component of supervision (Dewald, 1997). In psychoanalytic supervision, feedback from supervisor to supervisee is predominately corrective, aimed at improving supervisee skill, even if this means pointing out supervisee mistakes and/or limitations that might be difficult to provide and receive. In light of this, supervisors are encouraged to create a safe space for supervisees to share transference and countertransference experiences with their clients. Feedback styles among seasoned psychoanalysts vary greatly, with some providing a great deal of direction and suggestions, others withholding feedback, allowing supervisees to make mistakes and letting the process of analysis reinforce the supervisee, and still others providing a mix of positive and corrective feedback, providing multiple client interpretations from which the supervisee can choose to explore (Dewald, 1997).

   Psychodynamic model of supervision. There is no widespread consensus regarding the best practice for conducting psychodynamic supervision, although there is a focus on the parallel process of supervision and therapy, as well as the interpersonal skills of the supervisee (Binder & Strupp, 1997; Bradley & Gould, 2001). Conflict and anxiety are important themes in psychodynamic-based supervision, and the goals of supervision are to help supervisees identify sources of anxiety (in client relationships, as well as the supervision relationship) and promote emotional insight, resulting in progress with clients (Mueller & Kell, 1972). Impasses in the supervision relationship often develop as a result of supervisee anxiety, and successful supervision does not help supervisees avoid impasses, but instead assists supervisees in impasse resolution (Mueller & Kell, 1972). While supervisees oftentimes enter the supervisory relationship vulnerable, sensitive about adequacy and unsure of how a supervisor views their abilities (especially in the

context of corrective feedback), supervisors understand that errors are revocable and help

supervisees realize that human relationships can endure (and strengthen) as a result of

impasses (Mueller & Kell, 1972).

Evaluation of supervisees in psychodynamic-based supervision should be based

on a number of sources of information, including supervisee self-report of therapeutic

session content, as well as audio and video recordings of sessions (Binder & Strupp,

1997). Supervisors operating within this model may choose to focus solely on supervisee

self-report, believing that free association of supervisees will identify the most salient

themes (much as clients do in session). Other supervisors will compare audio and/or

video recordings of client sessions with supervisee's observations of these sessions, using

any discrepancies as powerful data and sources of feedback for supervisees (Mueller &

Kell, 1972). Binder and Strupp (1997) suggest identifying new areas of evaluation and

feedback within psychodynamic-based supervision, including computer simulated

therapy, to improve the immediacy of supervisor feedback.

Feedback within psychodynamic supervision is aimed at promoting supervisee

self-exploration in terms of emotional reactions to clients, as well as how supervisee

relationships with clients mirror the supervisor/supervisee relationship and supervisee

relationships in life in general (Beck et al., 2008). To this end, feedback focuses on

supervisee defensive processes, unconscious conflicts, and how disruptions in

relationships operate in supervisee work with clients and in supervision. Supervisors help

supervisees recognize glimmers of self-awareness (emergence), reflect on salient

moments in sessions with clients (immersion), understand the impact of

countertransference on the therapeutic process (elaboration), and facilitate growth in the

supervisee's self-reflective capacity and the ways in which these relationships can be useful in future therapeutic endeavors (interpretation) (Shafranske & Falender, 2008).

In addition to feedback aimed at highlighting moments of supervisee countertransference, the psychodynamic model of supervision endorses corrective feedback aimed at supervisee deficits in knowledge and technical skills. Supervisors should be prepared to provide corrective feedback to identify shortcomings in fundamental interpersonal skills, conflicts from unresolved supervisee psychological issues, and difficulties that stem from supervisee bias and prejudice (Bradley & Gould, 2001; Shafranske & Falender, 2008). A strong supervisory alliance marked by a high degree of trust facilitates providing feedback of this highly personal nature.

Cognitive model of supervision. The cognitive model of supervision is grounded in the cognitive theories of Albert Ellis, who suggested that irrational thoughts undergird psychological disturbance (Bradley & Gould, 2001). Cognitive therapy has emerged as a dominant force in mental health counseling, prompting the need for a model to instruct supervisees in cognitive therapy (Bradley & Gould, 2001; Temple & Bowers, 1998).

Primary supervisor responsibilities in cognitive-based models of supervision include teaching supervisees cognitive theories and techniques, as well as promoting supervisee self-awareness of cognitive processes and how these processes impact the therapy supervisees conduct (Liese & Beck, 1997). An important aspect of the supervision process is the contract between supervisor and supervisee, in which the goals and areas for evaluation are identified (Bradley & Gould, 2001). Supervisors engage in an ongoing assessment of supervisee competencies and structure supervision similar to the way in which a cognitive therapist structures sessions with clients; checking in,

setting an agenda, reviewing any homework, and providing feedback (Beck et al., 2008; Bradley & Gould, 2001). Additionally, supervisors utilize instructional techniques similar to cognitive therapy, such as guided discovery, role play, and responding to automatic thoughts or beliefs (Beck et al., 2008; Liese & Beck, 1997).

The Cognitive Therapy Rating Scale (CTRS) is one tool that has been created to help supervisors evaluate supervisee competence in conducting cognitive therapy (Beck et al., 2008). The CTRS prompts supervisors to identify supervisee strengths and weaknesses in 11 areas: agenda, feedback, understanding, interpersonal effectiveness, collaboration, pacing and efficient use of time, guided discovery, focusing on key cognitions or behaviors, strategy for change, application of cognitive and behavioral techniques, and homework. Supervisors can use the CTRS as a foundation for providing supervisee feedback, although supervisors are cautioned to take into account the strength of the supervision relationship and level of supervisee anxiety when providing results of the CTRS to supervisees (Beck et al., 2008).

Cognitive-based models of supervision may also call for supervisors to evaluate more personal aspects of supervisees, such as supervisee communication style, how supervisees handle delicate ethical matters, and any significant supervisee psychological difficulties (Liese & Beck, 1997). Regardless of the specific areas for evaluation and feedback, cognitive-based supervision models caution against the pitfalls of falling into three types of supervisors: the Mister Rogers supervisor, who fails to provide substantial corrective feedback to spur supervisee development, Attila the supervisor, who provides a great deal of corrective feedback in hopes that supervisees become exact replicas of the

supervisor, and the "how do you feel?" supervisor, who focuses solely on supervisee countertransference/personal feelings about clients (Liese & Beck, 1997).

Interpersonal models of supervision. The interpersonal approach to clinical supervision focuses on the relationships people have with one another, bridging the "text" of the psychoanalytic (i.e., individuals' inner experiences) with the "context" of behaviorism (Hess, 1997). From an interpersonal perspective, supervision is defined as a relationship that promotes supervisee acquisition of skills in conducting therapy and development of supervisee therapist identity (Hess, 1997). The task of supervision also involves demystifying therapy, which, in conjunction with teaching techniques to supervisees and the development of therapist identity, serves to promote client change.

Interpersonal-based models of supervision highlight the risk that supervisees take in exposing themselves to condemnation and shame by way of supervision (Hess, 1997). Moreover, evaluation is viewed as a possible hindrance to learning, with a recognition that supervisees might focus on obtaining a good evaluation rather than searching out nourishing supervision experiences. Interestingly, Hess (1997) advocates that in light of the potential deleterious consequences of evaluation, what occurs in the context of supervision should remain between supervisor and supervisee, aside from actions involving imminent harm and obligations to provide performance evaluations to training institutions. In the event that performance evaluations are required by training institutions, supervisors should typically rate supervisees towards the higher (i.e., more favorable) end of the scale (Hess, 1997).

Because the goals of therapy are ever-changing, so too should the goals of supervision be ever-changing. In light of supervisee anxiety over being subjected to the

shame of evaluation, feedback from supervisors to supervisees should be gentle, especially at the beginning, when supervisees are learning by trial and error and their theoretical orientations are still emerging (Hess, 1997; Safran, Muran, Stevens, & Rothman, 2008). As supervisees advance in their development, supervisors should continue to help supervisees become aware of their beliefs and attitudes, and the impact of these attitudes and beliefs on supervisee relationships with clients. Rather than imposing corrective feedback on how supervisees should relate to clients, supervisees will become aware, on their own, of their shortcomings and develop mechanisms for reducing the impact of these shortcomings in work with clients. Corrective feedback might be used in the form of a supervisor thinking aloud, indirectly providing information to supervisees regarding the impact of ruptures in the therapeutic alliance and how these might be experienced by the client and supervisee (Safran et al., 2008). In contrast with psychodynamic-based models of supervision, supervisors should avoid pointing out parallel processes and possible countertransference to supervisees; doing so preempts the possibility of supervisee coming to this awareness on her/his own, while also forcing the supervisee into a client/patient role (Hess, 1997).

When terminating the supervision relationship, supervisors are encouraged to provide a summary statement to supervisees so that there are no surprises or unfinished business at the conclusion of supervision. While not explicitly referred to as summative evaluation, this summary statement should communicate where the supervisor feels the supervisee is in terms of her/his relational abilities with clients, and identify supervisee strengths (Hess, 1997). If there are items of corrective feedback that have not previously

been communicated to the supervisee, these should be communicated to the supervisee verbally and not included in the written summary statement.

Client-centered models of supervision. In describing the client-centered model of supervision, Patterson (1983) highlights the significance of supervisor/supervisee matching based on theoretical orientation, recommending that a supervisor be explicitly committed to a theory and the supervisee sharing at least a tentative commitment to the same theory. This shared commitment to client-centered theory is a necessary condition for supervisee learning to occur. Mismatches between supervisor and supervisee theoretical orientation result in supervisors spending too much time teaching/informing supervisees about their approach, and supervisees spending too much time trying to understand where their supervisor is coming from, resulting in a considerable slowing in the process of supervision (Patterson, 1997).

In client-centered supervision, supervisees are informed that they will be evaluated according to their ability to convey empathic understanding, respect, therapeutic genuineness, and concreteness to their clients. Supervisees accept that these therapeutic conditions are necessary for change, and follow three rules in working with clients: therapist listens, client talks; therapist only asks questions when s/he does not understand what the client is saying; therapist remain in responsive mode, with client initiating and therapist following client's lead (Patterson, 1997).

Beyond self-report of sessions with clients, supervisees are encouraged to audiotape their work with clients and present them in supervision, especially those areas in which the supervisee is struggling (Patterson, 1997). However, because both supervisor and supervisee share in their client-centered theoretical orientation, evaluative

comments by supervisors are virtually nonexistent. Instead of receiving feedback from supervisors, supervisees provide themselves with evaluation and feedback. Additionally, supervisee personality is only a concern and addressed in supervision if it in some way impacts therapy; therefore, personal characteristics of supervisees are rarely addressed in supervision (Patterson, 1997).

Feminist models of supervision. Approaching supervision from a feminist theoretical orientation involves examining the process of supervision, including the ideal use of power, traditionally hierarchical models, and a search for a more collaborative approach to supervision (Porter & Vasquez, 1997). From a feminist perspective, supervision is the primary method of teaching psychotherapy and a profoundly memorable experience for supervisees. Porter and Vasquez (1997) collaborated with nine prominent feminist psychologists to develop a working definition of feminist supervision as:

> A collaborative, respectful process, personal but unintrusive, balanced between supervisory responsibility and supervisee autonomy. Feminist supervision emphasizes open discussion and analysis of power dynamics, and targets the best interests of the supervisee. It is a process that remains focused on the social context of the lives of the client, supervisee, and supervisor. (p. 169)

Feminist supervisors model feminist therapy and feminist process for supervisees in a collaborative relationship in which both supervisors and supervisees mutually reflect on the therapeutic and supervision relationships.

Several principles guide feminist supervisors and supervisees in the supervision relationship and many of these inform the processes of evaluation and feedback. For

example, supervisees are encouraged to be in charge of learning objectives and goals,

rather than blindly following supervisor directives. Furthermore, this collaborative

approach to supervision does not imply full agreement between supervisor and

supervisee; feedback should be used constructively by supervisors and should not

invalidate supervisee interpretation of their experience (Porter & Vasquez, 1997).

Supervisor feedback typically is used to promote examination of supervisee biases,

cultural influences, and contexts (Vargas, Porter, & Falender, 2008). Relatedly,

supervisors should model openness and reflexiveness, seeking and receiving feedback

from supervisees without becoming defensive.

The collaborative focus in feminist-based supervision models does not mean the

relationship is egalitarian; supervisors are responsible for evaluating supervisees' work

(Worell & Johnson, 1997) and provide direct and honest evaluations and feedback (Porter

& Vasquez, 1997). Supervisors are to maintain standards to ensure that supervisees are

carrying out their work with clients competently and ethically. This includes a focus on

cultural and gender responsiveness, which are considered core competencies and are

interwoven into instruction, supervision, evaluation, and feedback in feminist-based

supervision. This examination of social construction of meanings and practices (by both

supervisor and supervisee), along with a focus on social activism, reflection, power, and

oppression, distinguish feminist-based models from other models of supervision (Porter

& Vasquez, 1997; Vargas et al., 2008).

Concluding Thoughts: Psychotherapy-Based Models of Supervision. The

psychotherapy-based approaches described herein were among the first models to help

guide supervisors in working with supervisees (Stoltenberg et al., 1998). While

psychotherapy-based models might be helpful in instructing supervisees in techniques specific to a particular orientation, a survey of psychologists and postdoctoral fellows revealed that roughly one-third of psychologists and over two-thirds of postdoctoral fellows identified themselves as integrationists, suggesting that both supervisors and supervisees are likely to integrate multiple theoretical orientations (Kaslow & Bell, 2008; Patterson, 1997). Thus, an integrative psychotherapy-based model of supervision might be most comprehensive and flexible for both supervisor and supervisees.

A common criticism of many of the early psychotherapy-based models of supervision is the focus on supervisee blocks in conducting therapy, something perhaps best left to a supervisee's therapist, not supervisor (Stoltenberg et al., 1998). As clarified in the definition section, the role of supervisor and therapist differ, as do the goals and interventions. Moreover, psychotherapy models of supervision did not address changes in supervisee ability over time. Thus, developmental models of supervision were created to address this shortcoming of psychotherapy-based models of supervision.

Supervision Grounded in Developmental Models. Described as the *"zeitgeist* of supervision models" (Holloway, 1997, p. 209), developmental models of supervision are the most heuristic (Worthington, 1987), among the most researched, and currently the most prominent supervision theories (Stoltenberg & McNeill, 1997). Central to developmental models of supervision is the belief that supervisee ability to function in the role of therapist changes over time (Stoltenberg et al., 1998). In contrast with early psychotherapy-based models that were additive in nature and suggested a linear path to supervisee development (i.e., supervisees learn skills that are added to existing knowledge and abilities), developmental models typically account for a less linear path in

supervisee growth, with spurts and periods of delay and, occasionally, regression. As the supervisee matures, professional complexity emerges across a number of domains (e.g., cognitive, social, interpersonal), resulting in an integration of theory and practice and a well-developed clinical identity (Whiting, Bradley, & Planny, 2001).

Developmental models can be further differentiated by those that propose a step-by-step process that will be repeated for mastery of various skill levels (e.g., the Loganbill, Hardy, and Delworth Model), those that are based on successive stages of development (e.g., the Integrated Developmental Model [IDM]), and life-span developmental models (e.g., the Ronnestad and Skovholt Model). The following section examines each of these three types of developmental models.

The Loganbill, Hardy, and Delworth Model of supervision. Considered one of the first developmental models (Bernard & Goodyear, 2009; Holloway, 1997), Loganbill et al. (1982) identified three stages in supervisee development: stagnation, confusion, and integration. This was one of the first supervision models to propose that supervisees cycle and recycle through stages, in contrast to previous, more linear models. According to the model, supervisees experience eight critical issues in supervision, including issues of competence, emotional awareness, autonomy, identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. Supervisees progress through various stages in all of these domains, increasing their integration of skills as they develop (Bernard & Goodyear, 2009).

In the stagnation stage, supervisees are generally unaware of their shortcomings, experiencing a blind spot relative to their functioning in a particular domain. Supervisees in this stage will either idealize their supervisor or disregard supervisor feedback as

irrelevant (Bernard & Goodyear, 2009). In the confusion stage, supervisees experience

erratic fluctuations in confidence and motivation, and they will typically replace

idealization or disregard of supervisor with anger and/or frustration. The integration

stage, in which there is a calm following the storm, is characterized by a new supervisee

understanding, flexibility, and security despite occasional fluctuations in confidence

(Bernard & Goodyear, 2009). Supervisees at this stage have a more realistic view of their

supervisor, accepting and rejecting feedback.

The supervisor interventions described in the following IDM section originated

from the Loganbill, Hardy, and Delworth Model (1982) (Bernard & Goodyear, 2009).

Supervisors are encouraged to implement the interventions in much the same way IDM

proposes; facilitative and prescriptive interventions typify the stagnation stage, with

confrontive and catalytic interventions used more frequently in the confusion and

integration stages (Loganbill et al., 1982). In a similar vein to IDM, the Loganbill, Hardy,

and Delworth Model recognizes evaluation's anxiety evoking potential, noting that it is

not uncommon for supervisors and supervisees to avoid addressing this aspect of

supervision until it is necessary, typically when a grade or written report is due. The

authors suggest that an ongoing dialogue regarding the effects of evaluation on the

relationship and continually monitoring the level of trust in the relationship are a few

ways of avoiding negative consequences of the supervisor's role as evaluator.

Integrated Developmental Model (IDM) of supervision. Perhaps the best known

and most widely used stage developmental model (Bernard & Goodyear, 2009), IDM is a

four stage conceptualization that both describes supervisee processes and prescribes

appropriate supervisor interventions with respect to supervisee stage. IDM is an extension

of the Loganbill, Hardy, and Delworth Model (1982). Stoltenberg (1981) originally integrated Hogan's stages of supervisee development with a more conceptual model by Harvey, Hunt and Schroeder that focused on how individuals at various stages of cognitive development think, reason and make sense of their environments (Bernard & Goodyear, 2009). IDM has evolved over a few iterations of Stoltenberg's original model, retaining a focus on cognitions and replacing the conceptual element with a focus on motivational elements. IDM examines how cognitive and motivational elements interact to affect supervision, and how the learning environment can (and must) be modified to encourage optimal supervisee understanding, integration, and retention (Stoltenberg et al., 1998).

The Integrated Developmental Model posits that supervisees progress through four stages of development across eight domains, addressing the shortcomings of previous models in that supervisees can function at various levels in different domains (Stoltenberg & McNeill, 1997; Stoltenberg, et al., 1998). Additionally, the model provides markers to identify when supervisees have progressed from one stage to the next and offers specific supervisor interventions based on supervisee stage. These supervisor interventions are described as facilitative (e.g., communicating support), prescriptive (e.g., providing supervisee with intervention options), conceptual (e.g., tying theory and practice together), confrontive (e.g., pushing supervisees to use new interventions), and catalytic (e.g., expanding awareness of aspects of clinical practice the supervisee has missed). Supervisors use these interventions to improve supervisee skills across eight domains identified in IDM, including intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences,

theoretical orientation, treatment plans and goals, and professional ethics (Stoltenberg &

McNeill, 1997; Stoltenberg et al, 1998). Within each of these domains, supervisees

progress through the following stages.

In stage one, supervisees are both highly anxious and motivated, dependent on

supervisors for advice and guidance (Bernard & Goodyear, 2009; Stoltenberg et al.,

1998). Supervisees are apprehensive about evaluation, and they typically experience

performance anxiety. Supervisors are encouraged to use predominately facilitative and

prescriptive interventions, weaving in occasional conceptual interventions to promote

development of supervisee client conceptualization skills (Stoltenberg et al., 1998). Stage

two, referred to as the trial and tribulation stage, corresponds with the confusion stage in

the Loganbill, Hardy, and Delworth Model (1982). This stage involves fluctuating

supervisee motivation and confidence levels. Supervisees will often vacillate between

periods of dependence and autonomy, resulting in the need for supervisor flexibility.

Supervisors should continue the use of facilitative interventions, perhaps using self-

disclosure to normalize fluctuating supervisee confidence levels. Additionally,

supervisors can begin using some confrontive and catalytic interventions to prompt

supervisee reflection and increase self-awareness (Stoltenberg & McNeill, 1997).

Corrective feedback might be met with defensiveness, depending on supervisee

confidence level; in light of this, supervisors should be prepared to articulate a rationale

for providing corrective feedback.

In stage three, referred to as the calm after the storm, supervisee motivation

typically returns to a high level and is stable; occasional doubts of self-efficacy are no

longer as immobilizing as they are in stage two (Bernard & Goodyear, 2009; Stoltenberg

et al., 1998). Supervisees are more autonomous than they are in stages one and two, and supervision becomes more collegial. The primary task of the supervisor in this stage is to evaluate supervisee consistency across the eight aforementioned domains, especially those supervisees who are functioning at a stage one or two level in some of the domains (Stoltenberg & McNeill, 1997). In this stage, supervisors gently lead supervisees to make discoveries about themselves that may be more impactful than simply providing information. The fourth stage, also known as stage three-integrated, occurs when supervisees reach the third stage across nearly all domains. At this point, supervisees have a strong grasp of their strengths and weaknesses, and they are easily able to move across domains (Bernard & Goodyear, 2009).

The Integrated Developmental Model suggests that assessment and evaluation of therapists are ongoing and essential components of supervision (Stoltenberg et al., 1998). Although supervisee aversion to evaluation may decrease over developmental stage, there is always a certain amount of sensitivity to evaluation, given its role in grades, recommendations, licensure, and/or certification. Supervisees are not the only ones to experience this trepidation regarding supervision; supervisors, because of negative connotations and anxiety associated with evaluative procedures, "All too often avoid what they perceive as negative feedback or instead give only vague or general feedback to developing therapists" (p. 136). IDM attempts to provide context for supervisors and supervisees to normalize struggles, thereby facilitating conditions to provide evaluation and corrective feedback.

The Ronnestad and Skovholt Model of supervision. While most developmental models of supervision focus on graduate and internship training, the Ronnestad and

Skovholt model (1992) examines therapist development across the life span (Bernard & Goodyear, 2009). This is the first model that was derived from a qualitative study, based on interviews with 100 counselors and therapists ranging in experience from the first year of graduate school to 40 years post graduation. Ronnestad and Skovholt identify six stages and fourteen themes in counselor development; early stages in this model, known as the Lay Helper, Beginning Student, and Advanced Student Phases, roughly correspond with stages in IDM. In the Novice Professional Phase, the budding therapist is free from the constraints of supervision, despite not feeling as prepared as they imagined (Bernard & Goodyear, 2009). This feeling changes in the Experienced Professional Phase, as the therapist develops a style that matches values, interests and personality. There is an understanding in this stage of the way in which the therapeutic relationship promotes client change, a personal and flexible approach to therapy, and an acceptance of the many situations in which a clear answer is not evident. The Senior Professional therapist has more than 20 years of experience and has developed a very individualized approach to clients. There is also a sense of loss experienced in this stage, as experienced therapists look toward retirement.

A number of the developmental themes in Ronnestad and Skovholt's model (1992) incorporate aspects of evaluation and feedback (Bernard & Goodyear, 2009; Ronnestad & Skovholt, 2003). Supervisors provide the bulk of evaluation in the early stages of development, and in phase two, beginning supervisor feedback and evaluation have a significant impact on supervisees (Ronnestad & Skovholt, 2003). Criticism, either actual or perceived, can have a profound impact on supervisee morale, while explicit positive feedback can calm the intense anxiety experienced by supervisees at this level.

External dependency on supervisors for confirmation and feedback continues in phase three, the advanced student phase. However, an internal focus is beginning to emerge at this time (typically around internship), and in this phase and beyond, supervisees/therapists are encouraged to develop self-evaluation and self-supervision skills. Furthermore, therapists demonstrate an intense commitment to learn, typically from supervisors in early stages of development, and from colleagues in consultation later in development (Bernard & Goodyear, 2009). Professional development is described as a lifelong process, with beginning practitioners experiencing a high level of anxiety in their work and strong affective reactions toward more experienced members (e.g., supervisors) of the profession.

Concluding Thoughts: Developmental Models of Supervision. The developmental models of supervision described herein offer often overlapping views of the supervision process. A significant contribution of such models is to provide a way of examining supervision outside of theoretical orientation, as well as highlighting a non-linear approach to supervisee development. Perhaps overlooked in these models, however, are the various roles that supervisors occupy, and how these roles interact with the various tasks of supervision. This is the focus of the next category of supervision models, those that are grounded in social role theories.

Supervision Grounded in Social Role Model Theories. Social role models examine the set of roles for supervisors based on expectations, beliefs and attitudes about supervision (Holloway, 1995). Various role behaviors can occur in the context of supervision, including parent-child, teacher-student, evaluator-evaluated, mentor-apprentice (Bernard, 1997; Bernard & Goodyear, 2009; Holloway, 1997). In this section,

Bernard's (1997) Discrimination Model and Holloway's (1995) Systems Approach to

Supervision (SAS) are described. The various social roles supervisors occupy are a

significant part of these models, yet the models are not based solely on social role theory.

As such, these models have also been referred to as integrative models (Bradley, Gould,

& Parr, 2001).

The Discrimination Model of Supervision. Originally conceived as a teaching

tool in the mid 1970s, Bernard's Discrimination Model of supervision was an attempt to

organize supervision activities and focus supervisor teaching efforts (Bernard, 1997;

Bernard & Goodyear, 2009). The Discrimination Model proposes two axes, supervisor

focus or what s/he needs to address in supervision, and the most functional style in which

to achieve the focus or address the need (Bernard, 1997). The three areas of focus are

supervisee process or intervention skills (i.e., behavioral activity of the supervisee),

supervisee conceptualization skill (i.e., cognitive activity of the supervisee), and

supervisee personalization skills (i.e., affective activity of the supervisee). For each of

these areas, there is the potential for a related skill deficit, and supervisors are tasked with

the job of identifying the source of the skill deficit, as well as the proper role in which to

address the supervisee skill deficit (Bernard, 1997).

According to Bernard's Discrimination Model, there are three styles, or roles, that

a supervisor can take in addressing concerns in supervision, that of teacher, counselor,

and consultant (Bernard, 1997). When occupying the role of teacher, a supervisor takes

responsibility for what a supervisee needs to know in order to be more competent. To this

end, the supervisor might provide both positive feedback about appropriate interventions,

and corrective feedback about interventions that did not work as well. Additionally, the

evaluation aspect of this role typically focuses on supervisee interactions with clients. When supervisors are occupying a counselor role, the focus is on the inter- or intrapersonal reality of the supervisee; feedback in this role oftentimes focuses on identifying supervisee competencies and areas for growth, especially with regard to how supervisee thoughts, feelings and behaviors converge and impact work with clients. Evaluation in this role typically focuses on supervisees' ability to process their affect and possible defenses. Finally, as consultant, the supervisor allows the supervisee to share responsibility for her/his own development, with the supervisor serving as a resource for the supervisee. Feedback might focus on providing a number of alternative interventions or conceptualizations for a supervisee, allowing her/him to weigh the alternatives and select an appropriate course of action. Supervisors can evaluate this process of intervention or conceptualization selection, as well as the supervisee's ability to brainstorm her/his own set of options (Bernard, 1997).

According to the Discrimination Model, using an inappropriate role in approaching a supervisee and providing feedback can make providing feedback more difficult (Bernard, 1997). For example, asking a beginning supervisee what went wrong in a session (i.e., supervisor occupying a consultant role) might make a supervisee uncomfortable, because s/he will likely not have sufficient information to evaluate the session; approaching the supervisee from a teacher role might be more helpful in such a situation. The Discrimination Model also provides a framework for supervisors to examine their focus in supervision and determine if they focus on one role and one skill (e.g., a supervisor who predominately provides corrective feedback on supervisee client conceptualization skills, thus focusing on cognitive skills while occupying a teacher role).

Moreover, the model cautions against providing feedback that blurs two foci, encouraging supervisors to identify which focus is most salient and provide feedback concerning that specific area (i.e., supervisee behavior, cognitions, affect) (Bernard, 1997).

In terms of evaluation, the Discrimination Model suggests that supervisors depend mostly on direct samples of supervisees' work, noting that what is presented in self-report is the supervisee's subjective experience of a session. Bernard (1997) refers to this supervisee presentation of a session as a metaphor, and she notes that "a metaphor can be highly significant for supervision, but in the final analysis, it is still a metaphor" (p. 315). Comparing supervisees' self-reports of observed sessions with supervisor observations can be an important source of feedback for both supervisors and supervisees, informing supervisors of supervisee strengths and weaknesses, as well as the level of agreement between supervisee internal reality and what is observed in the session.

The Systems Approach to Supervision (SAS). Holloway describes the Systems Approach to Supervision as a framework for viewing supervision (Bernard & Goodyear, 2009; Bradley, Gould et al., 2001; Holloway, 1997) and providing a language that allows supervisors and supervisees to discuss aspects of supervision using terms and knowledge developed from both science and practice (Holloway, 1995). The Systems Approach to Supervision expands Bernard's Discrimination model, providing five supervisory tasks (counseling skills, case conceptualization, emotional awareness, professional role, and self-evaluation) and five supervisory functions, or roles (advising/instructing, supporting/sharing, consulting, modeling, and monitoring/evaluating) (Bernard & Goodyear, 2009; Holloway, 1995).

In addition to the five tasks of supervisees and five functions/roles of supervisors, SAS provides four contextual factors that influence the process of supervision: the supervisor, the supervisee, the client, and the institution (Holloway, 1995). Supervisor factors are one of these contextual factors and include the roles that supervisors play, in addition to supervisor characteristics such as professional experience, theoretical orientation, knowledge, cultural background, and self-presentation. Supervisee factors, another contextual factor, include psychological health, previous experience, theoretical orientation, learning style/needs, cultural background, and self-presentation. Client factors provide another contextual element, and these include client presenting concern, diagnosis, cultural background, and the counseling relationship (e.g., parallel processes). Lastly, institutional factors relate to the type of setting (e.g., university counseling center, in-house university department clinic, hospital) and how the setting impacts the goals and functions of supervision, including clients the organization serves and organizational structure and climate (e.g., political climate). Supervisors must balance the institutional contextual factor, such as organizational demands, with professional ethical standards (Holloway, 1995).

The supervision relationship is at the core of this process, with the five functions, five tasks, and four contextual elements serving as wings or extensions of the relationship (Bernard & Goodyear, 2009; Holloway, 1995). The model recognizes that both supervisor and supervisee are responsible for establishing a relationship that is sufficiently flexible to accommodate the supervisee's needs. The supervisor, however, has the responsibility of occupying a guiding role, and in this role s/he provides support for and evaluation of the supervisee (Holloway, 1997). The supervisor, by way of the

monitoring/evaluating function, communicates judgments and evaluations of a supervisee's behavior, accentuating the hierarchy of the relationship (Holloway, 1995). While this can be either informal (e.g., verbally during a supervision hour) or formal (e.g., in a summative evaluation at the end of a semester), the supervisor's perceptions and evaluations of supervisees, whether implicit or explicit, is important. Additionally, corrective feedback might occur while the supervisor is occupying a supporting/sharing role, and while this might result in confrontation, the SAS model recognizes that confrontation can increase the strength of the relationship if done constructively and appropriately (Holloway, 1997).

In sum, SAS provides seven components of supervision, all of which influence two primary tasks of the supervisor: what to teach and how to create a relationship that facilitates supervisee acquisition of learning objectives (Holloway, 1995). In taking into account contextual factors, supervisee tasks, and supervisor function/role, SAS provides a model to help supervisors reflect on what they do in supervision, discover patterns in their approach to supervision, and communicate this information to others with a common language.

Supervision: Concluding Thoughts. A wide range of supervision models have been discussed, including those based on approaches to psychotherapy, those with a developmental focus, and those with a role/integrated focus. In varying degrees of depth, many of the models include the role that evaluation of supervisees plays in the process of supervision. Moreover, these models acknowledge the potential difficulties associated with evaluation, from the perspective of both supervisor and supervisee. With these

supervision models in mind, we turn to a more in-depth examination of evaluation and its role in the process of supervision.

Evaluation

Evaluation has been widely recognized as an integral component of supervision (Bernard & Goodyear, 2009; Falender & Shafranske, 2008; Hess, 1997; Hoffman, 1990; Holloway, 1997; Milne, 2008; Watkins, 1997). In fact, evaluation has been described as the "nucleus" of and a "constant variable" in supervision (Bernard & Goodyear, 2009), the "linchpin" of quality assurance efforts in psychology (Robiner et al.,1993), a core component of counselor training (Halgin & Murphy, 1995), and the feature that distinguishes between counseling and supervision (Holloway, 1995; Stoltenberg et al., 1998). Watkins (1997) goes as far as stating that "whatever the nature of the supervisory relationship, some form of evaluation is involved, and that is how it must always be" (p. 4).

Ironically, despite numerous statements regarding the importance of evaluation in supervision, very little attention has focused on why evaluation is important. Additionally, little empirical research has been conducted to determine the essential elements that facilitate supervisee learning and evaluation (Gould & Bradley, 2001). This lack of clarity regarding why evaluation is important, what is evaluated, how evaluation is conducted in supervision, what conditions are conducive to evaluation, and why supervision is problematic for many supervisors (Falender & Shafranske, 2008), has led some to label evaluation as "the conundrum of supervision" (Gould & Bradley, 2001, p. 271) and "typically a weak suit for most supervisors" (Cormier & Bernard, 1982, p. 490).

The following sections critically examine the theoretical and empirical literature, where it exists, with regard to these questions surrounding evaluation.

The Importance of Evaluation. Much of what has been written regarding the importance of evaluation comes from the organizational psychology literature. According to Bittel and Newstrom (1990), evaluation has three purposes: to encourage good behavior and correct/decrease poor performance, to respond to employee questions regarding their level of performance, and to provide pertinent information on which future career decisions are made. A case can be made for the applicability of these purposes to clinical supervision. For the purposes of supervisee edification and client welfare, it is important for supervisees to understand what they are doing well and in what areas improvement is needed. This should allow supervisees to continue with interventions that are working and make modifications in areas that are less helpful to clients. Regarding Bittel and Newstrom's second purpose, there seems to be little doubt that supervisees, especially those new to the field, have concerns regarding their performance as counselors and their ability to help others (Bernard & Goodyear, 2009; Hess, 1997). Finally, given the gatekeeping function of supervisors, evaluation conducted within clinical supervision most certainly provides relevant information regarding future career decisions; in order to protect client welfare and the integrity of the field, the profession must monitor carefully those who join its ranks (Bernard & Goodyear, 2009; Falender & Shafranske, 2008; Watkins, 1997).

What is Evaluated in Clinical Supervision. The question of what is evaluated in supervision is not an easy one to answer. Unlike many fields, such as nursing, the counseling profession lacks universally agreed upon and empirically validated standards

of competency (Robiner, Fuhrman, Ristvedt, Bobbitt, & Schirvar, 1994). The reasons for this are many; there is a great deal of variability in supervisee training experiences including treatment modality, client population served, and agency/setting (Robiner et al., 1994). Additionally, and perhaps most significantly, despite a great deal of research, it remains unclear precisely what therapeutic factors lead to client change and/or improvement (Bernard & Goodyear, 2009; Newman, Kopta, McGovern, Howard, & McNeilly, 1988; Shaw & Dobson, 1988). According to Sechrest and Chatel (1987), it is difficult to identify precisely what factors are necessary for client change, let alone how skilled psychologists need to be in order to create such factors. As a result, clinical competence has been described as a "moving target with elusive criterion" (Robiner et al., 1993, p. 5).

Internships accredited by the American Psychological Association (APA) are mandated to evaluate intern performance and develop a clear and comprehensive system of evaluation, yet the accreditation criteria provide no details in terms of what should be evaluated, and they do not require programs to examine the validity and reliability of their evaluation processes (Robiner et al., 1994). For instance, in APA's Commission on Accreditation 2010 Self-Study Instructions, internship programs are required to submit documentation of evaluation procedures, yet aside from requiring that internships describe the process of providing written feedback to interns, there are no specific evaluation requirements identified in the self-study instructions (APA, 2009). The Commission on Accreditation states in their guidelines that rather than provide a checklist of specific evaluation areas, programs are allowed to develop a system of evaluation that best reflects the training experience they provide (APA, 2008). APA's

Joint Council on Professional Education in Psychology identified eight areas of

competence for exit criteria for doctoral internships: effective interpersonal functioning,

ability to make sound professional judgments, ability to extend and expand basic

assessment and intervention techniques to meet the needs of different settings, problems,

and populations, ability to apply ethical and legal principles to practice, ability to assess

and intervene appropriately with clients manifesting diverse characteristics, development

of a primary professional identity as a psychologist, awareness of personal strengths and

limitations and the need for continued supervision, consultation, and education, and

preparedness to enter residency training and to choose appropriate advanced training

(Bernard & Goodyear, 2009). Despite this guidance, while some APA accredited

internship sites implement quite extensive policies and procedures for the evaluation of

supervisees, many programs do not appear to meet APA accreditation requirements in

terms of using an explicit, comprehensive system for evaluation (Norcross, Stevenson, &

Nash, 1986).

        Other accrediting bodies, such as the Association for Counselor Education and

Supervision (ACES) and the Association of Psychology Postdoctoral Internship Centers

(APPIC) require that evaluation and feedback be included in clinical supervision. Similar

to APA's Commission on Accreditation, both ACES and APPIC provide general

guidelines regarding evaluation, indicating that evaluation should be provided formally

and informally and both verbally and in writing (ACA, 2005; APA, 2009). However, no

specific requirements for evaluation and feedback are provided, although APPIC does

request written documentation of internship programs' evaluation procedures. Thus, it

seems that while accrediting bodies note the importance of evaluation, programs are given a great deal of latitude in implementing processes of evaluation.

There has been additional guidance, beyond APA accrediting bodies, regarding the criteria by which supervisees should be evaluated. Overholser and Fine (1990) cited five areas of competence for supervisees: factual knowledge, clinical skills, orientation-specific technical skills, clinical judgment, and interpersonal attributes. Other theorists have specified a number of supervisee interpersonal and intrapersonal skills as part of evaluation, including ability of the supervisee to be open, flexible, positive, cooperative, willing to accept and apply feedback, awareness of impact on others, ability to cope with conflict, ability to accept personal responsibility and ability to express feelings effectively and appropriately (Frame & Stevens-Smith, 1995). Pope-Davis and Dings (1995), as well as Sue (1996) go a bit further, including multicultural competence in evaluating counselor competency. Still other models identify criteria based on supervisee developmental level. For example, Hatcher and Lassiter (2007) specify a number of competencies for the first doctoral practicum, including baseline knowledge (e.g., basic helping skills, knowledge and awareness of cultural difference, and ethical and legal parameters), skills, and attitudes, as well as inter- and intrapersonal skill that are similar to Frame and Stevens-Smith (1995). Finally, Falender and Shafranske (2008) suggest that client outcome should be included in the evaluation of supervisees.

As a result of this lack of clarity regarding exactly what criteria supervisees should be evaluated, supervisors are often left to determine what standards supervisees need to achieve in order to successfully complete their training (Holloway, 1995). And, while establishing the criteria for evaluation may be difficult and without much guidance,

there does not seem to be a lack of sources for criteria, including accrediting bodies, academic programs, agencies, and other psychologists (Bernard & Goodyear, 2009). According to Gould & Bradley (2001), the evaluation criteria supervisors typically establish are subjective, ambiguous and difficult to measure, perhaps because of the personal and complex nature of counseling skills.

Selecting the criteria (however difficult that might be!) on which supervisees will be evaluated is just the beginning of the process of evaluation that occurs within supervision. Developing a supervision contract, selecting the method of evaluation, choosing the instrument(s) of evaluation, and communicating summative evaluations comprise the remainder of the evaluation process. These components of evaluation are described next.

How Evaluation is Conducted in Clinical Supervision. According to Bernard and Goodyear (2009), the manner in which supervisors go about conducting evaluation provides insight into how they view evaluation processes in the overall context of supervision. For example, if supervisors incorporate evaluation at the beginning of supervision and carry this through until the end of the supervision process, this demonstrates that the process of evaluation is not separate from the process of clinical supervision, but is embedded within it. For the purposes of this review, the evaluation process includes negotiating the supervision contract, selecting methods of evaluation, choosing evaluation instrument(s), and conducting summative evaluation. An additional portion of the process, communicating formative feedback, will be addressed later in a separate section.

The supervision contract. According to Bernard and Goodyear (2009),

supervisees should receive a plan for supervision that parallels a class syllabus, including

requirements, objectives, outline of activities, and plan for evaluation. This plan serves as

a contract for what will occur in supervision, and should establish learning goals,

describe the criteria for evaluation, the methods of supervision, the length and frequency

of supervision meetings, the services and scope of supervisor's practice, and the way in

which summative evaluation will be handled (Bernard & Goodyear, 2009; Campbell,

2006; Gould & Bradley, 2001; Osborn & Davis, 1996). With regard to evaluation more

specifically, the contract should address procedures for both formative and summative

feedback, and make explicit the criteria for evaluation in the final, summative evaluation

(Campbell, 2006; Neufeldt, 1999). According to Osborn and Davis (1996), the

supervision contract reminds supervisors of their ethical and legal responsibilities to both

supervisees and consumers of mental health services, protecting all parties involved by

way of clarifying methods, goals and expectations, and encouraging collaboration

between supervisors and supervisees.

Methods for conducting evaluation. There are a number of sources of material

from which supervisors can evaluate supervisees. These include supervisee self-reports,

process notes, audio- or videotapes, and live supervision (Bernard & Goodyear, 2009;

Gould & Bradley, 2001). Peer group supervision can provide an additional source of

evaluation for supervisors; however, given the supervisor's ultimate responsibility for

evaluating supervisees, sole reliance on peer evaluations is strongly discouraged (Bernard

& Goodyear, 2009). The method of evaluation used in supervision can impact

supervisees (Bernard & Goodyear, 2009; Gould & Bradley, 2001). For example, self-

report requires much more self-reflection on the part of supervisees than live observation. Additionally, listening to audiorecordings or watching videotapes in the presence of a supervisee may have a different impact than a supervisor evaluating recordings without the supervisee present. In light of this, supervisors are encouraged to inform supervisees of the methods of evaluation (Bernard & Goodyear, 2009). A brief review of each method of supervision follows.

Self-report. Perhaps the most commonly used form of evaluation (Gould & Bradley, 2001), supervisee self-report has also been criticized as being prone to supervisee distortion and/or omission (Holloway, 1995; Wynne, Susman, Ries, Birringer, & Katz, 1994). In a study comparing supervisor perceptions of beginning supervisee preparedness to conduct therapy, those supervisees evaluated on self-report alone were rated as less prepared than those evaluated by more direct methods (Rogers & McDonald, 1995). McCarthy, Kulakowski, and Kenfield (1994), in a study of licensed psychologists, found that psychologists seeking supervision most often provided self-reports of session events to supervisors, and that direct observation was almost never conducted. According to Gould and Bradley (2001), self-report is perhaps best used in conjunction with other methods of evaluation, with consideration given to supervisee developmental level and the extent to which the supervisor trusts the supervisee to accurately and fully recall session events in supervision.

Process notes. Reviewing the process notes that are completed following sessions can be a useful source of information for supervisors, especially in terms of tracking the cognitive processes of supervisees (Gould & Bradley, 2001). Typically, process notes include counselor written documentation of client diagnosis, assessment of past sessions'

goals and interventions, specific objectives for next session, and interventions to achieve those goals. Process notes are a form of counselor self-report, and are therefore subject to the same criticisms of accuracy of counselor self-report of therapy sessions in supervision. Gould and Bradley (2001) recommend that similar to supervisee self-report in supervision, reliance on process notes should be reserved for more advanced supervisees, because they are less likely than beginning supervisees to distort and/or omit salient pieces of information from counseling sessions. Thus, process notes are perhaps best used in conjunction with other methods of supervisee evaluation, with consideration given to supervisee developmental level and supervisor comfort in trusting supervisee to document session events accurately and completely (Bernard & Goodyear, 2009; Gould & Bradley, 2001).

Audio- and videotapes. Supervisor review of supervisee audio- and videotaped sessions with clients can be used for a variety of evaluation and learning activities, including refinement of therapy techniques, development of perceptual and conceptual skills and analysis of supervisee counseling behaviors (Gould & Bradley, 2001). How tapes of sessions are used in supervision may depend on supervisee developmental level; Gould and Bradley (2001) suggest that with novice supervisees, supervisors should review the entire tape prior to supervision and highlight a few key areas in supervision with the supervisee present. According to Cashwell, Looby, and Housely (1997), these key portions of the session include the most productive part of session, the part in which the supervisee struggles most, segments that are confusing to the supervisor, and those sections that highlight interpersonal dynamics between the supervisee and client. Each of these areas can be a source of evaluation and feedback for the supervisee. With more

advanced supervisees, and in the more advanced stages of supervision with beginning supervisees, supervisors are encouraged to allow supervisees to play a more active role in selecting the portions of tape for review in supervision (Cashwell et al., 1997; Gould & Bradley, 2001).

Breunlin, Karrer, McGuire, and Cimmarusti (1988) suggest a number of guidelines for supervisors when reviewing tapes of client sessions with supervisee. Among them, supervisees should be given the chance to discuss their internal processes during the session as it relates to the portion of tape reviewed, corrective feedback should focus on supervisee counseling behaviors that can be changed, portions of tape selected should neither be the best nor worst portions of the session (in hopes of moderating the discrepancy between goal and actual behavior), and supervisees should be stimulated to grow and develop without becoming overly threatened.

There are some potential drawbacks associated with audio- and videotaping client sessions. It is possible that awareness that sessions are being taped can alter the counseling session, thus prohibiting the review of a typical counseling session between supervisee and client (Gould & Bradley, 2001). Relatedly, increased supervisee performance anxiety as a result of recording sessions can negatively impact not only the samples submitted for supervisors to review, but the care provided to clients as well (Gould &Bradley, 2001). Despite these drawbacks, audio- and videotapes can be a productive method of supervision, especially in highlighting any discrepancies between supervisee and supervisor perceptions of session events (Bernard & Goodyear, 2009; Gould & Bradley, 2001).

Live observation. Observing supervisees live while they are in session with clients combines direct observation of sessions with the ability to communicate directly with the supervisee, thereby influencing the supervisee's work and, potentially, the trajectory of the session (Gould & Bradley, 2001). There are various types of live observation, including bug-in-the-ear and monitoring from behind a one-way mirror with the opportunity for consultation breaks. Live observation has a number of advantages, including a greater likelihood of protecting client welfare (Bernard & Goodyear, 2009; Kaslow & Bell, 2008), freeing supervisees to take more risks because of the presence of a supervisor in the event that things go awry (Berger & Dammann, 1982), and the ability for supervisees to work with more challenging clients (Cormier & Bernard, 1982). Additionally, there is evidence to suggest that supervisees learn more efficiently from experiencing therapy sessions with real-time input from a more seasoned therapist (Landis & Young, 1994).

There are disadvantages associated with live supervision as well. This form of evaluation consumes a great deal of a supervisor's time, and it also carries the risk that a supervisee will become a blind imitator of her/his supervisor; the lack of autonomy associated with live observation may hamper the supervisee's ability to develop creativity and initiative in therapeutic relationships with clients (Gould & Bradley, 2001). Furthermore, Kivlighan, Angleone, and Swafford (1991) reported that there is no evidence to suggest that skills learned in live supervision generalize to therapeutic situations when supervisees are on their own. In light of these drawbacks, supervisors are encouraged to combine live supervision with other forms of evaluation, and consider

supervisee developmental level and the associated need for supervisee autonomy (Gould & Bradley, 2001).

There appears to be little research into the effectiveness of various methods of evaluation previously described. However, two consistent themes emerge from the theoretical literature on evaluation methods: relying solely on one method is likely not in the best interest of supervisee learning and development, and supervisee developmental level is an important consideration in selecting a method of evaluation (Bernard & Goodyear, 2009; Gould & Bradley, 2001).

Instruments for use in clinical supervision evaluation. It is perhaps not unexpected, given the lack of clarity regarding the criteria for evaluation, that there are few, if any, performance measures that reliably distinguish competent from incompetent practitioners (Bernard & Goodyear, 2009). There are standardized instruments to measure therapist competence in specific theoretical approaches to therapy (e.g., Young and Beck's Cognitive Therapy Scale), however, research suggests that such instruments are rarely used in doctoral programs and internship sites (Norcross et al., 1986). Reliable and valid assessments that measure a wider array of supervisee functioning (i.e., covering a number of domains) are more difficult to find, prompting the conclusion that there is a lack of psychometrically sound evaluation measures available for use in supervision (Watkins, 1997). According to Gonsalvez and Freestone (2007), a review of the empirical literature on supervision reveals:

> An unsettling dearth of research in core issues concerning supervision evaluation. It appears that psychology has applied its considerable expertise in measurement and evaluation more assiduously to a wide array of other domains and disciplines,

while neglecting what is arguably the most important component of its

professional training. (p. 24)

Gould and Bradley (2001) suggest that it might be unreasonable to expect that one

evaluation instrument could cover the myriad differences in supervision experiences,

including variations in treatment modality (e.g., individual, group, couples therapy),

competence of supervisee (e.g., intervention skills, client conceptualization, skills,

professionalism), segment being evaluated (e.g., specific session, part of a session, entire

work with a client, entire work at a setting), method (e.g., self-report, audiotapes), and

time period (e.g., early, middle, or late in client treatment and/or training experience).

Despite the lack of psychometrically sound evaluation measures, a survey of

training directors revealed that supervisor evaluations of supervisees was the most

important indicator of quality, ahead of 36 other indices of professional training

(Norcross et al., 1986). Furthermore, the dearth of empirically supported evaluation

measures does not seem to prevent practicum and internship sties from conducting

evaluation; 92% of programs surveyed used some form of written evaluation, with 41%

indicating they used a combination of structured and unstructured evaluation procedures

(Gonsalvez & Freestone, 2007).

Perhaps in response to a lack of psychometrically sound evaluation measures,

Bernard and Goodyear (2009) suggest that supervisors likely develop unvalidated Likert

scales, along with some open-ended questions, to evaluate supervisees. In fact, Bernard

and Goodyear suggest that there might be at least one evaluation instrument for each

training program in the mental health field! In what is perhaps an encouraging sign, there

has been a recent movement to develop anchored rubrics, which describe supervisee

behaviors at each point on the scale. This overcomes the drawback of being unable to readily identify what differentiates between points on a Likert scale (Bernard & Goodyear, 2009).

A review of just a few efforts to contribute psychometrically sound evaluation measures to the field reveals precisely how challenging such an endeavor is. In creating the Minnesota Supervisory Inventory (MSI), Robiner et al. (1994) found that evaluation practices at internship sites were general, varied and lacked validation. Such general approaches to evaluation allowed for glossing over specific, yet potentially significant supervisee problems. Additionally, most measures lacked the range of clinical (e.g., supervision) and professional (e.g., business) skills supervisees need to be successful in the field (Robiner et al., 1994). In response to this lack of standardized instruments, Robiner et al. (1994) created the MSI.

The MSI dimensions are face valid, and according to Robiner et al. (1994) most pertinent for evaluating hospital-based interns (again, developmental level and site specific). Specifically, the MSI addresses assessment, psychotherapy and intervention, consultation, professional and ethical behavior, supervision, case conference/presentation, and site-specific functioning. One obvious criticism of the MSI is that it might not be applicable across internship sites, especially those not based in hospitals. Interestingly, despite psychometric soundness, hospital internship sites reported viewing the MSI favorably but were unsure if they would actually use it. According to Robiner et al. (1994), the perception that supervisee evaluation instruments are not universally applicable has broad implications for supervision research, stating that

"resistance to such efforts prevents development of standard evaluation practices that arguably is fundamental to ethical and effective supervision and evaluation" (p. 12).

Lehrman-Waterman and Ladany (2001) developed a measure called the Evaluation Process within Supervision Inventory (EPSI), which contains 21 items that assess supervisee experiences of the extent to which goal-setting and feedback processes occurred in supervision. The authors report that the EPSI, which has shown both strong reliability and validity, can be added to the small list of empirically supported measures of evaluation. Additionally, it can be used as a tool to assess whether goals for supervisees meet guidelines for effective evaluation, as well as serving as a reminder for a balanced approach to feedback (i.e., both positive and corrective) and the need for both formative and summative forms of evaluation (Lehrman-Waterman & Ladany, 2001). While the EPSI might be a promising tool for evaluation, it is not clear how comprehensive it is in terms of measuring a broad array of supervisee functioning across professional and personal domains, a criticism rendered of many previous evaluation measures.

In sum, supervisors may struggle to determine the appropriate criteria to evaluate supervisees, as well as find empirically supported measures to evaluate those criteria. Hensley, Smith, and Thompson (2003) suggest that researchers interested in developing evaluation measures should perhaps look to legal and ethical considerations in order to develop an understanding of how supervisee professional and personal development relate to clinical competence. The inclusion of legal and ethical considerations may help establish best practices and aide in the development of systematic, written policies to clarify practices of evaluation. The authors note, however, that this might need to be

tailored to specific programs, a reminder of just how daunting it is to develop widely applicable, psychometrically sound evaluation measures.

Communicating summative evaluations. The criteria for evaluation have been identified, and a supervision contract is in place that elucidates the criteria, as well as the methods and instruments used to evaluate supervisees. The final component of the supervision process (aside from feedback, which will be addressed later in this review) is communicating summative evaluations to supervisees and, if applicable, training programs. In academic settings, summative evaluations are typically done at mid-semester, as well as end of semester. Outside of academic settings, summative evaluations are usually conducted at mid-year and end of year (Bernard & Goodyear, 2009). Summative evaluations should be conducted face to face with supervisees, and this conversation should be followed up with a written copy of the evaluation. Ideally, there should be no surprises contained within the summative evaluation, so long as formative evaluations and formative feedback were provided to the supervisee throughout the supervision process (Bernard & Goodyear, 2009).

Evaluation in Clinical Supervision as Problematic. It should be clear by now that there are many challenges in conducting sound evaluation in supervision. Unfortunately, murkiness surrounding evaluation criteria and a lack of psychometrically sound evaluation measures are not the only factors that contribute to difficulties in evaluating supervisees. Supervisor factors such as leniency bias and ambivalence about conducting supervision also contribute to perceptions of evaluation in supervision as problematic.

Supervisor leniency bias. The ability to objectively rate others' behavior is often influenced by bias in the rater. One form of this bias is the tendency to rate individuals more positively than is warranted based on objective data (i.e., leniency bias). According to Robiner and colleagues (1997), 59% of supervisors indicated that their own ratings of supervisees were biased, with only 11% indicating that their evaluations of supervisees were accurate and without bias. Most common biases were a tendency toward leniency (39%), with only 16% reporting a tendency toward strictness. Findings such as these have led some to conclude that the field of psychology should acknowledge that bias in the assessments of trainees is likely quite common and significant (Gonsalvez & Freestone, 2007). This tendency towards leniency bias is not unique to supervision in psychology; a study of speech-pathology supervisors found that supervisor evaluations of supervisees differed based on familiarity with supervisee, with increased familiarity resulting in more favorable evaluations (Blodgett, Schmitt, & Scudder, 1987).

In a study of psychology supervisors, Borders and Fong (1991) found no relationship between supervisor global ratings of supervisees and external judges' ratings of supervisees in a counseling session. The researchers hypothesized that supervisors and external judges based their evaluations on different criteria; essentially, knowing the supervisee impacted the supervisor's rating (Borders & Fong, 1991). Interestingly, external judges issued consistently higher ratings as supervisee experience increased, while supervisors rated second-year practicum supervisees lower than first-year supervisees. A potential explanation for this finding is that difficulties experienced by second year practicum students (i.e., the turbulent stage according to the IDM) translated to difficult supervisee behaviors, resulting in strained relationships between supervisee

and supervisor (Borders & Fong, 1991). In sum, this study lends credence to the theory that external judges may use more objective information in evaluating supervisees and are less biased than supervisors who work directly with supervisees.

Supervisor ambivalence about evaluation. According to Robiner et al., (1994), the leniency bias may reflect supervisors' discomfort with their role in quality assurance. Evaluation might be incompatible with professional identity for clinical supervisors, because they were initially trained as therapists (and accepting of clients' limitations) (Haber, 1996). With respect to counseling psychology specifically, much of the theoretical underpinnings of supervision practices come from Carl Rogers and unconditional positive regard, a concept viewed as at odds with evaluation (Hahn & Molnar, 1991). Additionally, supervisors may believe that evaluation interferes with developing a strong supervision relationship, which has been show to contribute to supervisee development. These concerns, combined with a lack of clarity in terms of what should be evaluated, results in dissonance that supervisors may alleviate through avoiding evaluation (Bernard & Goodyear, 2009). A survey of graduate clinical psychology programs, conducted by Tyler and Weaver (1981), found that about 75% of supervisors revealed entire summative evaluation to supervisees, with approximately 25% withholding some sort of information.

There are a number of potential ramifications associated with either overly favorable evaluation or a lack of evaluation. Interns who leave training with overwhelming positive evaluation may have a false sense of confidence, while others may leave internship with an imposter syndrome if overwhelmingly positive evaluations are incongruent with self-appraisals (Hahn & Molnar, 1991). Moreover, inflated

evaluations do a disservice to graduate programs, which will not receive meaningful

feedback about students' abilities that were developed in the graduate program. Looking

more long range, this lack of feedback regarding students' abilities can be harmful to

future employers, who might rely on internship sites to ensure graduating interns possess

a certain level of competence (Hahn & Molnar, 1991).

In sum, the potential for supervisor leniency bias, murkiness surrounding the

criteria to evaluate and how to rate supervisees, and the potential for administrative (e.g.,

additional paperwork and meetings) and legal repercussions of evaluation and

remediation can contribute to ambivalence and reticence regarding the supervisory role of

evaluator (Bernard & Goodyear, 2009). Perhaps these potential difficulties in evaluation

explain why only about two thirds of training programs provide written evaluations to

supervisees, despite nearly all providing some sort of verbal feedback (Tyler & Weaver,

1981).

Conditions that Facilitate Evaluation in Clinical Supervision. Despite an

abundance of factors that contribute to perceptions of evaluation as problematic, there has

been research conducted that reveals what conditions facilitate evaluation in clinical

supervision. Borders (1992) suggests that for those new to the role of supervisor,

developing a framework for evaluation is an important first step, as well as an awareness

of what evaluation entails and why it is important. This framework should translate into a

more thorough understanding of supervisor interventions associated with evaluator role,

providing for systematic, intentional, proactive, yet flexible approaches to supervisee

evaluation (Borders, 1992). Based on research that examined supervisee experiences of

evaluation in supervision, it appears that goal setting and effectively occupying the role

of both mentor and evaluator are important considerations in developing an evaluation framework for supervision.

Lehrman-Waterman & Ladany (2001) found that the process of goal setting with supervisees was highly correlated with a positive supervision alliance and increased supervisee satisfaction with supervision. A qualitative study by Talen and Schindler (1993) revealed that for first-year practicum supervisees, the development of goal-directed supervision plans were reported as the single most helpful aspect of supervision. These supervisees indicated that the supervision goals helped focus their learning and assisted them in developing strategies to meet supervision goals. Additionally, Talen and Schindler suggest that goals should be reexamined and possibly redefined every six months; the most progress toward supervision goals was completed in the first six months following goal setting.

In a study that examined doctoral students' perceptions of best and worst supervision experiences, Allen and colleagues (1986) found that supervisees valued those supervisors who were able to successfully navigate both mentor and evaluator roles, straddling the domains through the use of referent and expert power (French & Raven, 1959). Supervisees reported favorable supervision experiences when evaluation occurred in the context of a supportive relationship and clearly communicated expectations (Allen et al., 1986). In a study of internship supervision experiences, supervisees reported higher levels of satisfaction with supervision when both strengths and weaknesses were noted in evaluations, and when supervisors provided meaningful feedback about areas of supervisee expertise and those in which supervisees needed ongoing education and supervision (Hahn & Molnar, 1991).

Evaluation Practices. With an understanding of why evaluation is viewed by some as problematic, as well as a better understanding of conditions that might facilitate evaluation in supervision, it is time to review the literature on the actual practices of evaluation in supervision. The question of what actually occurs with regard to evaluation practices can be examined from many different perspectives, including supervisees and supervisors. Not unlike other facets of evaluation, the picture is unclear.

Ladany, Lehrman-Waterman, Molinaro, and Wolgast's (1999) study of supervisor ethical practices revealed that 33% of supervisees indicated that their supervisors did not provide sufficient evaluation of their counseling work. Barth and Gambrill (1984) found that supervisees indicated their supervisors rarely provided evaluation of their counseling behaviors and that audio and/or video tapes were seldom listened to/viewed. Interviews with experienced counselors who were asked to reflect on early supervision experiences revealed that supervisors who failed to clarify expectations and establish performance standards were associated with poor supervision experiences (Magnuson et al., 2000).

A very different perspective of evaluation practices emerges when training directors are asked. Tyler and Weaver's (1981) study of clinical training directors revealed that 91% of directors responded that regular evaluation of trainees occurred, and 84% indicated that they were very satisfied with supervisee evaluation practices (no data were gathered regarding how satisfied supervisees were with the evaluation practices). A study by Stevenson & Norcross (1985) found that 62% of psychology clinic training directors indicated that they engaged in both written and verbal evaluation of supervisees. Again, no data from the perspective of the supervisees were collected.

In sum, the empirical literature on evaluation practices is sparse, and the answer to the question of what evaluation practices actually occur in supervision likely depends on who you ask. What little research has been conducted seems to suggest that while supervisees are less than pleased with evaluation practices, the majority of training directors believe that sufficient evaluation is being conducted.

Concluding Thoughts Regarding Evaluation. A review of the literature on evaluation reveals that a great deal of information remains to be discovered about this critical aspect of supervision. While the theoretical literature provides guidance regarding the process of evaluation, including methods of obtaining evaluative data, specific criteria for evaluation, psychometrically sound evaluations measures, effectiveness of various modes of evaluation (e.g., self-report, live observation), and a clear picture of what evaluation processes actually occur within in supervision have yet to be established. Robiner et al. (1997) aptly and succinctly address this lack of clarity, stating that "the failure of organized psychology to establish supervisory standards is perplexing" (p. 131). What is clear, however, is that barriers to conducting effective evaluation in supervision, along with disparate supervisor and supervisee perceptions of evaluation processes in supervision, have direct implications (e.g., if feedback will be included in evaluation practices, if feedback pertains to supervision goals and evaluation criteria, the potential for supervisors and supervisees to have disparate perceptions of the effectiveness of feedback) for a key piece of the evaluation process, feedback.

Feedback

What is known from the supervision and evaluation literatures is that feedback, along with goal-setting, is a core component of clinical supervision (Bernard &

Goodyear, 2009; Hahn & Molnar, 1991). In fact, when asked about supervision

experiences, supervisees most often note the quality and quantity of feedback they

received (Bernard & Goodyear, 2009). Feedback is the vehicle by which supervisors

communicate their evaluation of supervisees and typically contains information regarding

multiple facets of supervisees, including skills, attitudes, behavior, and appearance - all of

which can impact their delivery of services to clients that may influence their

performance with clients (Hoffman et al., 2005). In the context of performance

appraisals, feedback also informs supervisees how well they performed a task relative to

a goal or standard level of performance (Claiborn et al., 2001). In noting difficulties

arriving at an operational definition of feedback, Friedlander, Siegel, and Brenock (1989)

suggested that it must contain an explicit or implied evaluation of the supervisee by

supervisor. Feedback has been conceptualized in a number of different ways, and the

following section examines a few of the approaches to identifying types of feedback.

Formative versus Summative Feedback. Similarly to evaluation, feedback can

be either formative or summative. Formative feedback is the ongoing communication of

supervisor perceptions of supervisee performance. Formative feedback focuses on

supervisee progress toward professional competence, and represents the majority of

feedback provided in the context of clinical supervision (Bernard & Goodyear, 2009).

Rather than passing judgment about whether a supervisee passes or fails, formative

feedback focuses on the learning process (Chur-Hansen & McLean, 2006). Summative

feedback communicates the results of a supervisor's summative evaluation, the "moment

of truth when the supervisor steps back, takes stock, and decides how the supervisee

measures up" (Bernard & Goodyear, 2009, p. 22). Typically, summative feedback occurs

at scheduled intervals, such as the middle and end of each semester (Lehrman-Waterman & Ladany, 2001).

Despite a distinction made between formative and summative feedback, what is known from the supervision literature is that both formative and summative feedback should relate directly to the same criteria, and they should be the foundation for teaching and learning objectives throughout supervision (Bernard & Goodyear, 2009). As is the case for summative evaluation, feedback that is summative should contain no surprises for supervisees, and it should essentially summarize the formative feedback that the supervisor has provided up until the point of summative evaluation and feedback (Bernard & Goodyear, 2009; Hess, 1997).

Linear versus Interactional Feedback. Feedback can also be examined in terms of direction of the communication. For instance, a linear conceptualization of feedback posits that information is communicated from supervisor to supervisee (Bernard & Goodyear, 2009). Much of the investigation into feedback within supervision has utilized this model (Allen et al., 1986; Hoffman et al., 2005; Kadushin, 1992; Lehrman-Waterman & Ladany, 2001; Magnuson et al., 2000; Robiner et al., 1993). An alternative way of conceptualizing feedback is to view it as an interactional process, in which the supervisee communicates back to the supervisor after receiving feedback.

According to the interactional perspective, supervisees can communicate any number of responses to supervisor feedback, such as "I didn't realize I was doing that" or "I don't agree with you." According to this perspective, even refusing to acknowledge feedback is a form of communication, sending the message, for example, "Leave me alone." Additionally, an interactional approach to feedback posits that any information

contains a message about the relationship (for the purposes of this review, the supervision relationship) and a message about content. For example, a supervisor can acknowledge a supervisee's difficulties in session with a client while also communicating a commitment to the supervision relationship (Bernard & Goodyear, 2009). Conversely, a supervisee can acknowledge finding supervisor feedback useful, while also communicating that s/he is too intimidated by the supervisor to disagree with the feedback.

While acknowledging these two perspectives on the directionality of feedback within supervision, Bernard and Goodyear (2009) suggest that most supervisors view feedback as linear, with the supervisor communicating to the supervisee an assessment of performance. Additionally, it is likely easier to research linear modes of feedback than conceptualizing and investigating interactional modes. Perhaps as a result of supervisor perceptions of feedback and the difficulty in researching interactional feedback, linear feedback has been the focus of clinical supervision research.

Immediate versus Delayed Feedback. Feedback can also be conceptualized in terms of timing, as either immediate or delayed. There is no official cutoff in terms of the amount of time that must elapse before feedback becomes delayed, and immediate feedback is typically associated with live observation evaluation methods, such as bug-in-the-ear techniques (Norcross & Halgin, 1997). However, immediate feedback can also be a part of other evaluation methods (e.g., review of audio- or videotapes), so long as the feedback comes as soon as possible after the experience to which the feedback relates (Freeman, 1985). Because immediate feedback follows so closely, for example, a client session, it allows supervisees to clarify the feedback and understand it (Sapyta, Riemer, & Bickman, 2005). Conversely, delayed feedback potentially allows supervisees to

unknowingly make errors over and over again, leading to the loss of time and, potentially, clients (Freeman, 1985).

Positive versus Corrective Feedback. In pointing out that most supervisors view feedback as primarily linear in nature, Bernard and Goodyear (2009) also acknowledge that supervisors view feedback as informing supervisees whether or not they are moving towards competence. Positive feedback, then, has been described as those instances when supervisors affirm that supervisees are on the right track (e.g., "Nice choice of intervention"), while corrective feedback is described as communication in which a supervisor notes that a supervisee is off track (e.g., "I'm not sure that was the best choice of intervention"). Corrective feedback has also been referred to as negative feedback in the theoretical and empirical research on feedback.

The distinction between positive and corrective feedback is included in many of the aforementioned models of supervision, perhaps most notably Stoltenberg et al.'s (1998) Integrated Developmental Model. According to IDM, supervisors have a number of intervention types available to them, and among them are facilitative (e.g., positive feedback that communicates support to supervisee) and catalytic (e.g., corrective feedback that increases supervisee awareness regarding something s/he has missed) interventions. Additionally, according to this developmental model, supervisees early in development need more positive feedback, while more advanced supervisees need a balanced mix of positive and corrective feedback (Stoltenberg et al., 1998). Friedlander et al. (1989), in an attempt to provide an operational definition of feedback, place feedback into a domain they refer to as valence, which is either positive (i.e., positive feedback) or negative (i.e., corrective feedback).

Theoretical Literature on Feedback. To a large extent, the theoretical literature

regarding feedback has focused on how supervisors should provide formative feedback in

order to maximize supervisee learning and skill acquisition (Bernard & Goodyear, 2009).

As a result, a number of guidelines have been suggested for supervisors in terms of

providing formative feedback to supervisees, including feedback that is corrective.

Not surprisingly, many of the suggestions for feedback relate directly to facets of

effective evaluation and/or feedback types previously discussed in this review. For

instance, formative feedback should be based on those goals identified by the supervisor

and supervisee in the supervision contract (Chur-Hansen & McLean, 2006; Farnill,

Gordon, & Sansom, 1997). Additionally, feedback should, as much as possible, be based

on a supervisor's direct observations of supervisee work (Chur-Hansen & McLean,

2006). When direct observation is not possible, any subjective impressions should be

clearly identified as such and offered to supervisees as tentative hypotheses (Farnill et al.,

1997). Formative feedback should also be direct and clear, preferably based on behaviors

that supervisees are able to modify (Bernard & Goodyear, 2009; Farnill et al., 1997). In

terms of timing, the feedback should be delivered as soon as possible after an evaluation

of a therapy session has occurred in order to help supervisees connect the feedback to

their behavior (Sapyta et al., 2005). Feedback should also occur continuously (i.e.,

formatively) over the course of supervision, rather than occurring at the end as

summative feedback (Bernard & Goodyear, 2009; Chur-Hansen & McLean, 2006; Sapyta

et al., 2005). Finally, feedback should be both positive and corrective. Despite the anxiety

that corrective feedback can elicit, supervisees desire this type of feedback and in

conjunction with positive feedback, has a stronger effect on behavior change than positive feedback alone (Sapyta et al., 2005).

Suggestions for feedback in supervision also highlight components of supervision models described earlier. For example, providing both positive and corrective feedback to supervisees highlights the dual role of supervisor as both supporter and evaluator (Farnill et al., 1997), roles identified in Holloway's (1995) SAS model. Additionally, providing a balance of feedback in terms of support and reinforcement, as well as challenge and criticism, allows supervisors to calibrate type of feedback (or intervention type, as described in IDM) according to supervisee developmental level (Stoltenberg et al., 1998) and/or supervisor role (i.e., as supporter, instructor, or evaluator) (Holloway, 1995).

Clearly, there is no shortage of recommendations for the provision of feedback in clinical supervision within the theoretical literature. However, the question remains: what does the empirical literature tell us about feedback?

Empirical Literature on Feedback in Supervision. Due to the scant amount of research on feedback within clinical supervision, the literature in organizational supervision and psychotherapy is reviewed along with clinical supervision in this section.

Feedback in Organizational Supervision. Much of what is known regarding feedback in supervision comes from the industrial-organizational literature (Hoffman et al., 2005). For example, in-depth, semi-structured interviews with 60 organizational executives revealed that accuracy of feedback was not executives' foremost concern in providing feedback to supervisees (Longenecker, Sims, & Gioia, 1987). What was most important in providing feedback to supervisees was ensuring that supervisees received sufficient raises and making sure that day-to-day interactions would not be disrupted as a

result of delivering corrective feedback. Additionally, supervisors shared that avoiding additional administrative work involved in remediating supervisees was more important to them than providing accurate feedback to supervisees (Longenecker et al., 1987).

Moss and Sanchez (2004) suggest that there are a number of supervisor types, and supervisors that fall into many of these types are typically unable to provide a balance of positive and corrective feedback to supervisees. For instance, the zero-tolerant supervisor is unable to accept mistakes, and, along with the micro-manager who is an expert at finding fault, focus on providing corrective feedback with little or no positive feedback. The conflict avoider, on the other hand, has a nurturing style and often delays, distorts, and/or avoids giving corrective feedback to employees. Taking an interactional perspective, Moss and Sanchez identify a number of effects that these managerial styles have on supervisees, including failure to self-report errors and a reticence to seek feedback. Moreover, because managers recognize that supervisee career paths are impacted by evaluations and feedback, they may be hesitant to provide feedback, instead of embracing it as a brief window of opportunity to correct performance problems when they can still be corrected (Moss & Sanchez, 2004).

In a study of automobile retail salespeople, Jaworski and Kohli (1991) examined perceptions of both positive and negative (i.e., corrective) feedback. Rather than focus on the feedback itself, the researchers examined the salespeople's perceptions of the feedback with regard to satisfaction with their supervisor, role clarity, performance, and motivation levels. Positive feedback was associated with a greater increase in salespeople's motivation than negative feedback. Interestingly, corrective feedback was associated with a greater level of role clarity than positive feedback. Furthermore,

corrective feedback did not lower salespeople's satisfaction with their supervisors; in fact, corrective feedback was associated with slightly higher levels of satisfaction with supervisors than positive feedback (Jaworski & Kohli, 1991). Although corrective feedback did not have as large of an impact on performance as positive feedback, it did not negatively impact motivation or decrease satisfaction with supervision, leading the researchers to conclude that supervisors should be aware that they can provide corrective feedback without the fear that this feedback will make employees unhappy. In fact, employees likely hold an expectation that they will be told when they are not performing adequately (Jaworski & Kohli, 1991).

Other research in the organizational literature provides insight into conditions that facilitate the provision of feedback to supervisees. Hillman, Schwandt, and Bartz (1990) suggest that providing both positive and corrective feedback to supervisees in an open and nonjudgmental manner create loops in which supervisees begin to seek out feedback and become increasingly open to evaluation and feedback. According to the researchers, this approach to feedback helps build trust in the relationship between supervisor and supervisee, allowing supervisors to continue providing effective feedback and coaching to supervisees (Hillman et al., 1990).

The importance of a close supervision relationship and its impact on providing feedback to supervisees was also addressed in a study by McKnight, Ahmad, and Schroeder (2001), who examined feedback and its impact on employee morale in a manufacturing environment. Results of their study suggest that the supervisor/supervisee relationship was a moderator variable in the impact of corrective feedback on employee morale; corrective feedback in the context of a strong supervision relationship enhanced,

rather than threatened, employee self-esteem and resulted in improved supervisee morale. The researchers concluded that relationship closeness with employees is important in ensuring that feedback is well-received (McKnight et al., 2001). Similar findings were reported in a study that found greater supervisee openness to corrective feedback in the context of supervisee perceptions of just interpersonal treatment within the supervision relationship (e.g., having corrective feedback communicated in private, a sense that supervisors cared for supervisee) (Leung, Su, & Morris, 2001). In turn, supervisee perceptions of proper handling of corrective feedback by supervisors resulted in improved attitudes toward supervisors.

In sum, the organizational literature lends support to the notion that executives and managers are often hesitant to provide feedback, especially corrective feedback, out of concern for a number of factors, including political ramifications (Fried, Tiegs, & Bellamy, 1992). These concerns exist in spite of evidence to suggest that supervisees desire corrective feedback, so long as it is provided in the context of a supportive supervision relationship. Furthermore, there is evidence to suggest that corrective feedback can actually enhance supervisee perceptions of supervisors. Next, we turn to an examination of feedback in the psychotherapy literature.

Feedback in psychotherapy. Despite occupying a prominent place in psychotherapy and being referred to in a number of ways (e.g., interpretation, immediacy, confrontation), feedback in therapy has received scant empirical investigation (Claiborn & Goodyear, 2005; Claiborn et al., 2001). Incorporating aspects of Lewin's (1951) change theory, feedback within psychotherapy can be viewed as information from an outside source about a person's behavior and its effects, in hopes of motivating (i.e.,

unfreezing) the individual to make behavioral modifications (Claiborn et al., 2001). Psychotherapeutic feedback has both descriptive and evaluative components, and oftentimes this feedback arouses emotions in the receiver that can either stimulate or hinder the motivational potential of the feedback (Claiborn et al., 2001).

In a review of the empirical literature on psychotherapy feedback in individual therapy, Claiborn et al. (2001) identify four studies that have investigated the effects of feedback in individual psychotherapy. In these studies, feedback was studied as a distinct intervention and compared with cognitive and behavioral interventions. Across all four studies, the feedback condition was associated with behavioral change, and in two of the studies, the feedback condition provided a more marked change in behavior than cognitive or behavioral interventions (Clairborn et al., 2001). In reviewing the literature on providing the results of personality assessment, two of three studies found that individuals who received feedback reported increased self-esteem and greater symptom alleviation than those individuals who did not receive feedback after assessments (Claiborn et al., 2001). Additionally, Miller, Benefield, and Tonigan (1993) reported that alcoholic clients who completed an alcohol screening instrument and received direct and confrontive feedback showed a greater reduction in drinking than those who completed the instrument and received no feedback.

An examination of the group psychotherapy literature reveals mixed findings with regard to the effectiveness of feedback in group therapy settings. Those groups in which therapist facilitators provided structure and modeled appropriate use of corrective feedback to group members produced more behavioral change than those groups in which facilitators failed to provide guidance for members in sharing corrective feedback with

one another (Clairborn et al., 2001). Fears of being rejected by fellow group members and concern over hurting other members of the group with corrective feedback contributed to participants' reticence in sharing feedback with one another (Morran, Stockton, & Bond, 1991).

In drawing some tentative conclusions regarding feedback in psychotherapy, Claiborn and Goodyear (2005) suggest that corrective feedback is beneficial in therapy when it is provided in the context of a strong client-therapist relationship. Similar to the literature on feedback within an organizational context, corrective feedback can also serve to reinforce an already strong relationship, prompting clients (much like supervisees) to not only be receptive to, but seeking of, feedback from therapists (Claiborn & Goodyear, 2005). Providing both corrective and positive feedback, tailoring it to client goals, and delivering the feedback as objectively as possible (again, not unlike the organizational feedback literature) also facilitates client acceptance of feedback.

In sum, while the empirical literature on the use of feedback in psychotherapy is small relative to its purported use in the context of individual and group therapy, the research that has been conducted suggests that it can be an effective means of motivating client change. We next focus on the empirical literature on the use of feedback in clinical supervision.

Feedback in clinical supervision. In perhaps one of the most referenced investigations into feedback in clinical supervision, Friedlander et al. (1989) had external judges view supervision sessions and classify behaviors that occurred during the sessions. Nine supervision sessions with different supervisor/supervisee pairings ranging in length from 45 to 60 minutes were reviewed, and only 14 speaking turns contained feedback.

Eight of these feedback exchanges occurred in the final two sessions, and three of the

nine sessions contained no feedback. Of the 14 feedback responses, 71% were classified

as global rather than specific, and 71% of the feedback was positive. Only four feedback

responses were corrective, and just two contained references to ideas or behaviors related

to specific therapist interventions (Friedlander et al., 1989).

Coincidentally, a lack of feedback from supervisors is a theme that has emerged

in various studies of supervisee perceptions of poor supervision experiences. For

example, in a study of experienced counselors' reflections on lousy supervision

experiences, participants stressed the importance of abundant feedback. In fact, one

participant noted that "I needed more criticism to see what I was doing and what I was

not doing. Most of the time I had to figure out what I wasn't doing" (Magnuson et al.,

2000, p. 200). Furthermore, global and/or vague feedback was also associated with poor

supervision, with supervisees noting that supervisors often would be so gentle with

corrective feedback that supervisees were left unaware that something needed correction.

A study of first-year practicum students found that supervisees early in their training

desire both positive and corrective feedback, despite concerns over competency and

being evaluated (Worthington & Roehlke, 1979). And Allen et al. (1986) reported that

laissez faire supervisors (i.e., those who provided little feedback and structure in

supervision) were associated with lower levels of trainee satisfaction than those students

with supervisors who were more active in the supervision process in terms of providing

both positive and corrective feedback; interns considered straightforward feedback to be

integral in their best supervision experiences. According to Robiner et al., (1993), interns

desired feedback about their strengths and weaknesses in order to know if they were

progressing towards goals. Supervisors who avoid providing interns with corrective feedback therefore are not acting in the best interests of the interns, the public, or the profession (Robiner et al., 1993). As a result of such internship experiences, interns may feel that they were betrayed by supervisors and deprived of opportunities to clarify and address areas in which they need additional supervision.

In a qualitative study of supervisors' experience in providing easy, difficult, or no feedback to supervisees, Hoffman et al. (2005) found that several factors facilitated or hindered the process of providing feedback in supervision, including content of feedback, supervisee openness, the supervisory relationship, and contextual issues. Supervisors indicated that feedback about clinical issues (especially if the feedback was objective rather than subjective) was easier to give than feedback concerning supervisee personality or professional behavior, because supervisors wondered about boundary issues and if feedback in these areas would in turn go from supervision to therapy (Hoffman et al., 2005). Additionally, feedback was easier to give when supervisees were perceived as open to feedback and expressed a desire for both positive and corrective feedback. Supervisees who were perceived as cold, resistant, defensive, and immature were less receptive to feedback, especially corrective feedback. It was also noted that many supervisees were not simply receptive or resistant to feedback; a supervisee could vacillate in terms of receptiveness, highlighting the importance of timing, especially in providing corrective feedback (Hoffman et al., 2005). Catching a supervisee by surprise with feedback has been identified in other research as a possible factor that contributes to feedback events that, according to supervisor perceptions, did not go well (Burkard et al., 2009).

Not unlike the organizational and psychotherapy research, the supervisory relationship also contributed to the delivery of feedback in the Hoffman et al. (2005) study, with some supervisors noting that their supervision relationship made it easier to provide feedback and others noting that the relationship did not facilitate this process. Interestingly, Hoffman et al. (2005) contextualized this data in terms of an earlier study conducted by Lehrman-Waterman and Ladany (2001), in which feedback and the supervision relationship were mutually reinforcing, with feedback and openness regarding goals and expectations facilitating a stronger supervision relationship, which in turn made it easier for supervisors to provide feedback to supervisees. Contextual issues also contributed to supervisor difficulty in providing supervisees with feedback, especially in those instances in which external pressures (e.g., fellow staff members, agency policies) prompted supervisors to provide feedback to supervisees (Hoffman et al., 2005).

The notion that the supervision relationship influences supervisors' delivery of feedback is not universally supported in the empirical literature, however. In a qualitative examination of supervisors' experiences in providing difficult feedback about multicultural concerns (defined as feedback that the supervisor was hesitant to provide yet not necessarily corrective in nature) in cross-cultural supervision relationships, the quality of the supervision relationship prior to the difficult feedback event did not always correspond to the quality of the relationship following the difficult feedback (Burkard et al., 2009). In fact, such difficult feedback events often led to an impasse in supervision, and only rarely did the difficult feedback lead to a more engaged and open supervision relationship. Furthermore, prior discussions of multicultural concerns did not necessarily

facilitate the provision of the difficult feedback, nor did they have an impact on the relationship following the feedback event. While it is not clear why the Burkard et al. (2009) study did not produce results consistent with previous research in terms of the quality of the supervision relationship and feedback, the researchers noted the subjective nature of the feedback (i.e., feedback about multicultural concerns may be difficult to put into specific behavior terms and may subsequently be perceived as more subjective in nature), along with the potential for this type of feedback to be perceived as crossing boundaries into personal characteristics of supervisees as potential explanations for these supervisors' experiences in providing difficult feedback (Burkard et al., 2009).

Heckman-Stone (2003), in a mixed-methods study of clinical and counseling psychology graduate student supervisees' perceptions of feedback and evaluation, found that supervisees desired a balanced approach to feedback, including both positive and corrective feedback. Additionally, infrequent feedback was noted as the most frequent supervisee concern regarding their supervision experiences. While this study did not assess supervisee perceptions of how feedback contributed to their clinical development, it did confirm what other investigations have found regarding supervisees and their desire for feedback. In studies of supervisee preferences with respect to supervision, supervisees report that they would prefer more specific and critical feedback about their performance (Carifio & Hess, 1987; Kadushin, 1992; Worthington & Roehlke, 1979). Interestingly, supervisee desire for corrective feedback is incorporated into Stoltenberg et al.'s Integrated Developmental Model (1998), which notes that "some supervisors think that being supportive means never giving corrective feedback, while supervisees intuitively want to explore options, be challenged and hear corrective feedback" (p. 172). Heckman-

Stone (2003) conclude that based on supervisee desire for corrective feedback, supervisor use of this type of feedback is low relative to its perceived effectiveness.

What little feedback that is provided in supervision seems to focus mostly on the positive (Friedlander et al., 1989; Larson, 1998). Perhaps this tendency to provide predominately positive feedback stems from the belief that positive feedback will increase counselor self-efficacy and reduce counselor anxiety, two relatively positive outcomes (Daniels & Larson, 2001). Yet, while positive feedback has been shown to reduce supervisee anxiety, there is also evidence to suggest that corrective feedback may increase supervisee anxiety to a level at which performance is actually enhanced in subsequent sessions with clients (Daniels & Larson, 2001). Counseling is a complicated endeavor, and research has shown that for difficult tasks, a moderate amount of anxiety serves as a motivator that can actually improve performance (Larson, 1998). Although intense supervisee anxiety can lead to an impasse in both the therapeutic and supervision relationships, addressing anxiety and resolving an impasse in supervision can model for supervisees how to address anxiety in the therapeutic relationship (Mueller & Kell, 1972). Additionally, corrective feedback can help developing counselors monitor work with clients, including how supervisees maintain the status quo, and how they can relate to and/or restructure sessions in ways to foster client change (Cormier, 1988; Dewald, 1997; Lambert et al., 2001).

Concluding Thoughts on Feedback in Supervision. Perhaps not surprisingly, themes that emerged in the evaluation literature also emerge in a review of the literature on feedback. More specifically, feedback can be difficult to provide, especially corrective feedback, and this appears to be the case across multiple contexts (i.e., organizational

supervision, psychotherapy, clinical supervision). The literature on feedback in organizational settings, psychotherapy and clinical supervision suggests that while corrective feedback can be difficult to provide and result in anxiety for both those who provide and those who receive it, this type of feedback is also desired and has the potential to effect change. Beyond desiring feedback (and evaluation), supervisees perceive a lack of evaluation and feedback as an ethical violation in clinical supervision (Ladany et al., 1999). Thus, while supervisors may avoid evaluation in feedback in hopes of avoiding legal repercussions, failing to engage in these critical supervision activities could result in greater risk in terms from a legal and ethical perspective. In the following section, ethical supervision, including evaluation and feedback processes is explored.

Supervision, Evaluation and Feedback: Ethical and Legal Implications

Evaluation and feedback can be difficult aspects of a supervisor's role, and the empirical literature suggests that evaluation and feedback may not always occur within supervision. This is alarming from a variety of perspectives, including a legal and ethical one. Legal and ethical guidelines suggest that evaluation of supervisees is important, with certain ethical guidelines being particularly relevant to supervision, evaluation and feedback (Robiner et al., 1994). This section begins with a review of ethical principles as they relate to supervision, evaluation, and feedback. This is followed by a review of ethical concerns related to supervision and legal considerations in conducting supervision. Recommendations for conducting ethical supervision and a review of the empirical literature on ethical supervision, evaluation and feedback conclude this section.

Review of Ethical Guidelines. In 1991, the Association for Counselor Education and Supervision (ACES), a division of the American Counseling Association (ACA),

developed standards for counseling supervisors. In 2005, these standards were

incorporated into the 2005 ACA Code of Ethics (ACA, 2005). The ethical guidelines for

supervisors are intended to: 1) observe ethical and legal protection of clients' and

supervisees' rights; 2) meet the training and professional development needs of

supervisees in ways consistent with clients' welfare and programmatic requirements; and

3) establish policies, procedures, and standards for implementing programs (retrieved

from http://www.acesonline.net/ethical_guidelines.asp, August 27, 2009).

Section F of the ACA Code of Ethics addresses supervision, training, and

teaching, indicating that one of the obligations of supervisors is to monitor the services

that supervisees provide (ACA, 2005). Section F.5 focuses specifically on evaluation,

remediation, and endorsement, stating that "supervisors document and provide

supervisees with ongoing performance appraisal and evaluation feedback and schedule

periodic formal evaluative sessions throughout the supervisory relationship" (ACA, 2005,

Section F.5.a.). Notably, this evaluation includes personal limitations of supervisees that

might impede performance. In the section on endorsement, the Code of Ethics provides

guidance for recommendations of supervisees, suggesting that supervisors refrain from

providing recommendations of supervisees who they believe are impaired and unable to

competently perform duties indicated in the endorsement (ACA, 2005).

The Association for Counselor Education and Supervision is not the only source

for guidance in terms of supervision and evaluation. Section 7 of the American

Psychological Association's Ethical Principles of Psychologists and Code of Conduct

(2002) outlines the ethical standards for education and training, stating that supervisors

establish both a timely and clearly identified process for providing feedback to

supervisees (APA, 2002). Beyond this ethical standard, a case can be made for the applicability of the General Principles (APA, 2002) to supervision, evaluation and feedback. While these principles are not obligations, they do represent ideals to which psychologists should aspire (APA, 2002). These ethical principles include beneficence and nonmaleficence, fidelity and responsibility, and justice, and they will be discussed in the next sections.

Beneficence and Nonmaleficence. The principle of nonmaleficence provides that a client's welfare be psychologists' first and foremost concern. This principle goes on to state that because of the significant impact that psychologists' work, in both science and practice, can have on others, they should be alert to the personal, social, organizational, or political factors that could lead to the misuse and abuse of this power (APA, 2002). Section 3.04 provides a standard for avoiding harm that states this more explicitly: "Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable" (APA, 2002). Applied to a supervision context, given supervisees' varying skill level, supervisors must continually monitor what a supervisee is capable of in terms of providing client care (i.e., the evaluative function) and balance this with the supervisee's needs for training and development (Bernard & Goodyear, 2009; Sherry, 1991). According to Frame and Stevens-Smith (1995), although one of the goals of supervision is to help foster competent and effective supervisees, supervisors' top priority should be to make sure that clients are protected from harm.

Corrective feedback can serve a protective function against client harm, highlighting areas in which supervisees need to improve their skills and the care they provide to clients. This also speaks to the importance of timely evaluation and feedback; left unchecked, client care could suffer as a result of a supervisee who is not being continually evaluated and provided with feedback (Sherry, 1991). This responsibility extends beyond listening to audiorecordings; according to Kapp (1984), there is direct liability in a situation where client care is impacted by a supervisor failing to listen and offer feedback to supervisees during case presentations. Conversely, a supervisor who listens to her/his supervisee and provides feedback that contributes to growth and development for the supervisee could be viewed as upholding the principle of beneficence.

Fidelity and responsibility. According to the principles of fidelity and responsibility, psychologists establish trust with those with whom they work, uphold professional standards of conduct, clarify their professional roles and obligations, and accept appropriate responsibility for their behavior (APA, 2002). In the context of supervision, not providing a supervisee with ongoing feedback and instead surprising her/him with a negative summative evaluation could be viewed as an infringement of these principles (Sherry, 1991). Furthermore, failing to clarify criteria for evaluation at the beginning of supervision and not conducting timely evaluations could also be viewed as failing to live up to the principles of fidelity and responsibility.

Justice. The principle of justice provides that all persons have equal quality in processes, procedures, and services provided by psychologists. Failing to explicitly identify criteria for evaluation, not providing timely evaluations and ongoing feedback,

and not allowing a supervisee a chance to improve in areas in which s/he is deficient could all be viewed as an infringement of justice and a failure of due process (Cormier & Bernard, 1982; Bernard & Goodyear, 2009; Bradley, Kottler, & Lehrman-Waterman, 2001; Sherry, 1991). This highlights the importance of formative evaluation and feedback; it is unethical for supervisors to dismiss and/or inform supervisees of deficiencies only in summative evaluation/feedback. Thus, supervisors have an ethical responsibility regarding justice and due process to both supervisees and the clients with whom supervisees work (Bradley, Kottler et al., 2001).

In sum, despite a lack of clarity regarding what should be evaluated in supervision (e.g., clinical skills, personal factors of supervisees), a lack of psychometrically sound measures of evaluation, and reticence of supervisors to evaluate certain aspects of supervisees (e.g., professionalism, personality), both the Association for Counselor Education and Supervision (ACES) and APA provide ethical guidance in conducting supervision, evaluation, and providing feedback to supervisees. The failure to monitor supervisee performance is a significant ethical violation in supervision and could very well jeopardize clients and supervisee development (Bradley, Kottler et al., 2001; Koocher, Shafranske, & Falender, 2008; Robiner et al., 1997). Fortunately, there have been a number of recommendations for the practice of ethical supervision and, more specifically, providing evaluation and feedback to supervisees.

Ethical Concerns in Supervision. A survey of licensed psychologists revealed that 64% indicated they spent at least part of their time providing supervision (Sherry, 1991). As discussed previously, the evaluation component of the supervisor role is not the favorite one for many supervisors, with many practicing an approach that

unconditionally accepts supervisees and promotes positive regard to facilitate

professional growth and maturity (Haber, 1996). As a result, supervisors may avoid the

responsibility or give uniformly positive evaluations to sidestep possible criticism, career

implications, or the potential for grievance associated with negative assessments (Falvey,

2002). Outside of the academic setting, if a credentialed professional is being supervised,

supervisors can either ignore supervisee incompetence, support the filing of a complaint

by a consumer, report supervisee behaviors to a regulatory body, consult with others

about how to respond, and/or discuss concerns directly with the professional (Falvey,

2002). Aside from consulting, likely none of these are attractive options.

In breaking down the evaluative responsibility further, it seems that summative

evaluations and formative feedback that is corrective in nature are most concerning to

supervisors, because they move beyond support and into a discussion of supervisee

competence and overall ability (Falvey, 2002). Complicating matters further is the fact

that summative evaluations are often used in various administrative decisions, including

academic, employment or credentialing. Without previously established evaluation

criteria and ongoing feedback linked to those criteria, supervisees are subject to the

possibility of irresponsible evaluation by supervisors. Thus, summative evaluations and

corrective feedback represent sources of ethical and legal liability for supervisors

(Falvey, 2002). The lack of resources available to supervisors in the area of evaluation

criteria contributes to legal and ethical risk, and it seems that supervisors are not helping

their own cause; Robiner et al. (1994) notes that supervisors' reticence to participate in

supervision research makes it difficult to develop standard, empirically supported

evaluation practices that could result in more effective and ethical supervision and evaluation.

In sum, supervisors play a critical role in mentoring supervisees and ensuring the future of the mental health profession. While sharing one's knowledge and expertise can be a profoundly rewarding experience, supervisors are cautioned to be cognizant of the responsibilities and risks involved in providing supervision. Although supervisors can provide guidance and be directive in supervision meetings, aside from live observation, it is difficult to explicitly direct supervisee behaviors while they are in sessions with clients. Furthermore, supervisors are responsible for the care provided to clients with whom they will rarely, if ever, have contact (Falvey, 2002). The responsibility for developing effective professionals requires that supervisors be comfortable with the role of gatekeeper of the profession. In light of this, expectations, competencies, and supervisee progress towards these competencies need to be addressed throughout supervision (Falvey, 2002).

Legal Considerations. In addition to the aforementioned ethical guidelines to which supervisors should attend, supervisors should also be mindful of some legal considerations in conducting supervision. Liability is perhaps the most significant legal concern for supervisors, and there are two types of liability that supervisors accept for their supervisees (Bradley, Kottler et al., 2001). Direct liability refers to those situations in which a supervisor's directive to a supervisee results in harm to the client (Bernard & Goodyear, 2009; Bradley, Kottler et al., 2001). This instruction from the supervisor is typically communicated to the supervisee in the course of formative feedback; for example, if a supervisor tells a supervisee that s/he is spending too much time assessing a

client's homicidal ideation, and the client later commits homicide, the supervisor may be directly liable.

The second type of liability is vicarious liability, and it refers to situations in which a supervisor is responsible for supervisee behavior of which s/he is unaware (Bradley, Kottler et al., 2001). This type of responsibility falls under the part of contract law that involves the concepts of employer as master and employee as servant. This doctrine, also known as *respondeat superior* (which translated from Latin means "let the master answer"), establishes that in an agency relationship an employer is liable for injuries caused by the negligence of an employee (Kapp, 1984). Thus, because a supervisor has accepted responsibility for training a supervisee, the supervisor is now responsible for all clients on that supervisee's caseload. Failing to evaluate and provide ongoing feedback to supervisees or providing supervisees with an excessive amount of corrective feedback are just two ways that supervisors can create an atmosphere in which supervisee concerns are not addressed in supervision. In either situation, the potential for problems to escalate exists, placing the supervisor at risk of being held vicariously responsible for harm caused by supervisee behavior of which s/he is unaware.

Malpractice, defined as negligence in the performance of professional duties, is another legal concern for supervisors. In order for a malpractice claim to be successful, four criteria must be met: a) there was a professional relationship and an associated legal duty of care; b) there is a demonstrable standard of care that was not met; c) the client was harmed or injured; and d) failure to meet the standard of care resulted in the harm or injury (Bradley, Kottler et al., 2001). Given the integral roles that evaluation and feedback play within the larger role of supervision, failing to evaluate and/or provide

feedback to supervisees places a supervisor at risk for meeting at least two of these four criteria. If a supervisee is able to assert and defend that s/he experienced psychological distress as a result of not receiving evaluation and/or feedback, the four criteria for supervisor malpractice have been met. Although no legal action has successfully demonstrated supervisor malpractice in clinical supervision (Bradley, Kottler et al., 2001), supervisors should be aware of these risks, especially in light of the theoretical and empirical literature that suggests supervisor discomfort and reticence in fulfilling the evaluation and feedback components of supervision.

Recommendations for Ethical Supervision. A number of suggestions have been offered to ensure that supervisors provide sound evaluation and feedback to supervisees, while at the same time protecting client welfare. These recommendations include what to evaluate, how to document evaluation and feedback, and how to handle supervisee remediation.

What to evaluate. According to Koocher et al. (2008), evaluation should address supervisee professionalism, openness to feedback, and clinical work, precisely the areas in which supervisors found providing feedback to supervisees difficult in the Hoffman et al. (2005) study. Supervisee professional limitations can impede work with clients and potentially do harm, and in these instances, supervisors have an ethical responsibility to recommend remedial assistance to the supervisee, while preventing supervisees who are unable to provide competent services from working with clients (Frame & Stevens-Smith, 1995).

While personal characteristics of supervisees can be a murky (and uncomfortable) area for supervisors to assess, Harris v. Blake and the Board of Trustees of the University

of Northern Colorado provides some legal guidance in this area (Frame & Stevens-Smith, 1995). In the case, Harris sued the Board of Trustees of the University of Northern Colorado after being denied the opportunity to register for practicum based on behaviors such as deficient listening skills and a lack of warmth and empathy in working with clients and fellow classmates. The court upheld the university's decision, citing that the skills noted directly related to the student's interpersonal abilities and an inadequacy in working with clients. Moreover, the court ruled that the university's decision was made conscientiously and with careful professional judgment, while at the same denying Harris' claim that he was deprived of liberty with regard to his reputation in the field of psychology (Frame & Stevens-Smith, 1995).

  Documentation. Having a clearly defined supervision contract, or "road map" as Haber (1996) refers to it, helps to ensure that supervisees are providing adequate care for their clients. The supervision contract identifies clear goals, objectives, duties, and responsibilities, as well as clarifies the supervisor's role in providing ongoing feedback (Falvey, 2002; Haber, 1996). This formative feedback serves as periodic signs to help correct supervisee misdirection (rather than informing supervisees at the end that they have arrived at the wrong destination) and facilitates the conditions necessary for both satisfactory and ethical supervision (Haber, 1996).

  Because human memory is fallible and feedback messages, especially those involving corrective components, can trigger emotional responses, it is recommended that supervisors document oral feedback (Bradley, Kottler et al., 2001; Kapp, 1984; Koocher et al., 2008). Documenting feedback in this way also allows supervisors the opportunity to revisit feedback at a later date, providing both supervisors and supervisees time for

thoughtful discussion of the feedback. Furthermore, documented feedback that pertains to direct work samples from all supervisee cases is one of the best ways to manage supervisor risk (Falvey, 2002).

Finally, beyond a clear supervision contract, supervisors/agencies should have clear written policies that identify processes for remediation and recommendations. As with the supervision contract, supervisees should be given these policies at the beginning of training, and they should be covered in initial supervision sessions. Within these policies, supervisees should be provided with notices of due process, identifying the opportunity to challenge any evaluation and/or feedback (e.g., filing a grievance regarding an evaluation a supervisee believes is unfair) (Falvey, 2002). Once a supervisee has had a chance to review the supervision contract that outlines evaluation and feedback procedures, as well as the remediation, recommendation and due process policies, supervisors should obtain a signed acknowledgment of informed consent from the supervisee (Falvey, 2002).

Remediation. According to Koocher et al. (2008), ethical practices in supervision means practicing sound risk management. Perhaps nowhere else is this more critical in protecting client welfare from supervisees who are not competent. Issuing failing marks for a practicum student or denying satisfactory internship completion should not come as a surprise to supervisees; rather, this should follow clearly documented attempts to give the supervisee opportunities to meet previously agreed upon standards of competence (Koocher et al., 2008). And, while supervisors may feel the pull to help advance supervisees' careers, clients should not be placed at risk by passing and/or endorsing unqualified supervisees.

Models of remediation plans have been developed, including one from Lamb, Cochran, and Jackson (1991) that provides for responding to impaired supervisees in internship settings. In step one of the model, supervisors who identify areas of concern regarding supervisee performance consult with one another to assess impairment based on the presence of a number of problematic areas (e.g., lack of supervisee awareness of impairment, quality of service is consistently negative, potential for ethical and legal risk, lack of supervisee responsiveness to feedback). Supervisees have an opportunity to respond in writing to supervisor feedback of these areas of impairment. If supervisees demonstrate no improvement, supervisors move to step two of the model, instigating additional discussion and documentation of problematic behavior. Supervisee response to this is also documented, and supervision is modified (e.g., additional supervision time, additional readings for supervisees) to address the concerns identified.

If further action is required, step three of the model involves consideration of supervisee probation or dismissal (Lamb et al., 1991). The supervisee is afforded the opportunity to challenge this decision with the appropriate level of staff (e.g., training director). The academic institution is notified in writing of this change in supervisee status, and ongoing feedback is provided to the supervisee/intern during the probationary period. If the supervisee is dismissed from the internship, letters are sent to the supervisee/intern and academic program, and the supervisee/intern is given a period of time in which to appeal the decision. Finally, supervisors and agencies are urged to consider the consequences of the supervisee's departure, including the impact on clients, other interns, staff, academic program, and the intern/supervisee (Lamb et al., 1991).

Training. According to Robiner et al. (1993), supervision is a complex activity in which many psychologists are engaged, but few have been trained (Robiner et al., 1993). As is often the case regardless of profession, therapists who show great promise are often identified as likely making strong supervisors, despite clear differences between psychotherapy and supervision and a lack of training in supervision. Robiner et al. (1993) propose a number of ways to address this concern. For instance, coursework in pre-doctoral education could help improve exposure to supervision, and could become a prerequisite for conducting supervision at accredited internship sites. Such coursework could include didactic material on administrative supervision, legal and ethical issues in supervision, and role playing with tasks related to clinical supervision (e.g., communicating formative and summative evaluations, delivering corrective feedback). Additionally, mandating APA accredited internship sites to ensure that only expert supervisors work with interns could improve supervision experiences at this level of training. Although such a national effort might be costly to employ, a collaborative effort between governmental agencies such as APA and the Association of Psychology Internship Centers could help reduce costs and the risk of litigation, thereby curbing premiums for professional liability insurance. Finally, consultative supervision teams could be established as an additional resource for supervisors, especially those who find themselves in difficult supervision situations (Robiner et al., 1993).

Empirical Literature on Ethical Supervision. Very few studies of ethical behavior in supervision exist, and prior to a study by Ladany et al. (1999), only one had examined supervisor ethical behavior from a supervisee perspective. Studies of supervisor ethical behavior from the supervisor's perspective utilized survey methods

and, not surprisingly, results suggested that supervisors adhered to ethical standards in

providing supervision. With regard to ethical and legal responsibilities surrounding

evaluation and feedback, Navin, Beamish, and Johanson (1995), in a study of supervisors

in the Midwest, found that most supervisors reviewed ethical and legal responsibilities

with supervisees, met regularly with and provided ongoing feedback to supervisees, and

offered referrals for those supervisees who needed remediation. The lone study from the

supervisee's perspective, however, found that supervisees (who were licensed

psychologists) had concerns regarding ethical supervision in the area of supervisor

investment in the process of supervision (e.g., failing to hold supervision appointments,

not providing adequate feedback) (McCarthy et al., 1994). Prior to this study, Keith-

Spiegel and Koocher (1985) hypothesized that supervisor failure to highlight areas of

supervisee deficiencies in a timely manner would be one of the most common sources of

ethical complaints against supervisors. The results of the McCarthy et al. (1994) study,

along with Keith-Spiegel and Koocher's (1985) hypothesis, prompted Ladany et al.

(1999) to examine supervisees' in training perceptions of ethical supervision.

Ladany et al. (1999) surveyed 151 supervisees from predominately counseling

and clinical psychology graduate programs, and 51% reported at least one ethical

violation by their supervisor. The researchers defined ethical performance evaluation and

monitoring of supervisee activities as ongoing communication between supervisor and

supervisee regarding evaluation, ongoing verbal and written supervisor feedback, and a

periodic review of supervisee tapes and/or case notes (Ladany et al., 1999). The most

frequently cited ethical guideline violation was inadequate performance evaluation, with

one-third of participants perceiving that supervisors did not provide sufficient evaluation

and/or feedback of their counseling performance (e.g., "At the end of the semester I was very surprised to find that she was unsatisfied with my work. I had never been evaluated or critiqued" and "Supervisor gives little feedback") (Ladany et al., 1999).

The results of this study also suggest that from the supervisee's perspective, supervisor ethical violations had a mild to moderate impact on quality of client care, correlated with a weaker supervisory working alliance, and resulted in lower satisfaction with supervision (Ladany et al., 1999). While the results of this study could be skewed as a result of supervisee perceptions (i.e., those supervisees who were satisfied with supervision minimized ethical violations of supervisors, while dissatisfied supervisees saw more ethical violations by the supervisor), it nonetheless highlights that supervisees desire evaluation and feedback, as well as the ramifications of a perceived lack of evaluation and feedback on client care and the supervision relationship.

In sum, the theoretical and empirical literature on evaluation and feedback within supervision, when reviewed in the context of ethical and legal guidelines for supervision, suggests that supervisors may be placing themselves at risk if they do not take seriously the processes of evaluating supervisees and providing feedback throughout supervision. To avoid doing so places supervisor potentially at risk of direct and vicarious liability, as well as malpractice. While there are a variety of recommendations to mitigate this risk, a number of factors, including ambiguity regarding what to evaluate and supervisor discomfort with evaluation, serve as barriers to providing ethical supervision to supervisees, possibly to the detriment of clients, supervisees, and the profession.

Areas for future research

A review of the supervision literature reveals that little research has been conducted in the areas of evaluation and feedback within clinical supervision, and that this has not been the focus of recent research. Moreover, much of the research conducted to date has focused on supervisors' experiences in providing feedback to supervisees. Only a handful of studies have focused on supervisors' experiences in providing a specific type of feedback, corrective feedback, and little is known about corrective feedback from the supervisee's perspective. To date, the empirical literature has failed to address how much corrective feedback is desired by supervisees, how if at all graduate coursework or practica shape supervisee preferences for corrective feedback, and how corrective feedback can be delivered in a way that it is heard by and useful for supervisees.

Another gap in the extant clinical supervision literature is an understanding of the impact that corrective feedback has on supervisees, along with supervisee perceptions of its impact on the supervision relationship, client care, and client outcome. Those investigations that have examined supervisee experiences in clinical supervision have focused on perceptions of supervision in general, rather than focusing on the areas of evaluation and feedback, much less corrective feedback. The empirical literature to date suggests that supervisees desire corrective feedback, supervisors are hesitant to provide it, and when supervisors do provide corrective feedback, it is oftentimes vague and provides little guidance for supervisees. Thus, little empirical attention has been paid to what appears to be the most troubling aspect of evaluation and supervision: corrective feedback. Information obtained in the area of supervisee perceptions of corrective

feedback may demystify this aspect of the supervision process that can be anxiety provoking for both supervisors and supervisees. Given this gap in the literature, consensual qualitative research (CQR) was chosen as an appropriate methodology for exploring a phenomenon that had not been the focus of the extant literature.

Consensual Qualitative Research (CQR)

Until the mid-1980s, traditional research methodology (i.e., quantitative methods) dominated the landscape of research in counseling psychology; this began to change as an emphasis on capturing the complexity and richness of human experience emerged (Morrow & Smith, 2000). A number of prominent authors called for increased pluralism in research to more accurately reflect the diversity of theory and practice in psychology, and expand knowledge of complex processes (Heppner, Kivlighan, & Wampold, 2007).

Qualitative research is a methodology that allows researchers to capture the richness of human experience in the context of a particular setting (Ponterotto, 2005).One goal of qualitative research, according to Heppner et al. (2007), is to better understand the social constructions of participants. Moreover, this methodology allows participants to share the meaning s/he has attached to the phenomena that is being studied (Morrow & Smith, 2000). Applied to this particular study, qualitative research will allow this researcher to capture the richness and complexity of the supervision relationship, and allow supervisees to share the meaning they have attached to an integral component of the supervision process, namely the communication of corrective feedback from supervisor to supervisee.

One specific qualitative methodology is consensual qualitative research (CQR). Introduced in 1997, CQR provides a way of analyzing data that retains the integrity of

participants' words and experiences in the setting in which they occur (Hill et al., 1997).

While qualitative analysis may be informed by researchers' hypotheses, discovery and

openness to findings is a key component of qualitative research and CQR.

CQR: Background, Theoretical Foundation, and Rationale. CQR involves

multiple researchers in a consensus process who rigorously analyze data across a number

of participants in search of representative results (Hill et al., 1997). As of 2005, 27

studies using CQR had been published (Hill et al., 2005), establishing it as a viable and

respected qualitative research methodology. As with any scientific methodology, CQR

can be examined in terms of ontology (i.e., nature of reality), epistemology (i.e., the

relationship between the participant and the researcher), axiology (i.e., the role of the

researcher's values have in the research process), rhetorical structure (i.e., the language

used to present the research to the audience), and methodology (i.e., the procedures and

process of the research) (Ponterotto, 2005). It will become clear that when reviewed in

terms of these constructs, CQR is primarily constructivist, with postpositivist elements.

As mentioned previously, qualitative research in general and CQR more

specifically is constructivist in terms of the nature of reality (i.e., ontology). Although

CQR looks for commonalities of experience among participants, there is a recognition

that multiple and equally valid experiences of the "truth" may exist (Hill et al., 2005). In

terms of the relationship between participant and researcher (i.e., epistemology), CQR is

also primarily constructivist, with both researcher and participant influencing one another

(Hill et al., 1997; Hill et al., 2005). Participants educate the researcher about the

phenomenon under investigation, and the researcher assists participants in exploring the

phenomenon through the use of protocol questions and probes. The interviewer does not

coconstruct meaning with the participants, although the use of standard questions across participants to allow for consistencies in the data to emerge does introduce aspects of postpositivism (Hill et al., 2005).

In CQR, the role that one's personal values have on the research process (i.e., axiology) represents a blend of constructivism and postpositivism (Hill et al., 2005). Researchers acknowledge and discuss their biases at length, and the results of such discussions are reported in terms of how they might have influenced the research process (constructivism). As much as possible, researchers' biases are kept in check so that participants' experiences are most accurately reflected in the data (postpositivistic) (Hill et al., 2005). In the language used to present the research to its intended audience (i.e., rhetorical structure), CQR is mainly postpositivist, reporting data objectively and in the third person. Participants' words are summarized with little interpretation by the researchers, and themes that emerge across participants are generalized to some extent to the population that the participants represent (Hill et al., 2005).

Finally, the procedures and process of the CQR (i.e., methodology) is constructivist. Researchers rely on interactive data collection methods to uncover meaning through words and text, and the research team uses consensus to construct the themes that emerge across cases. Researchers make every effort to prevent biases from impacting the accuracy of what participants have shared (Hill et al., 2005).

The theoretical foundation for CQR lies primarily in grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990), with elements of comprehensive process analysis (CPA) (Elliott, 1989, 1993) and phenomenological approach (Giorgi, 1970, 1985) incorporated as well (Hill et al., 1997). In CQR, research team members repeatedly

examine data, making sure that analysis and findings stay consistent with the raw data, a process similar to grounded theory's constant comparative method (Strauss & Corbin, 1990). CQR diverges from grounded theory in a number of ways. In CQR, a participant sample is defined at the outset of research and data is gathered using a pre-determined, semi-structured protocol to ensure that consistency of responses emerges from a relatively homogenous sample of participants (Hill et al., 1995). Additionally, CQR team members and auditors arrive at consensus and follow a different data analysis technique (e.g., coding data into domains, abstracting domained data into core ideas, and developing cross-case categories that capture common themes in core ideas) than grounded theory.

CQR also shares features of Elliott's (1989, 1993) CPA (Hill et al., 1997). The use of research teams to reach consensus and analyze data systematically across data are shared elements of CPA and CQR. CQR diverges from CPA in a number of areas, however; unlike CPA, CQR does not interpret implicit meanings of participant data, and CQR was developed to analyze interview data rather than multiple sources of data (e.g., participants' notes during the phenomenon being studied).

Finally, Giorgi's (1970, 1985) phenomenological approach influenced the development of CQR, primarily in the belief that one cannot understand data collected without studying the context from which the data emerges (Hill et al., 1997). CQR emphasizes gathering contextual information such as the setting, antecedents, and characteristics of those involved to obtain a fuller, richer description of the participants' experiences. CQR diverges from the phenomenological approach in its emphasis on consensus in analyzing data, which Giorgi's methodology did not stress.

Hill et al.'s (1997) CQR methodology is appropriate for this particular study for a number of reasons. Supervisee experiences of corrective feedback is a relatively unexplored topic in the empirical literature on supervision, and CQR's openness to all findings and the discovery-oriented nature of the methodology are particularly well-suited for this topic. Furthermore, CQR will allow researchers to capture a rich, comprehensive account of supervisees' perspectives and experiences in receiving corrective feedback in clinical supervision. Consistent with the methodology, data will be gathered from interviews with supervisees and will examine the process, factors affecting, and perceived outcomes of receiving corrective feedback in clinical supervision. Researchers will examine themes across participants' unique experiences of this specific process in clinical supervision, in search of common themes and representativeness across participants. This examination of data will be done with an understanding of the context and complexity of each participant's experience and in hopes of, to a certain extent, generalizing to the population of participants, supervises involved in clinical supervision. Finally, CQR was chosen because it is a rigorous and standardized method of qualitative research that has been well explicated, making it a particularly good fit for a doctoral dissertation study.

Purpose of Study

As described in the preceding review, the empirical literature on corrective feedback in clinical supervision is scant. Moreover, much of what is known about corrective feedback in supervision comes from the supervisor's, rather than the supervisee's, perspective. For purposes of clearly defining the phenomenon I wish to study, I have chosen to focus on corrective feedback that was given formatively rather

than summatively. Focusing on corrective feedback given formatively will also allow me to examine what, if any, impact the feedback had on the supervision relationship in ensuing interactions; if the feedback was delivered in a concluding summative evaluation, examining the impact of the feedback on the supervision relationship would not be possible.

I decided to focus on predoctoral interns for a number of reasons. The predoctoral internship represents the capstone of supervision prior to supervisees taking on a professional role (Hill et al., 2005). Supervisors may view this as the last opportunity to fulfill their gatekeeping role, providing corrective feedback surrounding clinical, ethical and professional behaviors to interns. Additionally, supervisors working with supervisees in practicum settings may leave the "dirty work" of corrective feedback to supervisors at the predoctoral internship level. Given the requirements of predoctoral internships, supervisors and supervisees are likely together during an extended period of time, allowing for clinical supervisors to gain more information about their supervisees than faculty or previous practicum supervisors. Finally, supervisees at the predoctoral internship level will have the benefit of being involved in previous supervision relationships, perhaps providing them a richer context from which to reflect on their preferences for receiving corrective feedback in clinical supervision.

Thus, the purpose of the proposed study is to fill a substantial gap in the empirical literature on supervision by focusing on predoctoral intern supervisees' experiences of corrective feedback in clinical supervision. CQR will provide a vivid, rich, contextual understanding of supervisees' experiences of corrective feedback, and inform the literature and profession regarding this integral process in clinical supervision.

Chapter 3: Method

Participants

The population of predoctoral psychology interns was chosen as a focus of this study because of their involvement in a clinical supervision relationship while on internship. Because the predoctoral psychology internship represents the capstone of training and perhaps the final supervision experience prior to occupying a professional role, supervisors of psychology interns may view this as the last opportunity to fulfill their gatekeeping role. Moreover, predoctoral psychology interns will likely have had previous supervision experiences during practica, perhaps providing a richer context from which to draw preexisting preferences for corrective feedback in clinical supervision.

Supervisees. Recruitment yielded 12 participants. All participants, all of whom were female, consented to participate in the study and completed both interviews. Nine participants identified as Caucasian, two identified as African American, and one identified as Biracial (Asian and Caucasian). Participants ranged in age from 26 to 42 years (M =31.25; SD = 4.59). Seven participants were completing internship at the time of participation, and five participants had completed internship. Five participants were either completing or had completed a PhD in clinical psychology, four participants were either completing or had completed a PsyD in clinical psychology, and three participants were either completing or had completed a PhD in counseling psychology. Five participants were at a hospital internship setting at the time of the corrective feedback event, three were at a department of corrections setting, two were at a college counseling center, and two were at a community mental health center. All participants had been involved in at least four individual clinical supervision relationships (M = 6.41; SD =

1.88) and had spent anywhere from 30 to 60 months in individual clinical supervision (M = 42.92; SD = 8.24). Participants' clinical experience ranged from 30 to 96 months (M = 53; SD = 18.08).

Supervisors. The twelve supervisors (eight female, four male) who provided the formative corrective feedback to participants ranged in age from their 30s to 50s, and all were identified as Caucasian. Nine supervisors held PhDs in clinical psychology, two held PhDs in counseling psychology, and one held a PsyD in clinical psychology. Six supervisors provided formative corrective feedback related to participants' therapeutic work, five supervisors provided formative corrective feedback about participants' written work (i.e., report, progress note), and one supervisor provided formative corrective feedback related to a participant's assessment work.

Participants also provided information about the frequency of supervision meetings with the supervisor who provided the formative corrective feedback, when in the supervision relationship the formative corrective feedback event occurred, and the total length of the supervision relationship. Seven participants met with their supervisors once per week, and five participants met with their supervisors twice per week. The corrective feedback event occurred in anywhere from the fourth to the fortieth supervision session (M = 16.67; SD = 11.91), and the total length of the supervision relationship lasted anywhere from 12 to 52 weeks (M = 26.33; SD = 15.56).

Research Team. Two European American graduate students enrolled in a doctoral program in counseling psychology, including the researcher, and a counseling psychologist comprised the primary research team. All three (David Phelps, Eric Everson, and Jacquelyn Smith) have previously been members on at least one CQR team.

Although all participant interviews were conducted by David Phelps, Eric Everson and

Jacquelyn Smith participated in all levels of data analysis. Alan Burkard served as the

auditor for this study. He is a European American associate professor of counseling

psychology who has extensive experience conducting CQR studies.

    Biases. Prior to data collection, the primary team members met to discuss their

biases with regard to the purpose of formative corrective feedback in clinical supervision,

the focus of formative corrective feedback that the researchers had received, how

supervision experiences prior to internship shaped researchers' expectations/beliefs about

formative corrective feedback, what made formative corrective feedback both easy and

difficult to hear, and what made formative corrective feedback useful for the researchers.

The other members of the primary research team are referred to here as male researcher

and female researcher.

    The primary author believed that there are many purposes of formative corrective

feedback in clinical supervision. Specifically, he believed that formative corrective

feedback helped supervisees develop professional skills, facilitated critical thinking and

problem solving in supervisees, and ensured that appropriate and ethical services were

provided to clients. The male and female researchers echoed these beliefs regarding the

purposes of formative corrective feedback in clinical supervision.

    The primary author recalled receiving formative corrective feedback focused

primarily on his therapeutic work with clients, including how to effectively use silence

and process comments in sessions. The male researcher echoed these themes and added

that he had received formative corrective feedback related to sticking with topics longer

in therapy with clients, and how to listen objectively and make corrections/adjustments

during therapy with clients. The female researcher, who has worked primarily with children in therapy, echoed these focuses and added that she had received formative corrective feedback about how to work more effectively with parents, especially when parents were upset or angry. All primary researchers recalled receiving formative corrective feedback pertaining to written work products, including reports, progress notes, and treatment plans. The female researcher noted receiving formative corrective feedback about how to navigate agency politics and working with other trainees.

Related to how supervision experiences prior to internship shaped researchers' expectations/beliefs about formative corrective feedback, the primary author recalled predominately positive experiences in receiving corrective feedback throughout his training. He described one supervision relationship, however, in which he received predominately corrective feedback. The primary author noted that this experience in receiving primarily corrective feedback resulted in a temporary decrease in self-efficacy related to his clinical performance, while also providing an increased appreciation for other supervision experiences in which he received a more balanced approach to feedback. The female researcher noted early negative experiences in receiving formative and summative corrective feedback that was delivered in an unprofessional manner and left her feeling personally attacked. A series of positive supervision experiences helped balance the female researcher's view of corrective feedback; she noted an increased comfort level in receiving corrective feedback as a result of an increased awareness of the variability in supervisors' styles in delivering corrective feedback. The male researcher noted predominately positive experiences in receiving formative corrective feedback across a variety of supervision experiences. He described the majority of formative

corrective feedback he has received as aimed at promoting professional growth, and that the feedback left him feeling supported by his supervisors. He noted that he now holds an expectation that formative corrective feedback will be aimed at his professional growth and delivered in a manner in which he feels supported.

The primary author noted that hearing positive, or affirming, feedback made it easier for him to hear formative corrective feedback. He also discussed the role of supervisor tone while delivering the formative corrective feedback, more specifically that which is offered tentatively or as an alternative approach, in making the feedback easy for him to hear. The female researcher echoed this and added that a warm and supportive supervision relationship made it easier for her to receive formative corrective feedback. The male researcher agreed with the female researcher in noting that a solid rapport and relationship with the supervisor was essential in making formative corrective feedback easy for him to hear. He also added that a non-confrontational, supportive tone helped make formative corrective feedback easier for him to hear.

In contrast to what makes formative corrective feedback easy to hear, the primary author noted that a lack of affirmation, as well as verbal (e.g., fumbling words) and non-verbal behavior (e.g., shifting in one's seat) that conveys a supervisor is uncomfortable, as factors that contribute to making corrective feedback difficult to hear. The female researcher added that a sarcastic tone, or a supervisor asking why something had happened, caused her to become defensive and made formative corrective feedback difficult to hear. Although the male researcher had relatively few experiences in which receiving formative corrective feedback was difficult for him, he discussed feedback that was out of context, feedback that came as a surprise, and feedback that emphasized his

role as a supervisee as factors that contributed to making formative corrective feedback difficult to hear.

The primary author noted that formative corrective feedback that was clear and direct, as well as that which included actual examples from a supervisor's body of work, as feedback that was particularly useful for him. The female researcher echoed this and added that formative corrective feedback was useful when it helped her identify precisely what change she needed to make. All primary researchers noted that formative corrective feedback pertaining to a specific moment during review of audiorecorded sessions was useful. The female researcher discussed how a supervisor's normalizing tone allowed her to better hear the formative corrective feedback, which also made the feedback more useful in her future work with clients. The male researcher noted that formative corrective feedback provided in small increments was more useful for him than that which was provided in large quantities, for this left him confused about what to focus on and unsure of his ability to make a number of corrections simultaneously.

Although the primary author's experiences of receiving formative corrective feedback were predominately positive, he believed that results from this study of supervisee experiences of formative corrective feedback would likely yield both positive and negative experiences from participants. The primary author wondered if supervisees who had especially vivid positive or negative experiences in receiving formative corrective feedback would be more likely to participate than supervisees who had neutral experiences in receiving formative corrective feedback. The male and female researchers believed that participants' interviews would yield mixed positive and negative experiences in receiving formative corrective feedback.

Measures

Demographic form. The demographic form gathered basic information about the participant such as age, gender, race/ethnicity, educational background, degree obtained, previous supervision experiences, and number of years of clinical experience.

Participant contact form. The participant contact form requested a name, email, and/or mailing address (if the participant would like a copy of the results), phone number, and availability for scheduling the interview.

Interview protocol. The complete interview protocol appears in Appendix F. The opening six questions were designed as introductory in nature and asked participants to describe their thoughts about formative corrective feedback in general. In this opening section, participants were asked to talk about their views of the role of formative corrective feedback in clinical supervision, describe representative examples of formative corrective feedback that s/he had received in supervision prior to internship, and how, if at all, supervision experiences prior to internship shaped participants' expectations or beliefs about formative corrective feedback. Additionally, participants were asked about what made formative corrective feedback easy to hear, difficult to hear, and useful.

The next section of the interview protocol asked participants to talk about a specific event in which s/he, as a supervisee, received formative corrective feedback in clinical supervision with a licensed psychologist. The specific event questions were designed to probe a participant's experiences in more depth. More specifically, the questions asked participants to describe what supervision was like with the supervisor before the formative corrective feedback event occurred, what led up to the participant receiving the formative corrective feedback, the content of the formative corrective

feedback, how the participant received the formative corrective feedback, and what the participant believed contributed to the manner in which s/he received the formative corrective feedback. Participants were also asked to describe the effects of the formative corrective feedback, what, if anything, changed as a result of the corrective feedback, and if something had or had not changed, why s/he believed something had or had not changed.

The next section of the interview protocol asked participants to provide basic demographics of their supervisor, such as approximate age range, educational background, sex, and race/ethnicity. Participants were also asked demographic questions about the supervision relationship, including the clinical issues being addressed at the time of the formative corrective feedback event, when in the course of the supervision relationship the event occurred, total length of the supervision relationship, the frequency of supervision meetings, and the setting in which the supervision relationship and formative corrective feedback event occurred.

The next section of the interview protocol covered concluding questions of the first interview. Participants were asked if there was anything else they would like to add regarding the formative corrective feedback event they described or about formative corrective feedback event in general. Finally, participants were asked how it was for them to talk about their experience of receiving formative corrective feedback in clinical supervision.

The final section of the interview protocol contains the questions asked during the follow-up interview. The follow-up interview served several purposes. First, it allowed participants to express any additional thoughts or feelings about formative corrective

feedback in general or the formative corrective feedback event that had occurred to them following the first interview. Second, participants were asked additional questions, including what they wish they would have known about formative corrective feedback prior to the event they described. Participants were also asked to identify what they wanted supervisors to know about formative corrective feedback from a supervisee's perspective, and how, if at all, participants' experiences in supervision, as either a supervisee or supervisor, was affected as a result of participating in the study. Finally, the follow-up interview allowed the researcher to debrief the participant about next steps in the study.

Procedures for Collecting Data

Piloting the protocol. The interview protocol was piloted with two individuals who had recently (i.e., within the past year) completed internship. These participants provided feedback to the interview regarding the wording, flow, and clarity of the questions. Based on the pilot interviews, only minor changes were made to two of the opening questions. The piloting procedure also allowed the interviewer to become more familiar with the protocol questions prior to collecting data that was used in the study. Finally, piloting the protocol allowed the interviewer to confirm that the length of the interview would be approximately 45-60 minutes, which helped participants make an informed decision regarding whether or not to participate in the study.

Recruiting participants. Three participants were selected via the "snowball technique," in which the primary investigator approached existing connections with predoctoral psychology interns and previous practicum placements (e.g., a hospital and college counseling center). If existing connections were unwilling or unable to

participate, they were asked to identify other individuals who might be appropriate for study participation. Nine participants were selected from a recruitment email, approved by the list manager, sent to the APPIC Post-Doc Network Listserv. All participants were approached via phone contact or email and asked if they would be interested in participating in a research study regarding their experience as a supervisee during their predoctoral psychology internship year.

These selection methods were chosen for a number of reasons. First, the APPIC Post-Doc Network Listserv email is intended for discussion of "training issues in professional psychology" (http://www.appic.org/email/8_3_8_email_postdoc_network.html, June 2, 2011) among current interns and those completing post-doctoral work. Additionally, while random sampling would be ideal, there is no readily available way to randomly sample all individuals who are either currently completing or have completed a predoctoral psychology internship within the past two years. Hill et al. (1997) suggest that random sampling is difficult with a number of populations because of availability and willingness of individuals to participate.

Contacting participants. Once chosen for participation in the study, initial contact with participants was made via phone call or email. Informed consent was obtained prior to participation in the study. Once initial contact with participants was made, a packet of information, including cover letter with relevant study information, consent forms, demographic form, participant contact information form, and interview protocol was mailed or emailed to the participant (see Appendices for these materials). The mailed packets also included a self-addressed, stamped envelope for participants to

mail the informed consent and demographic forms back to the primary investigator (David Phelps). Once these materials were received, the primary investigator contacted participants via phone or email to schedule a time for the initial interview.

Interviews and transcription. The primary investigator (David Phelps) completed all initial and follow-up telephone interviews with participants regarding their experiences of receiving corrective feedback in clinical supervision. The first interview began with a reminder of informed consent, confidentiality (i.e., use of code number rather than participant identifying information), and a review of the definition of corrective feedback and type of supervision experience that is the focus of the study. Interview questions were divided into three areas: opening questions, corrective feedback event questions, and closing questions. Although it varied slightly from participant to participant, the initial interview was designed to take approximately 45 minutes to 1 hour. A copy of the interview protocol can be found in Appendix F.

After the initial interview, the primary investigator reviewed notes and/or the transcript of the interview prior to conducting the follow-up interview. The follow-up interview was shorter in duration and less structured than the initial interview, and it occurred roughly two weeks after the initial interview. The primary investigator allowed the participant to share any additional thoughts that may have come up after the initial interview, as well as clarify any unclear content. Participants were then asked what they wish they would have known about corrective feedback prior to the event they described, what participants wanted supervisors to know about corrective feedback, and how, if at all, participation in the study affected participants' experience of supervision either as supervisee or supervisor. At the conclusion of the follow-up interview, participants were

asked if they would like to review and comment on a draft of the final results. The follow-up interview again varied from participant to participant and was designed to take approximately fifteen minutes.

All initial and follow-up interviews were audiorecorded and transcribed verbatim by the primary investigator. Minimal encouragers, non-language utterances (e.g., um, ah, etc.) and any identifying information related to the participant and/or her/his supervisor were excluded from the transcripts. Furthermore, each participant was assigned a code number to ensure confidentiality.

Draft of final results. Participants were invited to provide feedback on the results and discussion sections of the manuscript (see Appendix G). Five participants responded stating they had no additional feedback, and one participant noted a grammatical error, which corrected in the manuscript.

Procedures for Analyzing Data

Consensual qualitative research methodology. In their seminal work on CQR, Hill et al. (1997) outlined eight key components of the methodology: (1) data are gathered using open-ended questions so that participant's responses are not constrained; (2) words, rather than numbers, are used to describe phenomena; (3) a small number of cases are studied in-depth; (4) the context is used to understand specific parts of the experience; (5) conclusions are built from the data rather than imposing and testing an *a priori* structure or theory; (6) consensus is used among a primary team of three to five researchers so that the best possible data construction is developed; (7) one or two auditors check the team's consensus judgments and make sure that important data are not overlooked; (8) the research team continually checks raw data to make sure that results

and conclusions accurately reflect the data (pp. 522-523). In addition to these eight components, CQR consists of three steps. First, responses to open-ended interview questions are placed into domains (i.e., topic areas). Next, core ideas (i.e., the essence of participants' words) are developed for each domain within each individual case. Third, domains are analyzed across cases to develop categories that describe themesthat emerge in core ideas (Hill et al., 1997).

The process of consensus among research team members is integral to CQR (Hill et al., 1995). This is based on the belief that multiple perspectives increase the likelihood of approximating the "truth" and limit the influence of researcher bias. In CQR, research team members examine the data independently and then discuss their ideas as a group until one interpretation is agreed upon that is most suitable. Discussing a variety of opinions and perspectives helps to diminish the influence of individual researcher bias, while simultaneously capturing the complexity of participant experience. According to Hill et al., (1997), this consensus process requires "mutual respect, equal involvement and shared power" (p. 523). The process of reaching consensus involves working through differences, and questioning one another while remaining open to alternative perspectives is necessary for research team members.

Domaining the transcripts. Once interviews are completed and transcribed, data analysis begins by developing a list of topic areas, or domains (Hill et al., 1997). More recently, Hill et al. (2005) have suggested that researchers build the list of domains by reviewing transcripts; this allows researchers to work directly from the data rather than preexisting literature and expectations/biases. The process of consensus among team members allows for domains to be deleted, combined, or added until the team believes

that they have developed the most appropriate list for the data. Once initial domains are identified, team members independently read through each transcript and assign data to a domain. Every word must be placed somewhere, and data that do not appear to fit into a domain may be coded as "other" to be reexamined later. Data may be coded into multiple domains; if a lot of data are coded in the same two domains, the domains should probably be combined. Additionally, if data is being coded into multiple domains, the domains have likely not been clearly defined. Once researchers have independently coded all data from a transcript into domains, the group meets to discuss how they coded the data and arrive at a consensus version, which includes the domain titles followed by all of the raw data for each domain. The original transcript is never altered, which allows researchers to review exactly what was said and in what context during the interview (Hill et al., 1997).

  Developing core ideas. The next step in the data analysis process in CQR is to develop core ideas that summarize the content of each domain within each case (Hill et al., 1997). The goal of this process is to describe the interviewee's response in a briefer, more succinct manner, while remaining true to the explicit meaning of the interviewee's words. Similar to domaining, once researchers have completed this work independently, the group meets to discuss cores and arrive at a consensus version. Researchers may continue developing cores for each case as a team, or they may take turns writing cores for specific cases and then discussing with the team for review and editing (Hill et al., 2005). Once a consensus version of core ideas for each domain of a case is reached, the case is sent to the auditor(s) for review. Hill et al. (1997) suggest that auditor(s) review the raw material in every domain to ensure that: (1) the data is in the correct domain; (2) all important data in the domain are included in the core; and (3) the core idea is concise

and true to the original data (p. 548). Auditor(s) return the case along with comments to the research team, at which point members discuss and arrive at consensus regarding whether to accept or reject each item of feedback.

Once the data have been analyzed into domains and core ideas, the process of data interpretation begins. Consistent with other steps of the methodology, CQR identifies explicit steps in the data interpretation process.

Cross-analysis. Cross analysis involves examining all core ideas within domains and taking this information to another level of abstraction, determining what patterns emerge among the cases (Hill et al., 1997). The research team may do this collectively or work independently and then compare categories as a group until consensus is reached. The identification of categories is discovery oriented, as they are derived from the data rather than theories. Core ideas may go into one or several categories, or they may be divided among relevant categories. Similarly to other steps in the process, categories are continually revisited and modified and/or clarified throughout the interpretation process.

Once categories are identified, the team examines the representativeness of the sample by determining the frequency of categories within the whole sample. Based on Elliott's (1989, 1993) methods, the following terms are used to describe categories: (1) if a category applies to all or all but one of the cases, it is considered *general*; (2) if a category applies to half or more of the cases, it is considered *typical*; and (3) if a category applies to two or three and up to half of the cases, it is considered *variant.* Any categories that apply to only one case are dropped. In an update of CQR methodology, for studies with more than 15 participants, Hill et al. (2005) recommend adding a frequency title of

rare to categories that apply to two or three cases, changing the definition of *variant* to include more than three and up to half of the cases.

Auditor(s) should review the cross analysis to evaluate the fit of core ideas within the specified categories, the appropriateness of category labels, and if categories should be divided or combined. The research team then reviews this feedback from the auditor(s) and arrives at a consensus regarding whether to accept or reject the recommendations. The team again sends the modified cross analysis back to the auditor(s), and this process continues until all members believe that a strong understanding of the data has emerged.

Once these steps were completed, the data were examined for patterns or pathways that emerged. The primary investigator looked to see if specific categories in one domain aligned with specific categories in other domains. Patterns between general and typical categories across domains emerged and are discussed in the discussion section.

Results include the presentation of domains, associated categories, the number of cases that fit into each category, and one or two core ideas from each category. A brief narrative and a summary of a prototypical case are included in the results as well. Further discussion focuses on the meaning of the results, a review of the results in the context of the extant literature on corrective feedback in clinical supervision, limitations of the study, and areas for future research.

Chapter 4: Results

The results of this study are presented in four major sections. First, contextual findings (i.e., those related to participants' overall experience with formative corrective feedback, and thus not related to the specific event they later described) are presented (see Table 1). Findings from this section will provide a framework from which participant experiences of a specific formative corrective feedback event can be understood. The second section contains findings related to a specific FCFB event (see Table 2). Next, findings related to closing questions are presented (see Table 3). In the final section of the results, I provide two illustrative examples of FCFB events: one in which the participant described having a positive effect on herself, her clinical work, and/or the supervision relationship, and one that the participant described as having a negative effect on herself, her clinical work, and/or the supervision relationship. As stated earlier, categories are labeled with the following frequency descriptors based on 12 cases total: General = 11-12 cases, Typical = 6-10 cases, Variant = 2-5 cases. Themes that emerged in only one case were moved to an "other" category; "other" results are not described in this manuscript.

Contextual Findings Regarding FCFB

Participants were asked six opening questions, from which four domains emerged. These questions were designed to be introductory in nature and asked participants to describe their thoughts about formative corrective feedback in general. The responses to general questions about formative corrective feedback provide important context from which participants' experiences of a specific formative corrective feedback can be

understood. The findings from the background/contextual questions regarding FCFB are

presented in Table 1, which follows this section.

   Purpose of FCFB. Typically, participants reported that the purpose of FCFB was

to provide instruction and/or guidance related to clinical performance. For example, one

participant stated that FCFB helped deepen her clinical skills by providing "the logistics

of specific techniques and how to use myself as a tool in therapy." Two other participants

noted the role of FCFB in guiding and shaping supervisees' skills in order to provide the

best possible care for clients. Participants also typically indicated that the purpose of

FCFB was to promote supervisee reflection and increased awareness. For instance, one

participant stated that FCFB helped supervisees reflect on what occurred in sessions with

clients and "identify alternative ways of handling moments in therapy." Another

participant noted FCFB's role in helping supervisees identify moments when clients

"trigger supervisees and impact supervisees' decision making." Yet another participant

described the role of FCFB in giving supervisees a clearer sense of "blind spots" and to

point out things supervisees are doing of which they are not aware. In a third category,

participants typically indicated that FCFB promoted supervisee growth. One participant

noted the role of FCFB in challenging supervisees to take risks in therapy and do things

with which they may be uncomfortable. Participants also typically identified preventing

or correcting supervisee mistakes as a purpose of FCFB. One participant described FCFB

as an opportunity for supervisors to "correct serious offenses or supervisee mistakes such

as ethical violations or boundary crossings." In a fifth category, participants typically

noted FCFB as a way for supervisors to promote supervisees learning and adopting their

supervisor's style, and this was not viewed positively by participants. For example, on

participant described FCFB for some supervisors as an opportunity to "create a clone" of the supervisor if the supervisor was "nitpicky." Another participant stated that FCFB developed supervisees in the "mold of what supervisor's view as doing good work." Finally, participants variantly stated that FCFB communicated supervisee performance level. One participant indicated that FCFB let supervisees know if "they are on the right track" or needed to make adjustments.

Focus of FCFB. When asked to describe the focus of representative examples of FCFB that participants had received, they generally indicated that FCFB provided instruction about making changes in their clinical work. For example, one participant noted receiving FCFB that directed her to try a specific technique she had not tried before, and that the FCFB included her supervisor teaching the technique. Another participant described the focus of FCFB she had received as helping her work though the clinical aspects of work with suicidal clients, such as evaluating client safety and safety planning. Participants also typically indicated that they had received FCFB that promoted insight and increased awareness in their clinical work. For instance, one participant stated that her supervisor provided feedback that prompted her to reflect on the intention and purpose of her therapeutic interventions. Another participant described receiving feedback that helped "illuminate my process and point out moments in therapy when I was not going deep enough emotionally with my clients; it [formative corrective feedback] helped me sit in the dark with clients and identify times when I was triggered to pull away from clients." In a third category, participants typically indicated that they had received FCFB related to non-clinical topics, such as how to navigate the politics of a particular setting, how to organize supervision time, and how to approach internship

interviews, dissertation, and early career years. Finally, participants variantly noted receiving FCFB about how to improve the quality of written documentation such as reports, progress notes, and treatment plans.

Expectations/beliefs about FCFB. Generally, participants expected that FCFB would promote supervisee growth and clinical skill development. For example, one participant stated that she expected supervisors to provide FCFB in a "supportive way aimed at my growth, while correcting and guiding." Another participant noted that she expected to receive FCFB focused on how she could be a better clinician, rather than FCFB that was focused on personal characteristics such as her weight or manner of dress. In a second category, participants typically expected to receive FCFB. One participant viewed FCFB as a "necessary part of training." Another participant described FCFB as "beneficial, essential, and critical" to the supervision relationship. Participants also typically stated an expectation that FCFB would be given in the context of a supportive and collaborative supervision relationship. "I expect that FCFB is given in the context of a warm, positive, supportive, and trusting relationship," stated one participant. In a fourth category, participants variantly expected that FCFB would be direct, honest, and clear. One participant expected supervisors to be "blunt, honest, and let me know if a mistake is being made." Variantly, participants stated an expectation that FCFB would be accompanied by an affirmation of themselves as supervisees. As an illustration, one participant stated that she welcomed FCFB so long as it was delivered "in the context of an acknowledgement or understanding of the work I was doing in sessions with clients." Finally, participants variantly expressed an expectation that FCFB could be a negative experience for supervisees. For example, one participant believed FCFB could be a

"damaging experience confounded by the power differential that is inherent in supervision relationships."

What makes FCFB easy to hear/go well. When asked about what makes FCFB easy to hear and go well, participants generally indicated that a supervisor who normalizes or validates their work as a supervisee. For example, one participant stated that hearing from supervisors that she was not expected to have all the answers helped her to receive FCFB. Other participants noted that receiving positive feedback helped them to hear feedback that was corrective. Participants also generally noted that FCFB that was clearly explained as being well-received. To illustrate this, one participant described clear FCFB as that which was "specific and direct, because then there is no mystery in terms of what changes I need to make." Participants also typically indicated that perceiving a supervisor's demeanor positively contributed to FCFB going well. "If my supervisor delivers FCFB in a warm and supportive tone, I can talk with them about it in more detail," stated one participant. Another participant stated that formative corrective feedback went well for her "if my supervisor doesn't act like they know everything and if they allow me to call them by their first name, which levels the playing field and makes them human and approachable." In a fourth category, participants typically noted that FCFB went well when delivered in the context of a strong supervision relationship. For example, one participant described the importance of having a good supervision relationship and strong rapport with her supervisor, for it helped her talk about difficulties with her supervisor and be more open to receiving formative corrective feedback. Another participant stated that it was important for her to trust her supervisor and feel safe enough in supervision for her to "hear and digest" FCFB.

Participants typically indicated that working through FCFB together with their supervisor helped FCFB be well-received. For example, one participant stated that FCFB went well when her supervisor encouraged her to think through a problem rather than simply telling her what to do. In a sixth category, participants typically stated that FCFB aimed at promoting supervisee growth was favorably received. One participant described FCFB aimed at "promoting self-exploration so that I can generate my own alternatives" as being easy to hear. Participants also typically noted the role of supervisee openness to receiving FCFB as contributing to FCFB going well. One participant described herself as "open and responsive to FCFB; I can change gears easily and I genuinely enjoy learning new things." Another participant stated "I'm a laid-back person who isn't easily riled up, and that makes it easy for me to hear FCFB." Variantly, participants indicated that supervisors following-up on FCFB helped them receive this type of feedback. For instance, one participant stated that she was motivated to make a change if she knew her supervisor would revisit the FCFB. Finally, participants variantly noted the importance of perceiving a supervisor as credible in helping make FCFB easy to hear. One participant stated that believing a supervisor was competent allowed her to "take in the FCFB and trust it."

What makes FCFB difficult to hear/not go well. Typically, participants indicated that a supervisor's harshness made FCFB difficult for them to hear. One participant described a supervisor's interrogating tone as something that caused her to become defensive and not open to hearing FCFB. In a second category, participants typically noted difficulties in the supervision relationship as contributing to FCFB not going well. To illustrate this, one participant noted that "if my relationship with my

supervisor is awkward, that carries over into their delivery of FCFB and makes me anxious." Another participant described a lack of warmth, safety and trust in the supervision relationship as making FCFB difficult to hear. Participants typically indicated that FCFB that was not explained as difficult to hear. For example, one participant struggled with FCFB that was "like a commandment" with little discussion about why it was important for her to make a change. In a fourth category, participants typically indicated that a supervisee's poor reaction to FCFB as making FCFB difficult to hear. For instance, one participant stated that formative corrective feedback does not go well if it pertains to "an area that I'm already aware that I need improvement in and I'm already beating myself up over it." Participants typically indicated that FCFB not intended to help them grow contributed to FCFB not going well. One participant described FCFB that "lists everything that I did wrong, rather than help me grow" as difficult for her to receive. In a final typical category, participants indicated that FCFB is difficult to hear or does not go well when supervisors provide only corrective feedback. For instance, one participant recalled having a supervisor who did not provide positive feedback, which prompted her to wonder if she was "doing anything good" and left her feeling disconnected from her supervisor.

Four variant categories emerged in participants' responses to what made FCFB difficult for them to hear. Participants noted that supervisors who appear uncomfortable (e.g., "nervous," "weird," or "indirect") contributed to FCFB that was not well-received. Additionally, participants variantly indicated that FCFB focused on personal characteristics such as style of dress or hypotheses about intrapersonal processes, rather than observed clinical behaviors, was difficult to hear. In a third variant category,

participants believed that holding a different theoretical orientation from their supervisor made FCFB difficult to receive. One participant, who described herself as holding a predominately cognitive-behavioral theoretical orientation, noted that psychodynamic supervisors had a tendency to "read into and ascribe motivations or hypotheses about me, and I did not agree with their hypotheses." Lastly, participants variantly noted that FCFB delivered in front of others, such as peers, was difficult for them to hear, for it left them feeling competitive with – rather than supportive of – one another.

Table 1. Domains, Categories, and Frequencies of Contextual Findings Regarding Formative Corrective Feedback

Domain	Categories	Frequency*
1. Purpose of FCFB	Provide instruction/guidance related to clinical performance	Typical
	Promote SE reflection and increased awareness	Typical
	Promote SE growth	Typical
	Prevent/correct SE mistakes	Typical
	SR promoted SE learning and adopting SR's style	Typical
	Communicate SE performance level	Variant
2. Focus of FCFB	Provide instruction about changing clinical work	General
	Promote SE insight and awareness in clinical work	Typical
	Related to non-clinical topics (e.g., setting)	Typical
	How to improve quality of written documentation	Variant
3. Expectations/beliefs about FCFB	FCFB will promote SE growth/clinical skills	General
	SEs expect to receive FCFB	Typical
	That FCFB will be collaborative/given in context of supportive sup relationship	Typical
	That FCFB will be direct, honest, and clear	Variant
	That FCFB will be accompanied by affirmation of SE	Variant
	That FCFB can be a negative experience for SEs	Variant
4. What makes FCFB easy to hear/go well	SR normalizes FCFB/validates SE's clinical work	General
	FCFB is clearly explained	General
	SR's demeanor perceived positively by SE	Typical
	Strong sup relationship	Typical
	SE and SR work through FCFB together	Typical
	When FCFB is aimed at promoting SE growth	Typical
	SE is open to receiving FCFB	Typical
	When SR follows-up on FCFB	Variant
	When SE views SR as credible	Variant
5. What makes FCFB difficult to to hear/not go well	When SR is harsh	Typical
	Difficulties in sup relationship	Typical
	When SR does not explain FCFB	Typical
	When SE has poor reaction to SR's FCFB	Typical
	When SR's FCFB is not intended to help SE grow	Typical
	When SR provides only CFB	Typical
	When SR appears uncomfortable providing FCFB	Variant
	When FCFB is focused on P's personal character	Variant
	When SE and SR hold different theoretical orientations	Variant
	When SR provides FCFB to SE in front of others	Variant

* Twelve total cases. General = 11-12, Typical = 6-10, Variant = 2-5

Note. FCFB = Formative Corrective Feedback; CFB = Corrective Feedback; FB = Feedback; SE = Supervisee; SR = Supervisor; sup = Supervision

Formative Corrective Feedback Event Findings

Participants were asked to describe a specific instance in which they received formative corrective feedback in order to probe their experiences of this type of feedback in greater depth. Participants were asked to describe a formative corrective feedback event that occurred in individual supervision (in the third meeting or later) with a licensed psychologist during their predoctoral psychology internship. Participants described the event including what happened before, during, and after the FCFB. The findings from the FCFB event questions are presented in Table 2, which follows this section.

Supervision experience prior to event. When asked to describe their experience of supervision prior to the FCFB event, participants typically described experiencing difficulties in the supervision relationship. For instance, one participant stated feeling "unsafe" in supervision with her supervisor after her supervisor described her as "defensive" in response to the participant's request for specific examples of her missteps. Another participant described supervision as "very cold, unhelpful, and a punitive place for me." Other participants, however, variantly described supervision as a positive experience. "I felt empowered to determine priorities and set the agenda for supervision," noted one participant, who went on to state: "I left feeling supervision more confident and sure of myself, and my supervisor's corrective feedback never felt like criticism." Another participant noted that her supervisor was "positive and very helpful," and she indicated that the supervision relationship felt collegial because her opinion as a supervisee was valued. In a third category, participants variantly indicated that their supervisors questioned them intensely during supervision. To illustrate this, one participant described supervision as "being in the hot seat and having knives thrown at

me." Another participant also described her supervision experience as "a tough and intense quiz." Participants also variantly spoke about the amount of corrective feedback they received in supervision, indicating that their supervisors provided extensive amounts of this type of feedback. In one case, the participant noted: "The supervision experience was different from any previous supervision experience I had. My supervisor started with negatives, what I was doing wrong, and did not acknowledge what I was doing well." In a fifth category, participants variantly described their supervisor as personable outside of supervision; all participants who spoke of this stated that their supervisor would discuss personal topics with them outside of scheduled supervision meetings. Finally, participants were also variantly familiar with their supervisor prior to the start of a formal supervision relationship. One participant had chosen to work with her supervisor based primarily on his body of work and his reputation at the internship site.

What precipitated the FCFB event. Participants described what led up to the FCFB event, and typically, participants were struggling with an aspect of clinical practice. For example, one participant described feeling "really lost" in work with a client, which prompted her to bring an audiorecording of a session with the client to supervision. Another participant wondered if she was "on the right path" with her client and wanted her supervisor's thoughts on whether or not the client was ready for therapy. Yet another participant was asked by her supervisor to work from a specific model of therapy with which the participant had little experience, which left her struggling clinically. As a sub-category of those struggling clinically, participants variantly indicated that they were working with a client safety concern prior to the FCFB event. In each of these three cases, participants were unsure of how to work with a client who was

a threat to self. In a second category, participants variantly brought a segment of either audio- or videorecording to supervision, and review of audio- or videorecording prompted their supervisor to deliver FCFB. Similarly, other participants variantly indicated that a problem with a piece of written documentation (e.g., not explicitly addressing a referral question in an assessment report; being too expansive or concise in a progress note) prompted the FCFB event. Finally, participants variantly received the FCFB following a disagreement with their supervisor. For example, one participant and her supervisor held very different views about another psychologist at the agency; the participant believed that this disagreement led to a change in the supervision relationship and precipitated the FCFB event.

Content of FCFB. Consistent with what precipitated the FCFB event, participants typically described the content of the FCFB as informing them that they had not handled a clinical issue well. For example, one participant's supervisor informed her that she needed to change her approach in conducting intakes. Another participant, who was asked to evaluate a client for malingering, was told by her supervisor that she needed to explicitly address the referral question in her written report. Other participants were variantly told that they needed to try a different clinical strategy. For instance, a participant who was feeling unsure of a specific moment in session with a client was asked by her supervisor what might have happened in session had the participant been silent, rather than validating and supportive, following a client breakthrough. Another participant was told by her supervisor to be less passive and "more in control" of her sessions with clients. Finally, participants variantly indicated that the content of FCFB they received conveyed supervisor anger with their clinical work. One participant, having

not checked for client safety during each session, was yelled at by her supervisor and informed that her work was "shit." Another participant's supervisor shared that she was "disappointed and pissed" that the participant had wasted her supervisor's time in reviewing a videorecording made before the participant was able to demonstrate competence in a particular technique.

      Participant's immediate reaction to the FCFB. When asked to talk about their immediate (i.e., following the FCFB in the same supervision session) reaction to the FCFB they received, participants typically described having a negative reaction. One participant, having received written FCFB on an assessment report, "struggled to find the kernel of truth in wading through her [supervisor's] sarcastic corrective feedback." Another participant described feeling "frantic, self-conscious, and upset" as her supervisor provided the FCFB. In one case, a participant felt "hopeless" and unsure that she would be able to make the change her supervisor requested. There were two sub-categories that emerged under the broader category of negative reactions. In the first sub-category, participants typically disagreed with the FCFB they received. For example, one participant believed that rather than asking why she, as a supervisee, was not better prepared to deliver an intervention, the supervisor should have asked what, as a supervisor, she could have provided to ensure that the participant was better prepared. In another instance, a participant who had received FCFB to be more active in her work with clients "fundamentally disagreed with his [supervisor's] philosophical stance when it comes to the therapy relationship." In the second sub-category, participants were variantly confused by their supervisor's FCFB. Having received FCFB to shorten her reports, one participant was unsure how to accomplish this task, because she had

previously received feedback from the same supervisor that she had not gone into sufficient detail in her written reports.

In contrast with those participants who described having negative reactions to the FCFB, other participants variantly indicated that the FCFB from their supervisor was well-received. One participant described the FCFB as "helpful" because she felt supported by her supervisor, and her supervisor acknowledged that the participant's work was good, yet could still be improved. In a fifth category, participants variantly indicated that they initially reflected internally on the FCFB, rather than verbally respond in the moment with their supervisor. Finally, participants variantly dialogued with their supervisor about the FCFB. One participant continued to ask her supervisor questions in hopes of clarifying his rationale for providing the FCFB, while another participant asked her supervisor to show her a specific example of the area of concern in the participant's videorecorded sessions with clients.

What contributed to participant's immediate reactions to the FCFB. In addition to being asked about their initial reactions to the FCFB, participants were asked to consider what contributed to these immediate reactions to their supervisor's FCFB. Typically, participants noted that interpersonal difficulties with their supervisor contributed to their reaction. For instance, one participant described feeling "frustrated and blamed" by her supervisor, which led her to disagree with her supervisor. Another participant felt that her supervisor was "just watching [videorecordings] to correct" and felt the need to be "on guard at all times," prompting her to ask her supervisor for specific examples in her videorecroded sessions. There were four variant sub-categories that more explicitly described what contributed to participants' negative reactions to the FCFB.

Participants variantly indicated that they perceived their supervisor's demeanor or tone as harsh in the delivery of the FCFB. In a second variant sub-category, participants believed their supervisors were inconsistent with their FCFB. For example, one participant described feeling confused after her supervisor told her that overall her reports needed to be shorter, while also providing feedback that certain sections of her report were underdeveloped. Participants also variantly disagreed with their supervisor's FCFB. For instance, one participant stated that the formative corrective feedback "went against my philosophical stance of the therapy relationship and put me, as therapist, in a position that was not in my nature." Finally, participants variantly believed that their supervisor did not provide sufficient explanation or reasoning for providing the FCFB.

In a second broad category of contributors to participants' reactions to the FCFB, participants variantly indicated that their supervisors delivered the FCFB well. For instance, one participant described feeling supported by her supervisor and that the FCFB conveyed that her supervisor valued the participant's opinion. Another participant's supervisor normalized being unsure in therapeutic work with clients before providing an alternative way for the participant to respond to her client. Participants also variantly reported having a good supervision relationship, which helped participants receive the FCFB. To illustrate this, one participant stated: "I always got what I needed from my supervisor. I felt like I wasn't alone because my supervisor was always there to help me." Another participant noted her supervisor's ability to foster a "safe and comfortable" place for her to "make mistakes and grow." Finally, participants variantly indicated that their own personal characteristics contributed to their immediate reaction to the FCFB. One participant stated that she was "exhausted and frustrated" during supervision when she

received the FCFB. Yet another participant stated that she was embarrassed by the FCFB "because of my personality," and that this was further compounded by a belief that "I should have known these things [interventions] by the time I was on internship."

Effects of the FCFB. When asked about what participants perceived as the effects of the FCFB event, three distinct areas emerged: effects on the participant; effects on the participant's clinical work; and effects on the supervision relationship. Each of these areas is addressed separately below.

Effects of FCFB event on the participant. Participants detailed a number of perceived effects of the FCFB that were more personal in nature rather than related to their clinical work or the supervision relationship. Typically, participants had negative reactions to the FCFB event that lasted beyond the initial supervision session in which the feedback was received. One participant described feeling "upset and anxious" in later supervision relationships if she received FCFB similar to that which she received during the FCFB event; she reported consulting with peers and non-supervisory professionals as a result, and that she currently discloses very little in supervision. Another participant described the FCFB event as "ruining my view of clinicians; there's a dark side to them that I was not aware of prior to internship." One typical and three variant sub-categories emerged in the broader negative reaction category. Typically, participants noted being more withdrawn and guarded in supervision after the FCFB event. For example, one participant stopped "opening my mouth to say anything if it would appear I was questioning her [supervisor]." Another participant described herself in later supervision relationships as "very guarded" with "my boundary wall sky high" as a result of the FCFB event. Variantly, participants were angered by the FCFB event. One participant

was "angry for days, such that I couldn't sleep" following the event. Participants also variantly continued to disagree with their supervisor, while other participants variantly acknowledged ongoing confusion as a result of the FCFB event.

In a second broad category of effects of the FCFB, participants variantly indicated that they continued to reflect internally. For instance, one participant described engaging in much personal reflection about her personality and its influences on her clinical work. Participants also variantly noted a positive impact on their approach to work as a result of the FCFB. One participant noted that the FCFB prompted a shift for her: in the context of her reports, she was no longer writing for a grade but instead writing to help her client. In a fourth broad category, participants variantly noted that as current supervisors, they are more attentive when providing FCFB to their supervisees. To illustrate, one participant stated that she checks in regularly with her supervisee to see how he is receiving her FCFB, so that "we are on the same page and so I don't create unneeded pain for him." Finally, participants variantly noted seeking support from peers and/or loved ones in the days following the FCFB event.

Effects of FCFB event on the participants' clinical work. In addition to describing personal effects of the FCFB event, participants spoke to the effect of the FCFB on their clinical work. Typically, participants changed their clinical work based on the FCFB. There was some degree of variability within this category, however. Some participants made temporary changes in their clinical work to align with their supervisors' style in order to navigate the supervision experience. For example, one participant stated that she changed her report writing style throughout the duration of her supervision experience with her supervisor from the event, but returned to her previous

report writing style once supervision ended. Other participants incorporated more enduring changes to their clinical work: one participant noted, "I started using silence more with that client, and then several other clients where I felt the situation was similar to the event. I definitely use more silence today than I would have without that feedback." Participants also variantly indicated that the quality of their work improved as a result of the FCFB event. For instance, one participant noted an improved ability to "connect with clients" as a result of her supervisor's FCFB to consider using more silence in sessions with clients. A perceived improvement in the quality of clinical work was not the case for all participants, however, as some participants variantly noted that the quality of their work suffered as a result of the FCFB event. One participant spoke of being "fired" by her client, something she perceived as a direct result of incorporating her supervisor's FCFB into her work. Another participant noted that her work ethic diminished as a result of the FCFB event, and she "dialed it back to do the minimum amount for my clients."

Effects of FCFB event on the supervision relationship. Several participants spoke about the effect of the FCFB event on the relationship with their supervisor. Typically, participants noted that the FCFB event damaged the supervision relationship. For one participant, the relationship with her supervisor was "never the same. I limited my contact with her because she was not safe for me to be connected to and she was not worth my time." Another participant stated: "it [the FCFB event] served as a polarizing function and supervision was never a comfortable place." One sub-category emerged under the broader damaged supervision relationship category: participants variantly indicated that the supervision relationship concluded earlier than originally planned as a

result of the FCFB event. One participant noted that the event "fueled and re-established why I could no longer work with my supervisor… it solidified my perception of how corrupt our relationship was." In contrast with these experiences, other participants variantly noted that the FCFB event improved the relationship with their supervisor. For one participant, the FCFB event "chipped away" at tension and awkwardness in the supervision relationship and helped her to feel that her supervisor had her best interests at heart. Another participant, who was struggling with feeling frustrated in sessions with one particular client, felt even more comfortable with her supervisor following the event: "it took our supervision to another level because I knew I could go to him for help." The FCFB event also variantly stimulated further dialogue between participants and their supervisors. Finally, participants variantly sought guidance from other training professionals as a result of the FCFB event. For example, one participant met with her training director to express concerns that her supervisor was only watching portions of videorecorded therapy sessions rather than complete sessions.

Table 2. Domains, Categories, and Frequencies of Findings Regarding Formative Corrective Feedback Event

Domain	Categories	Frequency*
1. Sup experience prior to event	Difficulties in sup relationship	Typical
	Overall positive sup experience	Variant
	SR questioned participant intensely during sup	Variant
	SR provided extensive CFB	Variant
	SR personable with participant outside of sup	Variant
	Participant was familiar with SR prior to working together	Variant
2. What precipitated FCFB	Participant was struggling clinically	Typical
	Participant working with client safety concern	Variant
	SR had reviewed recording of participant's work	Variant
	SR had reviewed participant's written work	Variant
	Participant and SR had a disagreement	Variant
3. Content of FCFB	Participant had not handled clinical issue(s) well	Typical
	Participant needed to try a different clinical strategy	Variant
	SR was angry with participant/participant's clinical work	Variant
4. Participant's immediate reaction to FCFB	Participant had negative reactions to FCFB	Typical
	Participant disagreed with FCFB	Typical
	Participant confused by FCFB	Variant
	Participant received FCFB well	Variant
	Participant reflected on FCFB	Variant
	Participant and SR dialogued about FCFB	Variant
5. What contributed to participant's reaction to FCFB	Participant and SR had interpersonal difficulties	Typical
	Participant perceived SR's demeanor/tone as harsh	Variant
	SR was inconsistent with FCFB	Variant
	Participant disagreed with SR's FCFB	Variant
	SR did not provide reasoning for FCFB	Variant
	SR delivered FCFB well	Variant
	Participant and SR had good relationship	Variant
	Participant's personal characteristics	Variant
6. Effects of FCFB		
a. On Participant	Participant had negative reactions to FCFB	Typical
	Participant was more withdrawn/guarded in sup	Typical
	Participant was angry	Variant
	Participant disagreed with FCFB	Variant
	Participant was confused by FCFB	Variant
	Stimulated reflection on participant's work	Variant
	Influenced participant's work positively	Variant
	As SR, participant will be more attentive to SEs when providing FCFB	Variant
	Participant sought support from others	Variant
b. On Participant's	Participant changed clinical work based on FCFB	Typical

clinical work	Participant's clinical work improved	Variant
	Participant's clinical work suffered	Variant
c. On sup relationship	Damaged sup relationship	Typical
	Sup relationship concluded earlier than planned	Variant
	Improved sup relationship	Variant
	Stimulated further dialogue between participant and SR	Variant
	Participant sought guidance from other training professional	Variant

* Twelve total cases. General = 11-12, Typical = 6-10, Variant = 2-5

Note. FCFB = Formative Corrective Feedback; CFB = Corrective Feedback; FB = Feedback; SE = Supervisee; SR = Supervisor; sup = Supervision

Closing Findings

The closing questions allowed participants to reflect on the effects of participating in the study and add any additional information they felt was pertinent to the study. Participants were also asked to discuss what they wanted supervisors to know about formative corrective feedback from a supervisee's perspective, as well as how participating in the study impacted their experience of supervision as either a supervisee or supervisor. The findings based on these questions are presented in Table 3 following this section.

Effects of the interview on participant. Typically, participants found it helpful to reflect on and talk about formative corrective feedback and the formative corrective feedback event. One participant found it "therapeutic" and stated having "a little bit of a catharsis" in being able to share an experience "that nobody ever asks us about." Another participant had an increased appreciation for the good supervision she had received throughout her training. Variantly, participants found it difficult to articulate their experience of formative corrective feedback. "I had an example of the event in my head, and responses to the opening and event questions all ready to go, but it was more difficult to actually articulate my thoughts than I anticipated," remarked one participant. Finally, the interview variantly stimulated negative emotions or memories for participants. For example, one participant described the interview as "cathartic in some ways, retraumatizing in others."

What participants want supervisors to know about FCFB. Generally, participants wanted supervisors to know that the supervision relationship mitigates how FCFB is received by supervisees. Two sub-categories emerged within this category:

participants typically believed that a positive supervision relationship helped supervisees

receive FCFB, while participants variantly believed that difficulties in the relationship

made it difficult for supervisees to receive FCFB. For instance, one participant stated that

making supervision a supportive and comfortable place made it easy for supervisees to

ask for help and receive corrective feedback. Another participant felt that it was a

supervisor's job to be "a human being and a good psychologist" with supervisees and

address power differential so that supervisees can grow and learn. Speaking to the impact

of difficulties in the supervision relationship on how supervisees receive FCFB, one

participant believed that if FCFB was delivered in a punitive or unsupportive way it could

"scar the supervisee and leave them feeling less confident and competent in their

abilities." In a second broad category, participants typically wanted supervisors to know

that supervisees value and appreciate FCFB. "It [FCFB] should be one of the

foundational pieces of the supervision process," noted one participant. Typically,

participants wanted supervisors to know that FCFB should be balanced with positive

feedback. To illustrate this, one participate stated that it was easier for her to receive

FCFB if she had a sense that her supervisor believed she was competent and "not a

complete fool." Another participant wanted supervisors to know that supervisees are

corrected often and not to underestimate the power of positive feedback and hearing

about a "job well done." In a fourth category that emerged, participants typically wanted

supervisors to know that they wanted sufficient time to be able to have the FCFB

explained and discussed. "Corrective feedback will fall flat for me unless my supervisor

takes the time to process and discuss it," noted one participant. For one participant,

hearing "you did something wrong" was not helpful FCFB, because that left her unsure

how to make the correction. Typically, participants wanted supervisors to be sensitive to supervisees' circumstances or individual differences when providing FCFB. One participant believed that supervisors should understand the "waxing and waning" of supervisee motivation during internship as a result of other responsibilities, such as dissertation. Another participant wanted supervisors to understand that internship could be a "very intense and destabilizing" year, and that supervisees at any time in their training are likely experiencing a number of transitions. For one participant, it was important for supervisors to be aware of cultural differences between supervisor and supervisee, and the impact of culture on how FCFB is heard, received, and responded to.

In addition to the five typical categories described above, two variant categories emerged when participants discussed what they wanted supervisors to know about FCFB from a supervisee's perspective. First, participants variantly wanted supervisors to be clear and direct when providing FCFB. One participant expressed a desire for direct and honest FCFB, but also wanted supervisors to know that they should not be cruel or mean when giving FCFB. Another participant acknowledged that FCFB can be anxiety-provoking for both supervisor and supervisee, yet for FCFB to be truly effective, supervisors needed to be direct and clear rather than sarcastic or "talking around the issue." Finally, participants variantly wanted supervisors to know that supervisees are learning from FCFB. In one case, the participant believed it was important for supervisors to be reminded that "even on internship, supervisees are still in training." Another participant wanted supervisors to know that successfully incorporating the FCFB might take multiple attempts, and to be patient with supervisees in this process.

How participation in the study affected participant as supervisee or supervisor. Typically, participating in the study helped participants define how they wanted to be as a supervisor. Some participants were supervising at the time of participation, and they were prompted to reflect on their own delivery of FCFB to supervisees. "I check in a lot more often with him [participant's supervisee] about how my corrective feedback is received and what he heard me say," noted one participant. Other participants were not yet supervisors, although participating in the study prompted them to consider themselves in the role of supervisor. For one such participant, the study "made me more cognizant of how I will approach supervisees and deliver corrective feedback; I'll definitely be more aware." In addition to reflecting on their role as current or one-day supervisor, participants typically reflected on their role as supervisee having participated in the study. "I'm much more aware of supervision dynamics, including what I like and dislike as a supervisee," stated one participant. Another participant found that talking about FCFB allowed her to "reflect on all of my previous good and bad supervision experiences as a supervisee and see how it contributed to the developing psychologist I am today." Finally, participation in the study variantly sparked communication between participants and their supervisors about the supervision process and FCFB. For example, one participant noted being more open and able to express what she wanted and needed from supervision after participating in the study.

Table 3. Domains, Categories, and Frequencies of Closing Findings Regarding Formative Corrective Feedback

<u>Domain</u>	<u>Categories</u>	<u>Frequency</u>*
1. Effects of interview	Participant helped by reflecting/talking about FCFB event	Typical
	Difficult for participant to articulate experience of FCFB	Variant
	Stimulated negative emotions or memories	Variant
2. What participant wants SRs to know about FCFB	Sup relationship mitigates how SEs receive FCFB	General
	Positive relationship helps SEs receive FCFB	Typical
	Difficulties in relationship make it difficult for SEs to receive FCFB	Variant
	SEs value and appreciate FCFB	Typical
	FCFB should be balanced with positive FB	Typical
	Provide time to explain and discuss FCFB	Typical
	Be sensitive to SE's circumstances or individual differences	Typical
	Be clear and direct when providing FCFB	Variant
	SEs are learning through FCFB	Variant
3. How participation in study affected participant as SE or SR	Helped define how participant will be as SR	Typical
	Helped define participant's role as SE	Typical
	Sparked communication with SR about sup/FCFB	Variant

* Twelve total cases. General = 11-12, Typical = 6-10, Variant = 2-5

Note. FCFB = Formative Corrective Feedback; CFB = Corrective Feedback; FB = Feedback; SE = Supervisee; SR = Supervisor; sup = Supervision

Typical Pathways

Two distinct pathways emerged for participants describing FCFB events, and

subsamples of the data were utilized to highlight these differences. According to Ladany,

Thompson, and Hill (2012), it is appropriate to compare subsamples of data when

participants "differ in some manner that is meaningful and noticeable" (p. 125). Figures 1

and 2, which follow this section, reflect the pathways that emerged for FCFB events;

Figure 1 represents the pathway for FCFB events that resulted in positive effects for

supervisees, while Figure 2 details the pathway for FCFB events that resulted in negative

effects for supervisees. Although the recommendations of Hill et al. (1997) is to only

chart those categories that are typical or general, the pathway for positive FCFB events –

which were variant – is presented in addition to negative FCFB events – which were

typical – in order to clearly distinguish the distinct pathways participants described.

For FCFB events with positive effects (Figure 1), the supervisee viewed the

supervision relationship prior to the event as positive. Prior to receiving the FCFB,

participants stated that they were struggling clinically, and they received FCFB that they

had not handled an aspect of clinical work well. Participants noted that this FCFB was

well-received, and they attributed this to two things. First, participants felt that their

supervisors delivered the FCFB well, and this in turn helped them receive the FCFB.

Second, participants felt that the relationship with their supervisors was strong, which

helped them receive the FCFB. There were three effects of the FCFB for participants.

First, participants stated that the FCFB influenced their overall work positively. Second,

and somewhat related, participants felt that their clinical work improved as a result of the

FCFB. In a third effect, participants believed that the supervision relationship with their supervisor improved as a result of the FCFB event.

For FCFB events with negative effects (Figure 2), participants noted experiencing difficulties in the supervision relationship prior to the event. Similar to positive FCFB events, participants were struggling with an aspect of their clinical work, and supervisors provided FCFB that supervisees had not handled a clinical issue well. Participants noted experiencing a negative reaction to the FCFB, and attributed this to difficulties they experienced in the supervision relationship. Three effects emerged as a result of the FCFB event. First, participants described having a negative reaction to the FCFB, and they withdrew in supervision. Second, participants made changes to their clinical work based on the FCFB. In a third effect of the FCFB event, participants believed that the supervision relationship was damaged as a result of the FCFB.

All but one case fit into the positive and negative FCFB pathways. This participant was not included in either pathway because she described having a mixed supervision relationship prior to the FCFB event, and the effects of the FCFB were mixed as well; while she noted an improvement in her clinical work as a result of the FCFB, she also described that the supervision relationship continued to be "rocky, yet stable" following the FCFB event.

Domain

**Sup relationship
prior to event**

Overall positive
relationship
(4 cases)

**What precipitated
FCFB**

P was struggling
clinically
(4 cases)

Content of FCFB

P had not
handled clinical
issue(s) well
(4 cases)

**P's Reaction to
FCFB**

P received
FCFB well
(4 cases)

**What contributed
to P's Reaction**

SR delivered
FCFB well
(4 cases)

P & SR had good
relationship
(3 cases)

Effects of FCFB

Influenced P's
work positively
(4 cases)

P's clinical
work improved
(4 cases)

Improved sup
relationship
(4 cases)
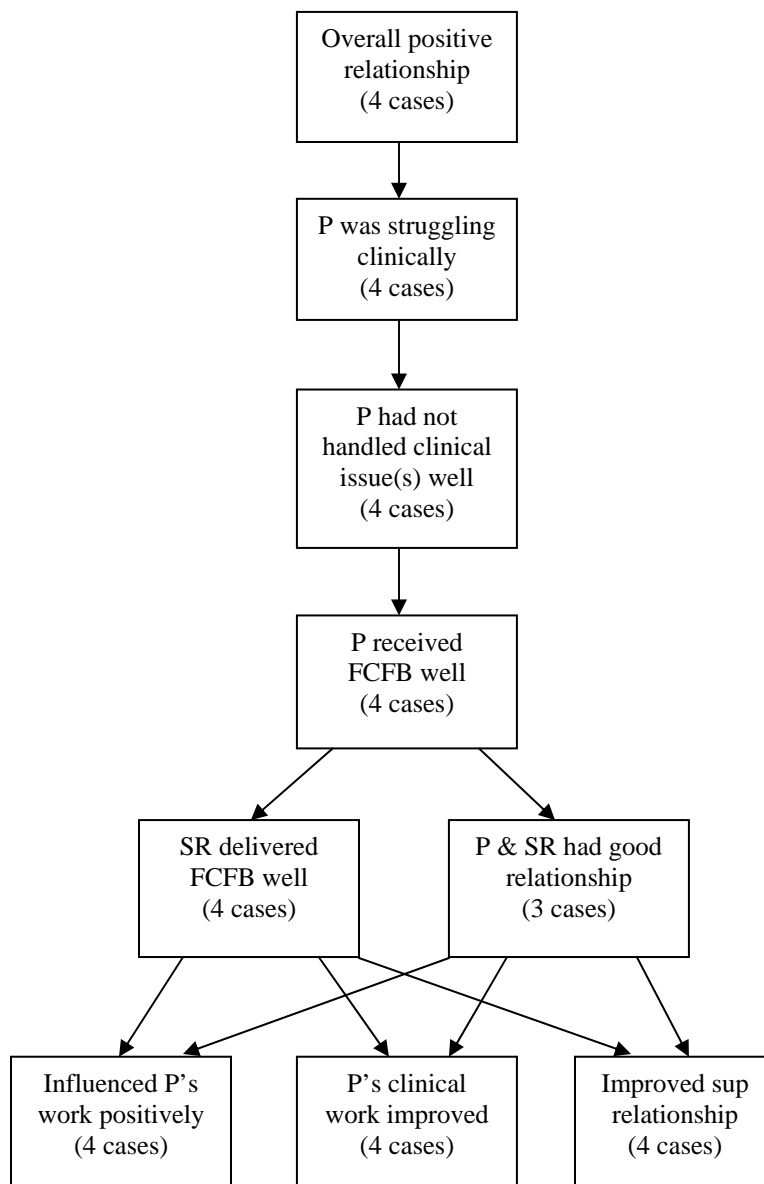
Figure 1. The pathway for FCFB events in clinical supervision that resulted in positive effects for the supervisee, her clinical work, and/or the supervision relationship. The number for each domain may add to more than 4 because some cases fit into multiple categories. P = participant; SR = supervisor; sup = supervision; FCFB = formative corrective feedback.

<u>Domain</u>

Sup relationship prior to event

What precipitated FCFB

Content of FCFB

P's Reaction to FCFB

What contributed to P's Reaction

Effects of FCFB

```
                              ┌────────────────────┐
                              │   Difficulties in  │
                              │  sup relationship  │
                              │     (7 cases)      │
                              └────────────────────┘
                                        │
                              ┌────────────────────┐
                              │  P was struggling  │
                              │     clinically     │
                              │     (7 cases)      │
                              └────────────────────┘
                                        │
                              ┌────────────────────┐
                              │    P had not       │
                              │ handled clinical   │
                              │   issue(s) well    │
                              │     (7 cases)      │
                              └────────────────────┘
                                        │
                              ┌────────────────────┐
                              │  P had negative    │
                              │     reaction       │
                              │     (7 cases)      │
                              └────────────────────┘
```

┌──────────────┐   ┌──────────────┐   ┌──────────────┐
│ P disagreed │   │ P & SR had │   │ P confused by│
│   w/FCFB   │   │ difficulties │   │   FCFB   │
│ (5 cases)   │   │ (7 cases)   │   │ (5 cases)   │
└──────────────┘   └──────────────┘   └──────────────┘

┌──────────────┐   ┌──────────────┐   ┌──────────────┐
│ P had negative│   │ P changed   │   │ Damaged sup │
│   reaction   │   │ clinical work│   │ relationship │
│ (7 cases)   │   │ (6 cases)   │   │ (7 cases)   │
└──────────────┘   └──────────────┘   └──────────────┘

┌──────────────┐
│ P withdrew in│
│   sup   │
│ (6 cases)   │
└──────────────┘
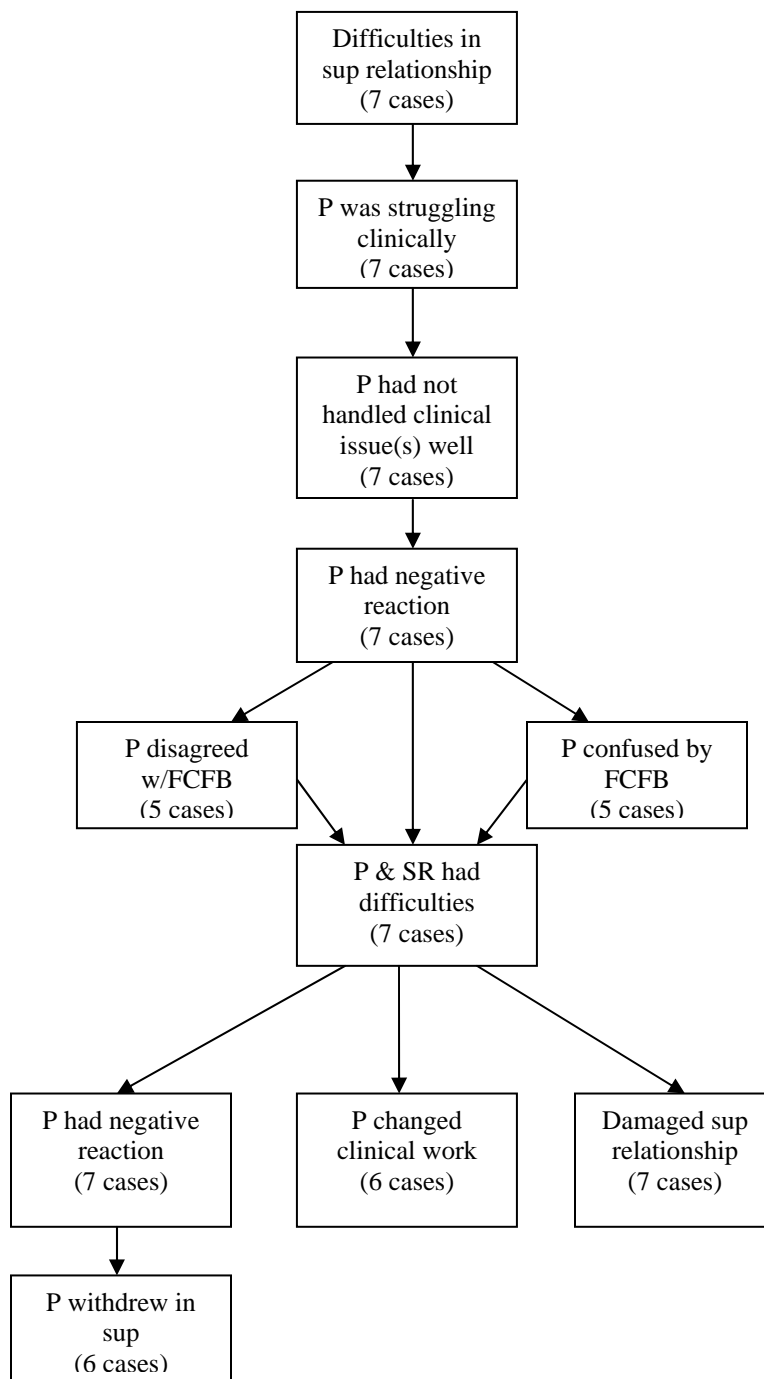
Figure 2. The pathway for FCFB events in clinical supervision that resulted in negative effects for the supervisee, her clinical work, and/or the supervision relationship. The number for each domain may add to more than 7 because some cases fit into multiple categories. P = participant; SR = supervisor; sup = supervision; FCFB = formative corrective feedback.

Illustrative Examples of FCFB Events

In this section, two participants' experiences of a formative corrective feedback event are detailed; both examples represent single cases. The first example illustrates a formative corrective feedback event in which the participant noted positive effects on herself, her clinical work, and the supervision relationship. The second example describes a formative corrective feedback event in which the participant noted negative effects for herself, her clinical work, and the supervision relationship. These examples were chosen because they illustrate a variety of the general and typical findings presented in the previous sections of this chapter. To maintain participant confidentiality, slight changes have been made to demographic information, as well as the experience itself, and participants and supervisors have been assigned pseudonyms.

Formative corrective feedback event with positive effects. Joan was a 29-year-old Caucasian woman completing her predoctoral psychology internship in a forensic setting. Prior to the supervision relationship in which the formative corrective feedback occurred, she had been in six supervision relationships, and she had approximately 40 months of clinical experience. Her supervisor, Jim, was a Caucasian male clinical psychologist in his 50s. Joan and Jim had been meeting twice a week for approximately 16 weeks prior to the FCFB event. Joan described supervision with Jim as very comfortable and informal, and that they "got along really well" and had strong rapport.

Several weeks into the supervision relationship, Joan began working with a client who presented to counseling with narcissistic personality disorder features. Joan struggled with this client and felt "really, really lost" in sessions with the client. Additionally, Joan found herself feeling angry, frustrated, and exhausted during sessions

with her client. She described feeling "up against a brick wall" and was unsure if the client could receive benefit from therapy. Although Joan and Jim had discussed this client in several supervision sessions, Joan decided to bring in an audiorecorded session with her client so that she and Jim could discuss the case in greater detail.

After listening to a portion of the recording, Jim suggested that Joan try to use more of an observing approach in session when she felt herself becoming angry and frustrated, rather than becoming emotionally involved with her client. Jim stated that clients demonstrating features of personality disorder often pull emotions from the people around them, including their therapists, and that by changing her pattern of reactions to her client (i.e., not becoming frustrated and angry with her client), she might be able to mirror for the client – in much the same way that parents mirror for children – how to interact more effectively with others. Joan noted feeling relieved immediately after hearing this FCFB from Jim. While Joan also felt somewhat embarrassed because she had not thought to change her approach in the manner Jim suggested, Joan left supervision feeling "ok" after Jim shared that even experienced therapists get pulled into unhelpful emotional dynamics with clients.

In the days and weeks following the FCFB event, Joan continued to reflect on Jim's feedback. As she and Jim discussed the FCFB in more depth in their next few supervision sessions, she began to feel an increased sense of self-efficacy and belief that she could "come up with this stuff [FCFB] for myself once I'm practicing independently." In her clinical work, Joan incorporated Jim's FCFB in the very next session and found that it allowed her client to "get to a real emotion and have an a-ha moment" without Joan being "sucked into his dynamic," something she and her client

had been unable to do in previous sessions. Joan brought an audiorecording of this breakthrough to supervision with Jim, and they both noted her ability to incorporate the FCFB, and to great success.

In addition to stimulating personal reflection and prompting a breakthrough in Joan's work with her client, the FCFB event impacted the supervision relationship. Joan felt even more comfortable with Jim than she had prior to the event, and the FCFB event "took our supervision to another level; I think he [Jim] felt more comfortable giving me corrective feedback and processing it with me." Joan found that she started to get more FCFB from Jim, something she noted as having an immediate and positive impact on their supervision relationship and her work with clients.

Formative corrective feedback event with negative effects. Angela was a 33-year-old Biracial woman completing her predoctoral psychology internship in a college counseling center. Prior to the supervision relationship in which the formative corrective feedback occurred, she had been in seven supervision relationships, and she had approximately 48 months of clinical experience. Her supervisor, Jeff, was a Caucasian male counseling psychologist in his 40s. Angela and Jeff had been meeting once a week for approximately eight weeks prior to the FCFB event. Angela described supervision with Jeff as "workable;" although she felt that her work was supervised "well enough," she did not feel there was a strong relational bond.

In their eighth supervision session, Angela brought in a videorecorded therapy session for her and Jeff to review together. She did not have a specific question about her work with the client; instead, she randomly selected a portion of recording because "that's what we did every week in supervision, we always watched video together." After

reviewing the recording together, Jeff asked Angela to consider her role as a therapist. He shared his observation that Angela was not often in control of the session with her client and that she should own more fully her role as an expert in the therapy process. Jeff proceeded to share specific things that Angela could have said and points in the videorecording in which she could interject. Angela began processing this FCFB internally as Jeff continued to talk; while she could understand his perspective and see how she had not been as in control of the session as Jeff would have liked, Angela also felt that his FCFB was "philosophically against the grain" of her beliefs about therapy. When asked what contributed to these initial reactions, she noted her tendency to reflect internally without verbally responding, and that the "not very strong" relationship with Jeff left her more likely to disagree with his FCFB. Prior to her relationship with Jeff, Angela experienced supervision as consultative, yet she felt that Jeff occupied a more expert role in supervision with her, an approach that she did not find helpful.

While Angela described herself as "somewhat guarded" in supervision because of a lack of relational bond with Jeff, she became increasingly guarded in supervision following the FCFB event. Angela liked the specificity of Jeff's FCFB, and it did raise her awareness of her presence in sessions with clients, although she did not incorporate his FCFB to occupy a more expert role in therapy. In fact, during therapeutic moments when Angela would wonder how Jeff might respond to her client, she thought, "No, I'm not going there. This is the way I want to go." Ultimately, Angela believed that the FCFB event served as a "polarizing function" in her relationship with Jeff. She felt that his FCFB did not "factor in who I am as a therapist," and that the event exacerbated her

belief that they held fundamentally opposing assumptions about therapy and the role of

therapist.

Chapter 5: Discussion

This study sought to examine supervisees' (i.e., predoctoral psychology interns) experiences of formative corrective feedback (FCFB) in clinical supervision. Given the integral role of feedback in clinical supervision and, thus, training for mental health practitioners (Bernard & Goodyear, 2009), the purpose of this study was to better understand perceptions of corrective feedback in general (e.g., the purpose of FCFB, the focus of FCFB, what makes FCFB go well, what makes FCFB difficult to hear), as well as learn about how a specific FCFB event impacted supervisees, supervisees' clinical work, and/or the supervision relationship.

The overall findings of the study suggest that, despite the assertion in the theoretical literature that FCFB is a way for supervisors to communicate evaluation of a supervisee's work (Bernard & Goodyear, 2009), participants viewed FCFB as an opportunity for supervisors to provide direct instruction or guidance, rather than communicate an evaluation of supervisee performance level. While it is possible that participants viewed evaluation as implicit in feedback, that participants did not identify evaluation as a purpose of FCFB is notable. Most participants not only expected to receive FCFB, they also held positive expectations/beliefs about FCFB. Intriguingly, despite positive expectations/beliefs about FCFB, participants discussed FCFB events that went poorly and resulted in negative consequences for themselves, their clinical work, and/or the supervision relationship. Most participants noted experiencing difficulties in their supervision experiences prior to the event, leaving one to wonder if the FCFB event was a consequence or cause of participants' views on their supervision relationship. Regardless of causality, this finding demonstrates that while supervisees

may be hopeful that FCFB will be a positive experience for them, such supervision events can have negative consequences that impact not only the supervisees themselves, but their clinical work and/or the supervision relationship as well. Moreover, participants – including those who detailed a negative FCFB event – made changes to their clinical work after receiving FCFB. It seems, then, that even in those instances in which FCFB has prompted a supervisee to make a change in their work – one of the fundamental goals of FCFB – this can come with negative consequences for the supervisee, their clinical work, and/or the supervision relationship. These and other findings are discussed below. The theoretical implications are reviewed, limitations of this study are noted, and future research is suggested.

Contextual Findings Regarding FCFB

The overall contextual findings of the study suggest that participants viewed FCFB as an opportunity to learn and grow through FCFB in the form of direct instruction and FCFB aimed at promoting self-reflection. Participants held mostly positive expectations and/or beliefs about the manner in which FCFB would be delivered, although they acknowledged that FCFB can be a negative experience for supervisees. Participants also identified a number of supervisor factors and the supervision relationship as contributing to FCFB that either was well-received or difficult to receive. Findings for the contextual domains are discussed in the following sections.

Purpose of FCFB. Participants identified a number of purposes of FCFB, predominately as an opportunity to receive direct instruction, promote self-reflection, stimulate growth, and prevent/correct supervisee mistakes. These purposes align with the theoretical literature on FCFB in clinical supervision, for FCFB is typically viewed as an

opportunity to transmit knowledge, develop competent counselors, and protect client welfare (Bernard & Goodyear, 2009; Hoffman et al., 2005). It seems that as supervisees, participants held a desire to learn and grow as clinicians, and they viewed FCFB as providing these opportunities either through direct instruction or less direct FCFB that prompted them to reflect on their clinical work.

In stark contrast with FCFB aimed at spurring supervisee growth, participants noted that FCFB could also provide supervisors the opportunity to promote supervisees learning and adopting their supervisor's style; notably, participants did not view FCFB to encourage adopting supervisors' style favorably. As discussed in the literature review, previous research has detailed the importance of involving supervisees in goal setting and providing FCFB related to agreed-upon goals for supervision (Chur-Hansen & McLean, 2006; Lehrman-Waterman & Ladany, 2001). It may be that participants did not respond favorably to FCFB viewed as nudging them to copy or mimic their supervisors, because copying their supervisors' style did not engage them in the FCFB process and/or failed to align with their goals for supervision and their clinical work.

Finally, participants less readily identified communication of SR's evaluation of SE as a purpose of FCFB. While the theoretical literature defines feedback as a core component of evaluation and, thus, a way for supervisors to communicate supervisee performance level (Bernard & Goodyear, 2009), it is possible that participants viewed FCFB as a discrete intervention that did not communicate an evaluation of their overall performance level. Perhaps supervisee anxiety about receiving FCFB makes it difficult for supervisees, in the moment, to integrate FCFB into an overall picture of their performance level. Regardless of the reasons for such perceptions, however, the fact that

supervisees may perceive FCFB as a discrete intervention has implications for explicitly

tying formative corrective feedback to summative evaluations of supervisees, for most

participants in this study did not appear to directly link FCFB as a way of gauging their

overall performance level.

Expectations/beliefs about FCFB. Although the literature suggests that both

supervisors and supervisees can be anxious about FCFB (Sapyta et al., 2005; Stoltenberg

et al., 1998), participants held largely positive expectations of and beliefs about FCFB. In

the context of this study, this finding may not be surprising, given that participants

predominately noted the opportunity to spur clinical growth as a purpose of FCFB. In

light of this finding, perhaps FCFB need not be such an anxiety-provoking intervention

for supervisors to deliver. A closer examination of additional supervisee expectations

may provide further guidance for supervisors in meeting the expectation of supervisees

that FCFB will largely be a positive experience.

Participant expectations of FCFB extended beyond the impact that such FCFB

would have on their clinical skill development, perhaps providing insight into the

conditions that facilitate the effective delivery of FCFB in clinical supervision. More

specifically, participants expected that FCFB would be given collaboratively and in the

context of a supportive supervision relationship. While the impact of the supervision

relationship in providing feedback has been examined from the supervisors' perspective

(e.g., Hoffman et al., 2005), it seems that supervisees expect to be involved in the process

of FCFB as collaborators with their supervisors; rather than being handed unidirectional

FCFB, supervisees want to dialogue with their supervisors about FCFB in the context of

being supported by their supervisors. Being able to dialogue about FCFB may help

supervisees see how formative feedback ties together with more summative evaluations, and it may also help supervisees see how FCFB ties in with goals and expectations of supervision. That supervisees expect to be involved in the process of FCFB appears to parallel those of Lehrman-Waterman & Ladany (2001), who found that feedback and the supervision relationship were mutually reinforcing, with feedback and openness about goals and expectations facilitating a stronger supervision relationship, which in turn made it easier for supervisors to provide FCFB.

In addition to expectations about the supervision relationship, participants expressed expectations about the content of FCFB and the manner in which it is delivered. More specifically, participants expected that FCFB would be direct, honest, and clear, a finding that parallels the theoretical literature on feedback (Bernard & Goodyear, 2009; Farnill et al., 1997) and a previous study that examined poor clinical supervision experiences (Magnuson et al., 2000). Thus, while supervisors might be hesitant to provide FCFB out of concerns for how it may be received, it seems that supervisees expect that FCFB will be delivered directly, clearly, and honestly – rather than FCFB that is talked around or nestled among qualifiers. Furthermore, participants expressed an expectation that supervisors would provide affirmation of supervisee skills along with FCFB. This finding perhaps speaks to the complex balancing act for supervisors in providing feedback to supervisees. While supervisees expect and desire direct and honest communication about areas in which they should consider making a change, supervisees also expect that supervisors will affirm them and speak to those areas in which the supervisee is demonstrating competence.

Factors that contribute to FCFB that goes well and does not go well. A closer examination of participant thoughts about times in which FCFB was either well-received or poorly received reveals that aspects of three areas contribute to how FCFB is received: the supervisor, the supervision relationship, and, to a lesser extent, the supervisee.

The supervisor. Participants made clear the role of the supervisor in discussing what contributed to instances in which FCFB was well-received, as well as those times when FCFB was difficult for supervisees to receive. More specifically, participants who perceived their supervisors' demeanor positively found FCFB easy to receive, and those times in which they perceived their supervisor as harsh or uncomfortable made it difficult for them to receive FCFB. It seems, then, that when receiving FCFB, supervisees are sensitive to their supervisors' demeanor, and this may impact how supervisees receive FCFB. Moreover, supervisors who provided a clear explanation of the FCFB, worked through the FCFB together with the supervisee, or normalized/validate the supervisee's clinical work helped supervisees to hear FCFB; if supervisors did not explain FCFB or provided exclusively corrective feedback, FCFB was difficult for supervisees to hear. Thus, how a supervisee will hear FCFB is impacted by circumstances that extend beyond the content of the FCFB and even the FCFB intervention itself. Supervisees are attuned to their supervisor's demeanor while supervisors deliver FCFB, yet they are sensitive to the manner in which a supervisor conducts her/himself before and after the FCFB is delivered: has the supervisor affirmed the supervisee?; has the supervisor provided predominately corrective feedback in the past?; does the supervisor explain the FCFB that was provided?; is the supervisor uncomfortable and abrupt in providing the FCFB? As discussed by Allen et al. (1986), supervisors have the difficult task of straddling the

domains of evaluator and mentor, and participants spoke to this very dichotomy in wanting clear, direct FCFB from a supervisor who is comfortable in delivering FCFB and dialoguing about it with their supervisee.

The supervisee. Participants much less readily identified themselves as playing a role in FCFB that either went well or was difficult to receive. In contrast with a variety of supervisor factors that were identified as contributing to how FCFB was received, participants noted that their openness to FCFB helped make FCFB events go well, while a supervisee's poor reaction to FCFB would make it difficult to receive FCFB. Perhaps because of the inherent power differential in the supervision relationship (Porter & Vasquez, 1997), participants more readily identified supervisor factors (e.g., supervisor's tone, comfort level in providing FCFB) than supervisee factors (e.g., supervisee openness to receiving FCFB) in evaluating how FCFB events were handled. It seems, then, that supervisees may be sensitive to a greater number of supervisor factors, while possessing a limited perspective on supervisee factors, in formulating their perceptions of FCFB events. Interestingly, this finding is perhaps parallel to the Hoffman et al. (2005) study that examined supervisor perceptions of giving easy, difficult, or no feedback to supervisees. In that study, supervisors identified a number of factors, including the content of the feedback, the supervision relationship, and supervisee openness to feedback – although they did not identify supervisor factors as contributing to feedback that was easy, difficult, or not provided. Thus, it seems that in the dyadic interaction between supervisor and supervisee, both participants look to the other in formulating perceptions of feedback events. Moreover, it is possible that both supervisors and

supervisees may possess a limited perspective on the role they play in contributing to feedback events that either go well or do not go well.

    The supervision relationship. In reflecting on FCFB that either went well or poorly, it appeared that the supervision relationship that had developed between supervisee and supervisor was a contributor in how supervisees received FCFB. Over the course of several supervision relationships, supervisees noted having strong supervision relationships with their supervisors, and the strength of the supervision relationship made it easier for them to hear FCFB. Other supervision relationships, however, were more tenuous, and difficulties in these relationships were viewed as contributing to FCFB that was difficult for supervisees to receive.

    This finding, that the nature of the supervision relationship contributes to FCFB events that either went well or poorly, can be partially understood in the context of findings by Lehrman-Waterman and Ladany (2001), who found that supervisee satisfaction with supervision was higher when supervisor feedback was directly related to mutually established goals. Participants in this study noted that FCFB aimed at promoting supervisee growth was easier to hear, and it may be that supervisees are more open to FCFB when they are able to see how FCFB relates to the mutual tasks and goals of the supervision relationship. This may result in greater openness in the supervision relationship, creating a mutually reinforcing pattern in which FCFB is well received and the supervision relationship is perceived as strong. The significant role of the supervision relationship in contributing to how FCFB is received by supervisees becomes even more evident upon closer examination of the FCFB event findings of this study.

FCFB Event Findings

In discussing a specific FCFB event, patterns emerged with respect to the type of FCFB events supervisees described. As such, the discussion of the FCFB event findings are presented below in two sections: FCFB events that were viewed favorably and resulted in positive effects for the participant, their clinical work, and/or the supervision relationship; and FCFB events that were viewed unfavorably and resulted in negative effects on the participant, their clinical work, and/or the supervision relationship.

Positive FCFB events. The pathway that emerged in positive FCFB experiences provides support for the idea that the quality of the supervision relationship impacts how FCFB is received. Participants who described positive FCFB events detailed supervision relationships that were positive, suggesting that a strong supervision relationship facilitates conditions that help supervisees perceive specific instances of FCFB positively. It may be, then, that positive supervision relationships create safety, trust, and an emotional bond between supervisor and supervisee that helps supervisees hear and receive feedback, even that which is corrective, positively. This finding parallels previous research that suggested the supervision relationship was a moderator variable in how supervisees received and responded to FCFB (McKnight et al., 2001), and another study in which supervisees were more open to FCFB in the context of a strong supervision relationship (Leung et al., 2001).

In the context of what participants already viewed was a positive supervision relationship, participants were struggling in their clinical work, and they received FCFB from supervisors that they had not responded to a clinical issue well. Participants attributed this positive response to the FCFB to the manner in which the supervisor

delivered the FCFB, as well as the strength of the supervision relationship. This finding, that the supervision relationship is integral in how FCFB is received, aligns with the theoretical literature on supervision. For example, Holloway's (1995) SAS model posits that the supervision relationship is a core component of supervision, and that corrective feedback can serve to increase the strength of the supervision relationship if done constructively and appropriately (Holloway, 1997). In this study, supervisees who described the quality of their supervision relationship as warm, supportive, and affirming were overwhelmingly more likely to detail FCFB events that went well. One participant in particular illustrates this point:

> I felt my supervisor was there to help me. Even though I felt somewhat embarrassed because I think part of being an intern and a supervisee, I feel like I should know these things by internship. But my supervisor helped me talk through it, along with me, and that helped me in my development and self-efficacy and that I can come up with this stuff, and that I may be ok to practice on my own one day. I think I might feel even more comfortable with the SR. I felt comfortable before, but I feel that I could go to him again with a question like this and he would help me. I guess it helped make the rapport even stronger. He was really helpful and good with this situation. I think my SR seeing that I took his advice and use it correctly helped him be more comfortable giving me more FCFB and processing FCFB more. So I feel like being able to use it and hear me use it in the audio helped my supervisor and I build rapport and strengthen the relationship.

It is interesting to note that the supervisee, in reflecting on the impact the FCFB had on the supervision relationship, believed that her supervisor hearing her implement the FCFB served to strengthen what was already a strong supervision relationship. This has implications for supervisees, for it seems that a component of the supervisee's reaction, namely whether or not to implement the FCFB, may impact how supervisors perceive the success of the FCFB, perhaps influencing their approach to the supervision relationship and future FCFB interventions. While it is not possible to determine the directionality of causation in the relationship between strong supervision relationships and positive FCFB events in this study, it seems that how supervisees receive FCFB and the perceived impact of FCFB is strongly related to supervisees' perceptions of the supervision relationship. The finding that a mutually reinforcing relationship exists between FCFB events and the quality of the supervision relationship parallels those of McKnight et al. (2001), who found that corrective feedback in the context of a strong supervision relationship enhanced, rather than threatened, employee self-esteem. This has a number of implications for supervisors, which will be discussed in a later section.

As noted earlier, supervisees attributed positive perceptions of FCFB to the supervision relationship, as well as the manner in which supervisors delivered the FCFB. Supervisors who validated and affirmed supervisees, took time to explain the rationale for providing the FCFB, and involved their supervisees in a dialogue about the FCFB (e.g., identifying strategies to implement the FCFB in clinical work) created conditions in which supervisees were able to hear the FCFB, dialogue about it, and incorporate it – successfully – into their clinical work. The importance of a collaborative approach to supervision and specific interventions within supervision is highlighted in feminist-based

models of supervision (Porter & Vasquez, 1997), and participants who detailed positive

FCFB events described feeling actively involved in FCFB events. It seems, then, that

specific supervisor behaviors, such as affirming supervisees and engaging supervisees in

FCFB, are viewed by supervisees as directly related to positive FCFB events. Moreover,

while there are likely myriad conditions that facilitate the development of a strong

supervision relationship, if a bidirectional relationship exists between FCFB and the

supervision relationship, supervisors who are able to create favorable conditions for

supervisees to hear FCFB may be fostering conditions that contribute to the development

of a strong supervision relationship.

In addition to further strengthening what participants already viewed as a positive

supervision relationship, participants perceived that positive FCFB events resulted in

improvements in their clinical work. Thus, it seems that a strong supervision relationship

not only impacts how supervisees receive FCFB in the moment, it allows supervisees to

make a change in their clinical work, one of the primary goals of FCFB (Bernard &

Goodyear, 2009). Furthermore, participants not only made a change to their clinical work

as a result of positive FCFB events, they viewed their clinical work and work in general

(e.g., interactions with coworkers, case presentation skills) as having improved because

of the FCFB. This finding parallels a study from the organizational literature, in which

workers reported improved work and, subsequently, self-esteem and morale, following

FCFB that was received in the context of a strong supervision relationship (McKnight et

al., 2001).

In contrast with FCFB events that went well, participants in the current study

detailed FCFB events that did not go well and negatively impacted themselves, their

clinical work, and/or the supervision relationship. The pattern that emerged in the negative FCFB events is described in the next section.

Negative FCFB events. Consistent with positive FCFB experiences, the pattern that emerged in negative FCFB experiences underscores the important role of the supervision relationship in how supervisees receive FCFB. Participants who described FCFB events with negative effects noted experiencing difficulties in the supervision relationship prior to receiving FCFB. Thus, it seems that quality (or lack thereof) of the supervision relationship impacts how supervisees receive and respond to FCFB; a strong supervision relationship of trust and safety helps supervisees perceive instances of FCFB positively, while supervision relationships in which there are difficulties may make it more likely that supervisees will perceive FCFB negatively.

In the context of difficulties in the supervision relationship, participants were struggling with an aspect of their clinical work, and they received FCFB from their supervisors that they had not handled clinical issues well. This portion of the negative FCFB event pathway is identical to the positive FCFB event pathway; however, the pathways diverge after this point. For participants who described FCFB events with negative consequences, the interpersonal difficulties in the supervision relationship resulted in participants having a negative reaction to the FCFB. Furthermore, it seems that supervisor demeanor (e.g., being harsh, inconsistent with FCFB, providing little rationale for feedback) was linked directly to supervisee experiences of the supervision relationship, with heavily corrective feedback and intense Socratic questioning tied to difficult moments in supervision that left supervisees feeling unsettled and confused. Thus, it seems that supervisees are attuned to supervisor demeanor and tone when

receiving FCFB, and supervisees may be more sensitive to supervisor demeanor and tone in supervision relationships in which interpersonal difficulties exist.

The impact on supervisees who detailed negative FCFB events is clear: they felt angry or confused by the FCFB, they disagreed with the FCFB, and they became more withdrawn and guarded in supervision. It is perhaps not surprising, then, that supervisees linked the FCFB event to further damaging their supervision relationship, for it is difficult to imagine angry, confused, or withdrawn supervisees strengthening a supervision relationship. Thus, a reciprocal relationship between the supervision relationship and FCFB appears to exist, with strong relationships reinforced by positive FCFB events, and strained relationships exacerbated by poorly received FCFB events. This finding seems to parallel the findings of Hoffman et al. (2005), that supervisors were more reluctant to give feedback in the context of supervision relationships in which they perceived difficulties existed. As noted earlier, supervisees appear to be sensitive to supervisor demeanor during FCFB events in the context of a supervision relationship in which difficulties exist. Perhaps supervisees sense the difficulties that supervisors experience in providing FCFB, mutually reinforcing and potentially exacerbating the interpersonal difficulties that previously existed in the supervision relationship. As a testament to the depth that damaging FCFB events can have, participants noted that such supervision relationships were terminated earlier than originally planned, and participants linked termination of the supervision relationship directly to the negative FCFB event.

Despite negative effects for supervisees and their supervision relationship, participants made changes to their clinical work in the negative FCFB events. This is an interesting finding, for it seems that despite being angry, confused, and/or withdrawn in

supervision, one of the goals of the FCFB – for a supervisee to make or consider making a change – was achieved. How supervisees perceived their clinical work following the FCFB, however, was not consistent: while some participants believed their clinical improved following the FCFB event, others believed their work suffered as a result of the FCFB. This is notable, for supervisors may believe that FCFB events have been effective if a supervisee implements the FCFB; from a supervisee's perspective, however, it appears that agreeing with FCFB or viewing a FCFB as having gone well is not necessary to make a change in clinical work. Thus, while supervisees may implement a change based on FCFB, a poorly received FCFB event can come with great cost to the supervisee and their perceptions of the supervision relationship, even in those instances when supervisees believe the FCFB resulted in improved clinical work.

Closing Findings

The overall closing findings suggest that participants were helped by reflecting on/talking about their overall experiences of FCFB and a specific FCFB event. In fact, it seems that talking about experiences of FCFB prompted participants to better define their role as supervisee in the supervision relationship, while also better defining either their current or future role as supervisor. Perhaps both supervisors and supervisees would benefit from this finding, for the results of the present study suggest that reflecting on experiences of FCFB resulted in greater clarity regarding expectations and beliefs about FCFB and the role that supervisors, supervisees, and the supervision relationship play in FCFB events.

Perhaps not surprisingly given that participants detailed FCFB events that went poorly and resulted in negative consequences, participating in the study stimulated

negative emotions or memories. It seems that even though several months and, in some instances, more than a year had passed since the FCFB event, participants continued to experience difficult emotions and memories related to FCFB events, perhaps speaking to the depth to which such supervision interventions can affect supervisees.

Other closing findings mirrored themes that emerged in opening and event findings. For instance, participants spoke about the role of the supervision relationship in mitigating how supervisees receive FCFB. Thus, it seems that supervisee perceptions of the quality of the supervision relationship informs how they will receive FCFB; supervisees in strong supervision relationships find it easier to receive FCFB than supervisees in strained supervision relationships. Results suggest that supervisees desire FCFB, yet supervisees also expect that supervisors will provide positive feedback, be clear and direct in FCFB, explain and discuss FCFB, and be sensitive to supervisee circumstances (e.g., managing multiple demands such as searching for a post-doc, completing dissertation, etc.). Clearly, while supervisees welcome and appreciate FCFB, the bar is set high for supervisors who want to deliver FCFB that is well-received and consistent with supervisee expectations and beliefs about FCFB.

Limitations

This study is limited in that it is based purely on self-report, and therefore only includes the retrospective account of the supervisee in the supervision relationship. Additionally, participants were able to select the FCFB event they shared during the interview. As a result, it is difficult to ascertain how representative the FCFB events, and, for that matter, quality of supervision relationships in which such events occurred, are. All but one participant detailed FCFB events that either had positive or negative effects,

with only one participant describing a FCFB event with mixed results; FCFB events in clinical supervision may be more complex than having positive or negative consequences. Thus, we are left with little information about FCFB events that supervisees may describe as neither positive nor negative, as well as how typical such nondescript FCFB events may be.

Results of this study are also limited because participants were interviewed about a past experience, exposing responses to retrospective recall errors. Additionally, results are limited to the supervisee's perspective; it is possible that supervisor's would have a different recollection of the event shared by his/her supervisee. It is also possible that supervisors and clients may hold different perceptions of the effect the FCFB had on the supervisee's clinical work.

Yet another limitation of the current study relates to the complexity of supervision. The supervision relationship is a highly intricate one, marked by exchanges that are continuously influenced by the personalities and experiences of the supervisor and supervisee. Thus, it is difficult to fully determine the effects of one specific intervention in the context of such a richly dynamic and complex relationship. Furthermore, supervisor's level of training was not included in demographic questions about the supervisors involved in the FCFB event; thus, we are left to wonder how level of supervisor training may impact FCFB events.

The results of this study may also be applicable only to supervisee samples similar to those who participated (e.g., predoctoral psychology interns), and thus should be applied more broadly with caution. Additionally, no male supervisees participated in the study, which further limits generalizability. The first author also conducted and

transcribed all of the interviews, potentially giving him disproportionate influence over the data collection. In addition, he was a graduate student who had been involved in supervision relationships solely as a supervisee; participants may have disclosed differently had they been talking to a licensed psychologist who had experience in supervision as both supervisor and supervisee.

Implications

Results of the present study yield a number of implications across several different areas. Implications for supervisors, supervisees, training, and future research are discussed in the sections below.

Supervisors. Supervisees expect to receive FCFB, and they view FCFB as an opportunity to promote growth and clinical skill development. Thus, supervisors should not shy away from providing FCFB because, as noted in previous studies (e.g., Ladany et al., 1999), supervisees expect to receive it as an inherent component of clinical supervision. While FCFB may be anxiety-provoking for both supervisors and supervisees, to avoid providing FCFB potentially places client welfare in jeopardy, and could leave supervisees wondering why such an expected piece of the supervision process is not incorporated into their supervision experience. As one participant noted, "If I'm not receiving corrective feedback, that makes me wonder if I'm really messing something up and they [supervisors] just don't even want to bring it up."

In addition to providing FCFB, supervisors should monitor their demeanor before, during, and after delivering FCFB, for it seems that supervisees' reactions to FCFB are heavily influenced by their supervisors' behaviors. More specifically, supervisors should reflect on the type of feedback they provide to supervisees: is the feedback provided to

supervisees heavily corrective, or is there a mix of affirming and corrective feedback? Additionally, supervisees expect to be involved in the process of FCFB and desire FCFB that relates to goals for supervision that supervisees and their supervisors establish together. In light of this, supervisors should initiate conversations related to goal setting early in the supervision relationship, and tie FCFB to these goals. It might also be helpful to ask supervisees what helps makes FCFB easier for them to hear, and incorporate these supervisee prefrences into the FCFB that is provided during the course of supervision.

Through goal setting and asking how supervisees best receive FCFB, supervisors demonstrate a willingness to meet supervisee expectations related to FCFB and clinical supervision. During specific FCFB events, supervisors should provide sufficient time to dialogue with supervisees about the FCFB, ensuring that the supervisee understands the FCFB and has a clear sense of how to implement the change associated with the FCFB. When talking about FCFB more generally and in specific FCFB events, supervisees noted the importance of feeling involved in FCFB, and they were most helped by supervisors who provided a rationale for the FCFB and engaged supervisees in a discussion of how to implement change.

Once supervisors have provided FCFB, they should follow-up with their supervisees to see how the FCFB was received and determine what, if any impact, the FCFB has had on supervisees, their perceptions of the supervision relationship, and their clinical work. While such direct conversations might be difficult, it appears that supervisees desire direct conversations about FCFB, and they appreciate it when supervisors inquire if supervisees made the change and how it went. Following up on FCFB allows supervisors to continue to monitor the supervision relationship, while

demonstrating a concern that their FCFB was effective (i.e., resulted in an improvement in the supervisee's clinical work) and holding supervisees accountable for making changes associated with FCFB. Given that supervisees across positive and negative FCFB events implemented their supervisor's FCFB, it is clearly not safe to assume that the FCFB went over well so long as a supervisee makes a change related to the FCFB.

Finally, given the finding in this study that supervisees may not view FCFB as communicating their overall performance level, supervisors should consider being more explicit when providing FCFB in tying it to overall themes or patterns in supervisees' work. The theoretical literature (e.g., Bernard & Goodyear, 2009) is clear that FCFB is an opportunity to provide evaluation of supervisee work throughout the supervision relationship, with summative evaluations serving as a summary of FCFB that has already been provided. Yet, it seems that supervisees may not recognize FCFB as an intervention that guides their work and communicates a supervisor's evaluation of supervisee work. Supervisors who are more explicit in tying FCFB to supervisee growth edges may help avoid moments in supervision where supervisees feel caught off-guard by FCFB and/or summative evaluations. Additionally, it may be helpful for supervisors to explicitly discuss the supervisor's role as evaluator, as well as supervisee expectations for and of FCFB, early in the supervision relationship and incorporate supervisee expectations in the FCFB that supervisors deliver during the course of the supervision relationship.

Supervisees. There are numerous expectations that supervisees have of supervisors when it comes to clinical supervision and FCFB. While supervisees might expect supervisors to initiate early discussions around goal setting and FCFB, it may be incumbent on supervisees to broach these topics if supervisors do not do so early in

supervision. Much as supervisees expect supervisors to approach FCFB directly, clearly, and honestly, supervisors may hold similar expectations of supervisees during discussions of goals and how supervisees best receive FCFB.

Beyond early discussions of goals and preferences for receiving feedback, supervisees may need to ask for an explanation/clarification if they are confused and/or angered by the FCFB they receive. In the current study, supervisees often consulted with others, rather than their supervisors, when they had negative reactions to the FCFB they received; one is left to wonder if the negative effects on the supervision relationship may have been mitigated if supervisees shared with supervisors their reactions to the FCFB. Such conversations may have resulted in greater dialogue about the FCFB, something supervisees associated with positive FCFB events and FCFB that was easy for them to hear.

Finally, while it may be difficult because of the inherent power differential in the supervision relationship, supervisees may need to provide direct and honest feedback to supervisors on the FCFB provided supervisees. Again, much as supervisees expect direct FCFB that is clear and honest, supervisors might look to supervisees to reciprocate direct communication patterns. The current study suggests that such open communication may have a bidirectional relationship with the supervision relationship, with open communication strengthening the relationship and in turn making it easier to receive FCFB.

Training. Beyond the implications for the two players in the individual supervision relationship, the results of this study hold implications for training for future supervisors and those who are currently supervisees. Beyond exposure to theories and

models of supervision, graduate courses in supervision should address the areas of evaluation and feedback. Similar to specific therapeutic interventions, it seems that evaluation and feedback are complex, nuanced supervision interventions that can have significant positive and negative effects on supervisees, their clinical work, and the supervision relationship. Supervisees expect supervisors to balance multiple roles in the supervision relationship, namely both mentor and evaluator (Allen at al., 1986), which may be no easy task and require considerable reflection, practice, and experience.

For those individuals who are presently supervisees, peer supervision courses held in academic programs and thus outside of clinical training settings may be good venue for supervisees to discuss supervision topics safely. Providing supervisees the opportunity to discuss supervision outside of the clinical training setting may help supervisees clarify their role in supervision, including how to collaborate with supervisors early in supervision to establish tasks and goals for supervision. Moreover, supervisees might be helped by talking about their preferences for supervision, exploring what types of supervisors with whom they work best and how feedback can be delivered in a way that allows them to take in, digest, and implement the feedback. With a clearer sense of their role and preferences in supervision, supervisees may be more comfortable being active agents in supervision, communicating their expectations and beliefs about supervision and FCFB. As demonstrated in this and previous studies, agreement on the tasks and goals of supervision may lead to a more open supervision relationship, which in turn facilitates the delivery and acceptance of FCFB and reinforces what is already viewed as a strong supervision relationship.

Future research. This study is hopefully a prelude to further researching examining feedback in clinical supervision. Because this study was qualitative with a relatively small number of participants, perhaps reexamining these findings incorporating quantitative elements (e.g., pairing FCFB events and scales of satisfaction with supervision) would help assess if participants' experiences are reflective of a larger population of supervisees. Furthermore, no males participated in this study, and future research in this area should seek a more gender-balanced participant pool. Investigating specific FCFB events in the same supervisory dyad (i.e., asking the same questions about FCFB of supervisors and supervisees) may also provide useful information about specific FCFB events from different perspectives. This may serve to clarify how/where/if perceptions of such events diverge. Additionally, obtaining information about level of supervisor training in future research may clarify how, if at all, this impacts evaluation and feedback in clinical supervision.

Another fruitful direction would be to examine summative evaluation events from both a supervisor and supervisee perspective. While summative feedback should be, theoretically, a summary of formative feedback given throughout the course of the supervision relationship, it may be helpful to more fully understand what, if any, differences exist in supervisee expectations/beliefs about summative evaluations, and what contributes to such events going well and going poorly. Given that oftentimes the supervision relationship concludes following summative evaluations, such evaluation events might be a critical juncture in consolidating, repairing, or damaging perceptions of the supervision experience – and perhaps impacting the course of any supervision relationships to follow.

Finally, it might be helpful to more fully examine the effects of a specific FCFB event in one specific area. In the present study, participants identified three main areas of impact: on themselves, their clinical work, and/or the supervision relationship. A more narrow focus on specifically how FCFB affects any of these three areas would be an interesting avenue of research. Specifically, in the area of effects of FCFB on clinical work, it would be interesting to obtain client perceptions of supervisee clinical work before and after FCFB events to determine what, if any, impact such events had on clinical work from the client's perspective. Also, FCFB events discussed in this study occurred at various points in the supervision relationship; it would be intriguing to examine what, if any, effects timing of FCFB in the context of the supervision relationship exist.

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Appendix A
IRB Submission

Human Research	MARQUETTE UNIVERSITY	Protocol #:
		ORSP #:
		Sponsor Tracking #:

Institutional Review Board
Protocol Summary Form

Directions: Submit this completed Protocol Summary Form with original signature(s) along with any additional materials, including consent forms, information sheets, surveys, interview questions, etc.

Submit to: Office of Research Compliance, 560 North 16th Street, Room 102, Milwaukee, WI 53233

Phone: 414-288-7570 **Fax:** 414-288-6281 **Web site:** http://www.mu.edu/researchcompliance

Type of Review being sought: Exempt Expedited ☒ Full Review

Exempt Review:	Submit **originals** of all materials; 1 copy of grant application.
Expedited Review:	Submit **originals** **AND 1 copy** of all materials; 1 copy of grant application.
Full Review:	Submit **originals** **AND 14 copies** of all materials; 1 copy of grant application.

Principal Investigator: David Phelps

Department: *Counselor Education and Counseling Psychology (CECP)*
Phone: *414.807.6216*
E-mail: *david.l.phelps@marquette.edu*

Project Title: Supervisee Experiences of Corrective Feedback in Clinical Supervision: A Consensual Qualitative Research Study

PI Certification

By signing below or submitting this document electronically, I agree to accept primary responsibility for the scientific and ethical conduct of this project as approved by the IRB. The project cannot begin until I receive documentation of IRB final approval.

David Phelps 9.29.10

Signature of Principal Investigator	Printed Name	Date

FOR STUDENTS, a Marquette faculty supervisor's signature is required or this document must be submitted electronically by the supervisor. **Faculty Supervisor:** By signing below or by submitting this document electronically, I certify that I have reviewed the research plan and this document and I have approved the scientific and ethical aspects of the project. I will supervise the above listed student and ensure compliance with human subjects' guidelines.

Alan Burkard	CECP

Signature of Faculty Supervisor	Printed Name	Department

Please note that in order to choose any of the check boxes on this form, you must double click the box and select "Checked" as the Default Value

Section A: RESEARCH PROJECT CHARACTERISTICS

1. This is a:
- ☐ Research Proposal
- ☒ Thesis/Dissertation
- ☐ Class Project (list Dept. & Course #)*:*
- ☐ Other (specify)*:*

2. Grant or Contract Funded: ☐ Yes   ☐ Funding is Pending   ☒ No

Sponsor/Source of funding*:*

If external funding, have you registered your project with Research and Sponsored Programs (ORSP)? ☐ Yes   ☒ No
If Yes, Please list your ORSP Reference #*:_____*

If your project is grant funded, submit a copy of the funding/grant proposal and list the AGENCY GRANT NUMBER*:_____*

If the project title listed on page 1 of this application is different from your grant title, list the grant title:_____

If the funding agency requires an official IRB approval letter or form, list the program area, contact person, title and complete mailing address*:*

3. Does the investigator or key personnel have a potential financial conflict of interest in this study that should be disclosed?
☐ Yes   ☒ No   If Yes, Please explain*:*

4. PI Status:
- ☐ Undergraduate
- ☒ Graduate

☐ Faculty/Administrator
☐ Other (specify)*:*

5. Provide the names, titles and affiliations of **all** investigators (include yourself, co-PIs, other investigators, and students). Please use an attachment if more space is required.

OHRP interprets an "**investigator**" to be any individual who is involved in conducting human subjects research studies. Such involvement includes:
- obtaining information about living individuals by intervening or interacting with them for research purposes;
- obtaining identifiable private information about living individuals for research purposes;
- obtaining the voluntary informed consent of individuals to be subjects in research; and
- studying, interpreting, or analyzing identifiable private information or data for research purposes.

Note that any collaborative work with another institution will require the submission of that institution's IRB approval letter.

Name	Institution	Status (Faculty, Grad., Undergrad., etc.)	Project Role (Co-PI, Key or Non-Key Personnel, Consultant, etc.)	Contact e-mail	Tutorial* (Attached or On File w/ MU ORC)
David Phelps	MU	Grad Student	PI	david.l.phelps@marquette.edu	On File
Jacquelyn Smith	MU	Grad Student	Team Member	Jacquelyn.smith@marquette.edu	On File
Eric Everson	MU	Grad Student	Team Member	eric.everson@marquette.edu	On File
Alan Burkard, PhD	MU	Faculty	Auditor	alan.burkard@marquette.edu	On File

*Please note that Training Certificates are required for all human subject investigators. Certificates can be obtained by visiting http://phrp.nihtraining.com/users/login.php and completing the IRB Tutorial Designed by the National Institute of Health. Copies of Training Certificates are to be forwarded to the Office of Research Compliance.

6. Do you wish to have this project considered for Exempted Review?
☐ Yes   ☒ No   (See Submission Requirements on ORC web site for definition and list of categories)

If Yes, identify the Exemption category number you believe covers your project*:*
☐ Category 1   ☐ Category 2   ☐ Category 3   ☐ Category 4   ☐
Category 5   ☐ Category 6

Explain your basis for this level of review here*:*

7. Do you wish to have this project considered for Expedited Review?
☒Yes ☐ No   (See Submission Requirements on ORC web site for definition and list of categories)

If Yes, identify the Expedited Review category number you believe covers your project*:*
☐ Category 1   ☐ Category 2   ☐ Category 3   ☐ Category 4   ☐ Category 5   ☐ Category 6   ☒ Category 7

Explain your basis for this level of review here*: This project presents no more than minimal risk to human subjects, and involves the collection of data from voice recordings of interviews made for research purposes.*

8. Inclusive dates of Project: (Project may not start prior to approval)

From*: IRB Approval Date*   To*: December 2012*

9. How long is the active involvement of participants in the study? (e.g. six half-hour sessions over six months)*: Two phone interviews, the first lasting approximately 45-60 minutes, the second lasting approximately 15 minutes and conducted two weeks after the first interview.*

10. Research Location: Where will the research be performed (if not on campus, please provide the full address; if online, please indicate online)*? In the Department of Counseling and Educational Psychology at Marquette, Research Room in Hartmann Center.*

Note: If the research will be conducted in a school or institution other than Marquette University, include a letter, on letterhead stationery, of permission from that institution and/or its IRB. This letter must be received by the ORC prior to IRB approval.

11. What do you intend to do with the data collected?

☒ Publish paper   ☒ Present at conferences/meetings
☒ Other (please describe)*: Complete dissertation requirements.*

Section B: SUBJECT RECRUITMENT

12. Indicate which of the following specially protected groups will be specifically targeted as research participants in this study (Check all that apply):

☐ Pregnant Women/Fetuses   ☐ Children (minors under 18)   ☐ Prisoners
☒ None of These

13. Indicate which of the following potentially vulnerable populations will be specifically targeted as research participants in this study (Check all that apply):

☐ College Students*　　　☐ Institutional Residents　　　☐ Cognitively Impaired

☐ Physically Disabled　　　☐ Terminally Ill　　　☒ None of These

***If using Marquette students, please consult HRP Policy 98.102 Participation of Students and Employees in Research (http://www.marquette.edu/researchcompliance/human/documents/HRPolicy98.102-StudentsEmployees.pdf)**

14. Will both genders have an equal opportunity to participate as subjects in this research project?

☒ Yes　　☐ No　　If No, explain your answer*:*

15. Will subjects of different racial and ethnic consideration have an equal opportunity to participate in this research project? ☒ Yes　　☐ No　　If No, explain your answer*:*

16. How many subjects will be recruited into your research project as justified by the hypothesis and study procedures?

a) Total number of subjects required to complete your study*: _10-15____*

How was this number determined? If a power analysis or other method was used, please include this in your response: *10-15 is a typical sample size for this qualitative method.*

b) Total number of subjects to be recruited (to account for drop out, etc.)*: _≅25____*

c) Explain the reason for difference between (a) and (b) above (e.g. past studies have shown that there is a 50% drop out rate for students, the study is longitudinal and a drop out rate of 30% is anticipated)*: Predoctoral psychology interns likely value their time and may be reluctant to discuss their experiences of receiving corrective feedback in clinical supervision, so we may need to recruit about 25 participants before we secure the 10-15 individuals who are willing to devote the 1 to 1.25 hour(s) required for participation.*

Please Note: If at a later time it becomes apparent that you need to increase your sample size, you will need to submit an IRB Protocol Amendment Form, including your justification for additional subjects.

17. What is the age range of subjects (please provide a specific range)*? Adults*

18. What is the source of the subject list*?*

- *Predoctoral psychology interns known to research team members/auditor who are willing to participate.*
- *Contacts/conduits to predoctoral psychology interns through research team contacts.*

19. Who will contact the subjects (name and affiliation)*? David Phelps, MA, MU Grad Student*

20. How will subjects be contacted? (Check all that apply)

☐ Advertisements*****   ☒Letters*****   ☐ Notices*****
☐ Telephone Lists   ☐ Student Pool   ☐ Random Telephone Dialing
☒ Direct person-to-person solicitation   ☒E-mail*****
☐ Other (please specify)*:*   ☐ University News Briefs*****

    * A copy must be submitted for IRB approval. For letters, notices, advertisements, and others, submit verbatim copies.

21. Data collection methods: (Check all that apply and **provide copies of all tools**)

☐ Questionnaire or Survey**[1]**   ☐ Observation**[4]**   ☒ Interview
☐ Archival Data**[2]**   ☐ Intervention   ☐ Video Recording**[3]**
☐ Instruction/Curriculum   ☐ Focus Groups   ☒ Audio Recording**[3]**
☐ Testing/Evaluation   ☐ Other (please describe)*:*

[1] If conducting an online survey, consult the University's Online Survey Policy (http://www.mu.edu/upp/documents/upp1-22.pdf)
[2] If using archival data, describe in the Narrative section (question 48) whether data are de-identified.
[3] If you select video and/or audio recording, please provide further explanation in the Narrative section (question 48) regarding confidentiality of the recording(s).
[4] If you select observation, please provide further explanation in the Narrative section (question 48) regarding who you plan to observe, where you plan to observe (public or private location), and the type of data you will be collecting.

    NOTE: If data collection tools are provided in a language other than English, provide both the English and non-English versions.

22. If deception or experimental manipulation is used, please explain why it is necessary (as opposed to convenient) for this study. Include plans for how and when subjects will be debriefed and attach a copy of your debriefing sheet, if applicable*: N/A*

23. Does any part of this activity have the potential for coercion of the subject (for example, a student being recruited by a teacher who controls his or her grade may feel coerced)? ☐ Yes ☒ No

24. If Yes, explain and describe the proposed safeguards*:*

Note: If you are planning to recruit Marquette employees or students, consult the HRP Policy regarding Participation of Students and Employees in Research (http://www.marquette.edu/researchcompliance/human/documents/HRPolicy98.102-StudentsEmployees.pdf)

Section C: CONSENT OF RESEARCH SUBJECT

25. What type of consent will be used? **You must attach a clean copy that will receive the IRB approval stamp. Consult the ORC website for the consent form instructions and <u>required</u> template.**

☒ Written Consent ☐ Waiver ☐ Online Consent
☐ Oral Consent ☐ Information Sheet ☐ Parent
Permission & Child Assent
☐ Guardian Permission & Adult Assent ☐ Other (please describe)*:*

26. If you are requesting a waiver of informed consent, address each of the following:
a) The research involves no more than minimal risk to the subjects;
b) The waiver will not adversely affect the rights and welfare of the subjects;
c) The research could not practicably be carried out without the waiver; and
d) Whenever appropriate, subjects will be provided with additional pertinent information after participation.

Considering the above requirements for a waiver of informed consent, please describe how your research qualifies for this waiver*:*

27. Do you intend to use an informed consent document in a language other than English?
☐ Yes ☒ No If Yes, provide both the English and non-English versions.

28. If you are using an oral consent, describe the rationale, how it will be documented, and include a copy of the oral presentation; it must include all information required of written informed consents*:*

Section D: CONFIDENTIALITY

29. Where specifically will consent forms be kept (building location, room #, please include full address if off campus) **AND** who will have access*?* **They will be**

locked in room 122F of Schroeder Complex. Only David Phelps will have access to the file cabinet.

30. How will research subjects be identified in the research data (by name, code, number, etc.)*?code number*

31. At any time during your research will a direct link exist between collected data and research subjects? (i.e. participants' data can be directly linked to their name). For example, data collection sheet has a location for participant's name to be recorded.
☐Yes   ☒ No

At any time during your research will an indirect link exist between collected data and research subjects? (i.e. participants' data can be indirectly linked to their name.) For example, data collection sheet has a location for subject number to be recorded. In addition, a spreadsheet exists that links that subject number to a participant's name. Many multi-session and longitudinal studies use indirect links.
☐ Yes   ☒ No

If either of the two above questions are answered "yes," please describe the provisions for security of any links*:*

32. When data results are reported/disseminated:
Will identifiers be used (for example: participant's name will be published in article)?
☐ Yes   ☒ No

Will it be presented in aggregate form (For example: Group characteristics only=Yes, Individual Quotations=No)?
☒ Yes   ☐ No

33. Will research data (raw data) be available to anyone other than the IRB, sponsor and study personnel?
☐ Yes   ☒ No

If Yes, who will this data be shared with, describe how the data will be safeguarded, and be sure to include this information in the consent form (if applicable)*:*

34. Describe how research records, data, electronic data, **(including deidentified data)** etc. will be stored (i.e. locked file cabinet, password protected computer file, etc.) **AND** for how long (research records must be maintained a minimum of 3 years; if kept indefinitely, please state this and indicate it on the consent form)*:Research records will be kept for 2 years in a locked cabinet in room 025 Schroeder Complex while PI is at Marquette. After that time, records will be kept in a locked file cabinet in PI's personal residence.*

35. Describe how the research records, data, electronic data, **(including deidentified data)** etc. will be destroyed (i.e. shred paper documents, delete electronic files,

etc.), **AND** address whether they may be used for future research purposes (If records will be used in the future, please indicate this on the consent form)*: 2 years post-publication/dissemination, data will be shredded.*

36. Could any part of this activity result in the potential identification of child/adult/older adult abuse?
☐ Yes ☒ No

If Yes, is the mandatory report of child/adult abuse outlined in your consent?
☐ Yes ☐ No

37. Could any part of this activity result in the potential identification of communicable diseases or criminal activities? ☐ Yes ☒ No

Section E: BENEFITS AND RISKS TO RESEARCH SUBJECTS

38. Are the direct and indirect benefits to the research subjects for involvement in this project described in their informed consent form? ☒ Yes ☐ No

39. Describe the possible direct benefits to the subjects. If there are no direct benefits, please state this. Also, describe the possible benefits to society*: The benefit is to help improve the subjects' profession's understanding of the use and effects of corrective feedback in clinical supervision.*

40. Will any electrical or mechanical systems that require direct human contact be used (does not include use of computers for data keeping and surveys)? ☐ Yes ☒ No

If Yes, attach a copy of the manufacturer's electrical/mechanical <u>safety</u> specification information for each instrument/device. If the device is custom made, attach detailed description/information on design and safety with respect to human subjects application.
***Also include the most recent safety inspection information documented on either the Marquette University Electrical Safety Testing Documentation form or an equivalent electrical safety testing documentation form.

NOTE: Electrical and mechanical safety inspections must be performed and documented on an annual basis. Documentation of the most recent safety inspection must be submitted with the initial protocol, as well as with any subsequent 3-year renewals.

41. Are the nature and degree of potential risks to research subjects described in the consent? Risks can be physical, psychological, economic, social, legal, etc.
☒ Yes ☐ No

42. Describe the risks to participants and the precautions that will be taken to minimize those risks (these risks should also appear on the consent form). If no risks identified, explain why*: In the unlikely event that a participant experiences*

significant discomfort as a result of involvement in the study, the interviewer, who is in the mental health field, is trained to respond supportively. As appropriate, the interviewer may also suggest that the participant seek additional consultation and/or support.

Section F: COMPENSATION FOR RESEARCH SUBJECTS

43. Will research subjects be compensated or rewarded? ☐ Yes***** ☒ No

If Yes, describe the amount of compensation, how and when it will be disbursed, and in what form*:*

* If subjects are recruited from MU classes, indicate whether students are receiving course credit (regular or extra credit) and, if so, what alternatives are offered to those students who do not wish to participate in the research.

Section G: NARRATIVE DESCRIPTION

For the following questions, try to use **non-technical** language that provides a first time reader (from any discipline) with a clear understanding of the research, and avoid abbreviations. **Do not "paste" text from the grant proposal, and do not refer to the grant proposal page numbers or include literature citations.** Information given should provide the first-time reader with a clear understanding of the proposed research. Focus your answers on the involvement and treatment of human subjects.

PROPOSED RESEARCH RATIONALE

44. Describe why you are conducting the study and identify the research question(s) being asked*:*

Supervision is considered by many to be at the heart of training for those entering the mental health profession. Evaluation, one of the core components of supervision, is considered by some to be the core of quality assurance efforts and protecting the integrity of the mental health profession (Robiner, Fuhrman, & Ristvedt, 1993). Feedback is a central activity of supervision and integral to evaluation, and research suggests that both positive and corrective feedback is highly correlated with supervisee satisfaction in supervision (Bernard & Goodyear, 2009). Additionally, research suggests that feedback, especially that which is corrective in nature, is difficult for supervisors to provide despite its potential to effect change. Although a large amount of theoretical literature exists in the areas of supervision, evaluation and feedback, little research has been conducted in the area of feedback in clinical supervision, and the little that has been conducted has focused on supervisors' perceptions of feedback events. The proposed study seeks to provide a vivid, contextual understanding of supervisee experiences of corrective feedback in clinical supervision. More specifically, research questions include: What are your preferences for feedback and how, if at all, was this communicated with your supervisor; how did the corrective feedback event impact the supervision relationship; what were the perceived effects of the corrective feedback on your

clinical and professional skill development; what were the perceived effects of the corrective feedback?

SUBJECTS TO BE INCLUDED

45. Describe any inclusion and/or exclusion criteria*:*
Participants must be predoctoral psychology interns who were receiving clinical supervision from a licensed clinical or counseling psychologist supervisor. In order to participate in the study, the individual must be able to identify and talk about a specific event in which s/he received corrective feedback from a supervisor in the context of clinical supervision. The event must have taken place within the last two years, and it must have occurred during or after the third supervision session. At the time of the event, the individual must have been involved in a clinical supervision relationship with a licensed psychologist. In the event, the participant may have received one piece of corrective feedback or a series of related corrective feedback statements.

RECRUITMENT AND OBTAINING INFORMED CONSENT

46. Describe your recruitment process in a step-by-step manner*:*
The researcher and team members will use existing connections with predoctoral psychology interns to recruit the sample. If existing connections are unwilling or unable to participate, the researcher will ask those individuals to identify other interns who might be appropriate for study participation. Initial contact with participants will be made via phone, mail, or email. Participants will be mailed a Letter to Potential Participants (Appendix B), along with the Consent, Demographic, and Participant Contact Forms (Appendices C, D and E, respectively).

47. Describe your informed consent process in a step-by-step manner:
After initial contact is made with potential participants, a packet including a cover letter with relevant study information, consent forms, demographic form, and interview protocol will be mailed to the individual (see attached documents). The packet will also include a self-addressed stamped envelope for participants to mail the informed consent and demographic form back to the researcher. Once these materials have been received, the researcher will call or email the participant to schedule a time for the initial interview.

SPECIFIC PROCEDURES TO BE FOLLOWED

48. Describe the methodology to be used and describe in a step-by-step manner the involvement and treatment of human participants in the research, through to the very end of participation. Identify all data to be collected*:*

Due to nature of the research questions, as well as the current state of knowledge regarding corrective feedback in clinical supervision (i.e., very limited), a qualitative method has been chosen (i.e., Consensual Qualitative Research [CQR]; Hill, Thompson, & Williams, 1997; Hill, Knox, Thompson, Williams, Hess,

& Ladany, 2005). This method is appropriate for exploratory research, such as this project, particularly when it examines participants' experiences, as will the current study. Hill et al. (1997) outlined the key components of CQR:

1. *Data are gathered using open-ended questions in order not to constrain participants' responses.*
2. *The method relies on words rather than numbers to describe phenomena.*
3. *A small number of cases are studied intensively.*
4. *The context of the whole case is used to understand the specific parts of the experience.*
5. *The process is inductive, with conclusions being built from the data rather than imposing and testing an a priori structure or theory.*
6. *All judgments are made by a primary team of three to five researchers so that a variety of opinions is available about each decision. Consensus is used so that the best possible understanding is developed for all data.*
7. *One or two auditors are used to check the consensus judgments to ensure that the primary team does not overlook important data.*
8. *The primary team continually goes back to the raw data to ensure that their results and conclusions are accurate and based on the data (Hill, Thompson, and Williams, pp. 522-523).*

Furthermore, CQR data analysis involves three primary steps: Responses to open-ended questions for each case are separated into domains or topic areas; for each domain in each case, summaries or core ideas are developed; cross analysis occurs by constructing categories from core ideas across cases (Hill, Thompson, & Williams).

If subjects choose to participate, upon receiving the completed Consent and Demographic forms, the principal investigator will contact the subject to schedule an initial interview (approximately 45-60 minutes in duration). Two weeks later, a 10-15 minute interview will occur. After data analysis and manuscript preparation, participants will be sent a draft so that they may comment on the degree to which the collective results match their individual experiences. This will also assure participants that confidentiality has been maintained. Participant involvement is complete after manuscript review.

Audiorecordings will be kept in a locked filing cabinet. Only the PI will have access to the audiorecordings, and they will be erased upon completion of the project.

Appendix B
Letter to Potential Participants

Dear <Name of Participant>:

My name is David Phelps, and I am a sixth-year counseling psychology doctoral student at Marquette University. I am currently seeking volunteers to participate in my doctoral dissertation research examining supervisees' experiences of receiving formative, corrective feedback in clinical supervision. Formative feedback is defined as feedback that is ongoing, refers to the progress and process of professional development rather than the outcome, and occurs outside of summative, formal evaluations such as mid- or end-of-year evaluations. Corrective feedback is defined as feedback that noted that you as the supervisee were off-track, or diverging, from competence in your work.

As a supervisee, you have the unique opportunity to engage in clinical supervision, and I am hoping that you will be able to give about an hour of your time to share some of your experiences in this area. The study has been reviewed and approved by Marquette University's Institutional Review Board. Participation in this study involves 2 audiorecorded, telephone interviews. The first interview will take about 45 to 60 minutes. The second interview will be scheduled for approximately 2 weeks after the first and will take about 15 minutes. I will also contact you upon completion of the manuscript for your feedback; providing feedback on the manuscript is optional and not required for participation in the study.

The focus of the interviews will be on your experiences in supervision, your experiences receiving corrective feedback in supervision, and your thoughts regarding feedback processes in clinical supervision. I am particularly interested in your describing one specific incident in which you received corrective feedback from a supervisor in clinical supervision. Recordings, as well as the resulting transcripts and data, will be assigned a code number. After transcription, recordings will be erased.

Participants must be currently or have been a predoctoral psychology intern who is participating/has participated in a supervision relationship with a licensed clinical or counseling psychologist supervisor. In addition, you must be able to identify and be willing to talk about a specific event within the past two years and during your predoctoral psychology internship in which you received formative, corrective feedback in the context of supervision. The corrective feedback event must have taken place in the context of individual, clinical supervision with a licensed psychologist, and it must have occurred during or after the third supervision session.

I recognize there is a slight chance that talking about your experience of corrective feedback in clinical supervision may be uncomfortable, and I am grateful for your willingness to do so. Participation in this project is strictly voluntary, and you may withdraw your consent at any time without penalty. Additionally, the purpose of this research is NOT to evaluate you or your supervision experience; instead, my goal is to

understand how supervisees experience corrective feedback in supervision and the effects of this supervision intervention. Thus, I am grateful for the experience and expertise you will share should you participate in this study.

If you choose to participate, please complete and return the enclosed Consent and Demographic forms as soon as possible (using the provided envelope). I will then contact you to set up a time for an initial interview. I have also included the interview protocol so that you may make fully informed consent. Please take a look at these questions prior to your first interview so that you have had a chance to think about your responses. If you do not meet the criteria for participation, I would be grateful if you would pass this packet along to a colleague who might be interested in participating.

Your comments and questions regarding this study are welcomed, so please feel free to contact me. I look forward to your response.

Appreciatively,

David Phelps
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Department of Counselor Education and Counseling Psychology
College of Education
Marquette University
Milwaukee, WI 53201
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david.l.phelps@marquette.edu

Alan Burkard, Ph.D.
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Appendix C
Informed Consent

Marquette University Agreement of Consent for Research Participants

When I sign this statement, I am giving consent to the following considerations: I understand the purpose of this study titled, "Supervisee Experiences of Corrective Feedback in Clinical Supervision: A Consensual Qualitative Research Study," is to gain a deep, contextual understanding of the antecedents and effects of corrective feedback in clinical supervision.

I understand that the study involves 2 audiorecorded phone interviews, with the first interview lasing 45-60 minutes. The second interview, scheduled for approximately 2 weeks after the first, will take an additional 10-15 minutes. I also understand that there will be approximately 10-15 participants in this study. I understand that the interviews involve a discussion of my experience of receiving corrective feedback in clinical supervision (see enclosed interview protocol) and that I will also be asked to complete a brief demographic form.

I understand that all information I share in this study will be kept confidential. Data associated with me will be assigned a code number rather than using my name or any other identifying information. When the results of the study are written, I will not be identified by name. I recognize that the data will be destroyed by shredding paper documents and deleting electronic files three years after the completion of the study. Furthermore, I understand that my interviews will be audiorecorded and that recordings will later be transcribed and erased after three years.

I understand that the risks associated with participation in this study are minimal, but may include minor discomfort when talking about my experience of receiving corrective feedback in clinical supervision. I also understand that the only benefit of my participation is to help improve my profession's understanding of the use and effects of this supervision intervention. I understand that study participation is completely voluntary and that I may withdraw from participating in this study at any time. If I do choose to withdraw, I understand that I may do so without penalty or loss of benefits to which I am otherwise entitled. In the event that I withdraw, I understand that all data collected prior to my terminating participation in the study will be destroyed.

All of my questions about this study have been answered to my satisfaction. I understand that if I later have additional questions concerning this project, I can contact David Phelps, M.A. at 414.807.6216 (david.l.phelps@marquette.edu) or Alan Burkard (Dissertation Advisor) at 414.288.3434 (alan.burkard@marquette.edu). Additional information about my rights as a research participant can be obtained from Marquette University's Office of Research Compliance at 414.288.1479.

_____ Date:_____
(signature of subject giving consent)

_____ Location:_____
(signature of researcher)

Appendix D
Demographic Form

Code Number (to be completed by researcher): _____

Age: _____

Sex: _____
        Race/Ethnicity:_____

Type of program currently enrolled in/completed (Clinical, Counseling, etc.):

_____

Type of Degree pursuing/obtained (Ph.D., Psy.D.):

_____

Are you currently completing or have you completed a predoctoral psychology internship?
        ___ Currently completing internship
        ___ Completed internship

Internship setting (e.g., college counseling center, hospital,
etc.):_____

At the time of the corrective feedback event:
# of total months involved in individual, clinical supervision as a supervisee (across all supervision relationships): _____
# of individual supervision relationships as a supervisee: _____
# of months of clinical experience: _____

Appendix E
Participant Contact Information Form

For the purposes of being able to contact you regarding participation in this study, please fill out the following information.

Name:_____   Phone number:_____

Mailing Address:

_____

Email Address:

_____

Best possible times to schedule interview:

_____

Appendix F
Interview Protocol

For this study, I'll be using a definition of formative corrective feedback from the supervision literature (Bernard & Goodyear, 2009): Formative (i.e., ongoing) feedback that refers to the process of professional development, rather than the outcome (e.g., midyear or end-of-year evaluation), and communicates that the supervisee is off-track or diverging from competence in her/his work. This corrective feedback may have been either directly (e.g., "You did not stick with the difficult emotion long enough") or indirectly (e.g., "I wonder what you think about your ability to stick with difficult emotions") communicated. I'd like to begin by asking you a few general questions, followed by some questions about a specific corrective feedback event, and then I have just a few closing questions. Do you have any questions for me before we begin?

Opening Questions:
1. What is your view of the role of formative corrective feedback in clinical supervision?
2. Please describe some representative examples of formative corrective feedback that you have received in supervision.
3. How, if at all, have your supervision experiences (i.e., prior to internship) shaped your expectations/beliefs about formative corrective feedback?
4. What makes formative corrective feedback easy for you to hear from supervisors?
5. What makes formative corrective feedback difficult for you to hear from supervisors?
6. How is formative corrective feedback delivered in a way that makes it useful for you (i.e., changes your clinical behavior)?

Corrective Feedback Event Questions:
Now I'd like you to talk about a specific event in which you, as a supervisee, received formative corrective feedback in clinical supervision with a licensed psychologist. The event must have taken place in the context of individual supervision during your internship, must have occurred in the third supervision session or later, and must have occurred within the last two years.

7. The corrective feedback event:
   a. Please describe what supervision was like with this supervisor before the formative corrective feedback event occurred.
   b. What led up to you receiving the formative corrective feedback?
   c. What was the formative corrective feedback you received?
   d. How did you receive the feedback? What contributed to you receiving the feedback in this manner?
   e. What were the effects of the formative corrective feedback?
   f. What, if anything, changed as a result of the corrective feedback you received? If something changed, why do you think it changed? If nothing changed, why do you think this was the case?

8. Please provide some basic demographics of your supervisor and supervision relationship (e.g., age, educational/training background, sex, race/ethnicity [SR and SE], clinical issue(s) being addressed at time of the corrective feedback, when in course of the supervision relationship the corrective feedback occurred, total length of supervision relationship, frequency of supervision meetings, setting [e.g., hospital, private practice, clinic]).

Closing Questions
9. Is there anything else you would like to add regarding the event you described, or about formative corrective feedback in general?
10. How was it talking about your experience of receiving formative corrective feedback?

Thank you again for taking the time to participate in this study. If you don't have anything additional to add at this point, I'd like to set up a time for a brief follow-up interview. The purpose of this 15-30 minute interview is to allow you an opportunity to share any thoughts you've had since the first interview, for me to review my notes to see if I need any further information from you, and to ask a few additional questions. I try to schedule the follow-up interview approximately 2 weeks from the first interview, but I can be flexible. When would work best for you?

Follow-up Interview Questions
1. What, if anything, has come up for you and/or have you remembered that you did not share in the initial interview?
2. What do you wish you would have known about formative corrective feedback prior to the event you described?
3. What do you want supervisors to know about formative corrective feedback from a supervisee's perspective?
4. How, if at all, has your participation in this study affected your experience of supervision – either as supervisee or supervisor?
5. Any other comments?

Appendix G
Letter for Participants to Provide Feedback on Manuscript

Dear <Participant>,

Thank you again for your willingness to participate and share your experience of receiving corrective feedback in clinical supervision. As you may recall, as part of your participation in my study titled, "Supervisee Experiences of Corrective Feedback in Clinical Supervision: A Consensual Qualitative Research Study," you have the option to provide feedback on the manuscript.

Enclosed you will find a copy of the manuscript for your review. This has been sent so that you may comment on the degree to which the collective results match your individual experience(s). It is also sent to assure you that your confidentiality has been maintained. Please make comments as you see fit (on the manuscript or another sheet of paper) and return your comments to me in the stamped envelope provided. You may keep the manuscript itself. If I do not hear from you, I will assume that you have no additional feedback.

Appreciatively,

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