

Clinical Supervision of Psychotherapists: A Systematic Review

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TITLE OF THE REVIEW

Clinical Supervision of Psychotherapists: A Systematic Review

BACKGROUND

Clinical supervision is increasingly being recognized as a core professional competency within the mental health field (Brosan, Reynolds, & Moore, 2008). Supervision is also considered an essential component of modern effective health care systems (Kadushin, 2002) and training programs for psychotherapists (Berger & Mizrahi, 2001; Milne, Sheikh, Pattison, & Wilkinson, 2011; Watkins, 2011). Despite the culture of evidence-based practices in mental health settings, the practice of supervision is lagging behind in its use of evidence-informed practices (Schoenwald et al., 2009). Further exacerbating the problem is the fact that most supervisors assume, perhaps erroneously, that the supervision they provide is effective (Kilminster & Jolly, 2000).

Effective supervision may be essential to enhance and maintain psychotherapists' competencies, increase fidelity to evidence-based treatment models, and reduce unnecessary interventions (e.g., psychotherapists making referrals to multiple services when contraindicated or failing to disengage services when goals are achieved) thereby helping reduce waitlist times and health care costs. Although outcome research regarding the effectiveness of supervision is mixed, due to methodological issues (Waller, 2009; Schoenwald, Sheidow, & Chapman, 2009), there is indication that supervision results in improved patient care outcomes (Bambling, King, Raue, Schweitzer, & Lambert, 2006; Bradshaw, Butterworth, & Mairs, 2007; Callahan, Almstrom, Swift, Borja, & Heath, 2009; Milne, Aylott, Fitzpatrick, & Ellis, 2008; Watkins, 2011) and that it acts as a quality assurance mechanism (Schoenwald et al., 2009). Without supervision the quality control of psychotherapy depends on the ability of therapists to self-evaluate their competencies (Hansen et al., 2006). Self-evaluations prove to be difficult with beginning and lower skilled clinicians who are found to typically over-rate their competencies (Vallance, 2005), which can have negative implications for patient outcomes and safety.

Supervision is an ongoing supportive learning process for clinicians of all levels to develop, enhance, monitor, and when necessary, remediate, professional functioning (Bernard & Goodyear, 2014). Supervision is a distinct professional practice with knowledge, skills, and attitudes; for some professions (e.g. Marriage and Family Therapy), supervisors require specific training to be recognised as "supervisors" (Falender, Burnes, & Ellis, 2013; Falender, Ellis, & Burnes, 2013; Bernard & Goodyear, 2014; Reiser & Milne, 2012). Supervision's chief function is to minimize non-purposeful activity and maximize intentionality with the goal of directly optimizing clinician competencies, ensuring quality control, and enhancing confidence for the end goal of optimizing care (Milne, 2009). Supervision and clinical training is provided in a variety of formats including one-on-one supervision, small group

supervision, peer-based consultation, and facilitated team-based consultation. Supervision can include presentations via case discussion/presentation, video review or live presentation/demonstrations (Todd & Storm, 2002).

For this research it is important to operationalize the term “supervision”. There are a number of definitions of supervision put forth by the various mental health professions. For example, the American Psychological Association (2014) defines supervision as:

... 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. (p. 5)

The Association for Counselor Education and Supervision (2011) provide a list of guidelines in twelve areas for addressing the ethical and legal protection of the rights of supervisors, supervisees, and clients; and meeting the professional development needs of supervisees while protecting client welfare. While the Council for Accreditation of Counseling and Related Educational Programs (2009) offer a definition of supervision in an educational setting as:

A tutorial and mentoring form of instruction in which a supervisor monitors the student’s activities in practicum and internship, and facilitates the associated learning and skill development experiences. The supervisor monitors and evaluates the clinical work of the student while monitoring the quality of services offered to clients. (p. 62)

Two more definitions are offered by the American Association for Marriage and Family Therapy (AAMFT) and the National Association of Social Work (NASW).

AAMFT (2014) describe the process of supervising marriage and family therapists (MFT) as: evaluating, training, and providing oversight to trainees using relational or systemic approaches for the purpose of helping them attain systemic clinical skills. Supervision is provided to an MFT or MFT trainee through live observation, face-to-face contact, or visual/audio technology-assisted means. (p. 5)

A final definition of supervision is offered from the NASW (2013). This organization defines professional supervision as:

the relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place. The supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency, and applicable ethical content in the practice setting. The supervisor and the supervisee both share responsibility for carrying out their role in this collaborative process. (p. 6)

Each of the definitions developed by the different professional organizations share developmental, ethical, and supportive roles while each offer different emphases based on the

epistemological roots of their professions and understandings of supervisory relationships. For the purpose of this systematic review we will include all research that defines supervision as including a supportive learning process for clinicians of all levels to develop, enhance, monitor, and when necessary, remediate, professional functioning. We will include research where the supervision sessions may include: case-presentations, presentation of video or audio-tapes from a therapy session, or process recordings (interpersonal process recall). And the supervision can take place: one-to-one, triadic (1 supervisor and dyad), in a group format, live (with call-in and/or with bug in ear), consultation teams, reflecting teams, or online. A further clarification is required to address the objective that will identify research pertaining to the supervision of multicultural competencies.

Developing multicultural competence is integral to the formation of clinical competence (Falender, Shafranske, & Falicov, 2014). Multicultural competencies in psychotherapy* include a range of attitudes, beliefs, knowledge, skills, and actions (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015) that provide a framework to optimize client engagement, participation and benefit from psychotherapeutic intervention and research. Developmental domains of multicultural competencies include psychotherapist self-awareness, the client's worldview, the psychotherapy relationship, and psychotherapy and advocacy interventions (Ratts et al, 2015). There are a number of obstacles to integrating cultural perspectives in supervision including the need to clarify the role of understanding what cultural heritage and sociopolitical context have to do with human suffering and critically examining the epistemological foundations of the psychotherapies that are used (Falicov, 2014). Multicultural competence is considered an ethical and practice imperative and there is a need to clarify the best research-based approaches to the supervision of psychotherapists in this area (Falender, Shafranske, & Falicov, 2014). The aim of this part of the systematic review is to identify the research pertaining to the supervision of multicultural competencies in psychotherapy. This will not include training or workshops about multicultural competencies.

This research is important for a number of reasons. First, little is known about what evidence exists for supporting the use of supervision or what supervision practices may be help/harmful for supervisees, which ultimately impacts the level of care received by patients accessing mental health services (Wheeler & Richards, 2007). Second, little is known about the evidence for multicultural and/or culturally sensitive supervision practices and how these may impact supervisee competence and patient care (Falendar et al., 2014). Third, there is indication in the research literature that competent supervision results in improved patient care outcomes and that it acts as a quality assurance mechanism (Tracey, Wampold, Lichtenberg, & Goodyear, 2014; Watkins, 2012). Without supervision the quality control of mental health interventions depends on the ability of psychotherapists to self-evaluate their competencies. Self-evaluations prove to be difficult with beginning and lower skilled clinicians who are found to typically over-rate their competencies, which can have negative implications for patient outcomes and safety. Finally, supervision is considered an essential component of modern effective health care systems and health care training programs in

general (Kilminster & Jolly, 2000). This systematic review will contribute to enhancing our knowledge of effective supervision practices, including the impact of multicultural supervision, which will lead to improved care, better training, and better management of care for those receiving psychotherapy.

* the terms psychotherapy and psychotherapist are used to refer to all mental health professions and clinicians including counselors, social workers, psychologists, psychiatrists, nurses, pastoral counselors and couple/marriage and family therapists as well as trainees in each of these professions.

OBJECTIVES

This systematic review will address the question: what is the extent, range, and nature of the research literature about evidence-based supervision for psychotherapists?

The objectives for this review are:

- 1) To assess the effectiveness of clinical supervision approaches to: a) enhance the competence of psychotherapists, and b) improve patient/client outcomes.
- 2) To synthesize data from rigorous studies to identify the effectiveness of clinical supervision to enhance multicultural competencies in psychotherapists.
- 3) To assess the effectiveness of clinical supervision approaches to improve patient/client outcomes.
- 4) To identify the components of clinical supervision that appears to be associated with more effective training outcomes for psychotherapists and patient/client outcomes.

EXISTING REVIEWS

Currently there are no systematic reviews on this topic registered with the Campbell or Cochrane collaborations. However, literature searches have been conducted by a number of authors.

For example Bogo and McKnight (2006) published a review of the research and non-research literature pertaining to clinical supervision within the broad field of social work and social work trainee field education. Due to the broad scope of practice of social workers this review did not focus on the practice of psychotherapy by social workers or the supervision of this practice. A systematic review of social work supervision practices specific to the field of child welfare was also conducted by Carpenter, Webb & Bostock (2013), however their scope did not include psychotherapeutic interventions.

Brunero and Stein-Parbury (2008), Francke and Graaff (2012), Butterworth, Bell, Jackson, and Pajnikhar (2007) as well as Cummins (2008) also conducted reviews of the literature examining the effectiveness of clinical supervision for nurses, however similar to Bogo and Mcknight's review the broad scope of nursing practice resulted in little inclusion of studies pertaining to nursing supervision specific to the practice of psychotherapy. Dawson, Phillips and Leggat (2013) broadened the population of their review to include all allied health professions, however, similarly they did not focus on psychotherapy.

Faman and colleagues (2012) completed a systematic review of outcomes of supervision on patient care and medical residents' competencies. Although this review included a targeted population for psychiatry, this study too did not search for, or identify studies specific to supervision for psychotherapy. Other reviews of studies within the field of medicine, such as those by Kilminster and Jolly (2000) identified key mechanisms of supervision leading to positive outcomes including the nature of the supervisory relationship. Other reviews looking at allied health professionals (Barak, Travis, Pyun, & Xie, 2009) focused on positive outcomes for supervising arising through the supervision process including enhanced job satisfaction and reduced burnout. Follow-up reviews are needed as these reviews did not specifically examine supervision pertaining to psychotherapy.

A review conducted by Milne and James (2000) did focus on supervision for psychotherapy, however, psychotherapy was narrowly defined as cognitive behavioral therapy.

Our examination of the state of the literature reveals that a systematic review of the research literature regarding the effectiveness of clinical supervision for psychotherapy does not exist. Furthermore, these parallel reviews suggest that there may well be sufficient RCTs and quasi-experimental studies on this topic area to warrant the conducting of a full systematic review.

INTERVENTION

Clinical Supervision of psychotherapists in which the intervention is delivered on a one-to-one or group basis in any setting (e.g. community clinic, hospital, part of a training program) by a supervisor, using a variety of methods (e.g., live session observation with feedback, tape review, case consultation) and with the primary aim of improving competence in psychotherapy with the broader goal of improved patient/client outcomes.

This review will not include studies pertaining to training or educational interventions that do not include supervision as the primary mechanism of instruction. Educational or training interventions such as workshops and seminars that are principally focused on knowledge development or exchange without a supervisory mechanism that integrates knowledge into the practice of psychotherapy will not be included.

POPULATION

The population to be included in this review are psychotherapists and supervisors who are engaged in clinical supervision. Psychotherapists include psychologists, counsellors, couple/marital and family therapists, social workers, psychiatrists, nurses, and pastoral counsellors.

OUTCOMES

Psychotherapist Competency Outcomes:

The primary outcomes will include standardized measures pertaining to psychotherapy competence including the Objective Structured Clinical examination. Additional measures including supervisor reports and evaluations will be included via qualitative research studies to provide context.

Multicultural Competency Outcomes:

Multicultural competencies in psychotherapy as measured by standardised assessments including Cultural OSCE, Cultural Awareness Tool, Cultural Sensitivity Tool, Cultural Competence Self-Assessment Questionnaire, Cultural Competence health Practitioner Assessment, Multicultural Awareness Knowledge/Skill Survey, Multicultural Counseling Inventory, and the Multicultural Counseling Knowledge Awareness Scale. Additional materials including client reports, supervisor reports, psychotherapist reports, and educator/trainer reports.

Supervision Outcomes/Outcomes Pertaining to the Supervisory Relationship:

The nature of the supervisory relationship will be assessed using outcome measures such as the Leeds Alliance in Supervision Scale, The Manchester Clinical Supervision Scale, Supervision Analysis Questionnaire, and Short form Supervision Satisfaction Questionnaire.

Adverse Outcomes:

Any adverse outcomes of supervision processes will be included as an outcome including a worsening of the psychotherapists skill-set, deterioration of the supervisor-supervisee relationship, and/or reduce multicultural sensitivity.

Secondary Outcomes:

Patient/client care outcomes will be viewed as a secondary outcome of interest. Patient care outcomes will include a range of standardized measures including the Global Assessment of Functioning, Beck Depression Inventory, Child Behavior Checklist, Behavior Assessment System for Children, Parent Stress Index, State-Trait Anxiety Inventory, Outcome Rating Scale, Patient Health Questionnaire, Clinically Useful Depression Outcome

Scale, Centre for Epidemiological Studies Depression Scale, Stages of Change Readiness and Treatment Eagerness Scale.

Adverse Outcomes:

Any adverse outcomes of supervision processes as they pertain to patient outcomes will be included as an outcome including a worsening of the patient/client's condition or circumstances for which they sought psychotherapy.

STUDY DESIGNS

List the types of study designs to be included and excluded (please describe eligible study designs). Where the review aims to include quantitative and qualitative evidence, specify which of the objectives noted above will be addressed using each type of evidence.

The study designs included in the review are controlled trials and qualitative research. The former includes: randomized controlled trials (RCT), quasi-randomized controlled trials, and non-randomized controlled trials (i.e. participants are allocated by other actions controlled by the researcher). Comparison conditions are no intervention, waitlist control, treatment as usual or alternative interventions. If the data allows a meta-analysis will be conducted. RevMan5 (Review Manager) will be employed to assist with organization of the review and the meta-analysis.

By incorporating qualitative research we plan to include an assessment of the quality of the intervention for available research, identify the characteristics associated with successful implementation and the nature of any problems that impede implementation, and the extent to which the effects of the intervention are associated with variation in the quality of the implementation. In addition, qualitative research included within this review will also be utilized to help interpret the findings from any potential meta-analyses conducted separately on RCT and quasi-experimental designs. Qualitative methods will be particularly valuable to understand the fourth objective of this review, that seeks to identify the key mechanisms underpinning supervisory interventions that contribute to supervision being effective for enhance psychotherapist competency and improved patient outcome. We will employ NVivo11 to support our analysis of the qualitative data in order to identify and determine the relationship, if any, between the facets of the supervision process that contribute to effective outcomes for supervisees and for patients/clients. Thematic analysis of qualitative studies will also provide context to interpreting the findings from the RCT and quasi-experimental studies, as well as from any meta-analytic results.

The rationale for including non-randomized study designs in this review is to include rigorous non-random designs common to real-world training facilities for psychotherapy (e.g. hospitals), seek international evidence and include studies from countries and research disciplines, which do not have a tradition for doing RCTs in the area of supervision of

multicultural competencies, and to increase the number of studies for moderator analysis, while attending to the issues related to methodological differences between studies.

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None known.

PRELIMINARY TIMEFRAME

- Date you plan to submit a draft protocol: January 5, 2016
- Date you plan to submit a draft review: February 28, 2017

AUTHOR DECLARATION

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Plans described above will become more refined / specific at protocol stage.**