APA GUIDELINES
for Clinical Supervision in Health Service Psychology

BOARD OF EDUCATIONAL AFFAIRS TASK FORCE ON SUPERVISION GUIDELINES

APPROVED BY APA COUNCIL OF REPRESENTATIVES
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AMERICAN PSYCHOLOGICAL ASSOCIATION

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APA Guidelines for Clinical Supervision in Health Service Psychology

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PREFACE

This document outlines guidelines for supervision of students in health service psychology education and training programs. The goal was to capture optimal performance expectations for psychologists who supervise. It is based on the premises that supervisors a) strive to achieve competence in the provision of supervision and b) employ a competency-based, meta-theoretical approach[1] to the supervision process.

The *Guidelines on Supervision* were developed as a resource to inform education and training regarding the implementation of competency-based supervision. The *Guidelines on Supervision* build on the robust literatures on competency-based education and clinical supervision. They are organized around seven domains: supervisor competence; diversity; relationships; professionalism; assessment/evaluation/feedback; problems of professional competence, and ethical, legal, and regulatory considerations. The *Guidelines on Supervision* represent the collective effort of a task force convened by the APA Board of Educational Affairs (BEA).

[1] A competency-based approach is meta-theoretical and refers to working within any theoretical or practice modality, systematically considering the growth of specific competencies in the development of competence.

CONTENTS

EXECUTIVE SUMMARY

The purpose of the *Guidelines for Clinical Supervision in Health Service Psychology* (hereafter referred to as *Guidelines on Supervision)* is to delineate essential practices in the provision of clinical supervision. The overarching goal of these *Guidelines on Supervision* is to promote the provision of quality supervision in health service psychology using a competency framework to enhance the development of supervisee competence ensuring the protection of clients/patients and the public. These *Guidelines on Supervision* are intended to be aspirational in nature to guide psychologists proactively towards enhancing supervision practice. The term *Guidelines on Supervision*, as used in this document, is consistent with the provisions of the American Psychological Association (APA) policy on Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology (Section I C[1]) (APA, 2004), as passed by the APA Council of Representatives.

An assumption underlying all supervision is that the supervisor is competent—both as a professional psychologist and as a clinical supervisor (Fouad et al., 2009). Supervision is for assessment, treatment, and other activities of the health service psychologist; and it occurs across varied settings. Ironically, however, minimal attention has been given to defining, assessing, or evaluating supervisor competence (Bernard & Goodyear, 2014; Falender & Shafranske, 2013) or to determining requisite training for clinical supervision. The supervisor is responsible for ensuring the protection of the public, and this duty cannot be achieved without supervisor competence. This requires developing the knowledge, skills, and attitudes in the provision of supervision, and receiving training specific to clinical supervision (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Reiser & Milne, 2012). Further, education and training in health service psychology increasingly employs a competency-based approach to the definition, assessment, and evaluation of student learning outcomes. Both the competence of supervisors and the application of competency-based approach to supervision can be enhanced by developing guidelines that assist supervisors in the provision of high quality supervision.

The *Guidelines on Supervision* are the product of a task force convened by the APA Board of Educational Affairs. Members of the task force were selected for their expertise in the area of supervision. The majority of their work was conducted through conference calls and electronic mail with one face-to-face meeting; and the task force adhered to a tight timeline in recognition of the considerable need for such a document.

The *Guidelines on Supervision* are predicated on a number of common assumptions and agreed upon definitions. Although an extensive list of definitions appears in Appendix A to this document, three key definitions are provided below:

HEALTH SERVICE PSYCHOLOGIST. "Psychologists are recognized as Health Service Providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic and therapeutic intervention services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level" (APA, 1996).

The *Guidelines on Supervision* focus on supervision for health service psychologists. A health service psychologist was defined by APA policy in 1996 and reaffirmed in the 2011 revision of the APA Model Act for State Licensure of Psychologists (APA, 2011c). Members of the task force agreed that a clear and delimited scope for the *Guidelines on Supervision* was important to promote understanding and use of this document. The term health service psychology (HSP) is preferred as it is narrower than professional psychology, a designation that includes the specialty of industrial-organizational psychology, which was not addressed by the task force. Health service psychology is inclusive of the specialties of clinical, counseling, and school psychology.

SUPERVISION is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. Henceforth, supervision refers to clinical supervision and subsumes supervision conducted by all health service psychologists across the specialties of clinical, counseling, and school psychology.

COMPETENCY-BASED SUPERVISION is a metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/cultural clinical setting (adapted from Falender & Shafranske, 2007). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision.

The *Guidelines on Supervision* are organized around seven domains:

Domain A: Supervisor Competence
Domain B: Diversity
Domain C: Supervisory Relationship
Domain D: Professionalism
Domain E: Assessment/ Evaluation/ Feedback
Domain F: Problems of Professional Competence
Domain G: Ethical, Legal, and Regulatory Considerations

Within each of these seven domains, guidelines for supervision are articulated with a supporting rationale informed by the empirical and theoretical literature. Although this framework is useful to present the *Guidelines on Supervision*, there is considerable conceptual and practical overlap among these domains. Consideration was given to the utility and implementation of the *Guidelines on Supervision* as well as to minimizing redundancy when making decisions about the best domain for a specific guideline.

INTRODUCTION

Statement of Need and Context for the *Guidelines on Supervision*

A primary goal of education and training programs in health service psychology is to prepare psychologists who are competent to engage in provision of psychological services and professional practice. Supervision is thus a cornerstone in the preparation of health service psychologists (Falender et al., 2004). There is a tremendous amount of conceptual, theoretical, and research literature pertaining to supervision, but prior to the development of these *Guidelines on Supervision*, there has been no set of consensually agreed upon guidelines adopted as association policy to inform the practice of high quality supervision for health service psychology.

Although supervisor competency is assumed, little attention has been focused on the definition, assessment, or evaluation of supervisor competence (Bernard & Goodyear, 2014; Falender & Shafranske, 2013). This has diminished the perceived necessity for training in supervision. As Kitchener (2000) concluded, it has been much easier to identify the absence of competence than to define it. Articulating practices consistent with competent supervision ultimately facilitates the provision of quality services by supervisees and minimizes potential harm to supervisees and clients (Ellis et al., 2014).

Competence entails performing one's professional role within the standards of practice and includes the ability to identify when one is not performing adequately. An essential aspect of competence is metacompetence, or the ability to know what one does not know and to self-monitor reflectively one's ongoing performance (Falender & Shafranske, 2007; Hatcher & Lassiter, 2007; APA, 2010, 2.01). Professional negligence is the failure of competence and is legally actionable: a failure of competence is practicing below a reasonable standard of care for supervision (Falender & Shafranske, 2014; Saccuzzo, 2002).

While clinical supervision has been recognized as a distinct activity in the literature, its recognition as a core competency domain for psychologists has been a long time coming (Bernard & Goodyear, 1992; Hess, 2011). Since the profession's adoption of supervision as a distinct professional competence (Fouad et al., 2009; Kaslow et al., 2004), a definition of supervision has emerged and encompasses the knowledge, skills, and values/attitudes specific to the practice of supervision (Falender et al., 2004; Falender & Shafranske, 2004, 2007; Fouad et al., 2009). This recognition of supervision as a distinct competency has evolved in the context of an overall focus on competency-based education and training in health service psychology that has gained momentum over the past decade (Fouad & Grus, 2014). The movement is consistent with the national dialogue about the responsibility of education and training programs to be accountable for ensuring quality education and training that leads to expected student learning outcomes (New Leadership Alliance for Student Learning and Accountability, 2012).

Supervisory competency includes valuing supervision as a distinct professional competency and valuing specific training in clinical supervision (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Reiser & Milne, 2012). However, the recognition that training in supervision is necessary has also been slow to occur (Rings, Genuchi, Hall, Angelo, & Cornish, 2009). A preliminary framework for supervisor competence was produced by the 2002 Competencies Conference (Falender et al., 2004), received confirmatory support from doctoral internship directors (Rings et al., 2009), and serves as a basis for this framework. To be a competent supervisor, an individual possesses and maintains knowledge, skills, and values/attitudes that comprise the distinct professional competency of clinical supervision as well as general competence in the areas of clinical practice supervised and in consideration of the cultural contexts.

Supervision that applies a competency-based approach entails the creation of an explicit framework and method to initiate, develop, implement, and evaluate the process and outcomes of supervision. A competency-based approach is predicated on supervisors having the knowledge, skills, and attitudes regarding the provision of quality supervision and professional psychology models, theories, practices. In addition, supervisors have knowledge, skills and values with respect to multiculturalism and diversity, legal and ethical parameters; and management of supervisees who do not meet criteria for performance. Supervisors also attain knowledge and skills in theories and processes for group, individual, and distance supervision. Implicit in the concept of competence is an awareness of and attention to one's interpersonal functioning and professionalism and valuing individual and cultural diversity (Kaslow et al., 2007). The competency-based approach is being adopted in multiple specialties (e.g., Stucky, Bush, & Donders, 2010), psychotherapy theoretical approaches (e.g., Farber, 2010; Farber & Kaslow, 2010; Sarnat, 2010), and internationally (e.g., Psychology Board of Australia, 2013).

A logical next step to build upon the identified elements of competence in supervision is to develop and approve guidelines that promote the provision of competent supervision. Other organizations have published guidelines on supervision that have informed the development of these *Guidelines on Supervision*. Specifically, the following regulatory boards and psychological associations have promulgated guidelines related to supervision.

- The Association for Counselor Education and Supervision (ACES), a division of the American Counseling Association developed supervision guidelines for counselor education (Borders et al., 2011). The ACES guidelines on supervision are organized around 12 domains.[2]
- The American Association of Marriage and Family Therapy developed a formal approval process for supervisors with nine learning objectives that candidates must demonstrate (American Association of Marriage and Family Therapy, 2007).[3]
- The National Association for School Psychologists addresses supervision as part of a more comprehensive document on the provision of integrated and comprehensive school psychological services (National Association for School Psychologists, 2010).
- The Psychology Board of Australia's *Guidelines for supervisors and supervisor training providers* consists of a document that focuses on competency-based supervision (Psychology Board of Australia, 2013).
- The Australian Psychological Society *Guidelines on Supervision* specifically addresses the supervision contract, ethical issues, and supervision contexts (Australian Psychological Society, 2003).
- The New Zealand Psychologists Board's *Best-practices guidelines for supervision* provides recommendations about a variety of aspects of supervision including the process and functions of supervision, supervisor competencies, the supervision relationship, and cultural issues (New Zealand Psychologists Board, 2007).
- The British Psychological Society, Committee on Training in Clinical Psychology has guidelines for clinical supervision within their criteria for the accreditation of postgraduate training programs in clinical psychology (British Psychological Society, Committee on Training in Clinical Psychology, 2008).
- The Association of State and Provincial Psychology Boards (ASPPB) is currently revising their supervisions guidelines (Steve DeMers, personal communication, 2013a).
- The California Board of Psychology has published a document on supervision best practices (California Board of Psychology, 2010).
- The College of Psychologists of Ontario, Canada has a *Supervision Resource Manual* (2nd edition) (College of Psychologists of Ontario, Canada, 2009).
- The Canadian Psychological Association developed the *Ethical guidelines for supervision in psychology: Teaching, research, practice, and administration* (Canadian Psychological Association, 2009) and a *Resource guide for psychologists: Ethical supervision in teaching, research, practice, and administration* (Pettifor et al., 2010). Four principles frame the guidelines(from the CPA Code of Ethics, 2000): respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society.
- The Association of Social Work Boards has developed guidelines on supervision for both educators and regulators using a competency framework identifying six domains of competence (Association of Social Work Boards, 2009).
- The National Association of Social Workers and the Association of Social Work Boards recently released a document on best practices for supervision (National Association of Social Workers and the Association of Social Work Boards,2013), articulating five standards: context in supervision, conduct of supervision, legal and regulatory issues, ethical issues, and technology.

[2] ACES categories are: initiating supervision, goal setting, giving feedback, conducting supervision, the supervisory relationship, diversity and advocacy considerations, ethical considerations, documentation, evaluation, supervision format, the supervisor, and supervisor preparation.

[3] AAMFT categories include: knowledge of supervision models, ability to delineate one's own model of supervision, ability to foster relationships with the supervisee and the client, assess relationship problems, conduct supervision using various modalities, able to act on considerations within the supervisory relationship, attentive to issues of diversity, knowledge of ethical and legal issues related to supervision, and AAMFT supervisor procedural knowledge.

Scope of Applicability

These *Guidelines on Supervision* are meant to inform the practice of clinical supervision with supervisees in areas of health service psychology and training. They apply to the full range of supervised service delivery including assessment, intervention, and consultation and across all aspects of professional functioning. The *Guidelines on Supervision* are predicated on a number of pre-existing policies, fundamental assumptions, and definitions:

Supervision can occur in a variety of contexts: supervision of service delivery by supervisees, administrative supervision, supervision of research activities conducted by supervisees, and supervision of individuals mandated by regulatory entities related to disciplinary actions. This document addresses supervision of clinical services provided by individuals in health service psychology education and training programs and applies to supervision of practicum experiences, internships, and postdoctoral training.

Interprofessional education is a valuable training activity and supervisees should have opportunities to learn from and with professionals other than a psychologist. Recent guidelines for Interprofessional Collaborative Practice (2011) were endorsed by APA (Interprofessional Education Collaborative, 2011). However, this supervision guidelines document refers exclusively to supervision provided by psychologists to supervisees in health service psychology.

Supervisors are committed to upholding the *APA Ethical Principles of Psychologists and Code of Conduct* (2010) and adhering to state and federal statues regulating psychologist and psychological practice. Supervisors strive to adhere to relevant APA general practice guidelines including but not limited to the *Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients, Guidelines for Assessment of and Intervention with Persons with Disabilities, Guidelines for Psychological Practice with Girls and Women, Guidelines for Psychological Practice with Older Adults,* and the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2011a, 2011b, 2007a, 2004a, 2003).

Supervisors are expected to comply with relevant education and training standards such as those promulgated through the APA Commission on Accreditation (APA, 2009) as well as other relevant guidelines, e.g., American Psychological Association *Guidelines for the Practice of Telepsychology* (APA, 2013a), *Guidelines for Psychological Practice in Health Care Delivery Systems* (APA, 2013b), and *Record Keeping Guidelines* (APA, 2007b).

Assumptions of the *Guidelines on Supervision*

The development of these *Guidelines on Supervision* is predicated on a number of assumptions. These assumptions were agreed upon by the members of the task force as foundational to the provision of clinical supervision and are reflected in the guidelines delineated in this document. Specifically, supervision:

- is a distinct professional competency that requires formal education and training
- prioritizes the care of the client/patient and the protection of the public
- focuses on the acquisition of competence by and the professional development of the supervisee
- requires supervisor competence in the foundational and functional competency domains being supervised
- is anchored in the current evidence base related to supervision and the competencies being supervised
- occurs within a respectful and collaborative supervisory relationship, that includes facilitative and evaluative components and which is established, maintained, and repaired as necessary
- entails responsibilities on the part of the supervisor and supervisee
- intentionally infuses and integrates the dimensions of diversity in all aspects of professional practice
- is influenced by both professional and personal factors including values, attitudes, beliefs, and interpersonal biases
- is conducted in adherence to ethical and legal standards
- uses a developmental and strength-based approach
- requires reflective practice and self-assessment by the supervisor and supervisee
- incorporates bi-directional feedback between the supervisor and supervisee
- includes evaluation of the acquisition of expected competencies by the supervisee
- serves a gatekeeping function for the profession
- is distinct from consultation, personal psychotherapy, and mentoring[4]

[4] Supervision is distinguished from these other professional activities by 1) professional responsibility and liability, 2) the purpose of the activity, 3) the relative power of the parties involved, and 4) the presence or absence of evaluation. In consultation, the consultant does not evaluate the referring provider, does not bear case responsibility, and the consultee is not required to implement the input of consultation. Supervision is distinguished from personal psychotherapy of the supervisee by maintaining the focus of inquiry on the client/patient, supervisee reactions to the client/patient, and/or the supervision process related to the client/patient (Bernard & Goodyear, 2014; Falender & Shafranske, 2004). Mentoring is distinguished from supervision by an absence of evaluation or power differential, and by the mentor's advocacy for the protege's professional development and welfare (Johnson & Huwe, 2002; Kaslow & Mascaro, 2007).

Use of the Term Guidelines

The term guidelines generally refers to pronouncements, statements, or declarations that recommend or suggest specific professional behaviors, endeavors, or conduct for psychologists. In this spirit, they are aspirational in intent. They are not intended to be mandatory or exhaustive and may not be applicable to every situation, nor are they intended to take precedence over the judgment of supervisors or others who are responsible for education and training programs.

Education and training guidelines may be written as an advisory set of procedures related to curriculum development, pedagogy, or assessment; as interpretive commentary or instruction on education policy or standards; as a set of guiding principles about teaching and learning or program development; or as suggested goals and objectives of learning. These *Guidelines on Supervision* are intended as suggestions or recommendations for psychologists providing supervision of students in education and training programs in health service psychology. As used in this document, the term guidelines is consistent with the provisions of the APA policy on Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology (Section I C[1]) (APA, 2004b), as passed by the APA Council of Representatives.

Process of Developing the Guidelines on Supervision

The *Guidelines on Supervision* were prepared by a task force convened by the APA Board of Educational Affairs in March of 2012. The task force was charged to:

> "develop education and training guidelines for promising practices in (1) supervision encompassing the range of requisite supervisor {supervision} competencies; (2) adoption of a competency-based approach to supervision mindful of the developmental trajectory of the supervisee {of the process}."

The task force met via conference call approximately once a month from late summer 2012 to early spring 2013. One face-to-face meeting of the task force occurred May 31-June 2, 2013 at which previously prepared drafts of the *Guidelines on Supervision* were discussed and revised. Following the meeting, the task force continued to refine the *Guidelines on Supervision* via electronic mail.

Purpose of these *Guidelines on Supervision*

The *Guidelines on Supervision* have the potential for broad impact on the profession by delineating practices relevant to quality supervision. Specifically, the *Guidelines on Supervision* are intended to have the following impacts:

- For supervisors, the *Guidelines on Supervision* provide a framework to inform the development of supervisors and to guide self-assessment regarding professional development needs.
- For supervisees, the *Guidelines on Supervision* promote the delivery of competency-based supervision with the goal of supervisee competency development.
- A goal of the *Guidelines on Supervision* is to provide assurance to regulators that supervision of students in education and training programs in health service psychology is provided with and places value on quality.

Implementation Steps

BEA will serve as the APA entity responsible for oversight of the implementation process. Implementation and dissemination of the *Guidelines on Supervision* will occur through:

- Distribution to and possible endorsement by the member organizations represented on the Council of Chairs of Training Councils, including the doctoral training councils and the Association of Psychology Postdoctoral and Internship Centers
- Presentations at the annual meetings of the APA and training council meetings.
- Submission to a peer-reviewed psychology journal for publication of a manuscript describing the *Guidelines on Supervision*.
- Submission to the APA Commission on Accreditation for consideration as a resource document in program reviews for accreditation.
- Development of continuing education programs targeted to health service psychologists who may not have had formal training in supervision.

Feedback

The *Guidelines on Supervision* is a "living document." Accordingly, APA has established a systematic plan for periodically reviewing and revising such documents to reflect developments in the discipline and the education and training process. Formal reviews will occur every ten years, which is consistent with APA Association Rule 30-8.3 requiring cyclical review of approved standards and guidelines within periods not to exceed 10 years. Comments and suggestions are welcomed at any time.

Feedback on the *Guidelines on Supervision* may be sent to: edmail@apa.org.

Content of the Guidelines

Guidelines for Clinical Supervision in Health Service Psychology

The *Guidelines on Supervision* are organized around seven domains:

Domain A: Supervisor Competence
Domain B: Diversity
Domain C: Supervisory Relationship
Domain D: Professionalism
Domain E: Assessment/ Evaluation/ Feedback
Domain F: Problems of Professional Competence
Domain G: Ethical, Legal, and Regulatory Considerations

These domains are drawn from a review of the literature on supervision as well as competency-based education and training. The domains and their associated *Guidelines* are interdependent and while some overlap exists among them it is important that they are considered in their entirety.

DOMAIN A

SUPERVISOR COMPETENCE

Supervision is a distinct professional practice with knowledge, skills, and attitudes, that supervisors require specific training to attain (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Bernard & Goodyear, 2014; Reiser & Milne, 2012). The supervisor serves as role model for the supervisee, fulfills the highest duty of protecting the public, and is a gatekeeper for the profession ensuring that supervisees meet competence standards in order to advance to the next level or to licensure.

1. **Supervisors strive to be competent in the psychological services provided to clients/patients by supervisees under their supervision and when supervising in areas in which they are less familiar they take reasonable steps to ensure the competence of their work and to protect others from harm.**
   Supervisors possess up-to-date knowledge and skills regarding the areas being supervised (e.g., psychotherapy, research, assessment), psychological theories, diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and individual differences and intersections of these with diversity dimensions. Supervisors also have knowledge of the clinical specialty areas in which supervision is being provided and of requirements and procedures to be taken when supervising in an area in which expertise has not been established (Barnett et al., 2007; Goodyear & Rodolfa, 2012; APA, 2010, 2.01, 2.03).

   Supervisors are knowledgeable of the context of supervision including its immediate system and expectations, and the sociopolitical context. Supervisors are knowledgeable too about emergent events in the setting or context that impact the client(s)/patient(s) (Falender et al., 2004).

2. **Supervisors seek to attain and maintain competence in the practice of supervision through formal education and training.**
   Competence entails demonstrated evidence-based practice as well as in the various modalities (e.g., family, group and individual), theories, and general knowledge, skills, and attitudes and research support of competency-based supervision. Supervisors obtain requisite training in knowledge, skills, and attitudes of clinical supervision (Newman, 2013; Watkins, 2012). Supervisors are skilled and knowledgeable in competency-based models, in developing and managing the supervisory relationship/alliance (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Ladany, Mori, & Mehr, 2013), and in enhancing the supervisee's clinical skills (Milne, 2009). The formal education and training should include instruction in didactic seminars, continuing education, or supervised supervision. At a minimum, education and training in supervision should include: models and theories of supervision; modalities; relationship formation, maintenance, rupture and repair; diversity and multiculturalism; feedback, evaluation; management of supervisee's emotional reactivity and interpersonal behavior; reflective practice; application of ethical and legal standards; decision making regarding gatekeeping; and considerations of developmental level of the trainee (Bernard & Goodyear, 2014; Falender & Shafranske, 2012; Newman, 2013). The supervision reflects practices informed by competency- and evidence-based practice to enhance accountability (Milne & Reiser, 2012; Reese et al., 2009; Stoltenberg & Pace, 2008; Watkins, 2011; Watkins, 2012; Worthen & Lambert, 2007). Assessment entails use of outcome measures and ratings from multiple supervisors (e.g., Reese et al., 2009, Watkins, 2011; Worthen & Lambert, 2007). Assessment strategies include both formative and summative evaluation and procedures for competence assessment.

3. **Supervisors endeavor to coordinate with other professionals responsible for the supervisee's education and training to ensure communication and coordination of goals and expectations.**
   Coordination can assist supervisees in managing these multiple roles and responsibilities as well as supervisory expectations. Coordination is especially important to seek when a supervisee is exhibiting performance problems, when the supervisory relationship is under stress, or when the supervisor seeks another perspective (Thomas, 2010).

4. **Supervisors strive for diversity competence across populations and settings (as defined in APA,2003).**
   Diversity competence is an inseparable and essential component of supervision competence that involves relevant knowledge, skills, and values/attitudes (for more information, see Domain B: Diversity).

5. **Supervisors using technology in supervision (including distance supervision), or when supervising care that incorporates technology, strive to be competent regarding its use.**
   Supervisors ensure that policies and procedures are in place for ethical practice of telepsychology, social media, and digital communications between any combination of client/patient, supervisee, and supervisor (APA, 2013b; Fitzgerald, Hunter, Hadjistavropoulos, & Koocher, 2010). Considerations should include services appropriate for distance supervision, confidentiality, and security. Supervisors are knowledgeable about relevant laws specific to technology and supervision, and technology and practice.

   Supervisors model ethical practice, ethical decision-making, and professionalism, and engage in thoughtful dialogues with supervisees regarding use of social networking and internet searches of clients/patients and supervisees (Clinton, Silverman, & Brendel, 2010; Myers, Endres, Ruddy, & Zelikovsky, 2012).

DOMAIN B

DIVERSITY

Diversity competence is an inseparable and essential component of supervision competence. It refers to developing competencies for working with diversity issues and diverse individuals, including those from one's own background. More commonly, these competencies refer to working with others from backgrounds different than one's own but includes the complexity of understanding and factoring in the multiple identities of each individual: client(s), supervisee, supervisor and differing worldviews. Competent supervision attends to a broad range of diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and includes sensitivity to diversity of supervisees, clients/patients, and the supervisor (APA, 2003, 2004a, 2007a, 2010 (2.03); 2011a, 2011b). Supervisors are encouraged to infuse diversity into all aspects of clinical practice and supervision, including attention to oppression and privilege and the impact of those on the supervisory power differential, relationship, and on client/patient and supervisee interactions and supervision interactions.

1. **Supervisors strive to develop and maintain self-awareness regarding their diversity competence, which includes attitudes, knowledge, and skills.**
   Supervisors understand that they serve as important role models regarding openness to self- exploration, understanding of one's own biases, and willingness to pursue education or consultation when indicated. Supervisors also are important role models regarding their diversity knowledge, skills and, attitudes. Supervisors' ability to self-reflect, revise and update knowledge and advance their skills in diversity serve as important lessons for supervisees. Modeling these competencies helps to establish a safe environment in which to address diversity dimensions within supervision as well as in the larger professional setting.

2. **Supervisors planfully strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of their supervisees.**
   Supervisors consider infusion of diversity competence in supervision as an ethical imperative and respect the human dignity of their supervisees and the clients/patients with whom the supervisee works (APA, 2010; Bernard & Goodyear, 2014; Falender, Shafranske, & Falicov, 2014). Supervisors play a significant role in developing the diversity competencies of their supervisees. Research finds that diversity competence among supervisors can lag behind that of their supervisees (Miville, Rosa, & Constantine, 2005). Fortunately, diversity competence can be directly and constructively addressed by supervisors, who in turn can facilitate the diversity competence of their supervisees. Moreover, all supervision can be viewed as multicultural in the same manner that all therapy is multicultural (Pederson, 1990). Adopting such a framework strengthens the supervisory relationship, enhances supervisor competence, and promotes the diversity competencies of both supervisors and supervisees (Andrews, Kuemmel, Williams, Pilarski, Dunn, & Lund, 2013; Dressel, Consoli, Kim,on, 2007; Snowman, McCown, & Biehler, 2012). Viewing diversity as normative, rather than as an exception, aids supervisors in being sensitive to important similarities and differences between themselves and their supervisees that may affect the supervisory relationship.

3. **Supervisors recognize the value of and pursue ongoing training in diversity competence as part of their professional development and life-long learning.**
   In order to ensure diversity competence sufficient to provide culturally sensitive supervision, supervisors seek to continue to develop their own knowledge, skills, and attitudes, particularly in diversity domains that are most commonly relevant to their clinical supervision. At a minimum, supervisors should have attained formal training in diversity through their own doctoral training program or continuing professional development workshops, programs, and independent study, should be familiar with APA guidelines addressing diversity (APA, 2003, 2004a, 2007a, 2011a, 2011b), and should pursue continuing education to maintain current competence and build knowledge in emerging areas (APA, 2010, 2.03).

4. **Supervisors aim to be knowledgeable about the effects of bias, prejudice, and stereotyping. When possible, supervisors model client/patient advocacy and model promoting change in organizations and communities in the best interest of their clients/patients.**
   Supervision occurs within the context of diversity and social and political systems. Of special importance is the impact of bias, prejudice and stereotyping, both positive and negative, on therapeutic and supervisory relationships within these systems. Supervisors promote the supervisee's competence by modeling advocacy for human rights and intervention with institutions and systems (Burnes & Singh, 2010).

5. **Supervisors aspire to be familiar with the scholarly literature concerning diversity competence in supervision and training. Supervisors strive to be familiar with promising practices for navigating conflicts among personal and professional values in the interest of protecting the public.**
   Considerable scholarship has been published on supervision and diversity (e.g., Bernard & Goodyear, 2014; Falender, Burns, & Ellis, 2013; Miville et al., 2009). Resources include competency-based training models for integrating diversity dispositions of supervisors and supervisees (Miville et al., 2009), and the duty of supervisors to assist supervisees in navigating inevitable tensions between personal and professional values in providing competent client/patient care (e.g., Behnke, 2012; Bienske & Mintz, 2012; Forrest, 2012; Mintz, Jackson, Neville, Illfelder-Kaye, Winterowd, & Loewy, 2009; Winterowd, Adams, Miville, & Mintz, 2009).

DOMAIN C

SUPERVISORY RELATIONSHIP

The quality of the supervisory relationship is essential to effective clinical supervision (e.g., Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Holloway, 1995; O'Donovan, Halford, & Walters, 2011). Quality of the supervision relationship is associated with more effective evaluation (Lehrman-Waterman & Ladany, 2001), satisfaction with supervision (Ladany, Ellis, & Friedlander, 1999), and supervisee self-disclosure of personal and professional reactions including reactivity and counter transference (Falender & Shafranske, 2004; Ladany , Lehrman-Waterman, Molinaro, & Wolgast, 1999). The power differential is a central factor in the supervisory relationship and the supervisor bears responsibility for managing, collaborating, and discussing power within the relationship (Porter & Vasquez, 1997).

1. **Supervisors value and seek to create and maintain a collaborative relationship that promotes the supervisees' competence.**
   Supervisors initiate collaborative discussion of the expectations, goals, and tasks of supervision. By initiating this discussion, they establish a working relationship that values the dignity of others, responsible caring, honesty, transparency, engagement, attentiveness, and responsiveness, as well as humility, flexibility, and professionalism (Ellis, Ring, Hanus, & Berger, 2013). In discussing the supervisory relationship, the supervisor should: (1) initiate discussions about differences, including diversity, values, beliefs, biases, and characteristic interpersonal styles that may affect the supervisory relationship and process; (2) discuss inherent power differences and supervisor responsibility to manage such differences wisely; and (3) take responsibility to establish relationship conditions that promote trust, reliability, predictability, competence, perceived expertise, and developmentally-appropriate challenge.

2. **Supervisors seek to specify the responsibilities and expectations of both parties in the supervisory relationship. Supervisors identify expected program competencies and performance standards, and assist the supervisee to formulate individual learning goals.**
   The supervisor is encouraged to explicitly discuss with the supervisee aspects of the supervision process such as: program goals, individual learning goals, roles and responsibilities, description of structure of supervision, supervision activities, performance review and evaluation, and limits of supervision confidentiality. The supervisor also provides clarity about duties including that the primary duty of supervisor is to the client/patient, and secondarily to competence development of the supervisee. (The supervision contract is discussed further in the Legal and Ethical Section.)

3. **Supervisors aspire to review regularly the progress of the supervisee and the effectiveness of the supervisory relationship and address issues that arise.**
   As the supervisory relationship and the supervisee's learning needs evolve over time, the supervisor should work collaboratively with the supervisee to revise the supervision goals and tasks. When disruptions occur in the supervisory relationship, supervisors seek to address and resolve the impasses and disruptions openly, honestly, and in the best interests of client/patient welfare and the supervisee's development (Safran, Muran, Stevens, & Rothman, 2008).

DOMAIN D

PROFESSIONALISM

Professionalism goes hand in hand with a profession's social responsibility (see Hodges et al., 2011; Vasquez & Bingham, 2012). The "professionalism covenant" puts the needs and welfare of the people they serve at the forefront (Grus & Kaslow, 2014). Grus and Kaslow (2014) summarized these as: "behavior and comportment that reflect the values and attitudes of psychology (Fouad et al., 2009; Hatcher et al., 2013). The essential components include: (1) integrity – honesty, personal responsibility and adherence to professional values; (2) deportment; (3) accountability; (4) concern for the welfare of others; and (5) professional identity."

1. **Supervisors strive to model professionalism in their own comportment and interactions with others, and teach knowledge, skills, and attitudes associated with professionalism.**
   Supervisory modeling of professionalism occurs across professional settings. Supervisees' understanding of what is professional or ethical is still developing (Gottlieb, Robinson, & Younggren, 2007). Modeling is a powerful means to teach attitudes and behaviors (e.g., Tarvydas, 1995), including professionalism (Cruess, Cruess, & Steinert, 2009).) Supervisors, in vivo, can exemplify virtue, humanism, and honest communication (Grus & Kaslow, 2014, modified from Hatcher et al., 2013).

   One important aspect of supervision is to socialize supervisees into a particular profession (e.g., Ekstein & Wallerstein, 1972); to help them learn to "think like" those in that profession.

   In interprofessional settings, supervisors model professionalism in cooperative, collaborative, and respectful interaction with team members.

2. **Supervisors are encouraged to provide ongoing formative and summative evaluation of supervisees' progress toward meeting expectations for professionalism appropriate for each level of education and training.**
   Modeling alone is insufficient to teach professionalism; it should be embedded in a larger training curriculum incorporating developmentally expected behaviors (Grus & Kaslow, 2014). Supervisees need clear criteria to judge the extent to which they are demonstrating developmentally appropriate professionalism (Fouad et al., 2009; Kaslow et al., 2009) as well as feedback about the extent to which they are meeting those criteria. The knowledge, skills, and attitudes associated with professionalism have been addressed within and across disciplines with much congruence. These include, "altruism, accountability, benevolence, caring and compassion, courage, ethical practice, excellence, honesty, honor, humanism, integrity, reflection/self-awareness, respect for others, responsibility and duty, service, social responsibility, team work, trustworthiness, and truthfulness" (Grus and Kaslow, 2014).

DOMAIN E

ASSESSMENT/EVALUATION/ FEEDBACK

Assessment, evaluation, and feedback are essential components of ethical supervision (Carroll, 2010; Falender et al., 2004). However, supervisors have been found to provide it relatively infrequently (e.g., Ellis et al., 2014; Friedlander, Siegel, & Brenock, 1989; Hoffman, Hill, Holmes, & Freitas, 2005), which leads to failures in gatekeeping and failures of supervisors in informing supervisees about their competency development (Thomas, 2010), and creates potential for ethical complaints (Falvey & Cohen, 2004; Ladany et al., 1999). To be effective, assessment, evaluation, and feedback need to be directly linked to specific competencies, to observed behaviors, and be timely (APA, 2010, 7.06; Hattie & Timperley, 2007).

1. **Ideally, assessment, evaluation, and feedback occur within a collaborative supervisory relationship. Supervisors promote openness and transparency in feedback and assessment, by anchoring such in the competency development of the supervisee.**
Establishment and maintenance of the supervisory relationship provide the basis for assessment, evaluation, and feedback. Supervisee disclosure of client data is enhanced by a strong relationship (See Domain C in this document on the Supervisory Relationship.)

2. **A major supervisory responsibility is monitoring and providing feedback on supervisee performance. Live observation or review of recorded sessions is the preferred procedure.**
Supervisee self-report is the most frequently used source of data on supervisee performance and client/patient progress (e.g., Goodyear & Nelson, 1997; Noelle, 2002; Scott, Pachana, & Sofranoff, 2011). The accuracy of those reports, however, is constrained by human memory and information processing as well as by supervisees' self-protective distortion and biases, (Haggerty & Hilsenroth, 2011; Ladany, Hill, Corbett, & Nutt, 1996; Pope, Sonne, & Green, 2006; Yourman & Farber, 1996) that result in their not disclosing errors, resulting in the loss of potentially important clinical data.

   The more direct the access a supervisor has to a supervisee's professional work, the more accurate and helpful their feedback will likely be. Supervisors should use live observation or audio or video review techniques whenever possible, as these are associated with enhanced supervisee and client/patient outcomes (Haggerty & Hilsenroth, 2011; Huhra, Yamokoski-Maynhart, & Prieto, 2008). Supervisors should not limit work samples only to those identified by the supervisee; some work samples should be selected by supervisors. Review of work samples should be planful and focus on specific competency development and defined supervision goals (Breunlin, Karrer, McGuire, & Cimmarusti, 1988; Hatcher, Fouad, Grus, Campbell, McCutcheon, & Leahy, 2013). In addition, the developmental level of the supervisee should be considered when identifying methods to monitor and provide feedback to the trainee. An organization can reduce legal risk through direct observation of the supervisee's work (e.g., using live or video observation of sessions) thus satisfying the monitoring standard of care in supervision.

3. **Supervisors aspire to provide feedback that is direct, clear, and timely, behaviorally anchored, responsive to supervisees' reactions, and mindful of the impact on the supervisory relationship.**
In delivering feedback, supervisors are sensitive to: (a) the power differential as a function of the supervisory evaluative and gatekeeping roles; (b) culture, diversity dimensions (e.g., gender, race, sexual orientation, socio-economic status) and other sources of privilege and oppression (Ancis & Ladany, 2001; Ryde, 2000; Shen-Miller, Forrest, & Burt, 2012); (c) supervisee developmental level (Stoltenberg & McNeill, 2010); (d) the possibilities of the supervisee experiencing demoralization (Watkins, 1996) or shame (Bilodeau, Savard, & Lecomte, 2012) in response to the feedback; and (e) timing and the amount of feedback that a supervisee can assimilate at any given moment (Westberg & Jason, 1993).

   Feedback should occur at frequent intervals, with some positive and corrective feedback in each supervision session so that evaluation is not a surprise (Bennett et al., 2006). In instances when a supervisee exhibits problems in professional competence, supervisors are expected to be courageous and provide this difficult feedback, doing so in a direct and supportive manner. Indirect delivery of difficult feedback to supervisees is not associated with good training outcomes (Hoffman et al., 2005). The difficulty of delivering difficult feedback is especially challenging in multicultural supervision (Burkard, Knox, Clarke, Phelps, & Inman, in press; Shen-Miller et al., 2012). Collaborative conversations among supervisors regarding diversity, consultation, and examination of biases were described as helpful in contextual understanding of individual supervisee development (Shen-Miller et al., 2012).

4. **Supervisors recognize the value of and support supervisee skill in self-assessment of competence and incorporate supervisee self-assessment into the evaluation process.**
Incorporating the use of supervisee self-assessment into the evaluation of supervisees can enhance skill development, provide useful reflection on the delivery of services, and inculcate attitudes of self-assessment as a lifelong learning tool (Wise, Sturm, Nutt, Rodolfa, Schaffer, & Webb, 2010). Research has shown that there are limitations to the accuracy of self-assessments (Dunning, Heath, & Suls, 2004; Gruppen, White, Fitzgerald, Grum, & Woolliscroft, 2000) indicating that the provision of significant feedback to supervisees should be used to enhance supervisee assessment of self-efficacy (Eva & Regehr, 2011).

5. **Supervisors seek feedback from their supervisees and others about the quality of the supervision they offer, and incorporate that feedback to improve their supervisory competence.**
It is important that supervisors obtain regular feedback about their work. Supervisors may not obtain regular feedback once they are licensed and as a result may tend to overestimate their competence (e.g., Walfish, McAlister, O'Donnell, & Lambert, 2012) and tend to grow in confidence about their abilities, even though that is not necessarily matched by corresponding increases in ability (see Dawes, 1994). Although studies on supervisee nondisclosures (e.g., Ladany et al, 1996; Mehr, Ladany & Caskie, 2010; Yourman & Farber, 1996) suggest difficulty in obtaining candid information from supervisees, it is important that supervisors routinely seek—and utilize—feedback about their own supervision (see e.g., Williams, 1994).

DOMAIN F

PROFESSIONAL COMPETENCE PROBLEMS

Only a small proportion of supervisees in health service psychology programs demonstrate significant problems in professional competence, but most academic and internship programs report at least one supervisee with competence problems in the previous five years (Forrest et al., 1999). When this occurs it can be helpful to consider the multiple contexts in which problem behavior is embedded (e.g., cultural beliefs, licensure and accreditation, peers, faculty, supervisors) (Forrest et al., 2008). Supervisors must be prepared to protect the well-being of clients/patients and the general public, while simultaneously supporting the professional development of the supervisee. They also must be mindful of the effects on the training program itself, as peers typically are aware of trainees with problems of professional competence and often have concerns that those problems are not being addressed (Rosenberg, Getzelman, Arcinue, & Oren, 2005; Shen-Miller et al., 2011; Veilleux et al., 2012).

Supervisors give precedence to protecting the well-being of clients/patients above the training of the supervisee. When supervisees display problems of professional competence decisions made and actions taken by supervisors in response to supervisees' competence problems should be completed in a timely manner (Kaslow, Rubin, Forrest, & et al., 2007). They also are guided by the training program's intentional and well-prepared plans for addressing such problems (Forrest et al., 2013).

1. **Supervisors understand and adhere both to the supervisory contract and to program, institutional, and legal policies and procedures related to performance evaluations. Supervisors strive to address performance problems directly.**
   Effective management of professional competence problems begins with the supervision contract (elements of that contract are presented in the Ethics section of these *Guidelines on Supervision*) (Goodyear & Rodolfa, 2012; Thomas, 2007). The contract provides prior written notice of the competencies required for satisfactory performance in the supervised experience (Gilfoyle, 2008) as well as the process of evaluation, the procedures that will be followed if the supervisee does not meet the criteria, and procedures available to the supervisee to clarify or contest the evaluation. This contract shall occur in the context of the program communicating clearly the Due Process Guidelines to the supervisees as required by the Commission on Accreditations Guidelines and Principles (Domains A and G). In the event a supervisee is exhibiting performance problems, supervisors seek consultation to ensure understanding of program, institutional, and legal policies and procedures related to performance evaluations.

2. **Supervisors strive to identify potential performance problems promptly, communicate these to the supervisee, and take steps to address these in a timely manner allowing for opportunities to effect change.**
   Supervisors evaluate on an ongoing basis the supervisee's functioning with respect to abroad range of foundational and functional competencies, including professional attitudes and behaviors that are relevant to professional practice. Their determinations about areas in which the supervisee does not meet competence expectations must (a) take into consideration distinctions between normative developmental challenges and significant competence problems (Fouad et al., 2009; Hatcher et al., 2013; Kaslow et al., 2004; Rodolfa et al., 2005) and (b) be attuned to the intersections between diversity issues and competence (Constantine & Sue, 2007; Kaslow, Rubin, Forrest, & et al., 2007; Shen-Miller et al., 2009). Supervisors also seek consultation from and work in concert with relevant program and institutional participants when addressing potential performance issues.

   Especially when potential performance problems are suspected, supervisors directly observe and monitor supervisees' work, and seek input about the supervisee's performance from multiple sources and from more than one supervisor. Supervisee's professional behaviors and attitudes should be carefully documented in writing with dates and specific behaviors included in the record. Documentation is essential throughout the training trajectory in establishing clarity regarding the performance expectations and the supervisee's attaining the requisite competencies and is important in remediation or in adversarial actions.

   Once supervisors have identified that a supervisee has professional competence problems, they have an ethical responsibility to discuss these with the supervisee and to develop a plan to remediate those problems (APA, 2010; 7.06). Supervisors do so in a manner that is clear, direct, and mindful of the barriers to assuring that such conversations are effective and likely to maintain the supervisory relationship (Hoffman et al., 2005; Jacobs et al., 2011).

   Conversations addressing competence problems shall occur with sensitivity to issues of individual and cultural differences (Constantine & Sue, 2007; Shen-Miller et al., 2012).

3. **Supervisors are competent in developing and implementing plans to remediate performance problems.**
   In conjunction with the supervisee and relevant training colleagues, the supervisor develops written documentation of areas in which the supervisee has competence deficits, performance expectations, steps to be taken to address deficits, responsibilities for each party, performance monitoring processes, and the timelines that will be followed (Kaslow, Rubin, Forrest, & et al., 2007). The supervisor will follow the steps outlined in this plan, including the development of timely written evaluations that are anchored in the stipulated performance criteria (Kaslow, Rubin, Forrest, & et al., 2007). Supervisors evaluate their role in the supervisory relationship and adjust their role as needed, providing more direction and oversight and assuring that client/patient welfare is not threatened and appropriate care is provided. These responsibilities need to be balanced with both training and gatekeeping responsibilities.

4. **Supervisors are mindful of their role as gatekeeper and take appropriate and ethical action in response to supervisee performance problems.**
   In most situations, supervisees are ethically and legally entitled to a fair opportunity to remediate the competence problems and continue in their program of study (McAdams & Foster, 2007). Supervisors strive to closely monitor and document the progress of supervisees who are taking steps to address problems of competence. Should the supervisee not meet the stipulated performance levels after completing the agreed-upon remediation steps, attending to supervisee due process, supervisors must consider dismissal from the training program. Supervisors must have a clear understanding of competence problems that reflect unethical and/or illegal behavior that is sufficiently serious to warrant immediate dismissal from the training program (Bodner et al., 2012). Such considerations occur in the context of the training program's organization's explicit plans for addressing such problems

DOMAIN G

ETHICS, LEGAL, AND REGULATORY CONSIDERATIONS

Valuing and modelling ethical behavior and adherence to relevant legal and regulatory parameters in supervision is essential to upholding the highest duty of the supervisor, protecting the public. Improper or inadequate supervision is the seventh most reported reason for disciplinary actions by licensing boards (ASPPB, 2013c). Supervisees may perceive their supervisors to engage in unethical behavior (Ladany, et al., 1999), sometimes due to misunderstanding the structure of the supervisory relationship and/or a supervisor's failure to secure informed consent. Generally, though, there is some evidence that supervisors and supervisees agree on what comprises ethical behavior (Worthington, Tan, & Poulin, 2002).

1. **Supervisors model ethical practice and decision making and conduct themselves in accord with the APA ethical guidelines, guidelines of any other applicable professional organizations, and relevant federal, state, provincial, and other jurisdictional laws and regulations.**
   Supervisors support the acculturation of the supervisee into the ethics of the profession, their professionalism, and the integration of ethics into their professional behavior (Handelsman, Gottlieb, & Knapp, 2005; Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). Supervisors ensure that supervisees develop the knowledge, skills, and attitudes necessary for ethical and legal adherence. The supervisor is a role model for ethical and legal responsibility.

   Supervisors discuss values that bear on professional practice, applications of ethical guidelines to specific cases, and the use of ethical decision-making models (Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2011).

   The supervisor is responsible for understanding the jurisdictional laws and regulations and their application to the clinical setting for the supervisee (e.g., duty to warn and protect; Werth, Welfel, & Benjamin, 2009).

   Supervisors are knowledgeable of legal standards and their applicability to both clinical practice and to supervision.

2. **Supervisors uphold their primary ethical and legal obligation to protect the welfare of the client/patient.**
   The highest duty of the supervisor is protection of the client/patient (Bernard & Goodyear, 2014). Supervisors balance protection of the client/patient with the secondary responsibility of increasing supervisee competence and professional development. Supervisors ensure that supervisees understand the multiple aspects of this responsibility with respect to their clinical performance (Falender & Shafranske, 2012). Supervisors understand that they are ultimately responsible for the supervisee's clinical work (Bernard & Goodyear, 2014).

3. **Supervisors serve as gatekeepers to the profession. Gatekeeping entails assessing supervisees' suitability to enter and remain in the field.**
   Supervisors help supervisees advance to successive stages of training upon attainment of expected competencies (Bodner, 2012; Fouad et al., 2009). Alternatively, if competencies are not being attained, in collaboration with the supervisee's academic program, supervisors devise action plans with supervisees, with the understanding that if the stated competencies are not achieved, supervisees who are determined to lack sufficient foundational or functional competencies for entry to the profession may be terminated to protect potential recipients of the supervisee's practice (Forrest et al., 2013). Descriptions of such processes are in the training program's or organization's explicit plans for addressing competency problems or the unsuitability of the supervisee for the profession.

4. **Supervisors provide clear information about the expectations for and parameters of supervision to supervisees preferably in the form of a written supervisory contract.**
   A supervision contract serves as the foundation for establishing the supervisory relationship by specifying the roles, tasks, responsibilities of supervisee and supervisor and performance expectations of the supervisee (Bernard & Goodyear, 2014; Osborn & Davis, 2009; Thomas, 2007, 2010). Supervisors convey the value of the points in the supervision contract through conversations with supervisees and may modify the understanding over time as warranted as the goals for supervision change. The contract includes a delineation of the following elements:

   a. Content, method, and context of supervision—logistics, roles, and processes
   b. Highest duties of the supervisor: protection of the client(s) and gatekeeping for the profession
   c. Roles and expectations of the supervisee and the supervisor, and supervisee goals and tasks
   d. Criteria for successful completion and processes of evaluation with sample evaluation instruments and competency documents (APA, 2010, 2.06)
   e. Processes and procedures when the supervisee does not meet performance criteria or reference to such if they exist in other documents
   f. Expectations for supervisee preparation for supervision sessions (e.g., video review, case notes, agenda preparation) and informing supervisor of clinical work and risk situations
   g. Limits of confidentiality of supervisee disclosures, behavior necessary to meet ethical and legal requirements for client/patient protection, and methods of communicating with training programs regarding supervisee performance
   h. Expectations for supervisee disclosures including personal factors and emotional reactivity (previously described, and worldviews (APA, 2010, 7.04)
   i. Legal and ethical parameters and compliance, such as informed consent, multiple relationships, limits of confidentiality, duty to protect and warn, and emergent situation procedures
   j. Processes for ethical problem-solving in the case of ethical dilemmas (e.g., boundaries, multiple relationships)

5. **Supervisors maintain accurate and timely documentation of supervisee performance related to expectations for competency and professional development.**
   Keeping supervision records is an important means of documenting the conduct of supervision and supervisee progress (e.g., APA, 2007b; Falvey & Cohen, 2004; Luepker, 2012; Thomas, 2010).

CONCLUSION

The *Guidelines on Supervision* address seven domains of supervision and offer specific suggestions in each of these domains that delineate essential practices in the provision of competency-based clinical supervision. The overarching goal of the *Guidelines on Supervision* is to promote the provision of quality supervision in health service psychology using a competency framework to enhance the development of supervisee competence while upholding the highest duties of supervision, ensuring the protection of patients, the public, and the profession. The *Guidelines on Supervision* are intended to be aspirational in nature and are responsive to current trends in education and training in health service psychology. They are considered a living document. Accordingly, they should be reviewed periodically and informed by developments, including the evidence-base regarding clinical supervision.

REFERENCES

American Association for Marriage and Family Therapy. (2007). *AAMFT approved supervisor designation standards and responsibilities handbook*. Retrieved from: http://www.aamft.org/imis15/Documents/Approved_Supervisor_handbook.pdf

American Psychological Association. (2013a). *Guidelines for the practice of telepsychology.* APA Council of Representatives. Washington, DC: Author.

American Psychological Association. (2013b). *Guidelines for psychological practice in health care delivery systems*. Retrieved from: http://www.apa.org/practice/guidelines/delivery-systems.aspx

American Psychology Association. (2011a). *Guidelines for psychological practice with lesbian, gay and bisexual clients*. Retrieved from http://www.apa.org/pi/lgbt/resources/guidelines.aspx

American Psychological Association. (2011b). *Guidelines for assessment of and Intervention with persons with disabilities*. Retrieved from: http://www.apa.org/pi/disability/resources/assessment disabilities.aspx

American Psychological Association. (2011c). Model act for state licensure of psychologists. *American Psychologist,* 66, 214-226. doi:10.1037/a0022655.

American Psychological Association. (2011d). *Revised competency benchmarks for professional psychology*. Retrieved from: http://www.apa.org/ed/graduate/revised-competency-benchmarks.doc

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Retrieved from http://apa.org/ethics/code/index.aspx

American Psychological Association. (2008). *Report of the APA Task Force on the implementation of the* Multicultural Guidelines. Retrieved from http://www.apa.org/about/governance/council/policy/multicultural-report.pdf

American Psychological Association. (2007a). Guidelines for psychological practice with girls and women. *American Psychologist*, 62, 949-979. doi.org/10.1037/0003-066X.62.9.949.

American Psychological Association. (2007b). Record keeping guidelines. *American Psychologist*, 62, 993-1004. doi: 10.1037/0003-066X.62.9.993.

American Psychological Association. (2004a). Guidelines for psychological practice with older adults. *American Psychologist*, 59, 236-260. Doi:10.1037/0003-066X.59.4.23

American Psychological Association. (2004b). Developing and evaluating standards and guidelines related to education and training in psychology. Retrieved from http://www.apa.org/about/governance/council/policy/bea-guidelines.pdf.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402. doi: 10.1037/0003-066X.58.5.377

American Psychological Association. (1996). *Recognition of health service providers*. Approved Council Resolution. C.(17). Washington, DC: American Psychological Association.

American Psychological Association Commission on Accreditation. (2009). *Guidelines and principles for accreditation of programs in professional psychology*. Washington, DC: Author.

American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. doi:10.1037/0003-066X.61.4.271.

Ancis, J. R., & Ladany, N. (2001). A multicultural framework for counselor supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (pp. 63-89). Philadelphia: Taylor & Francis.

Andrews, E. E., Kuemmel, A., Williams, J. L., Pilarski, C. R., Dunn, M., & Lund, E. M. (2013). Providing culturally competent supervision to trainees with disabilities in rehabilitation settings. *Rehabilitation Psychology, 58*, 233-244. doi: 10.1037/a0033338

Association of Social Work Boards. (2009). *An analysis of supervision for social work licensure*. Retrieved from: http://www.aswb.org/pdfs/supervisionjobanalysis.pdf.

Association of State and Provincial Psychology Boards. (2005). *Code of ethics*. Retrieved from: http://www.asppb.net/i4a/pages/index.cfm?pageid=3353

Association of State and Provincial Psychology Boards (ASPPB). (2013a.) *ASPPB supervision guidelines*. (Personal communication, Steve DeMers)

Association of State and Provincial Psychology Boards (ASPPB). (2013b). *Definitions of competence,* Day 2. 5th International Congress on Licensure, Certification and Credentialing in Psychology. Stockholm, Sweden, 7 – 9. July,2013

Association of State and Provincial Psychology Boards (ASPPB). (2013c). *ASPPB disciplinary date study*. Retrieved from: http://www.asppb.net/?page=DiscStats

Australian Psychological Society. (2003). *APS ethical guidelines: Guidelines on supervision*. Melbourne, Australia: Author. Retrieved from http://www.psychology4change.com/forms/APS_ethical_guidelines_on_supervision.pdf

Barnett, J. E., Erikson Cornish, J. A., Goodyear, R. K., & Lichtenberg, J. W. (2007). Commentaries on the ethical and effective practice of clinical supervision. *Professional Psychology: Research and Training, 38*, 268-275. doi:10.1037/0735-7028.38.3.268

Behnke, S. (2005). The supervisor as gatekeeper: Reflections on ethical standards 7.02. 7.04, 7.05, 7.06 and 10.01. *Monitor on Psychology, 36*(5), 90–91

Behnke, S. H. (2012). Constitutional claims in the context of mental health training: Religion, sexual orientation, and tensions between the first amendment and professional ethics. *Training and Education in Professional Psychology, 6*, 189-195. doi:10.1037/a0030809

Bennett, B. E., Bricklin, P. M., Harris, E., Knapp, S., VandeCreek, L., & Younggren, J. N. (2006). *Assessing and managing risk in psychological practice: An individualized approach*. Rockville, MD: The Trust.

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

Bernard, J. M., & Goodyear, R. K. (1992). *Fundamentals of clinical supervision.* Boston, MA: Allyn & Bacon.

Bieschke, K. J., & Mintz, L. B. (2012). Counseling psychology, model training values statement addressing diversity: History, current use, and future directions. *Training and Education in Professional Psychology,* 6, 196-203. doi:10.1037/a0030810.

Bilodeau, C., Savard, R., & Lecomte, C. (2012). Trainee shame-proneness and the supervisory process. *Journal of Counselor Preparation and Supervision, 4*, 37 – 49.

Borders, L. D., DeKruyf, L., Fernando, D. M., Glosoff, H. L., Hays, D. G., Page, B., & Welfare, L. E. (2011). *Best practices in clinical supervision*. Alexandria, VA: Association for Counselor Education and Supervision. Retrieved from https://www.acesonline.net/sites/default/files/ACES-Best-Practices-in-clinical-supervision-document-FINAL.pdf.

Bodner, K. E., (2012). Ethical principles and standards that inform educational gatekeeping practices in psychology. *Ethics and Behavior, 22,* 60-74. doi: 10.1080/10508422.2012.638827.

Bordin, E. S. (1983). A working alliance based model of supervision. *The Counseling Psychologist, 11*, 35-42. doi:10.1177/0011000083111007.

Brear, P., & Dorrian, J. (2010). Gatekeeping or gate slippage? A national survey of counseling educators in Australian undergraduate and postgraduate academic training programs. Training And Education In Professional Psychology, 4(4), 264-273. doi:10.1037/a0020714

Breunlin, D. C., Karrer, B. M., McGuire, D. E., & Cimmarusti, R. A. (1988). Cybernetics of videotape supervision. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision* (pp. 194-206). New York: Guilford.

British Psychological Society Committee on training in clinical psychology. (2008). *Criteria for the accreditation of postgraduate training programmes in clinical psychology*. Retrieved from: http://www.shef.ac.uk/polopoly_fs/1.150702!/file/5.1CTCP_Accreditation_Criteria_Printp1-31.pdf.

Burian, B. K., & Slimp, A. O. (2000). Social dual-role relationships during internship: A decision-making model. *Professional Psychology: Research and Practice, 31*, 332-338. doi:10.1037/0735-7028.31.3.332

Burkard, A. W., Knox, S., Clarke, R. D., Phelps, D. L., & Inman, A. G. (in press). Supervisors' Experiences of Providing Difficult Feedback in Cross-Ethnic/Racial Supervision. *The Counseling Psychologist*.

Burnes, T. R., & Singh, A. A. (2010). Integrating social justice training into the practicum experience for psychology trainees: Starting earlier. *Training and Education in Professional Psychology, 4*(3), 153-162. doi: 10.1037/a0019385

California Board of Psychology. (2010). *Supervision best practices.* Retrieved from: http://www.psychboard.ca.gov/applicants/supervision-best.shtml.

Canadian Psychological Association, (2000). *Canadian code of ethics for psychologists, 3rd*edition. Retrieved from: http://www.cpa.ca/aboutcpa/committees/ethics/codeofethics/.

Canadian Psychological Association. (2009). *Ethical guidelines for supervision in psychology: Teaching, research, practice and administration*. Retrieved from: http://www.cpa.ca/docs/file/Ethics/EthicalGuidelinesSupervisionPsychologyMar2012.pdf

Carroll, M. (2010). Supervision: Critical reflection for transformational learning (Part 2). *The Clinical Supervisor, 29*, 1–19.

Clinton, B. K., Silverman, B., & Brendel, D. (2010). Patient-targeted Googling: The ethics of searching online for patient information. *Harvard Review of Psychiatry, 18*, 103–112. doi:10.3109/10673221003683861

College of Psychologists of Ontario. (2009). *Supervision resource manual*. Retrieved from: http://www.cpo.on.ca/assets/0ce96e03bfe24af6b441f807fc9dd194.pdf.

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

Cruess, R. L., Cruess, S. R., & Steinert, Y. (Eds.). (2009). *Teaching medical professionalism.* Cambridge: Cambridge University Press.

Dawes, R. M. (1994). *House of cards: Psychology and psychiatry built on myth*. New York: Free Press.

Dressel, J. L., Consoli, A. J., Kim, B. S., & Atkinson, D. R. (2007). Successful and unsuccessful multicultural supervisory behaviors: A Delphi poll. *Journal of Multicultural Counseling and Development, 35*(1), 51-64. doi.org/10.1002/j.2161-1912.2007.tb00049.x.

Dunning, D., Heath, C. & Suls, J. M. (2004). Flawed self-assessment: Implications for health, education and the workplace. *Psychological Science in the Public Interest, 5*(3),69-106.

Ekstein, R., & Wallerstein, R. S. (1972). *The teaching and learning of psychotherapy* (2nded.). New York: International Universities Press, Inc.

Ellis, M. V., D'Iuso, N., & Ladany, N. (2008). State of the art in the assessment, measurement, and evaluation of clinical supervision. In A. K. Hess, K. D. Hess, & T. H. Hess, (Eds.), *Psychotherapy supervision: Theory, research, and practice* (2nded., pp. 473-499). New York: Wiley.

Ellis, M. V., Berger, L., Hanus, A., Alaya, E. E., Siembor, M. J., & Swords, B. A. (2014). Inadequate and harmful clinical supervision: Revising a framework and assessing occurrence. *The Counseling Psychologist, 42, 434-472.* Doi: 0011000013508656.

Ellis, M. V., Ring, E. E., Hanus, A., & Berger, L. (2013). *Exemplary clinical supervision: Testing a taxonomy and assessing occurrence*. Unpublished manuscript. Albany, NY: University at Albany.

Eva, K.W. & Regehr, G. (2011). Exploring the divergence between self-assessment and self- monitoring. *Advances in health science education, 16, 311-329. Doi: 10.1007/s10459- 010-9263-2.*

Falender, C. A., Burnes, T., & Ellis, M. (2013) Introduction to Major Contribution: Multicultural Clinical Supervision and Benchmarks: Empirical Support Informing Practice and Supervisor Training. *The Counseling Psychologist, 41*, 8-27. doi: 10.1177/0011000012438417.

Falender, C. A., Burnes, T. R., & Ellis, M. V. (2013). Multicultural clinical supervision and benchmarks: Empirical support informing practice and supervisor training. *The Counseling Psychologist*, 41, 8-27.doi.org/10.1177/0011000012438417.

Falender, C. A., Collins, C. J., & Shafranske, E. P. (2009). "Impairment" and performance issues in clinical supervision: After the 2008 ADA Amendments Act. *Training and Education in Professional Psychology, 3*, 240-249. doi:10.1037/a0017153

Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., . . . Sigmon, S. T. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology, 60*(7), 771-785. doi:10.1002/jclp.20013

Falender, C. A., Ellis, M. V., & Burnes, T. (2013). Response to reactions to major contribution: Multicultural clinical supervision and Benchmarks. *The Counseling Psychologist*, 41, 140-151. doi:10.1177/0011000012464061.

Falender, C. A., & Shafranske, E. P. (2014). Supervision. In B. Johnson, & N. Kaslow (Eds.) *Oxford handbook of education and training in professional Psychology*. In press.

Falender, C. A., & Shafranske, E. P. (2013). Responsibilities and liabilities in supervision. In G. P. Koocher, J. C. Norcross, & B. A. Greene (Eds.), *Psychologists' Desk Reference* (3rd. Ed.). pp. 730-734. New York, NY: Oxford University Press.

Falender, C. A., & Shafranske, E. P. (2012). *Getting the most out of clinical training and supervision: A guide for practicum students and interns*. Washington, DC: American Psychological Association.

Falender, C. A., & Shafranske, E. P. (2007). Competence in competency-based supervision practice: Construct and application. *Professional Psychology: Research and Practice, 38*(3), 232-240. doi:10.1037/0735-7028.38.3.232

Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association. doi:10.1037/10806- 000

Falender, C. A., Shafranske, E. P., & Falicov, C. (Eds.). (2014). *Multiculturalism and Diversity in Clinical Supervision: A Competency-based Approach*. Washington, DC: American Psychological Association.

Falvey, J. E., & Cohen, C. R. (2004). The buck stops here: Documenting clinical supervision. *The Clinical Supervisor, 22*(2), 63-80. doi.org/10.1300/J001v22n02_05.

Farber, E. W. (2010). Humanist-existential psychotherapy competencies and the supervisory process. *Psychotherapy: Theory, Research, Practice, Training, 47*, 28-34. doi:10.1037/a0018847

Farber, E. W., & Kaslow, N. J. (2010). Introduction to the special section: The role of supervision in ensuring the development of psychotherapy competencies across diverse theoretical perspectives. *Psychotherapy: Theory, Research, Practice, Training, 47*, 1-2. doi:10.1037/a0018850

Fitzgerald, T. D., Hunter, P. V., Hadjistavropoulos, T. & Koocher, G. P. (2010). Ethical and legal considerations for internet-based psychotherapy. *Cognitive Behaviour Therapy, 39*, 173-187. doi:10.1080/16506071003636046

Forrest, L. (2012). Educators' and trainers' responsibilities when trainees' personal beliefs collide with competent practice. *Training and Education in Professional Psychology, 6*, 187-188.doi:10.1037/a0030799

Forrest, L., Elman, N. S., Huprich, S. K., Veilleux, J. C., Jacobs, S. C., & Kaslow, N. J. (2013). Training directors' perceptions of faculty behaviors when dealing with trainee competence problems: A mixed method pilot study. *Training and Education in Professional Psychology, 7*, 23-32. doi: 10.1037/a0032068.

Forrest, L., Elman, N. S., & Shen-Miller, D. (2008). Psychology trainees with competence problems: From individual to ecological conceptualizations. *Training and Education in Professional Psychology, 2*, 183-192. doi: 10.1037/1931-3918.2.4.183

Forrest, L., Elman, N., Gizara, S., Vacha-Haase, T. (1999). Trainee impairment: A review of identification, remediation, dismissal and legal issues. *The Counseling Psychologist, 27*, 627-686. doi: 10.1177/0011000099275001.

Fouad, N., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B, Collins, F.L., Jr., & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3* (4, Suppl), S5-S26. doi: 10.1037/a0015832.

Fouad, N. A. & Grus, C. G. (2014). Competency-based education and training in professional psychology. In W. B. Johnson & N. J. Kaslow (Eds.), *Oxford handbook of education and training in professional psychology* (PP. 105-119). New York: Oxford.

Forrest, L. (2012). Educators' and trainers' responsibilities when trainees' personal beliefs collide with competent practice. *Training and Education in Professional Psychology, 6*, 187-188. doi :10.1037/a0030799.

Forrest, L., Elman, N. S., Huprich, S. K., Veilleux, J. C., Jacobs, S. C., & Kaslow, N. J. (2013). Training directors' perceptions of faculty behaviors when dealing with trainee competence problems: A mixed method pilot study. *Training and Education in Professional Psychology, 7*, 23-32.

Friedlander, M. L., Siegel, S. M., & Brenock, K. (1989). Parallel process in counseling and supervision: A case study. *Journal of Counseling Psychology, 36*, 149–157.

Gilfoyle, N. (2008). The legal exosystem: Risk management in addressing student competence problems in professional psychology training. *Training and Education in Professional Psychology, 2*, 202-209. doi: 10.1037/1931-3918.2.4.202

Gottlieb, M. C., Robinson, K., & Younggren, J. N. (2007). Multiple relations in supervision: Guidance for administrators, supervisors, and students. *Professional Psychology: Research and Practice, 38*, 241-247. doi:10.1037/0735-7028.38.3.241

Goodyear, R. K., & Nelson, M. L. (1997). The major supervision formats. In C. E. Watkins, *Handbook of psychotherapy supervision* (pp. 328-344). New York: Wiley.

Goodyear, R. K., & Rodolfa, E. (2012). Negotiating the complex ethical terrain of clinical supervision. In S.J. Knapp, M.C. Gottlieb, M.M. Handelsman, & L.D. VandeCreek (Eds.), *APA handbook of ethics in psychology: Practice, teaching, and research (Volume 2)* (pp. 261–276). Washington, D.C.: American Psychological Association.

Gruppen, L. D., White, C., Fitzgerald, J. T., Grum, C. M. & Woolliscroft, J. O. (2000). Medical students' self-assessments and their allocations of learning time. *Academic Medicine, 75*, 374-379.

Grus, C. L., & Kaslow, N. J. (2014). Professionalism: Professional values and attitudes in psychology. In W. B. Johnson & N. J. Kaslow (Eds.), *Oxford handbook of education and training in professional psychology* (pp. 491-509). New York: Oxford.

Haggerty, G., & Hilsenroth, M. J. (2011). The use of video in psychotherapy supervision. *British Journal of Psychotherapy, 27*, 193-210.doi:10.1111/j.1752-0118.2011.01232.x

Handelsman, M. M., Gottlieb, M. C., & Knapp, S. (2005). Training ethical psychologists: An acculturation model. *Professional Psychology: Research and Practice, 36*, 59-65. doi:10.1037/0735-7028.36.1.59

Hatcher, R. L., Fouad, N. A., Grus, C. L., Campbell, L. F., McCutcheon, S. R., & Leahy, K. L. (2013). Competency benchmarks: Practical steps toward a culture of competence. *Training and Education In Professional Psychology, 7*(2), 84-91. doi:10.1037/a0029401.

Hatcher, R. L., & Lassiter, K. D. (2007). Initial training in professional psychology: The practicum competencies outline. *Training and Education in Professional Psychology, 1*(1), 49-63. doi:10.1037/1931-3918.1.1.49.

Hattie, J., & Timperley, H. (2007). The power of feedback. *Review of Educational Research, 77*(1),81-112.

Hess, A. K., (2011). Psychotherapy supervision. In J. Norcross, G. R. VandenBos & D. K. Freedheim, (Eds), (2011). *History of psychotherapy: Continuity and change* (2nd ed., pp. 703-722). Washington, DC: American Psychological Association. doi: 10.1037/12353- 047.

Hodges, B. D., Ginsburg, S., Cruess, R., Cruess, S., Delport, R., Hafferty, F., Ho, M. J., et al. (2011). Assessment of professionalism: recommendations from the Ottawa 2010 Conference. *Medical teacher, 33*(5), 354–63. doi.org/10.3109/0142159X.2011.577300.

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

Holloway, E. L. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage.

Huhra, R. L., Yamokoski-Maynhart, C. A., & Prieto, L. R. (2008). Reviewing videotape in supervision: A developmental approach. *Journal of Counseling & Development, 86*, 412- 418.doi. org/10.1002/j.1556-6678.2008.tb00529.x.

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington DC: Interprofessional Education Collaborative.

Jacobs, S. C., Huprich, S. K.; Grus, C. L., Cage, E. A., Elman, N. S., Forrest, L., Schwartz- Mette, R., Shen-Miller, D. S., Van Sickle, K. S., & Kaslow, N. J. (2011). Trainees with professional competency problems: Preparing trainers for difficult but necessary conversations. *Training and Education in Professional Psychology, 5*, 175-184. doi: 10.1037/a0024656.

Johnson, W. B., & Huwe, J. M. (2002). Toward a typology of mentorship dysfunction in graduate school. *Psychotherapy: Theory, Research, Practice, Training, 39(1)*, 44-55. doi:10.1037/0033-3204.39.1.44.

Kaslow, N. J., Borden, K. A., Collins, F. L., Forrest, L., Illfelder-Kaye, J., Nelson, P. D., . . . Willmuth, M. E. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology, 60*, 699-712. doi:10.1002/jclp.20016.

Kaslow, N. J., Grus, C. L., Campbell, L. F., Fouad, N. A., Hatcher, R. L., & Rodolfa, E. R. (2009). Competency assessment toolkit for professional psychology. *Training and Education in Professional Psychology, 3*, S27 – S45. doi.org/10.1037/a0015833.

Kaslow, N. J., & Mascaro, N. A. (2007). Mentoring interns and postdoctoral residents in academic health sciences center. *Journal of Clinical Psychology in Medical Settings, 14*, 191-196. doi:10.1007/s10880-007-9070-y.

Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., . . . Smith, I. L. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice, 38*, 441-451. doi:10.1037/0735-7028.38.5.441.

Kaslow, N. J., Rubin, N. R., Forrest, L., Elman, N. S., Van Horne, B. A., Jacobs, S. C., … & Thorn, B.E. (2007). Recognizing, assessing, and intervening with problems of professional competence. *Professional Psychology: Research and Practice, 38*, 479-492. doi: 10.1037/0735-7028.38.5.479.

Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology*. Routledge.

Kitchener, K. S. (1992). Psychologist as teacher and mentor: Affirming ethical values throughout the curriculum. *Professional Psychology: Research and Practice*, 23, 190. doi.org/10.1037/0735-7028.23.3.190.

Knapp, S., Handelsman, M. M., Gottlieb, M. C., & VandeCreek, L. D. (2013). The dark side of professional ethics. *Professional Psychology: Research And Practice, 44*(6), 371-377. doi:10.1037/a0035110

Koocher, G. P., & Keith-Spiegel, P. (2008). *Ethics in psychology and the mental health professions: Standards and cases* (3rd ed.). New York: Oxford University Press.

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development*, 77, 447-455. doi. org/10.1002/j.1556-6676.1999.tb02472.x.

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. a. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*(1), 10-24. doi.org/10.1037/0022-0167.43.1.10.

Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy Supervisor Ethical Practices: Adherence to Guidelines, the Supervisory Working Alliance, and Supervisee Satisfaction. *The Counseling Psychologist*, *27*(3), 443–475. doi. org/10.1177/0011000099273008.

Ladany, N., Mori, Y., & Mehr, K. W. (2013). Effective and ineffective supervision. *The Counseling Psychologist, 41*, 28-47. doi:10.1177/0011000012442648.

Lehrman-Waterman, D. & Ladany, N. (2001). Development and Validation of the Evaluation Process within Supervision Inventory. *Journal of Counseling Psychology, 48*, 168-177. Doi: 10.1037//0022-0167.48.2.168.

Lewis, B. L. (2010). Social justice in practicum training: Competencies and developmental implications. *Training and Education in Professional Psychology, 4*, 145-152. doi: 10.1037/a0017383.

Luepker, E. T. (2012). *Record keeping in psychotherapy and counseling (2nded.)*. NY: Routledge.

McAdams, C. R., & Foster, V. A. (2007). A guide to just and fair remediation of counseling students with professional performance deficiencies. *Counselor Education and Supervision, 47*, 2-13. doi: 10.1002/j.1556-6978.2007.tb00034.x.

Mehr, K. E., Ladany, N., & Caskie, G. I. L. (2010). Trainee nondisclosure in supervision: What are they not telling you? *Counseling and Psychotherapy Research*, 10, 103–113. doi. org/10.1080/14733141003712301.

Merriam-Webster Online Dictionary. (2013). *Definition of professionalism*. Retrieved from: http://www.merriam-webster.com/dictionary/professionalism

Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice*. Leicester, England: Malden Blackwell Publishing.

Milne, D., & Reiser, R. P. (2012). A rationale for evidence-based clinical supervision. *Journal of Contemporary Psychotherapy*, 42(3), 139-149. doi.org/10.1007/s10879-011-9199-8.

Mintz, L. B., Jackson, A. P., Neville, H. A., Illfelder-Kaye, J., Winterowd, C. L., & Loewy, M. I. (2009). The need for a counseling psychology model training values statement addressing diversity. *The Counseling Psychologist, 37*, 644-675. doi. org/10.1177/0011000009331931.

Miville, M. L., Duan, C., Nutt, R., Waehler, C., Suzuki, L., Pistole, M. C., Arredondo, P., Duffy, M., Mejia, B., & Corpus, M. (2009). Integrating practice guidelines into professional training: Implications for diversity competence. *The Counseling Psychologist, 37*, 519- 563. doi. org/10.1177/0011000008323651.

Miville, M. L., Rosa, D., & Constantine, M. G. (2005). Building multicultural competence in clinical supervision contexts. In M. G. Constantine & D. W. Sue (Eds.), *Building multicultural competence in mental health and educational settings* (pp. 192-211). New York: Wiley.

Myers, S. B., Endres, M. A., Ruddy, M. E., & Zelikovsky, N. (2012). Psychology graduate training in the era of online social networking. *Training and Education in Professional Psychology, 6*(1), 28. doi. org/10.1037/a0026388.

National Association of School Psychologists. (2010). *Model for comprehensive and integrated school psychological services*. Retrieved from: http://www.nasponline.org/standards/2010standards/2_PracticeModel.pdf.

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

New Leadership Alliance for Student Learning and Accountability. (2012). *Committing to quality: Guidelines for assessment and accountability in higher education*. Washington, DC: New Leadership Alliance for Student Learning and Accountability.

Newman, C. F. (2013). Training cognitive behavioral therapy supervisors: Didactics, simulated practice, and 'meta-supervision.' *Journal of Cognitive Neuroscience, 25*, 5-18. doi: 10.18910889-83.91.27.1.5.

New Zealand Psychologists Board. (2007). *Guidelines on supervision*. Retrieved from: http://www.psychologistsboard.org.nz/cms_show_download.php?id=220

Noelle, M. (2003). Self-report in supervision: Positive and negative slants. *The Clinical Supervisor, 21*, 125–134. doi.org/10.1300/J001v21n01_10.

O'Donovan, A., Halford, W. K., & Walters, B. (2011) Towards best practice supervision of clinical psychology trainees. *Australian Psychologist, 46*, 101–112. doi.org/10.1111/j.1742-9544.2011.00033.x.

Osborn, C. J. & Davis, T. E. (2009). Ethical issues in the clinical supervision of evidence-based practices. In N.Pelling, J. Barletta, & A. Armstrong (Eds.) *The practice of clinical supervision*. (pp. 56-80). Sydney: Australian Academic Press.

Pedersen, P. B. (1990). The multicultural perspective as a fourth force in counseling. Journal of *Mental Health Counseling, 12*, 93-95. Retrieved from: http://search.proquest.com/docview/617746506?accountid=14512

Pepinsky, H. B., & Pepinsky, P. N. (1954). *Counseling: Theory and practice* (pp. 144-170). New York: Ronald Press.

Pettifor, J. L., McCarron, M. C. E., Schoepp, G., Stark, C., & Stewart, D. (2010). *Resource guide for psychologists: Ethical supervision in teaching, research, practice, and administration*. Canadian Psychological Association. Retrieved from www.cpa.ca/.../Ethics/CPAcoeEthicalSuperGuideApprovedNovember2010.Pdf

Pope, K. S., & Vasquez, M. J. T. (2011). *Ethics in therapy & counseling* (4th ed.). New York: Wiley.

Pope, K. S., Sonne, J. L., & Green, B. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients* (2nd ed.). Washington, DC: American Psychological Association.

Porter, N., & Vasquez, M. (1997). Covision: Feminist supervision, process, and collaboration. In J. Worell & N. Johnson (Eds), (1997). *Shaping the future of feminist psychology: Education, research, and practice*. Psychology of women book series, (pp. 155-171). Washington, DC: American Psychological Association, doi: 10.1037/10245-007

Psychology Board of Australia. (2013). *Guidelines for supervisors and supervisor training providers*. Retrieved from: http://www.psychologyboard.gov.au/Standards-and-Guidelines/Codes-Guidelines-Policies.aspx

Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisolm, R. R. (2009). Using client feedback in psychotherapy training: n analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology, 3*, 157-168. doi:10.1037/a0015673.

Reiser, R. P., & Milne, D. (2012). Supervising cognitive-behavioral psychotherapy: Pressing needs, impressing possibilities. *Journal of Contemporary Psychotherapy, 42*, 161-171. doi:10.1007/s10879-011-9200-6.

Rings, J. A., Genuchi, M. C., Hall, M. D., Angelo, M., & Cornish, J. A. E. (2009). Is there consensus among predoctoral internship training directors regarding clinical supervision competencies? A descriptive analysis. *Training and Education in Professional Psychology, 3*, 140-147. doi:10.1037/a0015054.

Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L. Ritchie, P. (2005). A Cube Model for Competency Development: Implications for Psychology Educators and Regulators. *Professional Psychology: Research and Practice, 36*, 347 - 354. doi.org/10.1037/0735-7028.36.4.347.

Rosenberg, J. I., Getzelman, M. A., Arcinue, F., & Oren, C. Z. (2005). An exploratory look at students' experiences of problematic peers in academic professional psychology programs. *Professional Psychology, Research and Practice, 36*, 665-673. doi: 10.1037/0735-7028.36.6.665.

Ryde, J. (2000). Supervising across difference. *International Journal of Psychotherapy, 5*, 37- 48. doi.org/10.1080/13569080050020254.

Saccuzzo, D. P. (2002; November). Liability for the failure to supervise adequately: Let the master beware, Part 1. *The Psychologist's Legal Update, 13*, 1-14. Washington, DC: Council for the National Register of Health Service Providers in Psychology.

Safran, J. D., Muran, J. C., Stevens, C., & Rothman, M. (2008). A relational approach to supervision: Addressing ruptures in alliance. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (pp. 137-157). Washington, DC: American Psychological Association.

Sarnat, J. (2010). Key competencies of the psychodynamic psychotherapist and how to teach them in supervision. *Psychotherapy: Theory, Research, Practice, Training, 47*, 20-27. doi:10.1037/a0018846

Schön, D. A. (1987). *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*. San Francisco, CA: Jossey-Bass.

Scott, T. L., Pachana, N. A., & Sofronoff, K. (2011). Survey of current curriculum practices within Australian postgraduate clinical training programmes: Students' and programme directors' perspectives. Australian Psychologist, 46(2), 77-89. doi.org/10.1111/j.1742-9544.2011.00030.x.

Shen-Miller, D. S., Forrest, L., & Burt, M. (2012). Contextual influences on faculty diversity conceptualizations when working with trainee competence problems. *The Counseling Psychologist, 40*, 1181-1219. doi: 10.1177/0011000011431832.

Shen-Miller, D. S., Grus, C. L., Van Sickle, K. S., Schwartz-Mette, R., Cage, E. A., Elman, N. S., Jacobs, S. C., & Kaslow, N. J. (2011). Trainees' experiences with peers having competence problems: A national survey. *Training and Education in Professional Psychology, 5*, 112-121. doi: 10.1177/0011000011431832.

Shen Miller, D. S., Forrest, L., & Elman, N. S. (2009). Training directors' conceptualizations of the intersections of diversity and trainee competence problems: A preliminary analysis. *The Counseling Psychologist, 37*, 482-518.doi.org/10.1177/0011000008316656.

Snowman, J., McCown, R. R., & Biehler, R. (2012). *Psychology applied to teaching*. Belmont, CA: Wadsworth.

Sommers-Flanagan, R. (2012). Boundaries, multiple roles, and the professional relationship. In S. Knapp, M. Gottlieb, M. Handelsman & L.D. VandeCreek, (Eds), *APA handbook of ethics in psychology*, Vol 1: Moral foundations and common themes. APA handbooks in psychology., (pp. 241-277). Washington, DC: American Psychological Association. doi: 10.1037/13271-009.

Stoltenberg, C. D., & McNeill, B. W. (2010). *IDM supervision: An integrative developmental model for supervising counselors and therapists* (3rd ed.). New York, NY: Routledge Taylor & Francis Group.

Stoltenberg, C. D. & Pace, T. M. (2008). Science and practice in supervision: An evidence- based practice in psychology approach. , In W. B. Walsh (Ed.). *Biennial review of counseling psychology* (Vol. 1), pp. 71-95. NY: Routledge/Taylor & Francis Group..

Stucky, K. J., Bush, S., & Donders, J. (2010). Providing effective supervision in clinical neuropsychology. *The Clinical Neuropsychologist, 24*, 737-758. doi:10.1080/13854046.2010.490788

Tarvydas, V. M. (1995). Ethics and the practice of rehabilitation counselor supervision. *Rehabilitation Counseling Bulletin, 38*, 294–306.

Thomas, J. T. (2007). Informed consent through contracting for supervision: Minimizing risks, enhancing benefits. *Professional Psychology: Research and Practice, 38*, 221–231. doi: 10.1037/0735-7028.38.3.221.

Thomas, J. T. (2010). *The ethics of supervision and consultation: Practical guidance for mental health professionals*. Washington, DC: American Psychological Association.

Van De Camp, K., Vernooij-Dassen, M. J., Grol, R. P., & Bottema, B. J. (2004). How to conceptualize professionalism: a qualitative study. *Medical Teacher, 26*(8), 696-702. doi. org/10.1080/01421590400019518.

Vasquez, M. J. T., & Bingham, R. P. (2012). Ethics in counseling psychology. In E. M. Altmaier & J. C. Hansen (Eds) (2012). *The Oxford Handbook of Counseling Psychology*. New York: Oxford University Press.

Veilleux, J. C., January, A. M., VanderVeen, J. W., Reddy, L. F., & Klonoff, E. A. (2012). Differentiating amongst characteristics associated with problems of professional competence: Perceptions of graduate student peers. *Training and Education in Professional Psychology, 6*, 113-121. doi: 10.1037/a0028337.

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self- assessment bias in mental health providers. *Psychological Reports, 110*, 639-644. doi.org/10.2466/02.07.17.PR0.110.2.639-644.

Watkins Jr, C. E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor*, 30(2), 235-256. doi.org/10.1080/07325223.2011.619417.

Watkins, C. E., Jr. (1996). On demoralization and awe in psychotherapy supervision. *Clinical Supervisor, 14*, 139-148. doi.org/10.1300/J001v14n01_10.

Watkins Jr, C. E. (2012). Psychotherapy supervision in the new millennium: Competency-based, evidence-based, particularized, and energized. *Journal of Contemporary Psychotherapy*, 42(3), 193-203. doi.org/10.1007/s10879-011-9202-4.

Werth Jr, J. L., Welfel, E. R. E., & Benjamin, G. A. H. (2009). *The duty to protect: Ethical, legal, and professional considerations for mental health professionals*. Washington DC: American Psychological Association. doi: 10.1037/11866-000.

Westberg, J., & Jason, H. (1993). Providing constructive feedback. In J. Westberg, & H. Jason (Eds.), *Collaborative clinical education: The foundation of effective health care* (pp.297- 318). New York: Springer Publishing.

Williams, L. (1994). A tool for Training Supervisors: Using the Supervision Feedback Form (SFF). *Journal of Marital and Family Therapy, 20*, 311–315. doi.org/10.1111/j.1752- 0606.1994.tb00119.x.

Winterowd, C. L., Adams, E. M., Miville, M. L., & Mintz, L. (2009) Operationalizing, instilling, and assessing counseling psychology training values in academic programs. *The Counseling Psychologist, 37*, 676-704.doi.org/10.1177/0011000009331936.

Wise, E. H., Sturm, C. A., Nutt, R. L., Rodolfa, E., Schaffer, J. B., & Webb, C. (2010). Life-long learning for psychologists: Current status and a vision for the future. *Professional Psychology: Research and Practice*, 41(4), 288.doi.org/10.1037/a0020424.

Worthington, R. L., Tan, J. A., & Poulin, K. (2002). Ethically questionable behaviors among supervisees: An exploratory investigation. *Ethics & Behavior, 12*(4), 323-351. doi.org/10.1207/S15327019EB1204_02.

Worthen, V. E., & Lambert, M. J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations**.** *Counseling & Psychotherapy Research, 7*(1), 48-53.doi:10.1080/14733140601140873.

Yourman, D. B., & Farber, B. A. (1996). Nondisclosure and distortion in psychotherapy Supervision. *Psychotherapy: Theory, Research, Practice, Training, 33*, 567–575. doi.org/10.1037/0033-3204.33.4.567.

APPENDIX

DEFINITIONS

Assessment refers to the processes supervisors use to gather, interpret, and synthesize data about clients/patients, supervisees, and supervision (Ellis et al., 2008). We define assessment to include observations of supervisees' psychological practice, clinical assessment, as well as formal measures, scales, rating protocols, and evaluation performance ratings. Assessment entails gathering data to make inferences, for example about evaluation performance of the supervisee, the supervisor, and the supervisory relationship. Assessment pertains to assessing and measuring *attributes* of supervisees (characteristics, traits, values, behaviors, competence, and so forth).

Benchmarks are standards for measuring performance that can be used for comparison and to identify where a need for improvement exists. They connote task or performance indicators (Kaslow, Rubin, Bebeau, & et al., 2007).

Boundaries are "a limit, rule, guideline or protective space that helps define the relationship or is defined by the relationship" (Sommers-Flanagan, 2012, p. 246).

Clients/patients refers to the child, adolescent, adult, older adult, couple, family, group, organization, community, or other population receiving psychological services.

Competence "in professional psychology is the ability to demonstrate context-relevant knowledge, skills and professional attitudes (as expressed in behavior) and their integration." Competence is judged in relation to a standard or a set of performance criteria" (adapted from ASPPB, 2013b).

Competencies are the integration of psychologically relevant knowledge, skills, values, and attitudes that are judiciously applied in context to the required standard for a desired outcome (ASPPB, 2013b). They are a constellation of demonstrable elements: knowledge, skills and attitudes, and their integration.

Diversity refers to self-awareness, competence, and respect for the multicultural identities (e.g., cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status), and the resultant multiple worldviews of the client(s)/patient(s), supervisee/therapist, and supervisor(s).

Diversity c**ompetency** refers to self-awareness and knowledge, skills, and attitudes regarding the multiple identities of the client(s)/patient(s), supervisee/therapist, and supervisor(s) to work within the context of individual and cultural diversity-awareness, and the infusion of these into professional practice and clinical supervision. Diversity competency includes the use of reflective practice and the sensitivity and skills to work with diverse individuals, groups, and communities who represent various cultural and personal background as well as characteristics defined broadly and consistent with APA policy (Fouad et al.,2009).

Evaluation involves determining the extent to which expected performance is congruent with actual performance (Ellis et al., 2008) and establishing a timely and specific process for providing information to supervisees regarding their performance. Evaluation also includes providing information regarding the evaluation process to the student at the beginning of supervision (APA, 2010, 7.06).

Evidence-based practice integrates "the best available research with clinical expertise in the context of client/patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-based Practice, 2006, p. 271).

Feedback refers to the "timely and specific" (APA, 2010, 7.06) process of explicitly communicating information about performance—Feedback can be verbal, written, or both. Effective feedback provides a balance of positive (that which meets or exceeds performance expectations) and constructive feedback (that which needs improvement) to the supervisee about (a) the supervisee's progress towards supervision goals, competency attainment, and professional development; and perceptions of (b) the process and content of supervision, the nature of the supervisory relationship, and effectiveness of supervision.

Formative evaluation refers to ongoing assessment and monitoring of the supervisee's performance in comparison to the expected, criterion-referenced goals for the supervisee's development of competence (knowledge, skills, and attitudes). The purpose of formative evaluation is fostering the supervisee's growth and professional development. Formative evaluation is the set of inferences and conclusions supervisors make about the supervisee's ongoing performance.

Foundational competencies refer to the knowledge, skills, and attitudes that serve as the foundation for the functions a psychologist is expected to carry out. Foundational competencies are interdependent with each other and with the functional competencies (Rodolfa et al., 2005). Foundational competencies are further described in the Competency Benchmarks (Fouad et al., 2009); and the 2011 (APA, 2011) revisions to the competency benchmarks model that include Professionalism, Ethics/Legal Standards, Individual and Cultural Diversity, Reflective Practice/Self-assessment/Self-care, Relationships, Scientific Knowledge and Methods, and Research/Evaluation

Functional competencies encompass the major functions that a psychologist is expected to carry out (Rodolfa et al., 2005). Functional competencies include Assessment, Intervention, Consultation, Evidence Based Practice, Supervision, Teaching, Interdisciplinary Systems, Management/Administration, and Advocacy (Fouad et al., 2009).

Gatekeeping is the ethical obligation not to graduate, promote, or allow to proceed "those who because of their incompetence or lack of ethical sensitivity would inflict harm on the consumers they have agreed to help"

(Kitchener, 1992, p. 190) to ensure maintenance of the integrity of the profession (modified from Brear & Dorrian, 2010, Behnke, 2005). A most important gate supervisees must pass through (or not) is licensure permitting independent practice (Goodyear & Rodolfa, 2012).

Inferences refer to tentative conclusions based on information that has been gathered (e.g., from observations, measures, or other data; Ellis et al., 2008).

Informed consent is a legal and ethical obligation and respectful process to provide information to supervisees about the nature of the supervision relationship, logistics, expectations, and the requirements and competencies that must be met for satisfactory completion (adapted from Thomas, 2010).

Observation refers to information that is secured by immediate sensory experience (visual, auditory, kinesthetic; Pepinsky & Pepinsky, 1954). In the case of supervision, observations may be conducted via video or live.

Problems of professional competence is the preferred terminology to refer to supervisees whose performance or behavior does not meet professional and/or ethical standards for professional practice. The use of the phrase, problems of professional competence, conveys three essential points: there is a performance problem or deficiency; there is a professional competency standard that the trainee is not attaining; the performance problem(s) is defined in a competency/behavioral framework..

Professionalism is a multidimensional construct that includes interpersonal, intrapersonal, and public elements (Van de camp, Vernooij-Dassen, Grol, & Bottema, 2004) including behavior and comportment that reflects the values and ethics of psychology, integrity, and responsibility as a psychologist (Fouad et al., 2009). Professionalism is defined as "the conduct, aims, or qualities that characterize or mark a professional or a professional person" (Merriam-Webster Online Dictionary, 2013).

Reflective practice is a process of self-regulated learning that occurs in the context of identification of an unforeseen situation that is in turn examined and results in new understanding (Shön, 1987). It creates an environment of inquiry marked by curiosity, attentiveness, and openness (Carroll, 2010). Reflection is "Purposeful focusing on thoughts, feelings, sensations and behaviour in order to make meaning from those fragments of experience" (Voller, 2009, cited by Carroll, 2010).

Remediation plan is a plan outlining the developmentally expected benchmarks for foundational and functional competencies that the supervisee has not met. The plan describes the problem in each competency domain identified, articulates specific expectations, supervisee responsibilities and actions, supervisor responsibilities and actions, timeframe, assessment, and consequences of successful and unsuccessful remediation (Competency Remediation Plan, APA; Kaslow, Rubin, Forrest, & et al., 2007).

Self-assessment refers to a supervisee "learning and responding to feedback for the purpose of fostering development, identifying and addressing competence challenges and preventing competence problems" (modified from Kaslow, Rubin, Forrest, & et al., 2007).

Summative evaluation refers to the supervisor's summary conclusions regarding the supervisee's status and progress towards competence standards, developmentally appropriate expectations, and program requirements. Summative evaluation necessarily includes formal written feedback to the supervisee. They typically occur at a minimum of twice during a supervisory experience: at mid-point and at the conclusion.

Social justice refers to "the fair and equitable distribution of rights, opportunities, and resources between individuals and between groups of individuals within a given society and the establishment of relations within the society, such that all individuals are treated with an equal degree of respect and dignity" (Lewis, 2010, p. 146).

Supervisee is a person who functions under the extended authority of the psychologist to provide, or while in training to provide, psychological services (ASPPB, 2005).

(Limits of) Supervision confidentiality refers to a statement describing the limits of confidentiality of supervisee disclosures to the supervisor. These limits relate to supervisors' responsibility to disclose supervisee statements/behavior/evaluation as necessary to uphold ethical and legal standards for client/patient protection, to prevent entry into practice of supervisees who are unsuitable for practice (i.e., gatekeeping responsibilities), and to communicate with training programs regarding supervisee development and performance.

Supervision contract is an informed consent document, describing the expectations, goals, requirements, and parameters of supervision; roles and responsibilities of supervisee and supervisor(s); specific limits of confidentiality in supervision (e.g., normative reporting/disclosures to graduate programs, licensing boards, training teams); and liability, direct and vicarious, of the supervisor(s), by virtue of their relationship with the supervisee.

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