Best Practices in Clinical Supervision: What Must Supervisees Do?

Johana Rocha

Old Dominion University, johana_L@yahoo.com

Follow this and additional works at: https://digitalcommons.odu.edu/chs_etds

Part of the Counselor Education Commons

Recommended Citation

https://digitalcommons.odu.edu/chs_etds/116

This Dissertation is brought to you for free and open access by the Counseling & Human Services at ODU Digital Commons. It has been accepted for inclusion in Counseling & Human Services Theses & Dissertations by an authorized administrator of ODU Digital Commons. For more information, please contact digitalcommons@odu.edu.
BEST PRACTICES IN CLINICAL SUPERVISION: WHAT MUST SUPERVISEES DO?

by

Johana Rocha
B.A. August 2013, Universidad Nacional Abierta y a Distancia
M.S.Ed. August 2017, Old Dominion University

A Dissertation Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELOR EDUCATION AND SUPERVISION

OLD DOMINION UNIVERSITY
May 2020

Dissertation Committee:

Gülşah Kemer (Chair and Methodologist)

Emily Goodman-Scott (member)

Amber Pope (member)

Ryan Cook (member)
ABSTRACT

BEST PRACTICES IN CLINICAL SUPERVISION: WHAT MUST SUPERVISEES DO?

Johana Rocha
Old Dominion University, 2020
Chair: Dr. Gülşah Kemer

Clinical supervision is critical for training competent counselors who provide ethical and professional services aimed at protecting the welfare of the populations they serve. Despite clearly outlining the roles and responsibilities of supervisors in supervision literature (Borders et al., 2014), scholars have not offered guidelines to inform supervisees with their responsibilities to make the most out of their supervision experiences. Therefore, the purpose of this study is to attend to the gap in the literature by understanding what supervisees perceive as their responsibilities in clinical supervision. Such an effort may inform further studies and provide an empirical basis to establish best practices for supervisees in clinical supervision. This study will be guided by an exploratory sequential mixed-methods design, Concept Mapping (Kane & Trochim, 2007) to explore what supervisees perceive as their responsibilities in clinical supervision. The results will have implications for supervisees, supervisors, and counselor education and supervision programs.
This dissertation is dedicated to my husband Luis, our daughter Valerie, and our noble and playful maltipoo, lily. Your love, support, and encouragement were the engine that helped me run the dissertation journey.

I love you!
ACKNOWLEDGMENTS

This dissertation study was financially sponsored by research grants from the Association for Assessment and Research in Counseling (AARC), the Association for Counselor Education and Supervision (ACES), and the Southern Association for Counselor Education and Supervision (SACES). Their interest on this study, their trust on my ability to conduct it, and their monetary contributions added extensively to the project.

This accomplishment does not only belong to me. Some people around me were the foundational piece in my ability to successfully complete my doctoral dissertation as well as my graduate studies. First and foremost, I want to thank my husband Luis and our daughter Valerie because your unconditional love, support, patience, and trust in my capability to succeed were vital in my ability to enjoy the graduate journey. My dearest Luis, you have always listened to my ideas, supported my decisions, and encouraged me to “go for it.” You were the first person that believed in me and constantly told me “You are an amazing person, mom, wife, student, friend, and worker. Whoever works with you will be lucky because you always give your best.” You have always been there for me and have told me the most caring and kind words when I have felt physically and mentally exhausted. My precious Valerie, you were the motivation that pushed me to get up every day thinking that it would be even better than the day before. Your sticky notes, texts, and voice messages telling me “Mommy, you are amazing, and I am so proud of you and your hard work” became the fuel of the vehicle that took me throughout this journey. Luis, you became my first mentor. Valerie, you became my biggest inspiration. My loves, your presence always reminded me that I was not walking the graduate path alone. Thank you!

Dr. Gülşah Kemer, thank you for your mentoring in the last three years. It has been significant in my role as a student, researcher, and scholar. You have stretched me in ways that
have revealed potential I was not aware of. Your support, encouragement, flexibility, and guidance have fostered the exploration of my talents and nurtured my strengths. Sometimes walking with you, and some others, acting more independently, both made me feel more prepared to go out in the field and continue to pursue my goals. I also want to acknowledge the huge influence that Dr. Jeffry Moe had in my life while in the last year of the doctoral program. I have enjoyed every second of our conversations about life, school, and academia. Your kindness, humor, genuine interest on my wellbeing, openness and collegial approach when discussing different topics, as well as your mentoring, were what kept me looking forward to our meetings. Additionally, I want to thank my dissertation committee: Dr. Gülşah Kemer, Dr. Emily Goodman-Scott, Dr. Amber Pope, and Dr. Ryan Cook for being a wonderful team to work with. Your professionalism, support, kindness, encouragement, contributions, and trust fostered an environment in which I felt respected, appreciated, and valued as a member of the profession moving into a new role. To all of you, thank you for being such wonderful human beings!

To me, it is not about the number of friends you have, but the key ones that are always there to support you. My key friends in this journey were Yesim Giresunlu, Alyssa Reiter, and Beth Orrison. Your encouragement and support added to this process in a way you may not even imagine. You celebrated my achievements, listened to me when all I needed was a listening ear, and constantly reminded me how proud you were of me. What you did not know, is all the time I kept thinking how lucky I was to have you in my life. I feel honored to be your friend, thankful for our friendship, and excited about all the great things you will continue to do for our field. Thank you, friends!

Last, this study could have not been possible without the commitment and hard work of my participants. I appreciate your involvement, efforts, and willingness to share your
perceptions. Your voices planted a significant seed in the field that will continue to be nourished by scholars willing to advance our current knowledge and expand on those voices. Many thanks!
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>iv</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>V</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>VIII</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>X</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>XII</td>
</tr>
<tr>
<td>CHAPTER 1: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Research Impact</td>
<td>4</td>
</tr>
<tr>
<td>Research Design</td>
<td>6</td>
</tr>
<tr>
<td>Research Question</td>
<td>7</td>
</tr>
<tr>
<td>Operational Definitions</td>
<td>7</td>
</tr>
<tr>
<td>CHAPTER 2: LITERATURE REVIEW</td>
<td>10</td>
</tr>
<tr>
<td>Theoretical Framework: Active Learning Theory (Bonwell &amp; Eison, 1991)</td>
<td>10</td>
</tr>
<tr>
<td>The Science of Clinical Supervision</td>
<td>12</td>
</tr>
<tr>
<td>Preliminary Efforts to Determine Standards for Counseling Supervisors</td>
<td>13</td>
</tr>
<tr>
<td>Subsequent Efforts to Outline Supervisors’ Responsibilities in Clinical Supervision</td>
<td>16</td>
</tr>
<tr>
<td>Supervision Models’ Presentations of Supervisors and Supervisees</td>
<td>20</td>
</tr>
<tr>
<td>Literature on Supervisees’ Responsibilities in Supervision</td>
<td>23</td>
</tr>
<tr>
<td>Supervisees and Supervision Outcomes</td>
<td>25</td>
</tr>
<tr>
<td>The Critical Role of Supervisees’ Knowledge of Responsibilities in Clinical Supervision</td>
<td>28</td>
</tr>
<tr>
<td>The Need for a Transactional and Informed Supervision Process</td>
<td>30</td>
</tr>
<tr>
<td>CHAPTER 3: METHODOLOGY</td>
<td>33</td>
</tr>
<tr>
<td>Concept Mapping</td>
<td>33</td>
</tr>
<tr>
<td>Concept Mapping Steps</td>
<td>34</td>
</tr>
<tr>
<td>Step 1: Preparation</td>
<td>35</td>
</tr>
<tr>
<td>Step 2: Generation of Statements</td>
<td>39</td>
</tr>
<tr>
<td>Step 3: Structuring the Statements (Sorting Task)</td>
<td>41</td>
</tr>
<tr>
<td>Step 4: Representation of Statements</td>
<td>43</td>
</tr>
<tr>
<td>Group Similarity Matrix (GSM)</td>
<td>43</td>
</tr>
<tr>
<td>Multidimensional Scaling (MDS)</td>
<td>43</td>
</tr>
<tr>
<td>Hierarchical Cluster Analysis (HCA)</td>
<td>44</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cluster 1: Supervisees’ Commitment to Ethical and Professional Responsibilities</td>
<td>133</td>
</tr>
<tr>
<td>2. Cluster 2: Supervisees’ Commitment to Supervision Time</td>
<td>133</td>
</tr>
<tr>
<td>3. Cluster 3: Supervisees’ Active Engagement in Setting Learning Goals and Expectations</td>
<td>133</td>
</tr>
<tr>
<td>4. Cluster 4: Supervisees’ Intentional Preparation for the Supervision Session</td>
<td>134</td>
</tr>
<tr>
<td>5. Cluster 5: Supervisees’ Positive Attitude and Investment in Supervision</td>
<td>134</td>
</tr>
<tr>
<td>6. Cluster 6: Supervisees’ Willingness to Be Open and Honest in Supervision</td>
<td>135</td>
</tr>
<tr>
<td>7. Cluster 7: Supervisees’ Comfort and Trust in the Supervisory Relationship</td>
<td>136</td>
</tr>
<tr>
<td>8. Cluster 8: Supervisees’ Active Participation in the Supervision Process</td>
<td>136</td>
</tr>
<tr>
<td>9. Cluster 9: Supervisees’ Active Collaboration with Their Supervisor</td>
<td>136</td>
</tr>
<tr>
<td>10. Cluster 10: Supervisees’ Communication of What They Need from Their Supervisor</td>
<td>137</td>
</tr>
<tr>
<td>12. Cluster 12: Supervisees’ Willingness to Offer Feedback to Their Supervisor</td>
<td>139</td>
</tr>
<tr>
<td>13. Cluster 13: Supervisees’ Willingness to Disagree in Supervision</td>
<td>139</td>
</tr>
<tr>
<td>14. Cluster 14: Supervisees’ Investment in Their Own Learning and Growth as Counselors</td>
<td>139</td>
</tr>
<tr>
<td>15. Cluster 15: Supervisees’ Personal Awareness and Reflections on Their Counseling Practice</td>
<td>140</td>
</tr>
<tr>
<td>16. Cluster 16: Supervisees’ Personal Awareness and Reflections on Their Supervision Experience</td>
<td>140</td>
</tr>
<tr>
<td>17. Cluster 17: Supervisees’ Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity</td>
<td>141</td>
</tr>
</tbody>
</table>
18. Cluster 18: Supervisees’ Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices .................................................................141

19. Cluster 19: Supervisees’ Willingness to Process Multicultural Considerations in the Supervisory Relationship ........................................................................................................141

20. Cluster 20: By-Itself-Cluster 1 ........................................................................142

21. Cluster 21: By-Itself-Cluster 2 ........................................................................142

22. Area 1: Essential Tasks of Supervision ................................................................52

23. Area 2: Supervisees’ Approach to Supervision ..................................................54

24. Area 3: Supervisory Relationship and Working Alliance ......................................56

25. Area 4: Supervisees’ Personal and Professional Growth .......................................58

26. Area 5: Inclusion of Multicultural Considerations .................................................60
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Point Map</td>
<td>131</td>
</tr>
<tr>
<td>2. Dendrogram</td>
<td>132</td>
</tr>
<tr>
<td>3. Two-dimensional Cluster Map with Areas</td>
<td>143</td>
</tr>
</tbody>
</table>
CHAPTER 1

Introduction

In this chapter, I will first offer a synopsis of the problem, the research impact, and the purpose of the current study. Next, I will provide an overview of the proposed research design. Last, operational definitions relevant to the study will be discussed.

Background of the Problem

Clinical supervision entails crucial responsibility given that it is a core component in enhancing counselor trainees’ and practicing counselors’ performance (Bernard & Goodyear, 2019; Barnett & Molzon, 2014). Supervisors are ethically responsible to honor the gatekeeping activity by making sure supervisees are fully equipped to engage in professional practices that protect clients’ wellbeing [American Counseling Association (ACA), 2014; Council of Accreditation of Counseling and Related Programs (CACREP), 2016; Bernard & Goodyear, 2019; Borders & Brown, 2005; Pearson, 2004]. Therefore, Borders et al. (2014) developed the Association for Counselor Education and Supervision (ACES) Supervision Best Practices with the purpose of equipping supervisors with a strong foundation for their clinical supervision practices. They offered 12 areas crucial to supervisors’ practices: 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: supervision training and supervision of supervision. These guidelines also provide supervisees with an instrument to advocate for the quality of supervision they receive in order to enhance their counseling practices. Along similar lines, Falender and Shafranske (2014) compiled a series of aspects that supervisors should engage in to guarantee effective supervisor practices. Some of those aspects were (1) effective clinical
supervision, (2) supervisory alliance, (3) diversity, (4) addressing personal factors and countertransference in supervision, (5) competences, self-assessment, feedback, and evaluation, and (6) ethical and legal competencies.

Bernard and Goodyear (2019) assert that supervisors engage in the following roles and responsibilities in their supervision practices: first, the formative role, in which supervisors promote the counselor-in-training development. Second, the normative role, wherein supervisors safeguard the welfare of the communities the trainee serves, as well as performs gatekeeping. Third, the restorative role, where supervisors attend to the emerging needs of the supervisees during the supervision experience as a way to avoid trainee’s burnout. Fourth, the mentoring role, in which supervisors shift their focus from supervisee’s skill competency to engaging in a more collaborative relationship with their supervisees. Last, the rehabilitative role, wherein supervisors oversee supervisees that are required to be under supervision due to an ethical violation. ACA Code of Ethics (2014), section F.4., also states that supervisors are responsible for providing supervisees with an informed consent that includes both policies and procedures for the supervisory encounter, for ensuring supervisees adherence to professional and ethical standards of the profession as well as legal obligations, for informing their supervisees about actions to be taken in case an emergency with their clients arises, and for referring a supervisee to other supervisor in case the supervisory relationship with a supervisee requires early termination due to emerging differences in the supervisory relationship that jeopardize a conducive supervision process. Additionally, supervisors are dually responsible for guaranteeing their own competence as much as their supervisees’ (Bernard & Goodyear, 2019). Lastly, beyond their supervisees, supervisors are responsible toward the agencies they work for,
communities their supervisees cater to, and the society in general (Bernard & Goodyear, 2019; ACA, 2014).

Despite putting an extensive effort on describing supervisors’ practices, placing supervisors as the sole responsible party of the supervisory process, the scholars and guidelines have not placed adequate emphasis on supervisees’ supervision practices. Similar to supervisors’ abovementioned roles and responsibilities, supervisees are responsible to the clients they serve, the supervisors who oversee their work, and society in general (Bernard & Goodyear, 2019). Supervisees hold ethical responsibility to comprehend, honor, and adhere to the ACA Code of Ethics (ACA, 2014). They are also encouraged to use the ACES supervision best practices guidelines with their supervisors to make sure supervisors engage in best practices when providing supervision, so that these practices result in effective counseling implementations (Borders et al., 2014).

Similarly, in the literature, scholars have often conducted research by situating the supervisor as the main subject of study (e.g., Kemer, Sunal, Li, & Burgess, 2019; Bambling & King, 2014). In Kemer et al.’s (2019) study, supervisors from different developmental levels and settings reported that supervisors and supervisees were both responsible for the effectiveness of supervision, and supervisees’ contributions held important weight in enhancing supervision. Furthermore, expert supervisors reported that supervisees enhanced the supervisory relationship and the overall supervision process when they assumed an active role in the supervision process and exhibited constructive attitudes (e.g., openness to supervision, engage in a collegial relationship, willingness to take risks, self-reflect on their own practices; Kemer & Borders, 2017). In other words, these researchers reported clinical supervision, particularly individual
supervision, requiring both supervisor’s and supervisee’s investment in the process (Cook & Sackett, 2018).

In this study, thus, I will examine supervisory roles and responsibilities in clinical supervision with a special focus on counseling supervisees (counselor trainees). Supervisees have a vital role in supervision, because their investment could influence supervisory processes and professional outcomes related to their competencies. Despite being a critical party of the supervision process, supervisees usually appear as passive learners, whose collaborative qualities may often times be shadowed by the hierarchical nature of supervision. To date, no research and/or scholarly work has outlined supervisees’ roles and responsibilities in supervision, or more specifically offered any best practices for supervisees as active agents of the process in order for supervision to be effective (Pearson, 2004; Cook & Sackett, 2018; Kangos et al., 2018). Beyond the necessity of defining supervisees’ part in clinical supervision for the gatekeeping responsibilities, supervision agreements may not always include supervisees’ roles and responsibilities outlining how to perform in supervision and/or collaborate with the supervisors to get the most out of their supervision experiences. Inclusion of descriptions for supervisee role and responsibilities may also offer supervisees with a tool to advocate for themselves. Therefore, in this study, I will focus on exploring and understanding the supervisees’ roles and responsibilities in clinical mental health supervision process, which may offer further guidelines to the stakeholders of clinical supervision.

Research Impact

The current study will have implications for supervisees, supervisors, and counselor education and supervision programs training counselors and supervisors. The findings may advance our knowledge on supervisees’ supervision behaviors by obtaining an understanding of
what supervisees must do in supervision to generate further personal and professional growth as well as positive supervisory outcomes (e.g., positive experiences in supervision for supervisors and supervisees, behaviors that enrich the supervisory dyad, triad and/or group, attention to supervisees’ and supervisors’ needs, improved client outcomes). Findings from this study could also provide supervisees with the guidelines that facilitate supervisees’ understanding and awareness of supervision and their roles and responsibilities. Offering clarity about supervisees’ roles and responsibilities in supervision may serve the dual purpose of creating more opportunities for supervisees to equip themselves to fulfill the diverse needs of clients they serve, as well as empowering supervisees to become co-owners of the supervision process and collaborate in creating a co-nurturing relationship that allows supervisees and supervisors to enrich each other’s practices. Additionally, the findings may provide supervisors with information on what supervisees perceive as their responsibilities when engaging in supervision to contribute to the supervision process. This information may not only facilitate a transactional process as both supervisors and supervisees have clarity about their own and each other’s roles and responsibilities, but also enhance the overall supervision experience as both parties contribute on enhancing the process by acting from an informed frame of reference.

Despite contributing indirectly, the current study may strengthen the mission of the Council for Accreditation of Counseling and Related Educational Programs’ (CACREP, 2016) standards for supervision in practicum and internship in accredited master’s and doctoral programs by enhancing counselor trainees’ professional competence as they understand their responsibilities as supervisees. Similarly, by providing further knowledge and understanding on better equipping supervisees with supervision skills, this study may fortify the Association for Counselor Education and Supervision’s (ACES, n.d.) primary purpose of advancing counselor
education and supervision through the improvement of the quality of counseling services that professionals provide to the communities they serve. Lastly, supporting the American Counseling Association *Code of Ethics*’ (ACA, 2014) goal of protecting client’s well-being, supervisees with more knowledge and awareness of their responsibilities in supervision may contribute to a more efficient supervision process that may parallel their work with the communities they serve in their role as counselors-in-training.

The findings of the current study will be the first empirical effort to establish an understanding towards supervisees’ *best practices in supervision*. Such an understanding may serve as the basis for expanding on this area by replicating the current study with other groups of participants and comparing and/or merging results that enhance the ultimate goal of describing supervisees’ best practices in supervision.

In brief, it is critical to understand and clarify supervisees’ roles and responsibilities inherent to their role in supervision. Such an understanding could enhance supervisees’ practices not only in supervision but also in their counseling; thus, enhancing the practices of other stakeholders (e.g., supervisors, counselor educators), wellness of the clients, and the advancement of the field of counselor education and supervision.

**Research Design**

To explore counseling internship supervisees’ perspectives on their responsibilities to enhance their supervisory experiences, I will utilize an exploratory sequential mixed-methods design (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005), Concept Mapping (CM; Kane & Trochim, 2007). Kane and Trochim described CM as a methodical approach that aims at organizing the thoughts of a group of stakeholders. CM integrates qualitative and quantitative components of inquiry with the purpose of arranging all the ideas (e.g., qualitative element)
generated by the stakeholders into visual representations (e.g., concept maps; quantitative component) of the subject of interest to aid participants in interpreting the results for the subsequent generation of a collective framework. The stakeholders of the subject are imperative to this design as the participants generate the ideas, sort them into clusters, and interpret the obtained maps. In other words, the data collection and analyses procedures prioritize stakeholders’/participants’ perspectives, and researchers are the facilitators of these processes. Researchers have used concept mapping to: (a) examine and (b) comprehend abstract constructs (e.g., expert supervisors’ supervision cognitions; Kemer et al., 2014), and improve existing knowledge by developing conceptual frameworks. Therefore, to obtain a conceptual understanding of supervisees’ supervision responsibilities/behaviors contributing to the supervision process, CM is an ideal design with its procedures; where supervisees will generate the ideas, sort them into conceptually meaningful groups, and engage in dialogues to interpret and finalize the results.

**Research Question**

The design of this study will address the following research question:

What are counseling master’s and doctoral supervisees’ perspectives on their responsibilities to enhance their supervisory experience?

**Operational Definitions**

**Clinical Supervision**

“Supervision is an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession” (Bernard & Goodyear, 2019, p. 9). According to Bernard and Goodyear, the supervision relationship is hierarchical and evaluative in nature, occurs for a period of time, and
has three immediate goals, which consist of (1) improving the performance of the supervisee, (2) tracking the quality of services offered to the populations supervisees serve, and (3) honoring the gatekeeping activity by making sure supervisees are apt to perform in their respective fields.

**Supervisor’s Roles and Responsibilities in Supervision**

Supervisors are responsible for engaging in formative, normative, restorative, mentoring, and rehabilitation roles (Bernard & Goodyear, 2019) to attend to the competency level of counselors-in-training (Borders, 2005) they are supervising, while being well-versed in the area of supervision and comply to the required qualifications (e.g., training, continuing education) in both counseling and supervision to provide quality supervision services [Bernard & Goodyear, 2019; ACA, 2014; American Mental Health Counselors Association (AMHCA), 2016].

**Supervisee’s Roles and Responsibilities in Supervision**

According to ACA Code of Ethics (2014), counselor trainees are ethically responsible for comprehending and honoring the ACA Code of Ethics, informing their supervisors about any existent or emerging impairment(s) that can impact their work with their clients, and disclosing with their clients their status as counselors-in-training receiving supervision from a senior professional counselor. Supervisee’s roles and responsibilities are demonstrated through supervisee’s behaviors in supervision. Thus, for the rest of the document, “supervisee’s behaviors” will be used to address the purpose of the current study.

**Best Practices in Clinical Supervision for Supervisors**

This term refers to “approaches to counseling practice that have empirical evidence to support their effectiveness” (Sexton, 1999, p. 1). ACES Best Practices in Clinical Supervision (Borders et al., 2014) offers clinical supervisors with precise guidelines for their work with their supervisees in 12 specific areas; (1) initiating supervision, (2) goal setting, (3) giving feedback,
(4) conducting supervision, (5) the supervisory relationship, (6) diversity and advocacy considerations, (7) ethical considerations, (8) documentation, (9) evaluation, (10) supervision format, (11) the supervisor, and (12) supervisor preparation: supervision training and supervision of supervision (Borders et al., 2014).

**Best Practices in Clinical Supervision for Supervisees**

As previously mentioned, although supervisors have a best practices guideline that help guide their work in clinical supervision, supervisees on the other hand, usually go into supervision as blank slates. Therefore, the current study aims at obtaining an initial conceptual understanding toward supervisees’ best practices in clinical supervision.
CHAPTER 2

Literature Review

In this chapter, I will provide a brief theoretical framework and a review of the existing literature on supervisors’ and supervisees’ roles and responsibilities in clinical supervision, informing the current study. The section will be concluded with a discussion of need for an understanding of supervisees’ behaviors in clinical supervision to enhance their gaining out of the supervisory process; thus, increase the quality of services supervisees provide to clients.

Theoretical Framework: Active Learning Theory (Bonwell & Eison, 1991)

Active Learning Theory (ALT; Bonwell & Eison, 1991) suggests experience through active participation as the core mean of knowledge acquisition. Active learning fosters environments that stimulate student’s involvement while encouraging students’ interest on the subject, promoting their confidence as they are invited to become co-owners of the experience, and sharing responsibility for the outcome. In addition, ALT aims at evoking students’ examination of their attitudes and values (Bonwell & Eison, 1991; Wrenn & Wrenn, 2009) that may enhance and/or hinder their learning experience. Bonwell and Eison (1991) asserted that students must defer from merely listening and integrate doing by engaging, discussing, and being part of problem-solving dynamics. Active learning is a highly involved process where the instructor creates an inviting environment for students to openly speak up, clarify, ask questions, and engage in analysis, synthesis, and evaluation as part of their learning process. In the meanwhile, students have to be intentional about what they do and place some thought into those actions to enhance their learning process (Bonwell & Eison; Wrenn & Wrenn).
**ALT and Clinical Supervision**

ALT appears as a natural fit to clinical supervision because the supervisory dyad involves a more experienced professional assisting a less experienced professional or professional in training in: (1) strengthening their skills to improve performance, (2) tracking quality of services offered by the supervisee, and (3) engaging in a gatekeeping activity in which supervisor makes sure the supervisee is fully equipped to perform in the field. In this process, the supervisor is typically described as the one more invested taking vast responsibility for supervision outcomes.

On the other hand, within the supervisory dyad, supervisees must not be passive receivers, but more of an active and involved party of the process. Supervisees must be aware of their behaviors in supervision, enable interaction and active participation by co-owning the supervision experience, embrace the supervisory dynamics, acknowledge they are equally important in the supervisory dyad, understand they are responsible to some extent for the supervision outcomes, and believe in their ability and potential to contribute to the supervisory process. Therefore, premises of ALT are an ideal fit for the supervisory dyad, where both supervisors and supervisees could have a clear understanding of their responsibilities in clinical supervision, while they display behaviors that are in tune with what is expected of each parties’ involvement and engagement. These behaviors may involve supervisor and supervisee taking ownership for the supervision process, supporting each other’s practices, and fostering an environment in which both parties understand they are both part of the task and their actions may directly impact each other’s experience satisfaction, learning, and outcome. Empowering both parties of the supervisory process, active participation in clinical supervision may also result in satisfaction that permeates both the supervisory encounter (i.e., supervisor – supervisee) as well as the counseling encounter (i.e., counselor – client). Therefore, the current study is based on the
fundamental premises of ALT, where both supervisors and supervisees are active participants of the supervisory process, holding similar and different responsibilities.

**The Science of Clinical Supervision**

Since 1920s, supervisee competence in clinical supervision has been the main focus of clinical supervision process, beyond the client welfare and counseling outcomes (Bernard & Goodyear, 2019). More specifically, clinical supervision provides the necessary tools for high-quality counseling delivery and client welfare (Borders et al., 2014). Borders et al. asserted that the aim is at building the legacy of improved supervision, as supervisees receive best practices and provide the same to their own clients. In order to fulfill these purposes, supervision scholars have offered different resources to the clinical supervisors in the last 29 years. Some of these resources include the ACES Standards for Counseling Supervisors (1990), ACES Best Practices in Clinical Supervision (Borders et al., 2014), American Counseling Association (ACA) *Code of Ethics* (2014), and Council for Accreditation of Counseling and Related Educational Programs Standards (CACREP, 2016).

ACES Standards for Counseling Supervisors were an initial effort aimed at providing recommendations for supervisors in their work with their supervisees (ACES, 1990; Dye & Borders, 1990). Such an effort was deemed to be crucial in the acknowledgement of clinical supervision as a specialty area (Borders et al., 2014). In the ACES Best Practices in Clinical Supervision, Borders et al. provided guidelines to supervisors with the goal of (1) assisting them as they work with their supervisees in enhancing supervisees’ professional development, and (2) enhancing supervisors’ decision making aimed at safeguarding clients’ welfare. The ACA *Code of Ethics* (2014) offers suggestions for supervisors in their work with their supervisees, and outlines supervisors’ ethical responsibilities in working with supervisees. CACREP (2016)
outlines the standards for supervision in practicum and internship in accredited master’s and doctoral programs. Similar to these organizations, authors (Borders & Brown, 2005; Person, 2004) also described and summarized the roles and responsibilities of supervisors to offer further guidelines for standards for counseling supervisors.

**Preliminary Efforts to Determine Standards for Counseling Supervisors**

The ACES Supervision Interest Network produced a document outlining the standards for counseling supervisors (1990). These standards encompassed 11 areas which account for supervisors’ knowledge, competencies, and personal traits that are ideal for supervisors’ effectiveness in supervision.

**The First Area**

Supervisors as effective counselors are knowledgeable in supervision theories, hold a supervision philosophy, and are skilled in counseling theory and methods.

**The Second Area**

Supervisors’ personal traits and their roles are congruent. In addition to engaging in continuous enhancement of own counseling skills, supervisors also engage in self-evaluation, commit to the supervisor role, and identify own strengths and areas for growth, while being respectful of individual uniqueness, open and receptive of feedback, comfortable with the hierarchical component of supervision, and optimist and encouraging.

**The Third Area**

Inherent to the counseling profession, supervisors’ knowledge of ethical, legal, and regulatory qualities includes, but not limited to, codes of ethics and communication of these to counselors, demonstration and enforcement of ethical and professional standards, current professional standards including licensure, and knowledge of counselors’ rights.
The Fourth Area

As part of their knowledge of the supervisory relationship, supervisors exhibit multicultural awareness, attention to counselor’s personal and professional needs, understand the evitative component of supervision and the anxiety it provokes on counselors, self-evaluate own work to model professional development, provide conditions that facilitate the supervision experience, expect counselor’s accountability, create mutual trust with the counselor, balance support and challenge, and engage in thought provoking dynamics.

The Fifth Area

Supervisors are knowledgeable of supervision methods and techniques and use of them to foster their supervisees’ growth. They express the supervision purpose and procedures, collaborate with supervisees in decision-making about approaches to attend to their learning needs, utilize conducive supervision interventions, wear the different supervision hats to include teacher, counselor, or consultant, evoke counselor’s thoughts about solutions, interventions, and responses in their work with clients, combine supervision knowledge and interpersonal style into their work with counselors, provide clarity about supervisor’s role, and incorporate technology in supervision work.

The Sixth Area

As part of their knowledge of counselor developmental process, supervisors understand that supervision is developmental in nature and that counselors’ and supervisor’ roles may vary according to the setting. In addition, supervisors identify counselors’ learning needs, while taking their developmental level into consideration when selecting supervisory methods.
**The Seventh Area**

Supervisors’ knowledge of case conceptualization and management includes, but not limited to, helping the client through the counselor by assisting counselor with referral processes, data collection and analyses procedures, client assessment and goal planning, and understanding of counseling procedures.

**The Eighth Area**

Supervisors’ knowledge and competency in client assessment and evaluation includes overseeing test use and interpretation and assisting counselors in the decision-making process involved in test selection (e.g., communication of test procedures, measurement and documentation of client and counselor change, and incorporation of findings to inform proper recommendations).

**The Ninth Area**

This area comprises supervisor’s knowledge and competency in oral and written reporting and recording. Supervisors comprehend accountability, assist counselors in client and supervision documentation, follow policies and procedures that protect counseling and supervisory confidentiality, present information in a logical manner, and practice adaptability in terms of the setting’s verbal and written report expectations.

**The Tenth Area**

As part of their knowledge of evaluation of counseling performance, supervisors interact with the counselor from an evaluator standpoint, identify counselor’s strengths and weaknesses, offer feedback on counselors’ performance, establish the level of counselors’ theoretical development and incorporation of theory into their work with clients, create evaluation tools to
establish counselor and program goal attainment, and provide evaluation of counselor for
practicum/internship and professional advancement requirements.

**The Eleventh Area**

Lastly, through *their knowledge on research in counseling and counseling supervision*,
supervisors facilitate, oversee, engage, disseminate, and incorporate research into their practices
with their supervisees.

Becoming a clear outline for the supervisors, these standards provided bases for the later
efforts to build best practices for counseling supervisors in clinical supervision.

**Subsequent Efforts to Outline Supervisors’ Responsibilities in Clinical Supervision**

In 2011, Association for Counselor Education and Supervision (ACES) appointed a
taskforce with the goal of producing more specific guidance to supervisors in their daily
supervision practices. Three years later, the taskforce presented the *best practices of clinical
supervision* document (Borders et al., 2014). The document entails 12 areas, each of which
contains a series of processes in which supervisors need to be well versed in order to engage in
effective supervision practices in their work with their supervisees. The areas consist of initiating
supervision, goal setting, giving feedback, conducting supervision, the supervisory relationship,
diversity and advocacy, ethical considerations, documentation, evaluation, supervision format,
the supervisor, and supervisor preparation. In a separate article, Borders (2014) also summarized
each of these best practices areas:

**Initiating Supervision**

This area informs supervisors about the administrative aspect of supervisory practice
(e.g., supervision contract, confidentiality, informed consent, professional disclosure,
expectations and responsibilities). While the area focuses on the administrative aspect of supervision, the working alliance may start to develop as part of this area’s processes.

**Goal Setting**

In this area, goal development and supervisor’s collaboration with the supervisee is presented as crucial in creating SMART goals, attending to the developmental needs of the supervisee, reviewing progress towards goals, assessing the supervisee’s competencies, and paying attention to supervisee’s emerging needs.

**Giving Feedback**

Supervisors provide the supervisee with constructive feedback based on observation of the material supervisee brings to supervision (e.g., video tapes, audios, case conceptualizations), while offering support and challenge in a balanced way that does not overwhelm the supervisee.

**Conducting Supervision**

Supervisors adhere to the professional standards when deciding on the modality (i.e., individual, triadic, group), frequency (e.g., weekly), and the setting (e.g., site, campus) of supervision sessions. Moreover, the supervisor provides structure for the supervision sessions, comes prepared to supervision, attends to the developmental level and needs of the supervisee, and uses supervisory interventions to address those needs.

**The Supervisory Relationship**

Supervisors acknowledge supervisees’ anxiety and resistance in supervision and provide a trusting and safe supervision environment that is conducive of growth. Supervisors also manage conflict and broach power differential and multiculturalism within the supervisory relationship. They are aware of their own biases, values, beliefs, and are able to identify transference and countertransference in their work with the supervisees.
**Diversity and Advocacy**

Supervisors engage in dialogue with supervisees about power and privilege, invite supervisees to consider cultural factors in their conceptualization of clients, assist supervisees with developing multicultural knowledge and competence, foster advocacy, implement multicultural sensitiveness in their work with supervisees, and are constantly assessing their own cultural competence.

**Ethical considerations**

Supervisors adhere to ethical and professional standards of the profession and supervision practice. Supervisors not only oversee supervisees’ work but also monitor their own competence in their work with supervisees. In addition, supervisors engage in peer consultation and/or supervision, as needed.

**Documentation**

Supervisors protect supervisees’ and clients’ confidentiality as well as keep up to date documentation (e.g., informed consent, contract, professional disclosure statement), supervision case notes, and supervisee evaluations.

**Evaluation**

Supervisors engage in formative and summative evaluation through observations of supervisees work (i.e., video and audio tapes). In the first supervision meeting, supervisors inform supervisees about the evaluative component of supervision and how it is going to be conducted throughout the supervision experience. As part of the gatekeeping activity, supervisors also engage in remediation procedures, as needed.
Supervision Format

Supervisors use different supervision formats (i.e., individual, triadic, group) to provide supervision. The use of these formats must adhere to accreditation standards, and respond to the needs of the supervisee, the site, and the clients seen by the supervisee. Hence, the format used in supervision is never decided based on meeting the supervisor’s needs (i.e., to save time).

The Supervisor

Supervisors are expected to have the required counseling and supervision training as well as experience. In addition, supervisors have to be knowledgeable in the supervision matter (e.g., supervision theories and dynamics, wearing different hats to meet supervisee’s developmental level and needs, communication of supervisor roles, style, and approaches), while being multiculturally competent and acknowledging their evaluative role. Supervisors also protect client’s welfare through their work with their supervisees and engage in continuous self-reflection in regard to culture, power, privilege, and receptiveness of supervisee’s feedback.

Supervisor Preparation

Supervisors engage in ongoing training on supervision (e.g., approaches, interventions, dynamics, and best practices) and develop a supervision philosophy.

Beyond the obvious statement on the need for supervisees’ adherence to ACA Code of Ethics in regard to “[having] the same obligation to clients as those required of professional counselors” (p. 13), and/or vicarious learning and applications of the guidelines for clinical supervisors (Borders et al., 2014), these guidelines barely stated supervisees’ behaviors in the supervision process. In other words, we do not have any guidelines and/or outline informing supervisees regarding standards for the best practices they could adhere to obtain the most out of supervision and increase its effectiveness. On the other hand, there is literature presenting
developmental characteristics and descriptions of supervisees and their qualities in and contributions to the supervisory process providing bases for the current study.

**Supervision Models’ Presentations of Supervisors and Supervisees**

**Developmental Models of Supervision**

Developmental models [e.g., Integrated Developmental Model (IDM; Stoltenberg & McNeill, 2010), Loganbill, Hardy, and Delworth model (Loganbill, Hardy, & Delworth, 1982)], emphasize the importance of assessing the counselor’s developmental level while providing an optimal supervisory environment for supervisees’ progression through those levels or stages (Stoltenberg & McNeill, 2010; Stoltenberg, 1981; Morgan & Sprenkle, 2007; Loganbill, Hardy, & Delworth; Bernard & Goodyear, 2019).

IDM (Stoltenberg & McNeill, 2010), one of the most commonly utilized of the developmental models, is descriptive in regard to the supervisee processes and prescriptive in regard to supervisor interventions. Stoltenberg and McNeill claimed that in order to appropriately meet the needs of a specific supervisee, the supervisor must be skilled in the supervision model and able to adjust to supervisees’ emerging needs within and across sessions. According to Stoltenberg and McNeill, for every supervisee developmental level (i.e., level 1, beginning; level 2; intermediate; level 3, advanced; and level 3i, master), there is an optimal environment that, if appropriately offered within the supervision experience, may help the supervisee to master the level characteristics and move to the next level. Thus, from a facilitative standpoint, the supervisor allows the supervisee to hold some control in the relationship, and this facilitative role can be taken by the supervisor across supervisee developmental levels (Stoltenberg, 2005; Loganbill, Hardy, & Delworth, 1982). On the other hand, from an authoritative standpoint, the supervisor exercises more relational control (Stoltenberg & McNeil,
2010). Through IDM, the supervisor places focus at each developmental level on supervisory structures such as supervisees’ motivation to perform the counseling work, autonomous functioning in their practices as clinicians in training, and cognitive and affective self-and-other awareness. In addition, IDM includes eight domains of clinical practice to measure counselor’s growth. The eight domains consist of intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment plans and goals, and professional ethics.

In terms of their descriptions of supervisees regarding their development, IDM consists of three levels which are representative of less experienced supervisees and a fourth level (i.e., 3i) representative of master supervisees. Supervisees in level 1 have limited training and experience, are highly dependent, anxious and self-focused, are in need of structure and positive feedback, and are concerned with doing the right thing. Also, they possess limited self-awareness, are apprehensive to evaluation, and are unaware of strengths and areas for growth. In level 2, supervisees fluctuate between feeling confident and unconfident, while being more independent and exhibiting greater ability to focus and empathize with their clients. Supervisees in level 3 express doubts about the effectiveness of the services they provide, are more self-aware and confident about their clinical judgement, attend to their own personal reactions to the clients, use those reactions as part of their decision-making process about the clients, and exhibit a personalized approach to their practices. Lastly, in level 3i, supervisees have moved through all of the previous three levels across multiple domains. At this point, supervisees exhibit high levels of competency awareness as well as a counseling style. Depending on the supervisee’s developmental level, supervisee’s motivation, autonomy, and awareness may vary, thus, require
supervisor’s interventions and a more directive presence or a more facilitative role fostering supervisee to act more independently.

**Process Models of Supervision**

Similar to developmental models, process models [e.g., the Discrimination Model (Bernard, 1979)], invite the supervisor to identify supervisee’s areas of difficulty and engage in the best suitable role within supervision process to attend to those areas in order to facilitate supervisee’s development of skills and goal attainment.

In one of the most well-known process models, Discrimination Model, Bernard (1979) suggests supervisors engage in a teacher role when the supervisee requires guidance, instruction, or direct feedback; in a counselor role when the supervisee needs to grow in terms of his or her reflectivity and self-awareness; and in a consultant role when the supervisor wants to collaborate with the supervisee in fostering supervisees’ independency and confidence. In addition, Bernard asserted that the supervisor is expected to be prepared to adopt all roles and discuss all supervisee’s focus areas (i.e., intervention/process, conceptualization, and personalization) at any developmental level. Bernard claimed that, through the discrimination model, supervisees have to pinpoint moments in which their behaviors evidence process, conceptualization, and personalization skills. They also role play counseling vignettes focusing on the three model functions, asses their own sessions, and plan for subsequent sessions with their clients. In addition, supervisees engage in collaboration with their peers to receive and provide feedback on their counseling sessions.

In brief, supervision models appear to suggest that as supervisees progress through different developmental levels and focus on different supervisory functions for their practices, their behaviors in supervision may vary, given that they may become less or more comfortable
with the supervision process. However, none of these models specify behaviors supervisees should engage in to make the most of their clinical supervision.

**Literature on Supervisees’ Responsibilities in Supervision**

Bernard and Goodyear (2019) asserted that supervisors have the duty of exhibiting competence while at the same time guaranteeing supervisees’ competence. Similarly, Barnett and Molzon (2014) asserted that as the supervisee progresses developmentally while in training, the supervisor’s active role within supervision starts to decrease in order to offer room for supervisees to increase their autonomy and responsibilities. Therefore, the authors described a series of tasks that supervisees may engage in as improved autonomy is reached. Bifarin and Stonehouse (2017) presented three main supervisees’ roles within supervision: (1) engaging in supervision knowing what they want to address, (2) “making the most of the time” (p. 332) and putting into action what has been learned in supervision, and (3) documenting what is discussed in supervision as well as “taking an active role in their own professional and personal development” (p. 332). Although, these roles may offer a glance of some of the tasks that supervisors expect supervisees to perform while receiving supervision, they also appear as vague descriptions. For example, the authors did not describe how “making the most of the time” or “taking an active role within supervision” may look like in supervision for supervisees.

On the other hand, Ellis (2017) provided supervisees’ bill of rights and responsibilities in supervision. Some of the supervisees’ rights included expectations, goals, and objectives of supervision, feedback and evaluation, being respected and treated as an individual, addressing and resolving conflicts, and being treated ethically. Supervisees’ responsibilities encompassed some of the administrative tasks (e.g., informed consent, documentation), professional and ethical standards, identification of areas for growth (e.g., skills, theoretical orientation, case
conceptualization), discussion of expectations and aspects of the supervisory relationship, as well as conflict resolution, and multiculturalism (e.g., acknowledgement of personal cultural assumptions, values, and biases, and enhancement of cultural practices). Additionally, supervisees’ responsibilities included reviewing video-recordings, preparing for supervision meetings, incorporating feedback into work with clients, providing feedback on the supervisory process, discussing termination, consenting to remedial assistance, informing of legal actions (e.g., court subpoena), as well as discussing client welfare concerns with their supervisors. The supervisees’ bill of rights and responsibilities in supervision document was an adaptation of two different resources: (1) an unpublished paper presented by Ellis, Chapin, Dennin, and Anderson-Hanley at the meeting of the American Psychological Association in Toronto, Canada in August 1996 and (2) Altekruse and Kern’s (2000) concepts from the third edition of Fundamentals of clinical supervision by Bernard and Goodyear (2004). The supervisees’ bill of rights and responsibilities in supervision offered clear descriptions of what supervisees must be doing in supervision; however, they also mainly reflected authors’ perspectives on the subject matter. Neither of these documents was a result of empirically-based research, and, to date, neither have been examined through research. In order to complement these deductive efforts, inductive explorations of supervisees’ responsibilities in clinical supervision from supervisees’ perspectives are critical.

In the same line, Pearson (2004) claimed that supervisor’s assessment of the supervisee is directly impacted by what supervisees do in supervision. In an outline for supervisor’s responsibilities and expectations of supervisees, Pearson (a) encouraged supervisees to comprehend areas that are important to supervisors and (b) offered ideas for supervisees to engage in a conducive and productive supervision experience (e.g., active participation, taking
initiative, monitoring self and reactions) with the goal of enhancing their work with their clients. These descriptions appeared to be supervisor-focused where supervisees are encouraged to engage in behaviors to facilitate supervisor’s assessment of the supervisee and satisfy supervisors’ expectations. In other words, collaboration appeared to be minimized and supervisees did not seem to be given much voice to shape their own supervision process.

In summary, majority of this literature on supervisees’ behaviors in clinical supervision included more descriptions than operational definitions, offering researchers opportunities to explore how supervisees’ contributions to supervision could be further examined and integrated in the supervisory process.

**Supervisees and Supervision Outcomes**

In the counseling psychology field, Vespia, Heckman-Stone, and Delworth, 2002 conducted a study to create a list of characteristics inherent to supervisees who used supervision effectively. In three different phases, authors (a) had 14 counseling psychology graduate students and 11 practicum supervisors from a university create a preliminary list of effective supervisee behaviors, (b) obtained feedback from 21 graduate students and 30 university counseling center psychologists from four different universities to inform the final version the Supervision Utilization Rating Form (SURF), and (c) administered the SURF to a sample of supervisors and supervisees in 13 nationwide counseling psychology programs and 10 accredited counseling center internship sites. With a sample of 145 supervisees and 31 supervisors, the SURF resulted in a 52-item instrument describing characteristics of effective supervisees (e.g., accepts feedback in a nondefensive manner, demonstrates a willingness to grow, admits mistakes and difficulties, asks for help when appropriate). Despite offering both supervisors and supervisees with criteria
For supervisees contributions to effective supervision, the authors did not provide reliability and validity psychometrics for the SURF.

To modify and validate the SURF (Vespia et al., 2002), Stark (2017) conducted an Exploratory Factor Analysis on a sample of 118 Licensed Professional Counselor (LPC) interns and 162 LPC supervisors. Stark aimed at providing supervisors with a valid and reliable tool containing supervisee behaviors that contribute to effective supervision. By using a five-point Likert scale, supervisors were asked to think of one of their supervisees (“neither the best nor the worst;” Stark, 2017, p. 173) and rate them on the SURF items. Similarly, a group of supervisees were also asked to rate the items based on their own SURF behaviors in supervision. Modifying Vespia et al.’s SURF, Stark’s Adapted SURF contained 46 items distributed among four factors. Factor one, *professionalism*, contained 12 items (e.g., following procedures, working well with colleagues and staff, active participation in supervision) with a reliability of .84. Factor two, *relational skills in the supervisory relationship*, comprised 13 items (e.g., setting appropriate goals for supervision, demonstrating effective verbal and nonverbal skills in supervision) with a reliability value of .86. *Signs of self-supervision*, factor three, included 13 items (e.g., identifying own developmental needs, critiquing own work, asking for help when appropriate) and showed a reliability of .86. Finally, factor four, *proactive*, contained 8 items (e.g., strive to achieve supervision goals, create and share treatment plans with supervisor, making own work available for feedback) and had a reliability value of .79. Stark reported the Adapted SURF as a reliable instrument not only informing supervisors’ practices with new supervisees while measuring supervisee contributions to supervision, but also providing supervisees with a variety of clear expectations in terms of their work in supervision.
Norem, Magnuson, Wilcoxon, and Arbel (2006) conducted a phenomenological research to gain an understanding of the characteristics of stellar supervisees with superior growth when compared to some of their peers. The researchers asked 12 counseling supervisors to provide descriptions of their experiences with stellar supervisees, whose contributions resulted in outstanding supervision outcomes. Maturity and autonomy were the strongest attributes identified by the supervisors, in which supervisees were described with the view of life experiences as opportunities to grow and promote personal development. This attitude appeared to assist supervisees in increasing self-confidence and insight, and developing autonomy. Perspicacity was the second supervisee attribute described as a contributor of successful supervision outcomes. This attribute was portrayed by supervisees’ knowledge of counseling, including a remarkable theoretical background, and counseling skills, as well as insight, cognitive complexity, and intuition. With their motivation, supervisees surpassed minimum requirements and exhibited willingness to engage in supervision work with a heightened commitment to enhance their professional growth. Similar to Stark’s findings (2017), stellar supervisees also had the ability to engage in self-monitoring, self-knowledge, and self-awareness of strengths and areas for growth. Finally, these supervisees were open to experience, as evidenced by their welcoming attitude to feedback and different perspectives, as well as exhibition of low levels of resistance.

In these studies, supervisors reported attributes of good supervisees positively impacting their supervision process and outcomes. Although, supervisors’ presentations inform about good supervisees’ qualities, these descriptions are limited to only one of the parties in the supervisory dyad. Thus, it is also crucial to understand behaviors supervisees consider to be critical in their own performance and compare those with supervisors’ perceptions.
The Critical Role of Supervisees’ Knowledge of Responsibilities in Clinical Supervision

In a study, Ellis, Creaner, Hutman, and Timulak (2015) explored supervisees’ perspectives on their supervision experiences to describe “inadequate, harmful, and exceptional supervision” (Ellis et al., 2015, p. 5) in Ireland and the United States. Researchers reported that inadequate and harmful clinical supervision supervisees were receiving in both countries was actually higher than the self-identified harmful supervision perceived by supervisees, which evidences supervisees’ lack of knowledge about what clinical supervision could entail (Ellis et al., 2015). Findings from this study suggested the vital need for equipping supervisees with the knowledge of supervision to protect themselves from harmful experiences.

In a complementary study, Mcnamara, Kangos, Corp, Ellis, and Taylor (2017) outlined a series of supervisee narratives that described harmful supervision experiences. According to the authors, supervisees-in-training are in a much more vulnerable position than considered, where the power differential may be intensified as supervisors hold vast power in the supervisee’s career (e.g., passing practicum and/or internship). The authors also claimed that it is not supervisees’ responsibility to resolve a harmful situation in supervision; however, supervisees must educate themselves on their: (a) rights and (b) responsibilities to prevent and/or address any situations that may evolve into harmful supervision. Becoming active agents by knowing their rights and responsibilities in their supervisory dyad, supervisees may be able to identify potential for harm and act on time to avoid adverse supervision. In this study, Mcnamara et al. (2017) highlighted the need for further studies outlining supervisees’ responsibilities in supervision. Such efforts, perhaps, bring up systemic change as supervisees know their rights and responsibilities, have voice, are self-empowered, and feel respected within the supervision
encounter, while actively collaborating in fostering a conducive supervision experience in presence of mutual respect.

In a study with undergraduate health students (e.g., nursing, medical radiation science, occupational therapy, physiotherapy, and medical), O'Brien, Mcneil, and Dawson (2019) studied participants’ clinical supervision perspectives and experiences, a prerequisite for their program completion and successful job attainment. O’Brien et al. reported that clinical supervisors valued supervisees’ learning as evidenced by “effective student orientation, the provision of structures learning and feedback, and in the positive attitudes of clinical supervisors” (O’Brien et al., 2019, p. 50). In describing positive supervision experiences, however, supervisees’ narratives were mainly on supervisors’ behaviors rather than their own behaviors that may have contributed to the positive outcomes of supervision. In other words, supervisees did not seem to see their contributions as essential and crucial in clinical supervision, perhaps, undervaluing their part in the supervision process and outcomes, given that supervisees appear to have the tendency to perceive their supervisors as the main responsible party in making supervision work and be successful. Thus, supervisees may not see themselves as sharing the supervisory responsibility and may not be externalizing both successes and failures of supervision. This constitutes a risk suggesting that supervisees may be positioning themselves as passive learners of the process; thus, failing to reciprocate supervisor’s efforts and taking ownership for the supervision process and outcomes.

To summarize, in the literature on supervisees’ behaviors in the supervisory process, several critical commonalities and gaps come to our attention. First, scholars emphasized the importance of clinical supervision in polishing the skills of counselor trainees as well as safeguarding the welfare of supervisees’ clients. Second, scholars/supervisors acknowledged the
importance of supervisees engaging in an active role so that they become active parties within the supervisory experience and make the most of out of it. However, third, a considerable amount of the focus has been placed on the supervisors as the main responsible party in guaranteeing satisfactory supervision outcomes. Fourth, among the few efforts on suggesting supervisees’ responsibilities/behaviors, without exception, all were based on supervisors’ perspectives, neglecting supervisees’ perspectives. Finally, supervisees may not gain much or even may become victims of harmful supervision, going into supervision without full awareness of their rights and responsibilities in their supervision experiences. Thus, supervision process and outcomes may be jeopardized by the lack of guidelines that inform and assist supervisees in becoming active agents in supervision, reciprocate supervisor’s efforts, engage in a transactional relationship, and take ownership of the supervision dynamics in order to make the most out of the supervision experience.

The Need for a Transactional and Informed Supervision Process

Supervisors are the main responsible party in clinical supervision as the more informed, trained, and experienced professionals in the supervision dyad. They are also responsible for structuring supervision in a conducive way where supervisees could understand and execute the tasks, while creating the space for the supervisee to adhere to such structure (Corey et al., 2010). This explains the reason why the responsibility for supervision outcomes is heavily placed on the supervisor (Barnett & Molzon, 2014). On the other hand, both supervisors and supervisees are essential components of supervision and subsequently each hold inherent responsibilities, thought these responsibilities are not of equal weight (Corey et al., 2010).

Similar to Bonwell and Eison’s (1991) premises, teachers/supervisors and students/supervisees must engage in active learning and share the responsibility about learning
outcomes. Parallel to ALT, by understanding and emphasizing supervisees’ roles in supervision, supervision scholars and practitioners could stimulate a transactional relationship, empowering the supervisees’ behaviors in supervision. In such a role, supervisees could be encouraged to invest in the supervision process, reciprocate supervisors’ efforts (Bifarin & Stonehouse, 2017), and become active agents of supervision.

This transactional relationship appears as an underemphasized area in the supervision literature, although expert supervisors consider it a crucial practice in supervision and have expressed their “…willingness on sharing authority and responsibility with their supervisees” (Kemer, Borders, & Willse, 2014, p.13). Shedding light to this underemphasized area could enhance supervisees’ practices in both supervision and counseling. Additionally, it would enhance practices of supervisors, wellness of the clients, and advancement of the field of counselor education and supervision. In an article, Sewell (2018) shared the thoughts of an experienced professional in the clinical supervision field. These thoughts pointed to the need for a process-oriented supervision where supervisees engage as active parties in supervision through an interactional and involved approach. Such approach is described as a process in which priority is given to the dynamics that emerge within the supervisory dyad over the evaluative component inherent to supervision. This with the aim of engaging in a parallel process; in which supervisors model what supervisees must be doing in the field with the client (Sewell, 2018; Shanley & Stevenson, 2006).

An Overview

The current study will be an attempt to address the need for an examination of supervisees’ perspectives on their behaviors to make the most of clinical supervision to achieve
the ultimate goal of making the supervision process a more involved and productive experience.
In the following chapter, I will describe the details of the proposed research study procedures.
CHAPTER 3

Methodology

In this chapter, I will offer a detailed description of the research methodology that I employed in the present study. To familiarize the reader with the specific design that I used in the current study, first, I will provide information on the fundamentals of Concept Mapping (Kane & Trochim, 2007). Second, I will provide a rational for the use of Concept Mapping as the blueprint of the current study. Lastly, I will explain the steps of Concept Mapping by expanding on each step according to the context of the current study.

Concept Mapping

Concept mapping (CM; Kane & Trochim, 2007) is a structured and integrated mixed-methods design positioned between post-positivism and constructivism. The design integrates qualitative and quantitative characteristics of both approaches with the goal of having stakeholders to express their ideas in a verbal or written format. Later, stakeholders’ ideas are transferred into quantitative pictorial products to generate a better understanding of their perceptions of a given focal issue. Kane and Trochim suggest that CM offers certain advantages: first, it facilitates the data collection procedures of any group in any setting. Second, the sample size does not represent an issue, given that CM is suitable for working with small or big groups of participants. Third, CM is a design that requires participants’ involvement in the data collection, given that they are the ones generating the input, shaping (e.g., sorting) that input, and interpreting the results obtained from data analyses procedures. Fourth, CM integrates the voices of a group of participants by utilizing statistical methods to generate a clear series of results (e.g., visual representations). Fifth, a framework emerges as a result of the collaborative group process.
(e.g., focus group) inherent to CM, and such frameworks add to the existing body of knowledge and can be utilized for planning and evaluation.

I aimed at exploring what supervisees (stakeholders of supervision) perceive to be their behaviors to make the most out of their supervision experiences. As a good fit for the examination of this purpose, CM allowed me to: (1) complete the data collection procedures at the university participants attend to, (2) work with a small sample size, (3) capture participants’ voices on what they perceive as their behaviors to make the most of their supervision experience by involving them in all the data collection rounds, (4) offer directions to participants to organize those voices into different groups, and (5) involve participants in a focus group to collaboratively interpret the results. Thus, with keeping supervisees connected to every round of data collection and analyses, the implementation of CM procedures and the obtained framework shed light to supervisees’ behaviors in clinical supervision to make the most out of their supervision experiences. Finally, as the facilitator of these processes, I was able to ensure obtaining and working with the supervisees’ perspectives on the studied phenomena.

**Concept Mapping Steps**

Concept mapping involves six steps consisting of (1) preparation, (2) generation of statements, (3) structuring of statements, (4) representation of statements, (5) interpretation of maps, and (6) utilization of maps (Kane & Trochim, 2007). In the current study, in order to address the research question of concern, I only used the first five steps. The sixth step, utilization of maps, is usually used to develop instruments based on the findings from the first five steps. This full step was beyond the scope of the current study. However, the results will be discussed for practical and research implication in the sixth step. The results of the current study were not used to create a measure, but rather will offer data for future studies. Concept mapping
also suggests a rating task to obtain descriptive statistics out of the data; however, I solely focused on the conceptualization of the data through a sorting task. I did not utilize a rating task as part of the data collection procedures in order to prevent participant burnout, particularly because a rating task would not offer beyond descriptive information and/or address an additional research question to the main research question of the current study. The rating task will be used more intentionally to address specific research questions in future studies based on the data obtained in this study.

**Step 1: Preparation**

This step consists of several sub-steps, each of which will be described in detail below.

**Defining the Issue.** Included establishing the topic of interest to be examined. Since we did not know what supervisees’ behaviors are to make the most of their supervision experience, in the current study, the issue was the lack of knowledge on supervisees’ behaviors that contribute to the supervisory process.

**Initiating the Process.** Encompassed identifying the group of stakeholders that was going to be involved in the concept mapping process. This group of people consisted of (a) an initiator responsible for the project (i.e., dissertation chair who is a counselor educator with extensive experience with concept mapping and supervision research), (b) a facilitator overseeing the concept mapping processes (i.e., the student investigator), (c) the advisory group overseeing and making recommendations on some or all the stages of the project (i.e., the dissertation committee conformed by counselor educators), and (d) a core participants group completing all or some of the concept mapping steps, such as generation, structuring, and representation of statements, and interpretation of the maps generated by the data analyses procedures (i.e., counseling master’s and doctoral supervisees participants).
**Selecting the Facilitator.** Consisted of choosing an individual who was going to work closely with the initiator. The facilitator was not only one of the main responsible parties but also worked on planning and conducting the concept mapping procedures and making decisions throughout the process that had critical impact on the study outcomes.

**Determine the Purpose.** To determine the purpose, both initiator and facilitator discussed and agreed on the purpose of using concept mapping as the design to address the research question of the study. In the current study, we aimed at understanding what supervisees perceived as their behaviors to make the most out of their supervision experience.

**Defining the Focus.** Included determining a prompt for the generation of statements. The dissertation chair and I had discussed and reached an agreement upon the prompt. This prompt was critical to make sure each participant understood the same phenomena we were trying to look at and to obtain concrete information that informs the issue. In addition, we also discussed and outlined specific instructions to provide participants with clarity of the task they will complete (Appendix A).

**Select the Participants.** In order to select the participants, we engaged in a dialogue over purposeful targeting for the goals of the study. In order to examine supervisees’ perceptions of their behaviors to make the most out of the supervision experience, to us, participants needed to have the body of knowledge in supervision and have the experience as supervisees. Therefore, we decided to invite participants who can speak of their experiences as supervisees receiving individual supervision while having an understanding of clinical supervision from a supervisor perspective. Supervision is received in different modalities (i.e., individual, triadic, group) and each modality may entail different behaviors supervisees engage in. Since I wanted to understand supervisees’ behaviors in individual supervision, it was imperative to (1) make sure supervisees
had received supervision in an individual modality and (2) help orient participants by asking them to solely focus on their individual supervision experiences. Participants in the current study were counseling master’s and doctoral students at a midsize southeastern university. The inclusion criteria consisted of (1) currently being under supervision as a counselor trainee or resident in counseling, and/or have completed supervised clinical practice within the last 1 year, and (2) currently taking or have taken COUN 670 (Introduction to Counseling Supervision), COUN 846 (Advanced Counseling Supervision), and/or COUN 868 (Internship Supervised Supervision Practice) at Old Dominion University within the last 1 year. Via purposeful sampling, we decided on targeting this group given their unique position of simultaneously being supervisees at their field placement and/or have completed this process recently, while taking an introductory or advanced supervision course as an initial step to become a supervisor (Pearson, 2004).

CM indicates that a sample of at least ten participants is desired to guarantee an array of opinions while allowing conducive group discussion and interpretation (Kane & Trochim, 2007). I aimed at recruiting at least ten participants, to obtain a larger extent of information to inform the analyses procedures and produce more robust results. Once Institutional Review Board (IRB) approval was received, at the end of Fall 2019 semester, I emailed the invitation to participate in my study to all counseling master’s and doctoral students through the counseling department’s listserv. The email included the invitation to participate in the study (Appendix B), a Qualtrics link for participants to fill out (1) the consent form (Appendix C), which detailed the purpose of the study, information on the researchers, description of the study procedures, inclusion criteria, risks and benefits, confidentiality, incentives, and withdrawal privilege. Through the Qualtrics
link, participants filled out the demographic questionnaire (Appendix D) and completed the generation of statements form (Appendix A).

I honored participants’ unwillingness to participate in the study as well as confidentiality and anonymity by removing any potential identifiers from the collected data and assigning an ID to each participant in the case they volunteered to participate. This ID consisted of their home address number [i.e., 1234], given that it was an ID, only supervisees would be able to remember easily while allowing for anonymity. Additionally, all collected data was placed in a locked locker to which only the dissertation chair and I had access.

Due to the nature of the design, participants’ retention was a challenge. Thus, in order to guarantee retention, I incentivized participants’ involvement in three rounds of data collection by using the grant funding (i.e., AARC, ACES, SACES) received for the study. I provided participants with the following incentives: each participant was offered $10 for their participation in the first round of data collection, $20 for the second round, and $20 for the third round. Therefore, a participant that went through all three rounds of data collection received a total of $50. Furthermore, an additional challenge I anticipated, was that at the time I was recruiting participants, I was co-teaching one of the potential participants’ class. However, in order to offer transparency and decrease social desirability, I informed participants that (1) their decision to participate in the study had to be completely voluntary, and (2) it would not affect their grade in the course. I collected the initial round of data from participants in this class on the last day of classes in Fall 2019.

**Determine the Methods.** This step included: (1) generation of statements in which participants individually brainstormed thoughts with the help of a prompt that addressed the focus of the conceptualization (i.e., supervisees’ behaviors to make the most of their supervision
experience), (2) structuring of the statements in which participants sorted the list of statements obtained from the generation of statements based on their conceptual similarity, and (3) focus group in which participants discussed and reached agreement about the clusters list and cluster labels.

**Develop the Schedule.** We developed the schedule by agreeing on the study timeline for the CM procedures. This timeline consisted of conducting the first data collection round late November, completing the editing and syntheses of the statements in December, having participants complete the sorting task by mid-January, completing the data analyses for the sorting task by the end of January, and holding the focus group meeting in the first week of February.

**Step 2: Generation of Statements**

In this step, the goal was to obtain a series of ideas that portrayed the conceptual area of interest, supervisees’ behaviors to make the most out of their clinical supervision. The details of the different tasks of this step are provided below.

**Preparing for the Generation of Statements Session.** As part of this task, I contacted the COUN 670 course instructor and asked permission to have participants who were willing to participate in the study go to the Qualtrics link during the last day of class. The course instructor agreed and allowed me to collect data from these participants that day. This task took approximately 30 minutes. Volunteering participants that were not taking this class, were able to access the Qualtrics link that same week. Once the task was completed by all participants, I scheduled the date and time for the next round of data collection (i.e., structuring the statements/sorting task) with the interested participants.
Introducing the Concept Mapping and Generation of Statements Process. The goal of this step was to provide participants with a brief, yet, clear explanation of the CM process as well as an overview for the generation of statements. The Qualtrics link provided participants with a generation of statements instructions form (Appendix A) that included explanations about the task and a prompt to assist participants with generation of the ideas on their behaviors to make the most of their supervision experiences. Participants wrote their statements on the Qualtrics link. The link also contained a demographic questionnaire form (Appendix D) to collect information concerning participants’ personal and educational background (e.g., gender, age, ethnicity, counseling track) as well as participation intention on subsequent rounds (e.g., sorting and focus group) of data collection. In addition, the link collected participants’ contact information to follow-up with the relevant information (e.g., place, date, and time) of the second round (structuring of the statements) of data collection.

Idea Synthesis. Once this round of data collection was completed, I exported the data from Qualtrics to an excel document. Then, I transferred each participant’s statements into a word document and numbered them. The statements generated in the previous task underwent a synthesis and editing process to ensure clarity and understanding across participants. In this step, I read statement by statement and made sure that: (a) all statements had a consistent language (e.g., be vs being), (b) each statement represented a clear and unique idea, (c) the statements communicated several ideas (e.g., compound statements) were split, (d) each statement was relevant to the focus of the study, (e) redundant statements (e.g., identical statements) were eliminated, (f) identifiers were removed, and (g) grammar and editions were intact. I did not modify any statements to avoid altering participants’ original ideas. Kane and Trochim (2007)
asserted that a total of 100 statements as a result of the generation of statements step is ideal to prevent excessive data input time and participant burnout when completing the sorting task.

**Step 3: Structuring the Statements (Sorting Task)**

In this step, participants sorted all the statements into different groups based on their conceptual similarity. This step included planning of the structuring activity, introduction and agenda, and statements’ sorting.

**Planning of the Structuring Activity.** Since the date and time for completing this task was already discussed with the participants during the first round of data collection, one week previous to the second round (sorting task) of data collection, I emailed a brief announcement to the participants attending in-person to remind them of the place, date, and time the sorting task would take place. I mailed a package containing the sorting task to a participant whose in-person attendance was not possible. The day before of the sorting task, I emailed participants attending in-person a brief follow-up reminder. This session took place on campus in a room that provided square footage per person for all participants to complete the sorting task comfortably. I prepared the materials (e.g., statements, big and small envelops, pens and pencils, rubber bands) for this task in advance. I pulled up a word document containing the list of statements and assigned a number to each statement. Then, I printed out the word pages containing those statements. Last, I cut the statements separately with the goal of providing participants with individual statements for them to sort.

**Introduction and Agenda.** The goal of this step was to set the tone for the in-person session by outlining the agenda, offering task instructions, and answering questions before the task begun. I made sure to honor the length of time (e.g., activity starting time, the duration of the task) previously presented to the participants.
Statements Sorting. In this phase, the goal was to have participants classify all the statements into piles based on their conceptual similarity to get a better understanding of participants’ observation of the data given its interrelationships of ideas (Kane & Trochim, 2007). Thus, I had participants sort the final set of statements that emerged from the editing and synthesis in the second step. I explained the goal of the sorting task, offered verbal instructions in addition to the written ones, and allowed a couple minutes to address questions. Additionally, I let participants attending the round in-person know that although this round of data collection was completed in a group format (i.e., all participants in the same room), confidentiality was required, and the task had to be completed individually. Participants were provided with a package including: (1) a large envelope containing instructions for the sorting task (Appendix E), (2) a stack of the statements resulting from the generation of statements, and (3) 20 small envelopes. Participants sorted the statements that resulted from the editing and synthesis process into piles based on their conceptual similarity. They were informed that each statement had to be placed in one pile only; however, if a statement appeared to fit several piles, they needed to select the one pile into which the statement best fitted. A statement could also be a pile itself. Once participants were done sorting all the statements into piles, they placed each pile separately into one of the small envelopes and wrote a word or short phrase on the envelope describing the statements in it. Lastly, all the small envelopes were placed into the big envelop and given back to the researcher. The participant who did not attend the round in-person, received a sorting package via mail and followed the same steps described above. I reviewed the task instructions with this participant over the phone and allowed for questions. After completing the task, the participant mailed the package back to the researcher. The completion of this activity took around 60-90 minutes.
Step 4: Representation of Statements

In this step, the data analysis started with the data generated out of the sorting task and resulted in a series of materials (e.g., maps) that provided the researcher with a holistic picture of the participants’ thinking in relation to the focus of the conceptualization (i.e., supervisees’ behaviors in supervision). The statistical program R (R version 3.6.2, 2019) was utilized to conduct multivariate statistical procedures (i.e., Group Similarity Matrix, Multidimensional Scaling, Hierarchical Cluster Analysis). These statistical procedures were incorporated to transfer all the sorted data into maps containing groups of ideas in an attempt to provide a visualization of the results (Kane & Trochim, 2007).

**Group Similarity Matrix (GSM).** Once I had each participants’ piles of sorted statements, I entered the results into a sort recording sheet to create a Group Similarity Matrix (GSM). The purpose of GSM is to create a square symmetric matrix that displays the number of participants that grouped pairs of statements together while going through the sorting task. As a result of this process, I was able to see the number of participants who sorted every set of statements together when sorting the data with the goal of understanding participants’ perceptions of interrelationships among statements.

**Multidimensional Scaling (MDS).** Utilizing the GSM, I ran a two-dimensional nonmetric MDS to obtain a visual plot showing the location of the statements represented by dots (statement number on the list) on the map. This point map also yielded coordinate values for each statement’s location on the map. Proximity of statements on the point map indicated that those statements were placed in the similar piles by participants. The central diagnostic statistic in MDS is called stress index. The stress index indicates the degree of discrepancy between the values in the input GSM and the distances on the point map. Therefore, a good fit between the
input matrix data and the representation of that data on the product of the MDS will yield a low stress value indicating point map’s ability to truly represent the grouping data (Kane & Trochim, 2007). Kane and Trochim indicated an appropriate stress value of 0.285 and added that 95% of concept mapping projects have produced a stress value that ranges between about 0.205 and 0.365.

**Hierarchical Cluster Analysis (HCA).** The goal of this statistical procedure was to transfer the points (statements) of the map into clusters of statements to reveal similar concepts. Hence, I conducted an HCA utilizing MDS results to offer a more concrete visual representation of the domain areas. As a result of conducting this step, I obtained a dendrogram which organized all the statements into clusters based on conceptual similarity (Kane & Trochim, 2007). I worked simultaneously with the point map from the MDS and the dendrogram from the HCA to create a preliminary list of clusters and a cluster map embodying underlying structures of the data. Focusing on conceptual fit, this process entailed: (1) going over each cluster to ensure conceptual similarity, (2) brainstorming cluster labels guided by the labels generated by participants (e.g., the word or short phrase they wrote on each small envelope containing piled statements) when completing the sorting task, and (3) merging some clusters as well as moving statements around for best conceptual similarity fit. After I had worked on the preliminary clusters several times, I consulted with the dissertation chair three times about statements’ fit into the assigned clusters, cluster labels, as well as statement-cluster congruency with their location on the point map. These consultations aimed at increasing trustworthiness by decreasing researcher bias. After consulting the last time with the dissertation chair, I did a last review of the clusters. Lastly, in a continuous attempt to decrease researcher bias and increase statement-cluster fit, I sent the document to an auditor (e.g., a dissertation committee member who is a
counselor educator) for auditing purposes to ensure congruency of the statements between assigned clusters and their positions on the map. I chose this auditor for this portion of the project intentionally, because the auditor specialized in clinical supervision with a specific focus on supervisee behaviors. Along with the clusters document, the auditor also received the following instructions delineating the task in accordance with CM:

1) Please, go over each cluster and check for conceptual similarity among statements in the cluster (are they talking about the same?). If a statement seems to fit better in a different cluster, please make comments.
2) Please go over each cluster’s label and see if it is fully describing the statements in the cluster. If statements seem to be better described by a different label, please make suggestions. If you think of words that would enhance the current labels, please make comments about that too.

**Anchoring and Bridging Analysis.** According to Kane and Trochim (2007), sometimes the position of a statement assigned by the MDS process is unclear given that many participants sorted that statement with statements that are adjacent to it. In that case, the statement would be considered an anchor and the researchers can decide if manually assigning that statement into the immediately adjacent cluster, given its conceptual similarity with that given cluster. On the other hand, sometimes statements are placed in the middle of two clusters without reflecting conceptual similarity to any of them, which may indicate that during the sorting process, participants sorted that particular statement in piles that are distant from each other, thus, the algorithm ends up placing that statement in an intermediate position. In this case, the statement would be considered a bridging statement because it links two distant clusters on the map. When reviewing the statements and clusters, the dissertation chair, auditor, and I identified two anchoring statements. The dissertation chair and I decided to keep each one of them as by-itself-clusters, given that they did not reflect conceptual similarity with the clusters around it.
Selection of Final Number of Clusters. In this task, I decided on the number of clusters in the final map. Concept mapping does not provide a recommendation for an appropriate number of clusters. However, it recommends having an advisory group of people knowledgeable on the methodology in order to help determine if the results of the analyses are clearly representing the issue (Kane & Trochim, 2007). Thus, after completing the HCA step in which the dissertation chair, the auditor, and I revised the clusters, I communicated with the dissertation chair and we made decisions on the number of the preliminary clusters to have on the final map, the core component involved in the interpretation of the maps step.

Step 5: Interpretation of the Maps Through a Focus Group

The purpose of this step was for researchers to collaborate with stakeholders (supervisees) in the interpretation of the maps. The following are the details of how this step was completed.

Preparing for the Focus Group Session. The expectation of this step was to make decisions about the logistics (e.g., place, date, time) of it for participants attending the focus group. Once decisions and arrangements were made, I emailed a brief announcement to the participants indicating the details of the focus group. The focus group session took place on campus in a secure room that had a computer and screen to display the focus group materials. The day before of the focus group, I sent a reminder email to the participants.

The Focus Group Session. I started the focus group by providing an outline of the agenda (Appendix F). I made sure to honor the times (e.g., activity starting time, the duration of the task; 120 minutes) previously presented to the participants. Once the task was understood, I displayed the preliminary clusters obtained from the analyses on the screen. Then, each participant was provided with a printout document containing the preliminary clusters of
statements. I facilitated the focus group and collaborated with participants in the interpretation of the results by discussing, making suggestions, and reaching agreement upon the conceptual relevance of statements and corresponding clusters. I encouraged participants to express their disagreements about cluster-statement fit and/or cluster labels and provide suggestions for a better fit. I allocated the necessary time to review each cluster, the statements in it, and the cluster label. Upon completion of the cluster revisions, participants identified the different areas (clusters of clusters) on the map and labeled them. The result of the final agreement on clusters and cluster labels among participants constituted the conceptual framework and the product of the concept mapping process.

**Testimonial Validity**

In order to increase trustworthiness, CM procedures integrate *testimonial validity* by reaching agreements between researchers and participants regarding the interpretation of the data with the goal of fully capturing participants’ perspectives and controlling for researchers’ bias (Bedi, 2006). In this study, I incorporated testimonial validity by including participants in all three rounds of data collection, as well as by inviting them to collaborate with me in the interpretation of the results that emerged from the data analyses procedures. By doing this, I made sure the data analyses clearly reflected participants’ voices instead of mine.
CHAPTER 4

Results

In the current study, I aimed at exploring what supervisees perceive as their behaviors to make the most out of their supervision experiences. In order to address this gap in the literature, I employed Concept Mapping (CM; Kane & Trochim, 2007), a mixed-methods design, to address the following research question: What are counseling master’s and doctoral supervisees’ perspectives on their responsibilities to enhance their supervisory experience? Thus, this chapter will take the reader through the execution of the three rounds of data collection and analyses by CM, as well as the findings yielded by the study.

Concept Mapping Process

Participants

Guided by CM, I collected the data from December 2019 to February 2020 in three different rounds. Out of 16 participants, fourteen were women (87.5%) and two were men (12.5%); while nine identified as White (Non-Hispanic; 56.25%), two identified as Black/African American (12.5%), one as Hispanic (6.25%), one as multiracial (6.25%), one as European (6.25%), and two as other (12.5%). The mean age of participants was 29.4 years old with a standard deviation of 6.87. Seven participants were students from a counseling master’s program (43.75%), while nine were from a counselor education and supervision doctoral program (56.25%) at a midsize Southeastern university. All master’s level participants were in the clinical mental health counseling track, in either their first semester (57.1%; n=4) or second semester (42.9%; n=3) of internship.

Out of nine doctoral student participants, five received their master’s in clinical mental health counseling (55.5%), one in clinical mental health counseling and school counseling
(6.25%), one in clinical mental health counseling and substance abuse (6.25%), and two in school counseling (12.5%). Four doctoral student participants reported being in their first (44.4%), four in fourth (44.4%), and one in seventh (11.1%) semesters of their doctoral studies.

Participants in the doctoral program had graduated with a master’s degree between 6 and 24 months ago (33.3%; n=3), 25 and 48 months ago (33.3%; n=3), and 49 and 72 months ago (33.3%; n=3). All had received an average of 119 hours of individual supervision as supervisees (Median= 50, Mode = 50, range 30~500). All participants had taken a prerequisite didactic course on counseling supervision, six doctoral student participants reported providing supervision in previous semesters (66.7%), while three had never provided supervision (33.3%).

In terms of their current supervision practices, two doctoral student participants reported currently providing supervision to master’s students in practicum (22.2%), while seven of them were not providing supervision at the time of the data collection (77.8%). The number of supervisees (counselor trainees) to whom doctoral student participants provided supervision ranged from 2 to 19 supervisees. Doctoral student participants reported providing an average of 71.5 hours of clinical supervision ($SD = 40.22$). Lastly, five participants (83.3%) in the doctoral program ranked individual, triadic, and group supervision as the order in which they delivered those modalities of supervision most frequently, while one participant (16.7%) ranked it as group, triadic, and individual.

**First Round: Generation of Statements**

Kane and Trochim (2007) suggested an ideal number of 100 statements as a result of the editing and synthesis process to prevent researcher’s excessive data input time and participant burnout during the second round of data collection. In the first round of data collection of the current study, 16 participants generated a total of 313 statements (range 6 ~ 42, $M = 19.56$, range 30~500).
Median = 18.5, Mode = 12, 19, 30, SD = 8.62) reflecting participants’ thoughts about behaviors they had engaged in or should engage in to make the most out of their supervision experiences. After undergoing the editing and synthesis process, I obtained a final data set containing 191 statements. Upon consulting with the dissertation chair, and in order to maintain the conceptual richness, nuances, and value of the data set, we agreed keeping all 191 statements rather than randomly splitting the data into two.

**Second Round: Sorting of Statements**

In the second round, I conducted in-person meetings in two different days within the same week to accommodate participants’ schedules. Fifteen out of the 16 participants involved in the generation of the statements completed the sorting task. Fourteen participants attended the in-person meetings, and a participant requested the package to be mailed to them for completion. After completing the task, all participants returned the big envelopes containing the data to the researcher. All participant envelopes contained a different number of small envelopes (range 5~19, M = 10.8, Median = 11, Mode = 11, 12, SD = 3.64). Once the sorting was completed, I ran the statistical procedures of CM (e.g., GSM, MDS, and HCA) using R program.

**Group Similarity Matrix (GSM).** I entered each pile of sorted statements into a sort recording sheet to create a GSM. The GSM generated a square symmetric matrix that displayed the number of participants that arranged sets of statements together during the sorting task.

**Multidimensional Scaling (MDS).** I utilized the GSM to conduct MDS through a two-dimensional solution for the 191 sorted statements. The MDS generated a point map (See figure 1; Appendix G) which allowed me to obtain a visualization of the location of each statement on the map. In addition, the point map generated coordinate values for each statement’s location on the map. Sorting of statements into conceptually similar piles was evidenced by proximity of
statements on the point map. The results generated by the current study’s MDS indicated a stress value of 0.303, which was indicative of the point map’s ability to truly represent the grouping data (Kane & Trochim, 2007).

**Hierarchical Cluster Analysis (HCA).** The HCA was conducted to transfer the results of the MDS into clusters of statements which were depicted on a dendrogram (See figure 2; Appendix H) to reflect conceptual similarity and facilitate a visualization of the domain areas. After the dissertation chair and I revised the clusters of statements several times, I sent the document to the auditor. The auditor offered 32 comments and suggestions about moving statements from one cluster to another for better conceptual fit, cluster label additions or modifications, cluster blend and split, cluster specificity, and cluster overlaps. Out of the 32 comments made by the auditor, I accepted 22 and disregarded 10. The disregarded ones were due to suggestions about modifying original statements which is not in tune with CM procedures, since that would alter participants’ original voices. Some other suggestions (e.g., moving statements from cluster to cluster) were not accepted due to the significant distance between the statement and the recommended cluster on the point map. As a result, I obtained a final list containing 21 clusters to be utilized for the third and last round of data collection, the focus group.

**Third Round: Focus Group**

In the third round, six participants attended the in-person focus group. A smaller sample of original participants attending the focus group was anticipated because participant retention is challenging in CM due to the significant involvement required by participants in three different round of data collection. However, this group of attendees allowed for participants’ active engagement and contributions during the revision, discussion, and consensus seeking on the
material presented. Thus, the participant sample was still significant to balance the participants’ and researcher’s views. Out of the 29 suggestions generated in group discussions, focus group participants applied 20 revisions and disregarded 9. The disregarded suggestions were due to the statements’ substantial distance on the point map. As a result of the focus group, a final list of 21 clusters representing 191 supervisee behaviors to make the most out of their clinical supervision experiences was obtained (See Appendix I). In an attempt to honor the time commitment promised to participants (e.g., activity starting time, the duration of the task; 120 minutes), the focus group process did not include a discussion for labeling the two dimensions of the map. I discussed the two dimensions with the dissertation chair.

During the focus group, participants also had suggestions for the areas of the clusters and the map. After reviewing those suggestions, I ended up with five areas that represent the areas of the map (groups of clusters). These areas are depicted in Table 22 to Table 26. Figure 3 (Appendix J) also shows a visual representation of the five areas as well as the two dimensions of the map.

**Five Areas of Supervisee Behaviors Representing the 21 Clusters**

*Area 1: Essential Tasks of Supervision*

This first area of supervisees’ behaviors consisted of five clusters (see Table 22), encompassing seventy-eight statements total, and was located in the mid-bottom area of the map spreading to both bottom quadrants.

**Table 22**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 1</td>
<td>Supervisees’ Commitment to Ethical Standards and Professional Responsibilities</td>
</tr>
<tr>
<td>Cluster 2</td>
<td>Supervisees’ Commitment to Supervision Time</td>
</tr>
<tr>
<td>Cluster 3</td>
<td>Supervisees’ Active Engagement in Setting Learning Goals and Expectations</td>
</tr>
</tbody>
</table>
Cluster 1. Supervisees’ Commitment to Ethical Standards and Professional Responsibilities, included nine statements emphasizing independent behaviors supervisees engage in to honor the ethical and professional standards of the field (e.g., knowing my rights as a supervisee before going into the supervision relationship, reviewing ACA Code of Ethics, completing an agreement with my supervisor, presenting my client’s information in a professional way).

Cluster 2. Supervisees’ Commitment to Supervision Time, was represented by 10 statements pointing out to supervisees’ behaviors to honor the supervision time and process (e.g., being dedicated to attend all supervision sessions when they are scheduled, paying attention in supervision, completing assigned tasks in supervision, keeping my commitments and not cancelling supervision unless it is necessary).

Cluster 3. Supervisees’ Active Engagement in Setting Learning Goals and Expectations, included four statements referring to behaviors supervisees engage in to provide a purpose to the supervision experience as well as to understand what to expect from it and both parties in the supervisory dyad [e.g., creating supervision goals/objectives for myself at the beginning of the semester, making personal goals and striving towards them, setting honest clinical goals (i.e., counseling skills) and making that a part of supervision, having clear expectations of myself and my supervisor].

Cluster 4. Hosting 15 statements, Supervisees’ Intentional Preparation for the Supervision Session, entailed diligent preparation supervisees do on their own (independent work) for the supervision session, as well as task-oriented behaviors to facilitate their learning [e.g., coming to supervision prepared ahead of time with all materials expected, bringing videos...
to every supervision session, reviewing counseling recordings and transcripts prior to supervision, coming to supervision with specific topics and questions (i.e., interventions to use with clients) on a regular basis, especially when needed, documenting concerns for discussion in supervision to prevent losing details].

**By-Itself- Cluster 1.** *Being Cognizant of the Gatekeeping Functions of Supervision,* contained the aforementioned statement only. This statement suggested the importance of supervisees being educated about gatekeeping in the counseling field which permeates the supervision experience.

**Area 2: Supervisees’ Approach to Supervision**

The second area of supervisees’ behaviors was mainly located on the upper left quadrant of the map, sharing a portion of all four quadrants. This area consisted of four clusters containing a total of forty-one statements. The area described supervisees’ positive attitudes and qualities that may contribute to the supervision experience (see Table 23).

**Table 23**

<table>
<thead>
<tr>
<th>Area 2: Supervisees’ Approach to Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 5</td>
</tr>
<tr>
<td>Cluster 6</td>
</tr>
<tr>
<td>Cluster 12</td>
</tr>
<tr>
<td>Cluster 16</td>
</tr>
</tbody>
</table>

**Cluster 5.** With 13 statements, *Supervisees’ Positive Attitude and Investment in Supervision,* reflected supervisees’ conducive attitudes and personal disposition displayed in supervision (e.g., valuing supervision, approaching supervision with a positive attitude, showing respect towards my supervisor, being fully present in supervision, being willing and ready to do the supervision work).
Cluster 6. *Supervisees’ Willingness to Be Open and Honest in Supervision*, involved 16 statements and represented behaviors in which supervisees are transparent within their roles as counselors and supervisees [e.g., being honest about my weaknesses as a counselor, being honest about the challenges I face with clients, being open in supervision about personal reactions (i.e., feelings, thoughts, countertransference) I experience while working with clients, being open about my failures with clients, communicating positive and negative aspects of my performance, admitting when I don’t understand something].

Cluster 12. *Supervisees’ Willingness to Offer Feedback to Their Supervisor*, was represented by five statements referring to supervisees’ insight about the supervision process and willingness to openly let the supervisors know how the supervision experience is going for them (e.g., telling my supervisor how I prefer to receive feedback, communicating my thoughts as clearly and specifically as possible to my supervisor, providing my supervisor with feedback on what is and/or what is not working for me in our supervisory work, providing my supervisor with feedback on what is and/or what is not working for me in our supervisory relationship).

Cluster 16. With seven statements, *Supervisees’ Personal Awareness and Reflections on Their Supervision Experience* denoted supervisees’ acknowledgement and understanding of their own personal characteristics that may facilitate growth as they emerge during the work with the supervisor (e.g., being aware of personal aspects that might affect process in supervision, remaining mindful that there are things my supervisor knows more about than I do, recognizing that supervisors have the intention of supporting counselors for purposes of professional growth, being prepared to have assumptions challenged by the supervisor).
Area 3: Supervisory Relationship and Working Alliance

The third area of supervisees’ behaviors was mainly situated in the upper right quadrant of the map sharing a small portion of the upper left and bottom right quadrants. This area consisted of five clusters that described sixty-three behaviors supervisees bring to the supervision experience and that require of supervisors’ collaboration (see Table 24).

Table 24

<table>
<thead>
<tr>
<th>Cluster 7</th>
<th>Supervisees’ Comfort and Trust in the Supervisory Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 8</td>
<td>Supervisees’ Active Participation in the Supervision Process</td>
</tr>
<tr>
<td>Cluster 9</td>
<td>Supervisees’ Active Collaboration with Their Supervisor</td>
</tr>
<tr>
<td>Cluster 10</td>
<td>Supervisees’ Communication of What They Need from Their Supervisor</td>
</tr>
<tr>
<td>Cluster 13</td>
<td>Supervisees’ Willingness to Disagree in Supervision</td>
</tr>
</tbody>
</table>

Cluster 7. Supervisees’ Comfort and Trust in the Supervisory Relationship hosted eight statements and focused on positive behaviors supervisees engage in to contribute to the supervisory relationship (e.g., understanding and establishing good boundaries within the supervisory relationship, feeling comfortable working with my supervisor, being genuine in the supervision relationship, trusting my supervisor has my best interest in mind, being comfortable with conflict resolution with my supervisor).

Cluster 8. Supervisees’ Active Participation in the Supervision Process encompassed six statements entailing actions that supervisees engage in to bring themselves as active participants of the supervision process. In addition, behaviors in this cluster also pointed out supervisees’ willingness to put what has been discussed in supervision into action (e.g., remaining committed to and actively engaged in supervision, following through with feedback, and implementing
counseling ideas discussed in supervision and bringing them up in the following supervision session).

**Cluster 9.** *Supervisees’ Active Collaboration with Their Supervisor* comprised twelve statements emphasizing the collaborative work that supervisee and supervisor engage in supervision sessions [e.g., processing my counseling sessions with my supervisor (i.e., interventions used, clinical judgement), role playing in supervision to work on counseling skills, collaborating with my supervisor about my professional development, and reflecting on the supervision session with my supervisor].

**Cluster 10.** With 32 statements, *Supervisees’ Communication of What They Need from Their Supervisor* highlighted supervisees’ open communication with their supervisor to get their needs met [e.g., expressing my needs to my supervisor in supervision, asking for a pre-rating of my counseling skills and a post-rating (pre-supervision and post-supervision) to detect growth and development, asking for help on how to correctly conceptualize my clients, asking my supervisor to watch my videos, asking for written feedback, requesting live supervision for challenging clients, requesting forms of supervision that help me (i.e., role play, creating a treatment plan), and advocating for myself, specifically for my learning and needs as a supervisee].

**Cluster 13.** *Supervisees’ Willingness to Disagree in Supervision* included five statements and stressed supervisees’ assertiveness in acknowledging disagreements and communicating those to their supervisor (e.g., being willing to disagree with my supervisor, communicating my disagreements with my supervisor, speaking up if I do not agree with an evaluation, not being afraid to challenge the supervisor’s perspective on clinical work, and telling my supervisor when I am uncomfortable with their methods of supervision).
**Area 4: Supervisees’ Personal and Professional Growth**

The fourth area of supervisees’ behaviors was displayed on the left of the upper and bottom quadrant of the map, consisting of five clusters (see Table 25) with forty-one statements total. This area hosted clusters that reflected behaviors supervisees engage in to foster and promote self-growth as supervisees and clinicians.

**Table 25**

<table>
<thead>
<tr>
<th>Cluster 11</th>
<th>Supervisees’ Receptiveness and Management of Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 14</td>
<td>Supervisees’ Investment in Their Own Learning and Growth as Counselors</td>
</tr>
<tr>
<td>Cluster 15</td>
<td>Supervisees’ Personal Awareness and Reflections on Their Counseling Practice</td>
</tr>
<tr>
<td>Cluster 17</td>
<td>Supervisees’ Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity</td>
</tr>
<tr>
<td>By-itself-cluster 2</td>
<td>Taking Clinical Risks in Supervision and with Clients</td>
</tr>
</tbody>
</table>

**Cluster 11. Supervisees’ Receptiveness and Management of Feedback** encompassed eleven statements and focused on how supervisees receive, intake, and process supervisor’s feedback [e.g., being open to positive feedback and constructive criticism from my supervisor, being open and willing to consider my supervisor’s perspectives and suggestions, being flexible with recommended interventions from my supervisor, being honest, but respectful, if feedback offends me (not holding negative feelings in), not getting defensive when receiving constructive feedback].

**Cluster 14. Supervisees’ Investment in Their Own Learning and Growth as Counselors** hosted eleven statements pointing out supervisees’ work on what is expected and beyond to enhance their professional practice [e.g., doing my own research on different topics of practice outside of supervision (i.e., theories, techniques), doing my own research on specific populations.
in which I will be working outside of supervision, researching my theoretical orientation, being motivated to record session tape, having a case conceptualization for each client.

**Cluster 15.** Including twelve statements, *Supervisees’ Personal Awareness and Reflections on Their Counseling Practice* underlined supervisees’ acknowledgement and understanding of personal characteristics that may facilitate growth as they emerge throughout their clinical practice (e.g., being aware of personal aspects that might affect process in counseling, identifying and remaining aware of my strengths as a developing counselor, identifying and remaining aware of my areas of growth as a developing counselor, working on personal matters that might be impacting my clinical work, engaging in critical thinking when reviewing session tapes).

**Cluster 17.** *Supervisees’ Willingness to Learn from Their Supervisor while Developing Their Own Counseling Style and Professional Identity* featured six statements denoting acknowledgement of differences between supervisor’s and supervisee’s approach to counseling and supervision and tolerance of those differences. This cluster also highlighted supervisees’ disposition to learning as a result of interacting with the supervisor, as well as polishing their own professional identity. Some of the behaviors in this cluster were: learning about my supervisor’s theoretical perspective and preferred treatment modalities, learning from my supervisor’s counseling style, while also working actively to create my own counseling style (not copying supervisor’s style), and being respectful of difference between my counseling style and my supervisor’s counseling style.

**By-Itself-Cluster 2.** *Taking Clinical Risks in Supervision and with Clients* suggested the importance of supervisees taking appropriate clinical risks that enhance supervisees’ practice as well as client’s wellbeing.
**Area 5: Inclusion of Multicultural Considerations**

The fifth and last area of supervisees’ behaviors appeared on the far upper right quadrant of the map. Including two clusters, this area referred to seven behaviors supervisees engage in to enhance their multicultural awareness in their supervision and clinical practices (see Table 26).

**Table 26**

| Cluster 18 | Supervisees’ Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices |
| Cluster 19 | Supervisees’ Willingness to Process Multicultural Considerations in the Supervisory Relationship |

**Cluster 18.** *Supervisees’ Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices* specified the work supervisees do to raise discussions and awareness around cultural competencies as it refers to their work as clinicians. The three behaviors in this cluster were: talking about cultural differences with my supervisor and how might that be playing out in the counseling session, seeking help how to recognize cultural differences between my clients, and consulting with my supervisor about how to address multicultural issues with client.

**Cluster 19.** *Supervisees’ Willingness to Process Multicultural Considerations in the Supervisory Relationship* emphasized the work supervisees do to initiate and further discuss multicultural dynamics in supervision as well as in the supervisory relationship. This cluster included the following four behaviors: talking about cultural differences with my supervisor and how might that be playing out in the supervision session, addressing multicultural issues between me and my supervisor, seeking help how to recognize cultural differences between my supervisors, and expressing thoughts about multicultural considerations.
Two Dimensions of the Concept Map

Five areas entailing supervisees’ behaviors to make the most out of their supervision experiences consisted of 21 clusters displayed on two conceptually meaningful dimensions. Starting from the left side of the map to the right side, Dimension 1 appeared to include areas highlighting supervisees’ autonomous to collaborative behaviors in supervision. On the other hand, spanning from the top of the map to the bottom, areas of clusters in Dimension 2 appeared to range from process to task-oriented behaviors.

Additional Observations

Throughout the CM procedures, I had observations that could inform our understanding and interpretation of the results at a deeper level. My first observation was during editing and synthetizing the initial pool of 313 statements. Several statements were specified by several participants. For example, creating goals for supervision, dressing professionally, advocating for myself, reaching out in crises, bringing up countertransference, and preparing for termination were generated by 3 of the 16 participants. Similarly, requesting continuous and consistent supervision was a statement generated by 4 of the 16 participants, while being open to feedback/evaluation and being prepared for supervision were repeated by 7 participants. Eight participants generated the statement being on time, while 9 participants considered being honest in supervision and asking questions to be the two behaviors that supervisees should engage in to make the most of their supervision experience. Frequency among these statements may be an indicative of behaviors some supervisees consider to be foundational to make the most of their supervision experience.

Secondly, when working on the point map along with the dendrogram, clusters appeared to overlap significantly, requiring researcher’s intentionality in regard to conceptual specificity
among statements. Such overlaps may point out the relatedness among these supervisees’ behaviors, while maintaining nuances and a clear differentiation among clusters.

Thirdly, when working on the preliminary clusters before the focus group, in some instances, a group of statements referred to behaviors that supervisees engage or should engage in motivated by a different set of tasks. For example, cluster 4: *Supervisees’ Intentional Preparation for the Supervision Session*, cluster 5: *Supervisees’ Positive Attitude and Investment in Supervision*, and cluster 9: *Supervisees’ Active Collaboration with Their Supervisor* initially overlapped significantly. Therefore, I had to read all the statements in those three clusters repetitively to identify actions that may have pointed out to the same overall aspect (e.g., supervisees’ presence in supervision), yet could be distinguished through different actions. After working on these three clusters several times guided by the chair’s and auditor’s feedback to have as much clarity as possible among clusters, I was able to complete assignment of all statements in their respective clusters by intentionally differentiating between behaviors that reflected supervisees’ independent work, personal disposition, and collaborative work with the supervisor.

Finally, 2 out of the 191 final statements were determined to be by-it-self clusters, due to their unique conceptual meaning, which although seemed to be related to statements in other clusters, their conceptual alignment was not significatively enough to be assigned to established clusters. Therefore, these two statements were identified as anchoring statements and remained on their own.
CHAPTER 5

Discussion

In this chapter, I will discuss the results of the current study as well as limitations, implications for future research, and implications for supervision and counselor education. The results of the current study addressed the following research question: What are counseling master’s and doctoral supervisees’ perspectives on their responsibilities to enhance their supervisory experience?

In the present study, the researcher attended to the gap in the literature about the need for scholarly work that outlines supervisees’ behaviors as active agents of the process to enhance the supervision experience (Pearson, 2004; Cook & Sackett, 2018; Kangos et al., 2018). This is one of the very first studies describing specific supervisee behaviors to contribute to the supervision process and outcome. The results of the study concur with previous research findings in regard to the importance of supervisees’ awareness of their behaviors as well as active role and constructive attitudes (i.e., openness to supervision, engage in a collegial relationship, willingness to take risks, and self-reflection on own practices) toward enhancing the overall supervision process and outcomes (Kemer et al., 2019; Kemer & Borders, 2017).

Discussion of the Results with the Premises of Active Learning Theory (ALT)

In the current study, the researcher incorporated a pedagogical approach to supervisees’ supervision behaviors and experience. The yielded results appeared to support certain premises presented in Active Learning Theory (ALT) that refer to encouraging learners to abstain from merely listening, and engage in doing, discussing, and being part of the learning experience (Bonwell & Eison, 1991). Although all five areas were in line with how ALT may be reflecting in supervision, specific statements from these areas displayed ALT’s premises. For example,
active participation as the core mean of learning was echoed by “remaining committed to and actively engaged in supervision.” Student’s active involvement was represented by “being willing and ready to do the supervision work.” Interest on the subject was exemplified by “being fully present in supervision.” Students’ confidence by co-owning the experience resonated with “seeking for a collegial relationship with my supervisor as I do not want my supervisor to tell me what I must do, but to give me different options with rationales.” Sharing responsibility for learning outcomes was echoed by “expressing my needs to my supervisor in supervision.” Additionally, ALT aims at encouraging students’ examination of their attitudes and values (Bonwell & Eison, 1991; Wrenn & Wrenn, 2009), which was represented in “being aware of personal aspects that might affect process in counseling” and “expressing thoughts about multicultural considerations.”

By aiding supervision stakeholders with understanding supervisees’ responsibilities, these results may facilitate the process of supervisees’ engagement in active learning processes to enhance the overall supervision experience. Furthermore, the parallels between ALT and the results also highlight that supervision may be more efficient if supervisees, as well as supervisors, are aware of their responsibilities and fully engage in a transactional process knowing what they can be doing to contribute to the learning, the supervisory dyad, and the supervision process in general.

Discussion of the Areas and Clusters Based on Previous Literature

After completing the data collection and analyses procedures, I obtained five areas that reflected supervisees’ behaviors to make the most out of their clinical supervision experience. The Essential Tasks of Supervision area contained five clusters of behaviors. The Supervisees’ Approach to Supervision area entailed four clusters of behaviors. The Supervisory Relationship
and Working Alliance area hosted five clusters of behaviors. Supervisees’ Personal and Professional Growth area consisted of five clusters of behaviors. The fifth and last area, Inclusion of Multicultural Considerations, comprised two clusters of behaviors.

In a general review of the map and the areas, the arrangement of the five areas was noticeable in a manner that displayed sets of behaviors supervisees engage in as the supervision experience progresses. These areas also appeared to layout in two dimensions in the continuums of autonomy-collaboration (dimension 1) and process-task oriented behaviors (dimension 2). This may indicate how supervisees may see supervision logically and progressively occurring. It may also suggest that structure is fundamental for supervisees in the early developmental stages of practice as counselors-in-training (master’s students) and beginning supervisors (doctoral students). Moreover, some areas presented clusters of statements indicating behaviors that supervisees appear to feel exclusively responsible for, such as the Essential Tasks of Supervision, Supervisees’ Approach to Supervision, and Supervisees’ Personal and Professional Growth areas. On the other hand, some other areas were represented by clusters of statements denoting behaviors that supervisees may initiate, yet, require supervisor’s involvement, as in Supervisory Relationship and Working Alliance, and Inclusion of Multicultural Considerations areas.

**Area 1. Essential Tasks of Supervision**

Clusters in this first area appeared to require supervisees’ independent work. These clusters pointed out behaviors that supervisees could engage in on their own to contribute to a conducive supervision experience. Statements among the five clusters of the area also appeared to address what we may call as housekeeping, particularly at the beginning, yet in all stages of the supervision experience. For example, in *Supervisees’ Commitment to Ethical and*
Professional Responsibilities cluster, participants indicated behaviors such as “completing an agreement with my supervisor,” “reviewing ACA code of ethics” and “advocating for my clients.” In Supervisees’ Commitment to Supervision Time cluster, the behaviors “being dedicated to attend all supervision sessions when they are scheduled” and “completing assigned tasks in supervision” were highlighted. Supervisees’ Active Engagement in Setting Learning Goals and Expectations cluster was represented by statements such as “creating supervision goals/objectives for myself at the beginning of the semester” and “having clear expectations of myself and my supervisor.” Supervisees’ Intentional Preparation for the Supervision Session cluster was characterized by behaviors, such as “reviewing counseling recordings and transcripts prior to supervision” and “coming to supervision prepared ahead of time with all materials expected.” Lastly, By-itself-cluster 1 was represented by “being cognizant of the gatekeeping functions of supervision” as important knowledge for supervisees to have and act accordingly. Behaviors within these clusters are perhaps most likely to emerge early in the supervision process, given that they all may provide the foundation that sustains the rest of the supervision experience. They also seemed to resemble some of the areas from Borders et al.’s (2014) best practices for clinical supervisors (i.e., initiating supervision, goal setting, conducting supervision, ethical considerations, documentation). In addition, Supervisees’ Commitment to Supervision Time and Supervisees’ Intentional Preparation for the Supervision Session clusters also had similarities with supervisee’s preparation for/investment/engagement in supervision theme from Kemer and Borders (2017) and Kemer et al. (2019); pointing out the importance of investing time and efforts during and in preparation for the supervision session.
Area 2. Supervisees’ Approach to Supervision

This second area seemed to reflect supervisees’ dispositions, which is prominent in all stages of the supervision experience. For instance, Supervisees’ Positive Attitude and Investment in Supervision cluster was exemplified by statements such as “being willing and ready to do the supervision work” and “being fully present in supervision.” Supervisees’ Willingness to Be Open and Honest in Supervision cluster consisted of statements such as “being open in supervision about personal reactions (i.e., feelings, thoughts, transference, countertransference) I experience while working with clients” and “being honest about the challenges I face with clients.” Supervisees’ Willingness to Offer Feedback to Their Supervisor cluster included behaviors like “providing my supervisor with feedback on what is and/or what is not working for me in our supervisory work” and “providing my supervisor with feedback on what is and/or what is not working for me in our supervisory relationship,” which aligned with the giving feedback area in Borders et al. (2014). Lastly, Supervisees’ Personal Awareness and Reflections on Their Supervision Experience cluster was represented with statements such as “being aware of personal aspects that might affect process in supervision” and “remaining mindful that there are things my supervisor knows more about than I do.” Supervisees’ Positive Attitude and Investment in Supervision cluster in this area also supported the theme, supervisee’s attitude toward client, site, and/or supervisor, in Kemer and Borders (2017) and Kemer et al. (2019). These similar findings further highlight the critical role of Supervisees’ Approach to Supervision to enhance supervisory process and outcomes.

Moreover, this area’s findings shared similarities with two of the six salient characteristics of stellar supervisees (i.e., autonomy and motivation) identified by counselor supervisors (Norem, Magnuson, Wilcoxon, & Arbel, 2006). Similarities within Norem et al.’s
work and this area may respond to Norem et al.’s following question: “can these qualities be identified prior to supervision?” Findings from the present study appear to indicate that participants recognized and stated the importance of their dispositional characteristics in making the most out of their supervision experiences. Thus, if supervisees are encouraged to become aware and reflect on these characteristics (i.e., prompting them about what they think are the qualities they can display to be stellar supervisees), they could recognize their enhancing dispositions, and may engage in them in an efficient manner to (1) help shape the route supervision takes by displaying a positive attitude in supervision, (2) co-author the manner in which supervision occurs by being transparent about their strengths and weaknesses, and (3) co-own supervision outcomes as a result of their investments and work as supervisees.

**Area 3. Supervisor Relationship and Working Alliance**

Along with area five, area three suggested supervisee behaviors to initiate and invite supervisors’ involvement and interactions. The Supervisor Relationship and Working Alliance area presented working relationship clusters, such as *Supervisees’ Comfort and Trust in the Supervisory Relationship* (e.g., “understanding and establishing good boundaries within the supervisory relationship,” “collaborating with my supervisor about my professional development,” “telling my supervisors when I am uncomfortable with their methods of supervision,” and “asking for written feedback”), supporting previous research (Kemer & Borders, 2017; Kemer et al., 2019) findings that indicated the supervisory relationship as a critical part of supervisors’ supervision considerations in relations to supervisees. In addition, *Communication of What They Need from Their Supervisor* cluster in this area represented the highest number of statements across 21 clusters, evidencing communication of needs as a critical behavior that supervisees must engage in; a unique result of the current study when compared to
previous studies with supervisors (Kemer & Borders, 2017; Kemer et al., 2019; Norem et al., 2006). Statements within this area embodied behaviors in which not only supervisees engage in, but also require both supervisees and supervisors to invest and collaborate in the supervision process. In other words, this area may highlight a transactional process in which both supervisees’ and supervisors’ behaviors feed into each other to co-create a working alliance.

**Area 4. Supervisees’ Personal and Professional Growth**

The fourth area appeared to point out supervisees’ intentional work to enhance their own personal and professional growth. Statements in Supervisees’ Receptiveness and Management of Feedback cluster [e.g., “being open to positive and constructive criticism,” “being honest, but respectful, if feedback offends me (i.e., not holding negative feelings in)”] and in Supervisees’ Personal Awareness and Reflections on Their Counseling Practice cluster (e.g., “identifying and remaining aware of my areas of growth as a developing counselor”) supported three of the themes (i.e., counseling skills/conceptualization abilities, self-awareness/self-reflectivity, supervisory relationship) obtained in Kemer and Borders (2017), as well as two of the themes (i.e., openness to experience, self-awareness) from Norem et al. (2006). Furthermore, complementing the previous research, the current results also pointed out additional supervisee behaviors. For example, Supervisees’ Active Collaboration with Their Supervisor, Supervisees’ Willingness to Disagree in Supervision, or Supervisees’ Communication of What They Need from Their Supervisor were unique behaviors supervisees specified as critical aspects of their supervision involvement, while suggesting that supervisees perceived a dual responsibility not only for enhancing their practices as clinicians through supervision to protect clients’ welfare, but also to improve their practices as supervisees to contribute to the supervision experience.
Area 5. Inclusion of Multicultural Considerations

The fifth area hosted two clusters pointing out the necessity of supervisees’ engagement in multicultural considerations and discussion not only in their counseling practices but also in supervision. Supervisees’ Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices cluster included statements such as “talking about cultural differences with my supervisor and how might that be playing out in the counseling session,” while Supervisees’ Willingness to Process Multicultural Considerations in the Supervisory Relationship cluster embodied statements such as “addressing multicultural issues between me and my supervisor.” This area appeared to support Borders et al.’s (2014) diversity and advocacy considerations area, Kemer and Borders’ (2017) exploring self and biases/values within the self-awareness/self-reflectivity theme, and Kemer et al.’s (2019) sensitive to and skilled in diversity issues under supervisee’s counseling competencies and background/experience theme. These studies highlighted the importance of supervisees’ multicultural competencies within their practices as counselors and supervisees.

In summary, the five areas of supervisees’ supervision behaviors highlighted supervisees’ independent work as well as initiation of collaboration with their supervisors through expressing their needs, as opposed to being passive receivers of the supervision process. Concurring with previous findings on supervisees’ active investment being a crucial aspect of individual supervision (e.g., Kemer & Borders, 2017; Kemer et al., 2019), the obtained five areas in the present study also supported Cook and Sackett’s (2018) emphasis on the importance of both supervisor’s and supervisee’s investment in the process.
Further Discussion of Results Based on Additional Literature

By voicing supervisees’ perspectives, the current study results yielded a framework supportive and complementary to the previous research efforts that have focused mainly on supervisors’ perceptions or authors’ perspectives (e.g., Ellis, 2017; Kemer & Borders, 2017; Norem et al., 2006).

In one of those efforts, Bifarin and Stonehouse (2017) described three main supervisee roles within supervision (i.e., engaging in supervision knowing what they want to address, making the most of the time and putting what has been learned in supervision into action, and documenting what is discussed in supervision as well as taking an active role in their own professional and personal development). The results from this study complemented Bifarin and Stonehouse’s descriptions by attending to the operational gap and offering specific supervisee behaviors or tasks within those roles. For example, engaging in supervision knowing what they want to address may be operationalized and exemplified in the current study’s statements, such as “coming to supervision with specific topics and questions (i.e., interventions to use with clients) on a regular basis, especially when needed” and “documenting concerns for discussion in supervision to prevent losing details” (from Supervisees’ Intentional Preparation for the Supervision Session cluster). Similarly, making the most of the time and putting what has been learned in supervision into action may be represented in the statements “being willing and ready to do the supervision work” and “implementing counseling ideas discussed in supervision and bringing them up in the following supervision session” (from clusters Supervisees’ Positive Attitude and Investment in Supervision and Supervisees’ Active Participation in the Supervision Process). Lastly, documenting what is discussed in supervision as well as taking an active role in their own professional and personal development could be represented in statements like “taking
notes during supervision to track and reflect on topics discussed and increase accountability” and “doing my own research on specific populations in which I will be working with outside of supervision” (from clusters *Supervisees’ Intentional Preparation for the Supervision Session* and *Supervisees’ Investment in Their Own Learning and Growth as Counselors*).

Likewise, the framework obtained in the present study was also complementary to Ellis’s (2017) *Supervisees’ Bill of Rights and Responsibilities*. In the document, Ellis presented a list of supervisees’ responsibilities, mainly reflective of the author’s perspectives on the subject matter, not based on empirical findings. In the current study findings, Ellis’ supervisees’ responsibilities were echoed in some of the statements from different clusters in this study and complemented by some others. For example, the following are some of the ones that were echoed by the current study: *Supervisees’ Commitment to Ethical Standards and Professional Responsibilities* with statements such as “reviewing ACA Code of Ethics” and “advocating for my clients” among others. *Supervisees’ Willingness to Be Open and Honest in Supervision* by engaging in behaviors such as “communicating positive and negative aspects of my performance” and “admitting when I don’t understand something.” *Supervisees’ Willingness to Disagree in Supervision* by “speaking up if I do not agree with an evaluation” and “not being afraid to challenge the supervisor’s perspective on clinical work.” *Supervisees’ Investment in Their Own Learning and Growth as Counselors* by displaying behaviors such as “working with one or more counseling theories” and “doing my own research on different topics of practice outside of supervision (i.e., theories, techniques).” *Supervisees’ Willingness to Process Multicultural Considerations in the Supervisory Relationship* by “talking about cultural differences with my supervisor and how might that be playing out in the supervision session” and “addressing multicultural issues between me and my supervisor.” Some additional aspects that appear to add to Ellis’ work are
behaviors such as *Supervisees’ Active Collaboration with Their Supervisor* by “reflecting on the supervision session with my supervisor” and “discussing my theoretical orientation with my supervisor” and *Supervisees’ Communication of What They Need from Their Supervisor* by “asking for a pre-rating of my counseling skills and a post-rating (pre-supervision and post-supervision) to detect growth and development,” “asking for help on how to correctly conceptualize my clients,” and “consulting on ethical dilemmas with my supervisor regularly.” Thus, supervisees’ perceptions of their behaviors to make the most out of their clinical experiences are not so far from the author’s perceptions in reference to what supervisees are responsible for within the dyad. On the other hand, current study findings also highlighted supervisees’ acknowledgement of certain behaviors as critical components of the supervision process, such as expression of needs, which appeared as complementary to Ellis’ Bill of Rights and Responsibilities.

Similarly, Pearson (2004) asserted that what supervisees do in supervision directly impacts supervisor's assessment of the supervisee. Thus, the author encouraged supervisees to comprehend areas that are important to supervisors, while offering suggestions to supervisees about different tasks they could be doing to engage in a conducive and productive supervision experience (e.g., active participation, taking initiative, monitoring self and reactions). In this study results, active participation task was exemplified by *Supervisees’ Active Participation in the Supervision Process* (e.g., “remaining committed to and actively engaged in supervision”). Taking initiative task was mirrored by *Supervisees’ Communication of What They Need from Their Supervisor* (e.g., “asking questions about client statements and behaviors that I do not understand”). Lastly, monitoring self and reactions task was represented on *Supervisees’ Personal Awareness and Reflections on Their Counseling Practice* (e.g., “being aware of personal aspects
that might affect process in counseling”), *Supervisees’ Awareness and Reflections on Their Supervision Experience* (e.g., “working on managing my anxiety”), and *Supervisees’ Willingness to Be Open and Honest in Supervision* [e.g., “being open in supervision about personal (i.e., feelings, thoughts, transference, countertransference) I experience while working with clients].

In terms of supervisees’ behaviors that make supervision effective, Stark’s (2017) adapted SURF presented four factors; professionalism, relational skills in the supervisory relationship, signs of self-supervision, and proactive. These factors emerged as a result of the original SURF in which items were created by counseling psychology graduate students and practicum supervisors (Vespia et al., 2002). Out of 46 adapted SURF items, 29 were represented in the current study’s generated statements for supervisee behaviors to make the most out of the supervision experience. Distributed across clusters, different statements in this study emulated some of those factors from the adapted SURF. For example, the professionalism factor was mirrored by statements, such as “paying attention in supervision,” “remaining committed to and actively engaged in supervision,” and “Not getting defensive when receiving constructive feedback” in clusters *Supervisees’ Commitment to Ethical Standards and Professional Responsibilities, Supervisees’ Receptiveness and Management of Feedback, and Supervisees’ Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity*. Relational skills in the supervisory relationship factor resonated with statements, such as “communicating my disagreements with my supervisor,” and “providing my supervisor with feedback on what is and/or what is not working for me on the supervisory relationship” in clusters *Supervisees’ Willingness to Offer Feedback to Their Supervisor and Supervisees’ Willingness to Disagree in Supervision*. The third factor, signs of self-supervision, was paralleled by statements, such as “doing my own research on different topics of practice
outside of supervision (i.e., theories, techniques),” and “being willing to ask for more help if I feel that I need it in certain areas” in clusters *Supervisees’ Investment in Their Own Learning and Growth as Counselors* and *Supervisees’ Communication of What They Need from Their Supervisor*. The proactive factor was comparable to statements, such as “following through with feedback,” “bringing videos to every supervision session,” and “expressing my needs to my supervisor in supervision” in clusters *Supervisees’ Active Participation in the Supervision Process, Supervisees’ Intentional Preparation for the Supervision Session*, and *Supervisees’ Communication of What They Need from Their Supervisor*. These similarities between the studies further evidence that these supervisee behaviors are critical in contributing to an efficient supervision experience.

On the other hand, the current study presented clusters of statements that were not addressed within Stark’s adapted SURF’s four factors. Some of these were by-itself-cluster 1, *Being Cognizant of the Gatekeeping Functions of the Supervisor*, and other statements such as “being flexible,” “approaching supervision with a positive attitude,” and “developing my comfort level engaging in supervision” (*Supervisees’ Positive Attitude and Investment in Supervision* cluster); “processing my counseling sessions with my supervisor (i.e., interventions used, clinical judgment”) and “role playing in supervision to work on counseling skills” (*Supervisees’ Active Collaboration with Their Supervisor* cluster); “being prepared to have assumptions challenged by the supervisor,” “recognizing that supervisors have the intention of supporting counselors for purposes of professional growth” (*Supervisees’ Personal Awareness and Reflections on Their Supervision Experience* cluster); and all statements in clusters *Supervisees’ Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices* as well as *Supervisees’ Willingness to Process Multicultural*
Considerations in Relation to Their Supervisory Relationship. Different than the participants in Vespi et al. (2002) and Stark (2017), the current study participants have/had taken an introductory and/or advanced course to counseling supervision, which may be an explanation for the richer and more nuanced data obtained in the current study.

Participants’ statements in the current study also appeared to offer more process-oriented behaviors representing supervision as a continuous process (e.g., Supervisees’ Active Participation in the Supervision Process, Supervisees’ Active Collaboration with Their Supervisor, Supervisees’ Willingness to Offer Feedback to Their Supervisor, Supervisees’ Willingness to Disagree in Supervision, and Supervisees’ Personal Awareness and Reflections on Their Supervision Experience clusters, and the Inclusion of Multicultural Considerations area), in addition to mainly task-focused practices provided in Borders et al.’s (2014) best practices document.

The results of the current study presented a framework for supervisees to become aware of their roles and responsibilities to make supervision successful, advocate for their role as supervisees, engage in a transactional process with their supervisor, be active learners and agents of their supervision experience, and take ownership for the supervisory process and outcomes.

Limitations

As in all research, the current study also holds some limitations. First, the generalizability of the results is limited to the demographics and characteristics of the students that took the introduction to counseling supervision and advanced counseling supervision courses at the southeastern university from which the researcher collected the data. Although the researcher distributed the invitation for participation in the study through the participants’ department
listserv, which includes a diverse group of students, participants of the current study were mainly white and female students.

Second, participant retention was portrayed as a common issue across concept mapping studies (Kane & Trochim, 2007). Despite the monetary incentives offered to the participants in the current study, the number of participants in the last round of data collection was smaller than the other two rounds. It is important to note that the researcher had to move the focus group to a week later than previously agreed, since the data analyses took longer time than anticipated. As a result, participant attendance to the focus group decreased by six participants. Even though having all participants attend all rounds of data collection increases results validity, a smaller final focus group is also a common procedure in concept mapping studies (Kane & Trochim, 2007).

Lastly, notwithstanding the testimonial validity procedures (i.e., including participants in all three rounds of data collection, consulting with the dissertation chair, as well as with an auditor) included into the current concept mapping study, the editing and syntheses of the statements as well as preliminary structuring of the statements may not have been entirely free from the researchers’ interpretations of the data. Thus, a different organizational structure of the results could have been yielded if the analyses were conducted by another group of researchers.

**Implications for Future Research**

The current study was a preliminary effort to explore and understand supervisees’ perceptions on the behaviors they may want to engage in to make the most out of their clinical supervision experiences. However, a single study may not be saturated enough with a comprehensive list of supervisee behaviors; thus, further research studies to expand on our understanding on this topic are needed. Firstly, the replication of the present study with a
different sample of supervisees may offer researchers the opportunity to compare and contrast similarities, differences, and complementary pieces among findings. Secondly, due to small sample size and sample-specific (e.g., demographics) inferences in the present study, future studies with larger and more diverse participant samples may yield different results than the present study results. Thirdly, the present study provided us with an initial understanding of supervisees behaviors to make the most of the supervision experience. A further examination of participants’ ratings for most and least frequently engaged behaviors may offer us with an understanding of behaviors supervisees are most likely to display in supervision (rating task (Kane & Trochim, 2007). Lastly, upon replication of the current study with additional samples, an instrument to assess supervisees’ supervision behaviors may be developed and validated through exploratory and confirmatory factor analyses procedures.

Implications for Supervision and Counselor Education

The current study results also have implications for different stakeholders of the supervision processes; supervisees, supervisors, and counselor training programs.

Supervisees

Results of the current study may be used as an operational roadmap to (1) inform supervisees about behaviors they could reflect on and consider engaging in to facilitate the supervision process (e.g., Supervisees’ Positive Attitude and Investment in Supervision, Supervisees’ Willingness to Be Open and Honest in Supervision, and Supervisees’ Communication of What They Need from their Supervisor), (2) encourage supervisees to display all or some of those behaviors to enhance their own learning and reciprocate supervisors’ efforts (e.g., Supervisees’ Active Participation in the Supervision Process), (3) enable co-ownership of the supervision experience by sharing responsibility for supervision process and outcomes (e.g.,
Supervisees’ Active Collaboration with Their Supervisor), and (4) support their experience within the supervisory dyad by having a reference point to look at throughout the supervision process (all clusters).

Furthermore, findings of the current study may provide supervisees with an outline of behaviors to engage in to make the most out of their supervision experiences, as well as to advocate for themselves as the main stakeholder of the supervision process. Attending to Ellis et al.’s (2015) and McNamara et al.’s (2017) suggestions on aiding supervisees’ knowledge regarding both parties’ responsibilities in clinical supervision, findings of the current study may help supervisees to identify and avoid harmful supervision experiences. This could be facilitated by supervisees’ awareness of (1) supervisors’ best practices in their work with supervisees (i.e., Borders et al., 2014), and (2) behaviors they could engage in such as “knowing my rights as a supervisee before going into the supervision relationship,” “understanding and establishing good boundaries within the supervisory relationship,” “providing my supervisor with feedback on what is and/or what is not working for me in our supervisory work,” “telling my supervisor when I am uncomfortable with their methods of supervision,” and “advocating for myself, specifically for my learning and needs as a supervisee.” Incorporating these practices into their roles and responsibilities may provide supervisees with the tools to advocate for themselves about the quality of supervision they receive and their part in the supervision process, while empowering them to have mutual voice, respect, and collaboration with their supervisors.

Supervisees’ understanding of critical behaviors they could engage in supervision may foster a learning environment where they may be able to engage in co-jointed efforts with their supervisors. Once supervisees engage in open communication (e.g., “communicating my thoughts as clearly and specifically as possible to my supervisor,” “being honest about the
challenges I face with clients” “expressing my needs to my supervisor in supervision,” “being willing to ask for more help if I feel that I need it in certain areas”), both parties in the dyad may have the ability to come up with a more precise identification of supervisees’ areas of strengths and growth. Such a process may foster a collaborative process that results in a more intentional and efficient supervision process in which both parties do their part to make the most of the supervision experience.

Supervisors

Results of the current study may also provide tools for the supervisors. Along with the Best Practices in Clinical Supervision document (Borders et al., 2014), supervisors may want to incorporate a check list of supervisees behaviors to make the most out of their supervision experiences in supervision agreements and discuss them with their supervisees during the first supervision session. The checklist could include clusters of behaviors such as Supervisees’ Commitment to Ethical Standards and Professional Responsibilities, Supervisees’ Commitment to Supervision Time, Supervisees’ Active Engagement in Setting Learning Goals and Expectations, Supervisees’ Intentional Preparation for the Supervision Session, Supervisees’ Active Participation in the Supervision Process, Supervisees’ Active Collaboration with Their Supervisor, and Supervisees’ Communication of What They Need from Their Supervisor.

Informing supervisees about behaviors they could engage in to be active learners in supervision may complement supervisors’ efforts to improve the overall supervision experience for both parties. By doing this, supervisors may foster balance in terms of attending to their responsibilities as supervisors while also inviting supervisees to become aware and accountable for their part in the supervision process. Additionally, supervisors could do overviews of the supervision work at different points (e.g., bi-monthly) throughout the supervision experience,
where supervision time is exclusively allocated to discuss how supervision is going (e.g., what is working, what is not working, what could be enhanced). Such an effort may also facilitate supervisors’ assessment of the supervisory dyad work from a process-oriented standpoint. During these overviews, supervisors may go over some additional clusters obtained in this study (e.g., *Supervisees’ Positive Attitude and Investment in supervision, Supervisees’ Willingness to Be Open and Honest in Supervision, Supervisees’ Receptiveness and Management of Feedback, Supervisees’ Willingness to Offer Feedback to Their Supervisor, Supervisees’ Investment in Their Own Learning and Growth as Counselors, Supervisees’ Personal Awareness and Reflections on Their Supervision Experience*) and collaborate with the supervisee in the identification of behaviors they have engaged in to make of supervision a productive experience, and/or identify the ones they could start using to enhance the overall supervision process.

The current study could also inform supervisors’ work in supervision in accordance with different supervision models. The Integrated Developmental Model of supervision (IDM; Stoltenberg & McNeil, 2010) presents that it is imperative to assess supervisees’ developmental level as well as to offer supervisees a conducive environment to move across different levels. The assessment of supervisees’ developmental level (i.e., IDM; Stoltenberg & McNeil, 2010) may be facilitated by certain supervisee behaviors. For example, clusters *Supervisees’ Willingness to Be Open and Honest in Supervision, Supervisees’ Receptiveness and Management of Feedback, Supervisees’ Personal Awareness and Reflections on Their Counseling Practice,* and *Supervisees’ Personal Awareness and Reflections on Their Supervision Experience* may facilitate supervisors’ identification of supervisees’ developmental needs, challenges, and strengths, resulting in a more accurate supervisee assessment, as well as a more meaningful and growing experience for the supervisee. Similarly, per Bernard’s Discrimination Model (Bernard,
1979), supervisors identify supervisees’ area of difficulty within supervisees’ focus areas (i.e., intervention/process, conceptualization, and personalization) and choose the necessary supervisor roles (e.g., teacher, counselor, consultant) to stimulate supervisees’ development in the identified area. This dynamic may be facilitated by supervisors’ intentional utilization of the knowledge provided by clusters such as *Supervisees’ Communication of What They Need from Their Supervisor* and *Supervisees’ Willingness to Be Open and Honest in Supervision*.

**Counselor Education and Training**

*ACA Code of Ethics* (2014) section F.4. informs supervisors about their responsibilities in clinical supervision. This study’s findings may expand on ACA’s section F.5. “student and supervisee responsibilities” by adding two new subsections such as (1) autonomous and collaborative behaviors, and (2) process-oriented and task-oriented behaviors. Bernard and Goodyear (2019) asserted that supervisors are responsible for their own competence and their supervisees’ competence. Similarly, the results yielded by the current study may indicate that supervisees are responsible for their own competence, as well as being responsible to the clients they serve, supervisors who oversee their work, and society in general. Therefore, these new subsections would require supervisees to become aware of behaviors they could engage in to make the most out of their supervision experiences to protect their clients’ welfare.

Current study findings may also inform Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) standards entail eight areas as the essential knowledge of entry-level counselor graduates. Even though “the role of counseling supervision in the profession” is included as a CACREP standard in Section 2, majority of the accredited programs address this standard in various courses and do not offer a separate introductory supervision course as part of their curriculum. Upon entering practicum and internship, counselor
trainees become supervisees, many of whom engage in this role for the first time. Therefore, not knowing much about how to be a ‘good’ supervisee, counselor trainees may spend a great deal of time to understand their roles and responsibilities before becoming active agents of supervision, co-joining the supervision experience, and reciprocating supervisors’ efforts. Asking supervisees to take an active role in supervision may be redundant if supervisees are not knowledgeable about and/or trained in their role and behaviors in supervision. Sample of the current study demonstrated an in-depth reflection on their behaviors and expressed the critical dispositions in supervision to make their supervision experiences worthwhile, particularly because they had at least taken an introductory supervision course. Thus, it seems imperative to consider inclusion of an introductory supervision course in CACREP-accredited master’s counseling programs. Such a course may offer supervisees with a more comprehensive understanding of supervision and encourage them to engage in supervision in more intentional, meaningful, and efficient ways that not only enhances counselors-in-training performance, but also protects clients’ welfare.
CHAPTER 6

Manuscript

Best Practices in Clinical Supervision: What Must Supervisees Do?
Abstract

Guided by an exploratory sequential mixed-methods design, Concept Mapping (Kane & Trochim, 2007), I attended to the gap in the literature by exploring and understanding what supervisees perceive as their responsibilities in clinical supervision. Five areas of supervisees’ responsibilities (i.e., Essential Tasks of Supervision, Supervisees Approach to Supervision, Supervisory Relationship and Working Alliance, Supervisees’ Personal and Professional Growth, and Inclusion of Multicultural Considerations) were represented by 21 clusters. The results are discussed with implications for supervisees, supervisors, and counselor education and supervision programs.

*Keyswors*: clinical supervision, best practices, supervisees’ responsibilities, counselor education
Introduction

Scholarly efforts have been made to describe supervisors’ practices in clinical supervision [i.e., American Counseling Association (ACA), 2014; Council of Accreditation of Counseling and Related Programs (CACREP), 2016; Bernard & Goodyear, 2019; Borders & Brown, 2005; Pearson, 2004; Borders et al., 2014; Falender & Shafranske, 2014]. Most supervision literature has situated the supervisor as the main subject of study as well as the main responsible party of the supervision process (e.g., Kemer, Sunal, Li, & Burgess, 2019; Bambling & King, 2014). However, individual supervision requires the investment of both parties in the supervision dyad (Cook & Sackett, 2018). Researchers reported that both supervisors and supervisees are responsible for the effectiveness of supervision (Kemer et al., 2019), as supervisees’ active role improved the supervisory relationship and the overall supervision process (Kemer & Borders, 2017). Despite acknowledging supervisees’ vital role in supervision, to date, researchers have neither outlined supervisees’ roles and responsibilities in supervision, nor presented any best practices for supervisees as essential agents of the process for supervision to be effective (Pearson, 2004; Cook & Sackett, 2018; Kangos et al., 2018). Thus, it is critical to explore and understand supervisees’ roles and responsibilities in the clinical mental health supervision process.

Active Learning Theory (ALT; Bonwell & Eison, 1991) suggests experience through active participation as the core mean of knowledge acquisition. Active learning fosters environments that stimulate student’s involvement and interest on the subject, promote their confidence by inviting them to become co-owners of the experience and share responsibility for the outcome, and evokes students’ examination of their attitudes and values (Bonwell & Eison,
1991; Wrenn & Wrenn, 2009) that may enhance and/or hinder their learning experience.

Bonwell and Eison (1991) assert that students must defer from merely listening and integrate doing by engaging, discussing, and being part of problem-solving dynamics. ALT appears as a natural fit to clinical supervision because the supervisory dyad involves a more experienced professional assisting a less experienced professional or professional in training. In this process, the supervisor is typically described as the more invested party taking vast responsibility for supervision outcomes. However, within the supervisory dyad, supervisees must not be passive receivers, but more of an active and involved party of the process. Supervisees must be aware of their behaviors in supervision, enable active participation by co-owning the supervision experience, embrace the supervisory dynamics, acknowledge they are equally important in the supervisory dyad, understand they are responsible to some extent for the supervision outcomes, and believe in their ability and potential to contribute to the supervisory process.

**Supervisors’ Roles and Responsibilities in Clinical Supervision**

Since 1920s, supervisee competence in clinical supervision has been the main focus of clinical supervision process, beyond the client welfare and counseling outcomes (Bernard & Goodyear, 2019). More specifically, clinical supervision provides the necessary tools for high-quality counseling delivery and client welfare (Borders et al., 2014). Borders et al. asserted that the aim is at building the legacy of improved supervision, as supervisees receive best practices and provide the same to their own clients. In order to fulfill these purposes, supervision scholars have offered different resources to the clinical supervisors in the last 29 years, such as the ACES Standards for Counseling Supervisors (1990), ACES Best Practices in Clinical Supervision (Borders et al., 2014), American Counseling Association (ACA) *Code of Ethics* (2014), Council
for Accreditation of Counseling and Related Educational Programs Standards (CACREP, 2016), and the roles and responsibilities of supervisors (Borders & Brown, 2005; Pearson, 2004).

Similarly, supervision models [e.g., Integrated Developmental Model (IDM; Stoltenberg & McNeill, 2010); Discrimination Model (Bernard, 1979)] provided supervisors with roadmaps by describing different characteristics of supervisees progressing through developmental levels, while how supervisors could focus on different roles and focus area to address supervisees’ growth needs. However, none of these models specify behaviors supervisees should engage in to make the most out of their clinical supervision.

Reviewing the supervision literature on supervisees’ behaviors in the supervisory process, I observed several critical commonalities and gaps. First, scholars emphasized the importance of clinical supervision in polishing the skills of counselor trainees as well as safeguarding the welfare of supervisees’ clients (Bernard & Goodyear, 2019; Barnett & Molzon, 2014). Second, scholars/supervisors acknowledged the importance of supervisees engaging in an active role in order to become active parties within the supervisory experience and make the most out of it (Bifarin & Stonehouse, 2017). Third, a considerable amount of the focus has been placed on supervisors as the main responsible party in guaranteeing satisfactory supervision outcomes (O’Brien, McNeil, & Dawson 2019). Fourth, among the few efforts on suggesting supervisees’ responsibilities/behaviors, all were totally or partially based on supervisors’ perspectives, (Ellis, 2017; Pearson, 2004; Norem, Magnuson, Wilcoxon, & Arbel, 2006; Vespia, Heckman-Stone, & Delworth, 2002; Stark, 2017) overlooking supervisees’ perspectives solely. Finally, supervisees may not gain much or even may become victims of harmful supervision going into supervision without full awareness of their rights and responsibilities in their supervision experiences (Ellis, Creaner, Hutman, & Timulak 2015; Mcnamara, Kangos, Corp,
Ellis, & Taylor, 2017). In other words, the collaboration between supervisors and supervisees appear to be left to the discretion of supervisors’ practices and supervisees have not been emphasized as an active contributor of their own supervision process. Moreover, majority of this literature on supervisees’ behaviors in clinical supervision included more descriptions than operational definitions, offering researchers opportunities to explore how supervisees’ contributions to supervision could be further examined and integrated in the supervisory process. Thus, it is crucial to understand behaviors supervisees consider to be critical in their own performance.

The Need for a Transactional and Informed Supervision Process

Supervisors are the main responsible party in clinical supervision as the more informed, trained, and experienced professionals in the supervision dyad. They are responsible for structuring supervision in a conducive way where supervisees could understand and execute the tasks, while creating the space for the supervisee to adhere to such structure (Corey et al., 2010). This is the reason why supervision outcomes are heavily seen as supervisors’ responsibility (Barnett & Molzon, 2014). On the other hand, both supervisors and supervisees are essential components of supervision, subsequently holding inherent responsibilities, even though these responsibilities are not of equal weight (Corey et al., 2010). Similar to Bonwell and Eison’s (1991) ALT premises, teachers/supervisors and students/supervisees must engage in active learning, share the responsibility about learning outcomes, and understand and emphasize supervisees’ roles in supervision. In such a role, supervisees could be encouraged to invest in the supervision process, reciprocate supervisors’ efforts (Bifarin & Stonehouse, 2017), and become active agents of supervision. This transactional relationship appears as an underemphasized area in the supervision literature, although (1) scholars expressed the need for a process-oriented
supervision where supervisees engage as active parties in supervision through an interactional and involved approach (Sewell, 2018; Shanley & Stevenson, 2006), and (2) expert supervisors consider it a crucial practice in supervision and have expressed their “…willingness on sharing authority and responsibility with their supervisees” (Kemer, Borders, & Willse, 2014, p.13).

Purpose of the Current Study

In the current study, I explored counseling master’s and doctoral supervisees’ perceptions of their behaviors to make the most out of their clinical supervision experiences. As a result of this study, I aimed at (1) giving voice to supervisees as one of the main stakeholders of supervision and (2) obtaining a framework that offers an understanding and descriptions for essential supervisee behaviors. Thus, the research question of the current study was: What are counseling master’s and doctoral supervisees’ perspectives on their responsibilities to enhance their supervisory experience?

Methodology

Participants

Participants in the current study were counseling master’s and doctoral students at a midsize southeastern university. Guided by CM, I collected the data from December 2019 to February 2020 in three different rounds. Out of 16 participants, fourteen were women (87.5%) and two were men (12.5%); while nine identified as White (Non-Hispanic; 56.25%), two identified as Black/African American (12.5%), one as Hispanic (6.25%), one as multiracial (6.25%), one as European (6.25%), and two as other (12.5%). The mean age of participants was 29.4 years old with a standard deviation of 6.87. Seven participants were students from a counseling master’s program (43.75%), while nine were from a counselor education and supervision doctoral program (56.25%) at a midsize Southeastern university. All master’s level
participants were in the clinical mental health counseling track, in either their first semester (57.1%; $n=4$) or second semester (42.9%; $n=3$) of internship. Out of nine doctoral student participants, five received their master’s in clinical mental health counseling (55.5%), one in clinical mental health counseling and school counseling (6.25%), one in clinical mental health counseling and substance abuse (6.25%), and two in school counseling (12.5%). Four doctoral student participants reported being in their first (44.4%), four in fourth (44.4%), and one in seventh (11.1%) semesters of their doctoral studies. Participants in the doctoral program had graduated with a master’s degree between 6 and 24 months ago (33.3%; $n=3$), 25 and 48 months ago (33.3%; $n=3$), and 49 and 72 months ago (33.3%; $n=3$). All participants had received an average of 119 hours of individual supervision as supervisees ($Median= 50$, $Mode = 50$, range 30~500). All participants had taken a prerequisite didactic course on counseling supervision, six doctoral student participants reported providing supervision in previous semesters (66.7%), while three had never provided supervision (33.3%). In terms of their current supervision practices, two doctoral student participants reported currently providing supervision to master’s students in practicum (22.2%), while seven of them were not providing supervision at the time of the data collection (77.8%). The number of supervisees (counselor trainees) to whom doctoral student participants provided supervision ranged from 2 to 19 supervisees. Doctoral student participants reported providing an average of 71.5 hours of clinical supervision ($SD = 40.22$). Lastly, five participants (83.3%) in the doctoral program ranked individual, triadic, and group supervision as the order in which they delivered those modalities of supervision most frequently, while one participant (16.7%) ranked it as group, triadic, and individual.

Data Collection Procedures and Analyses
Once Institutional Review Board (IRB) approval was received, I emailed an invitation to participate in the study to all counseling master’s and doctoral students through the institutions counseling department’s listserv. Via purposeful sampling, I targeted this group given their unique position of simultaneously being supervisees at their field placement and/or have completed this process recently, while taking an introductory or advanced supervision course as an initial step to become a supervisor (Pearson, 2004). The current study was funded by AARC, ACES, and SACES research grants. Each participant received $10 for their participation in the first round of data collection, $20 for the second round, and $20 for the third round. At the time I was recruiting participants, I was co-teaching one of the potential participants’ class. Thus, in order to offer transparency and decrease social desirability, I informed participants that their decision to participate in the study had to be completely voluntary, and it would not affect their grade in the course. I collected the initial round of data from participants in this class on the last day of classes in Fall 2019.

To explore counseling internship supervisees’ perspectives on their responsibilities to enhance their supervisory experiences, I utilized an exploratory sequential mixed-methods design (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005), Concept Mapping (CM; Kane & Trochim, 2007). Researchers have used concept mapping to: (a) examine and (b) comprehend abstract constructs (e.g., expert supervisors’ supervision cognitions; Kemer et al., 2014), and improve existing knowledge by developing conceptual frameworks. Therefore, to obtain a conceptual understanding of supervisees’ supervision behaviors contributing to the supervision process, CM was an ideal design with its procedures; where supervisees generated the ideas, sorted them into conceptually meaningful groups, and engaged in dialogues to interpret and finalize the results for the subsequent generation of a collective framework. In the current
study, I followed three rounds of data collection per CM procedures: (1) generation of statements, (2) sorting of statements, and (3) interpretation of the results through a focus group. 

**Generation of Statements**

In this round of data collection, the goal was to obtain a series of ideas that portrayed supervisees’ behaviors to make the most out of their clinical supervision. The invitation sent to participants contained a Qualtrics link, which provided participants with a demographics and a generation of statements instructions form that included explanations about the task and a prompt (i.e., “One specific behavior I engage/could engage in supervision to make the most out of my supervision experience is:”) to assist participants with generation of the statements. As a result of this data collection round, 16 participants generated a total of 313 statements (range 6 ~ 42, $M = 19.56$, $Median = 18.5$, $Mode = 12, 19, 30$, $SD = 8.62$). Participants’ statements underwent a synthesis and editing process to make sure all statements had a consistent language, each statement represented a clear and unique idea, and was relevant to the focus of the study. Statements that communicated several ideas were split, identical statements were eliminated, identifiers were removed, and grammar check was conducted. I did not modify any statements to avoid altering participants’ original ideas. Kane and Trochim (2007) suggested an ideal number of 100 statements as a result of the editing and synthesis process to prevent researcher’s excessive data input time and participant burnout during the second round of data collection. After undergoing the editing and synthesis processes, I obtained a final data set containing 191 statements. In order to maintain the conceptual richness, nuances, and value of the data set, I decided to keep all 191 statements rather than randomly splitting the data into two. 

**Sorting of Statements**
In this round of data collection, the goal was to have participants sort the final set of statements to get a better understanding of participants’ observation of the data given its interrelationships of ideas (Kane & Trochim, 2007). Fifteen out of the 16 participants involved in the generation of the statements completed the sorting task. Participants were provided with a package including: (1) a large envelope containing instructions for the sorting task, (2) a stack consistent of the 191 statements, and (3) 20 small envelopes. Participants sorted the 191 statements that resulted from the editing and synthesis process into piles based on their conceptual similarity. They were informed that each statement had to be placed in one pile only; however, if a statement appeared to fit several piles, they needed to select the one pile into which the statement best fitted. A statement could also be a pile itself. Once participants were done sorting all the statements into piles, they placed each pile separately into one of the small envelopes and wrote a word or short phrase on the envelope describing the statements in it. Lastly, all the small envelopes were placed into a bigger envelop and given back to the researcher. All participant envelopes contained a different number of small envelopes (range 5~19, $M = 10.8$, Median = 11, Mode = 11,12, $SD = 3.64$).

Once the sorting was completed, I used the statistical program R (R version 3.6.2, 2019) to conduct multivariate statistical procedures to (1) transfer all the sorted data into maps containing groups of ideas, (2) provide a visualization of the results (Kane & Trochim, 2007), and (3) obtain the preliminary representations of supervisees’ behaviors to make the most out of their supervision experiences. First, I entered each pile of sorted statements into a sort recording sheet to create a Group Similarity Matrix (GSM). The GSM generated a square symmetric matrix that displayed the number of participants that arranged sets of statements together during the sorting task. Then, I utilized the GSM to conduct Multidimensional Scaling (MDS) through a
two-dimensional solution for the 191 sorted statements. The MDS generated a point map which allowed me to obtain a visualization of the location of each statement on the map. In addition, the point map generated coordinate values for each statement’s location on the map. Sorting of statements into conceptually similar piles was evidenced by proximity of statements on the point map. The results generated by the current study’s MDS indicated a stress index of 0.303, which was indicative of the point map’s ability to truly represent the grouping data. This stress index was slightly higher than the recommended value of .285, yet within the range of yielded values from approximately 95% of CM studies (.205–.365; Kane & Trochim, 2007). Lastly, I conducted a Hierarchical Cluster Analysis (HCA) utilizing MDS results to offer a more concrete visual representation of the domain areas. As a result of conducting this step, I obtained a dendrogram which organized all the statements into clusters based on conceptual similarity (Kane & Trochim, 2007). I worked simultaneously with the point map from the MDS and the dendrogram from the HCA to create a preliminary list of clusters and a cluster map embodying underlying structures of the data. After reviewing and obtaining the preliminary clusters and cluster map, I consulted with an auditor (a counselor education faculty) for the suitability of the statements in their respective clusters and locations on the map. Out of the 32 comments made by the auditor, 22 were accepted and 10 disregarded. As a result, I obtained a final list including 21 clusters to be utilized for the third and last round of data collection, the focus group.

**Interpretation of the Results: Focus Group**

In the third round, six participants attended the focus group to review, discuss, and revise (if necessary) the 21 preliminary clusters. Participants also worked on identifying and labeling the areas (clusters of clusters). A smaller sample of original participants attending the focus group was anticipated because participant retention is challenging in CM due to the significant
involvement required by participants in three rounds of data collection. However, this group of attendees allowed for participants’ active engagement and contributions during the revision, discussion, and consensus seeking on the material presented. Thus, the participant sample was still significant to balance the participants’ and researcher’s views. In order to increase trustworthiness, CM procedures integrate testimonial validity by reaching agreements between researcher and participants regarding the interpretation of the data with the goal of fully capturing participants’ perspectives and controlling for researchers’ bias (Bedi, 2006).

**Results**

Participants created 191 statements representing supervisees’ behaviors to make the most out of their clinical supervision experiences. Statements were distributed among 21 clusters. The clusters were distributed in five areas (groups of clusters) as depicted in Table 1 (Appendix A). Additionally, Figure 1 (Appendix B) shows a visual representation of the five areas as well as the two dimensions of the map.

This first area of supervisees’ behaviors, Essential Tasks of Supervision, was located in the mid-bottom area of the map spreading to both bottom quadrants, and consisted of five clusters: *Supervisees’ Commitment to Ethical Standards and Professional Responsibilities, Supervisees’ Commitment to Supervision Time, Supervisees’ Active Engagement in Setting Learning Goals and Expectations, Supervisees’ Intentional Preparation for the Supervision Session,* and *By-itself-cluster 1,* describing behaviors that require supervisees’ independent work.

The second area of supervisees’ behaviors, Supervisees Approach to Supervision, was mainly located on the upper left quadrant of the map, sharing a portion of all four quadrants. This area consisted of four clusters: *Supervisees’ Positive Attitude and Investment in Supervision, Supervisees’ Willingness to Be Open and Honest in Supervision, Supervisee’s Willingness to...*
Offer Feedback to Their Supervisor, and Supervisees’ Personal Awareness and Reflections on Their Supervision Experience, which described supervisees’ positive attitudes and qualities that may contribute to the supervision experience. The third area of supervisees’ behaviors, Supervisory Relationship and Working Alliance, was mainly situated in the upper right quadrant of the map sharing a small portion of the upper left and bottom right quadrants. This area consisted of five clusters: Supervisees’ Comfort and Trust in the Supervisory Relationship, Supervisees’ Active Participation in the Supervision Process, Supervisees’ Active Collaboration with Their Supervisor, Supervisees’ Communication of What They Need from Their Supervisor, and Supervisees’ Willingness to Disagree in Supervision, representing behaviors supervisees bring to the supervision experience and that require of supervisors’ collaboration. The fourth area of supervisees’ behaviors, Supervisees’ Personal and Professional Growth, was displayed on the left of the upper and bottom quadrant of the map, and it consisted of five clusters: Supervisees’ Receptiveness and Management of Feedback, Supervisees’ Investment in Their Own Learning and Growth as Counselors, Supervisees’ Personal Awareness and Reflections on Their Counseling Practice, Supervisees’ Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity, and By-itself-cluster 2, reflecting behaviors supervisees engage in to foster and promote self-growth as supervisees and clinicians. The fifth area of supervisees’ behaviors, Multicultural Considerations, appeared on the far upper right quadrant of the map. Including two clusters: Supervisees’ Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices and Supervisees’ Willingness to Process Multicultural Considerations in the Supervisory Relationship, this area referred to behaviors supervisees engage in to enhance their multicultural awareness in their supervision and clinical practices.
The five areas entailing supervisees’ behaviors to make the most out of their supervision experiences consisted of 21 clusters displayed on two conceptually meaningful dimensions. Starting from the left side of the map to the right side, Dimension 1 appeared to include areas highlighting supervisees’ autonomous to collaborative behaviors in supervision. On the other hand, spanning from the top of the map to the bottom, areas of clusters in Dimension 2 appeared to range from process to task-oriented behaviors.

**Discussion**

The present study results yielded a concept map including a wide range of supervisee behaviors represented in five areas (i.e., Essential Tasks of Supervision, Supervisees Approach to Supervision, Supervisory Relationship and Working Alliance, Supervisees’ Personal and Professional Growth, Multicultural Considerations). Offering a framework for both supervisees and supervisors to utilize for the enhancement of supervision process as well as outcomes, the concept map laid on two dimensions of supervisee behaviors ranging from autonomy and collaboration (dimension 1) to process and tasks (dimension 2).

In a general review of the map and the areas, the five areas arrangement was noticeable in a manner that displayed sets of behaviors supervisees engage in as the supervision experience progresses and circles around. This was particularly apparent in the continuum of two dimensions on the map (dimension 1: autonomy-collaboration; dimension 2: process-tasks). More specifically, in some of the areas supervisees presented clusters of statements indicating behaviors that they appeared to feel exclusively responsible for (i.e., Essential Tasks of Supervision, Supervisees’ Approach to Supervision, and Supervisees’ Personal and Professional Growth), while some other areas were represented by clusters of statements denoting behaviors
supervisees may initiate, yet, request and invite supervisors’ involvement (i.e., Supervisory Relationship and Working Alliance, and Inclusion of Multicultural Considerations).

The first and second areas appeared to require supervisees’ independent work to address what we may call as housekeeping, particularly at the beginning, yet in all stages of supervision, as well as reflect supervisees’ dispositions, which are prominent in all supervision stages respectively. These areas seemed to resemble some of the areas from Borders et al.’s (2014) best practices for clinical supervisors (e.g., initiating supervision, goal setting, conducting supervision, ethical considerations, giving feedback), as well as align with the supervisee’s preparation for/investment/engagement in supervision, and supervisee’s attitude toward client, site, and/or supervisor themes from Kemer and Borders (2017) and Kemer et al. (2019). These similarities point out (1) the importance of investing time and efforts in preparation for and during the supervision session, and (2) the critical role of Supervisees’ Approach to Supervision to enhance supervisory process and outcomes. Additionally, the second area concurred with two of the six salient characteristics of stellar supervisees (i.e., autonomy and motivation) identified by counselor supervisors (Norem, Magnuson, Wilcoxon, & Arbel, 2006). Norem et al.’ posed the following question: “can these qualities be identified prior to supervision?” Findings from the present study appear to indicate that participants recognized and stated their dispositional characteristics in making the most out of their supervision experiences. Thus, if supervisees are prompted/encouraged to become aware and reflect on these characteristics, they could recognize their enhancing dispositions, and engage in them in an efficient manner to (1) help shape the route supervision takes, (2) co-author the manner in which supervision occurs, and (3) co-own supervision outcomes as a result of their investments and work as supervisees.
Areas three and five suggested supervisee behaviors to initiate and invite supervisors’ involvement and interactions. These areas presented working relationship statements that supported previous research (Kemer & Borders, 2017; Kemer et al., 2019) findings that indicated the supervisory relationship as a critical part of supervisors’ supervision considerations in relation to supervisees, as well as the necessity of supervisees’ engagement in multicultural considerations and discussion in their counseling practices and supervision. With the highest numbers of statements across 21 clusters, Supervisees’ Communication of What They Need from Their Supervisor cluster in the third area evidenced communication of needs as a critical behavior that supervisees must engage in; a unique result of the current study when compared to previous studies with supervisors (Kemer & Borders, 2017; Kemer et al., 2019; Norem et al., 2006; Ellis, 2017). This area may highlight a transactional process in which both supervisees’ and supervisors’ behaviors feed into each other to co-create a working alliance.

Supporting three of the themes (i.e., counseling skills/conceptualization abilities, self-awareness/self-reflectivity, supervisory relationship) obtained in Kemer and Borders (2017), as well as two of the themes (i.e., openness to experience, self-awareness) from Norem et al. (2006), the fourth area, appeared to point out supervisees’ intentional work to enhance their own personal and professional growth. Furthermore, complementing previous research, the current results also pointed out additional supervisee behaviors. For example, Supervisees’ Active Collaboration with Their Supervisor, Supervisees’ Willingness to Disagree in Supervision, or Supervisees’ Communication of What They Need from Their Supervisor were unique clusters of behaviors supervisees specified as critical aspects of their supervision involvement, while suggesting that supervisees perceived a dual responsibility not only for enhancing their practices
as clinicians through supervision to protect clients’ welfare, but also to improve their practices as
supervisees to contribute to the supervision experience.

In summary, the five areas of supervisees’ supervision behaviors highlighted supervisees’
independent work as well as initiation of collaboration with their supervisors through expressing
their needs, as opposed to being passive receivers of the supervision process. Concurring with
previous findings on supervisees’ active investment being a crucial aspect of individual
supervision (e.g., Kemer & Borders, 2017; Kemer et al., 2019), the obtained five areas in the
present study also supported Cook and Sackett’s (2018) emphasis on the importance of both
supervisor’s and supervisee’s investment in the process.

Further Discussion of Results Based on Additional Literature

By voicing supervisees’ perspectives, the current study results yielded a framework
supportive and complementary to the previous research efforts that have focused mainly on
supervisors’ perceptions or authors’ perspectives (e.g., Ellis, 2017; Kemer & Borders, 2017;
Norem et al., 2006). The results from this study complemented Bifar and Stonehouse’s (2017)
descriptions by attending to the operational gap and offering specific supervisee behaviors or
tasks within those roles. For example, engaging in supervision knowing what they want to
address may be operationalized by statements, such as “coming to supervision with specific
topics and questions (i.e., interventions to use with clients) on a regular basis, especially when
needed” and “documenting concerns for discussion in supervision to prevent losing details.”
Similarly, making the most of the time and putting what has been learned in supervision into
action may be represented in the statements such as “implementing counseling ideas discussed in
supervision and bringing them up in the following supervision session.” Lastly, documenting
what is discussed in supervision as well as taking an active role in their own professional and
personal development could be represented in statements like “taking notes during supervision to track and reflect on topics discussed and increase accountability” and “doing my own research on specific populations in which I will be working with outside of supervision.” Likewise, Ellis’ (2017) Supervisees’ Bill of Rights and Responsibilities resonated with some of the statements in the framework obtained in the present study (e.g., “communicating positive and negative aspects of my performance,” “speaking up if I do not agree with an evaluation,” “not being afraid to challenge the supervisor’s perspective on clinical work” and “talking about cultural differences with my supervisor and how might that be playing out in the supervision session”). Thus, supervisees’ perceptions of their behaviors to make the most out of their supervision experiences are not so far from the author’s perceptions in reference to what supervisees are responsible for within the dyad.

This study results echoed (1) Stark’s (2017) adapted SURF factors (i.e., professionalism, relational skills in the supervisory relationship, signs of self-supervision, and proactive;) describing supervisees’ behaviors that make supervision effective, and (2) Pearson’s (2004) tasks (i.e., active participation, taking initiative, monitoring self and reactions) that directly impact supervisors’ assessment of supervisees. Similarities between the studies further evidence these supervisees’ behaviors as critical in contributing to an efficient supervision experience. On the other hand, the current study presented statements that were not addressed in Stark’s work such as “approaching supervision with a positive attitude,” “role playing in supervision to work on counseling skills,” “being prepared to have assumptions challenged by the supervisor,” “recognizing that supervisors have the intention of supporting counselors for purposes of professional growth,” as well as statements in the Multicultural Considerations area, and By-

*italics-cluster 1*. Different than the participants in Vespia et al. (2002) and Stark (2017), the
current study participants had taken an introductory and/or advanced course to counseling supervision, which may be an explanation for the richer and more nuanced data obtained in the current study.

Participants’ statements in the current study also appeared to offer more process-oriented behaviors representing supervision as a continuous process (e.g., *Supervisees’ Active Collaboration with Their Supervisor, Supervisees’ Willingness to Offer Feedback to Their Supervisor, Supervisees’ Personal Awareness and Reflections on Their Supervision Experience* clusters, and the Inclusion of Multicultural Considerations area), in addition to mainly task-focused practices provided in Borders et al.’s (2014) best practices document.

Finally, the yielded results also supported certain premises of Active Learning Theory (ALT; Bonwell & Eison, 1991), encouraging supervisees to engage in doing, discussing, and being part of their learning experience beyond merely listening to their supervisors. Although all five areas were in line with how ALT may be reflecting in supervision, specific statements from these areas displayed ALT’s premises as follows: supervisees’ active participation was exemplified by “remaining committed to and actively engaged in supervision,” confidence by co-owning the experience aligned with “seeking for a collegial relationship with my supervisor as I do not want my supervisor to tell me what I must do, but to give me different options with rationales,” sharing responsibility for learning outcomes was supported by “expressing my needs to my supervisor in supervision,” and examination of their attitudes and values concurred with “being aware of personal aspects that might affect process in counseling.” Such parallels between ALT and this study results highlighted supervisees awareness of these responsibilities to contribute to their learning, the supervisory relationship, and the supervision process in general.

**Limitations**
As in all research, the current study also holds some limitations. First, the generalizability of the results is limited to the demographics and characteristics of the participants that took the introduction to counseling supervision and advanced counseling supervision courses at the southeastern university from which the researcher collected the data. Second, despite the monetary incentives offered to the participants in the current study, the number of participants in the last round of data collection was smaller than the other two rounds. Even though having all participants attend all rounds of data collection increases results validity, a smaller final focus group is also a common procedure in concept mapping studies (Kane & Trochim, 2007). Lastly, notwithstanding the testimonial validity procedures (i.e., including participants in all three rounds of data collection, research team of two as well as an auditor) included into the current concept mapping study, the editing and syntheses of the statements as well as preliminary structuring of the statements may not have been entirely free from the researchers’ interpretations of the data. Thus, a different organizational structure of the results could have been yielded if the analyses were conducted by another group of researchers.

**Implications for Future Research, Supervision, and Counselor Education**

The current study was a preliminary effort to explore and understand supervisees’ perceptions on the behaviors they may want to engage in to make the most out of their clinical supervision experiences. However, a single study may not be saturated enough with a comprehensive list of supervisee behaviors; thus, further research studies to expand on our understanding on this topic are needed. Firstly, the replication of the present study with a different sample of supervisees may offer researchers the opportunity to compare and contrast similarities, differences, and complementary pieces among findings. Secondly, due to small sample size and sample demographics in the present study, future studies with larger and more
diverse participant samples may yield different results than the present study results. Thirdly, the present study provided us with an initial understanding of supervisees' behaviors to make the most of the supervision experience. A further examination of participants' ratings for most and least frequently engaged behaviors may offer us with an understanding of behaviors supervisees are most likely to display in supervision (rating task; Kane & Trochim, 2007). Lastly, upon replication of the current study with additional samples, an instrument to assess supervisees' supervision behaviors may be developed and validated through exploratory and confirmatory factor analyses procedures.

The current study results also have implications for different stakeholders of supervision (e.g., supervisees, supervisors, and counselor education). In terms of supervisees, current study results may be used as an operational roadmap to (1) inform supervisees about behaviors they could reflect on and consider engaging in to facilitate the supervision process, (2) encourage them to display all or some of those behaviors to enhance their own learning and reciprocate supervisors’ efforts, (3) enable co-ownership of the supervision experience by sharing responsibility for supervision process and outcomes, and (4) support their experience within the supervisory dyad by having a reference point to look at throughout the supervision process.

Attending to Ellis et al.’s (2015) and McNamara et al.’s (2017) suggestions on aiding supervisees’ knowledge regarding both parties’ responsibilities in clinical supervision, findings of the current study may help supervisees to identify and avoid harmful supervision experiences through supervisees’ awareness of (1) supervisors’ best practices in their work with supervisees (i.e., Borders et al., 2014) so that supervisees advocate for the quality of supervision they receive, and (2) behaviors they could engage in to take part in the supervision process, and empower a mutual voice, respect, and collaboration with their supervisors.
Supervisees’ understanding of critical behaviors they could engage in supervision may foster a learning environment where they may be able to engage in co-jointed efforts with their supervisors. Once supervisees engage in open communication of challenges and ask for help, both parties in the dyad may have the ability to come up with a more precise identification of supervisees’ areas of strengths and growth. Such a process may foster collaboration which could result in a more intentional and efficient supervision process in which both parties do their part to make the most out of the supervision experience.

Results of the current study may also provide tools for supervisors. Along with the Best Practices in Clinical Supervision document (Borders et al., 2014), supervisors may incorporate current study results in supervision agreements and discuss them with their supervisees during the first supervision session. Informing supervisees about behaviors they could engage in to be active learners in supervision may complement supervisors’ efforts to improve both parties’ overall supervision experience. By doing this, supervisors may foster balance in terms of attending to their responsibilities as supervisors while also inviting supervisees to become aware and accountable for their part in the supervision process. Supervisors could do overviews of the supervision work at different points (e.g., bi-monthly) throughout the supervision experience, where supervision time is exclusively allocated to discuss what is working and what is not. Such an effort may also facilitate supervisors’ assessment of the supervisory dyad work from a process-oriented standpoint. During these overviews, supervisors may go over the relevant clusters obtained in this study and collaborate with supervisees in the identification of behaviors they have engaged in or could start engaging in to make of supervision a productive experience.

The current study could also inform supervisors’ work in supervision in accordance with different supervision models. Supervisees assessment through the Integrated Developmental
Model of supervision (IDM; Stoltenberg & McNeil, 2010) may be facilitated by supervisees’ behaviors included in this study results. Such behaviors, could aid supervisors’ identification of supervisees’ developmental needs, challenges, and strengths, resulting in a more accurate supervisee assessment, and meaningful experience for the supervisee. Similarly, supervisors’ identification of supervisees’ area of difficulty within supervisees’ focus areas (Bernard’s Discrimination Model; Bernard, 1979), may be facilitated by supervisors’ intentional utilization of the knowledge provided by supervisees’ Willingness to Be Open and Honest in Supervision and supervisees’ Communication of What They Need from Their Supervisor clusters.

Last, ACA Code of Ethics (2014), section F.4. informs supervisors about their responsibilities in clinical supervision. This study’s findings may expand on ACA’s section F.5. “student and supervisee responsibilities” by adding a section that serves as an overview for supervisees to get in touch with behaviors they could engage in to make the most of supervision. Bernard and Goodyear (2019) asserted that supervisors are responsible for their own competence and their supervisees’ competence. Similarly, the results yielded by the current study may indicate that supervisees are responsible for their own competence, as well as being responsible to the clients they serve, supervisors who oversee their work, and society in general.
References


O’Brien, Mcneil, & Dawson. (2019). The student experience of clinical supervision across health


## APPENDICES

### Appendix A

**Table 1**

*Five Areas of Clusters*

<table>
<thead>
<tr>
<th>Area 1: Essential Tasks of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 1</td>
</tr>
<tr>
<td>Cluster 2</td>
</tr>
<tr>
<td>Cluster 3</td>
</tr>
<tr>
<td>Cluster 4</td>
</tr>
<tr>
<td>By-itself-cluster 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area 2: Supervisees’ Approach to Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 5</td>
</tr>
<tr>
<td>Cluster 6</td>
</tr>
<tr>
<td>Cluster 12</td>
</tr>
<tr>
<td>Cluster 16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area 3: Supervisory Relationship and Working Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 7</td>
</tr>
<tr>
<td>Cluster 8</td>
</tr>
<tr>
<td>Cluster 9</td>
</tr>
<tr>
<td>Cluster 10</td>
</tr>
<tr>
<td>Cluster 13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area 4: Supervisees’ Personal and Professional Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 11</td>
</tr>
<tr>
<td>Cluster 14</td>
</tr>
<tr>
<td>Cluster 15</td>
</tr>
<tr>
<td>Cluster 17</td>
</tr>
<tr>
<td>By-itself-cluster 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area 5: Inclusion of Multicultural Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 18</td>
</tr>
<tr>
<td>Cluster 19</td>
</tr>
</tbody>
</table>
Appendix B

Figure 1

Two-dimensional cluster map with areas

AREA 1. ESSENTIAL TASKS OF SUPERVISION

1. SEE’S Commitment to Ethical Standards and Professional Responsibilities
2. SEE’S Commitment to Supervision Time
3. SEE’S Active Engagement in Setting Learning Goals and Expectations
4. SEE’S Intentional Preparation for the Supervision Session
5. SEE’S Positive Attitude and Investment in Supervision
6. SEE’S Willingness to Be Open and Honest in Supervision
7. SEE’S Comfort and Trust in the Supervisory Relationship
8. SEE’S Active Participation in the Supervision Process
9. SEE’S Active Collaboration with Their Supervisor
10. SEE’S Communication of What They Need from Their Supervisor
11. SEE’S Receptiveness and Management of Feedback
12. SEE’S Willingness to Offer Feedback to Their Supervisor
13. SEE’S Willingness to Disagree in Supervision
14. SEE’S Investment in Their Own Learning and Growth as Counselors
15. SEE’S Personal Awareness and Reflections on Their Counseling Practices
16. SEE’S Personal Awareness and Reflections on Their Supervision Experience
17. SEE’S Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity

AREA 2. SUPERVISEES’ APPROACH TO SUPERVISION

18. SEE’S Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices
19. SEE’S Willingness to Process Multicultural Considerations in the Supervisory Relationship

AREA 3. SUPERVISORY RELATIONSHIP AND WORKING ALLIANCE

18. SEE’S Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices
19. SEE’S Willingness to Process Multicultural Considerations in the Supervisory Relationship

AREA 4. SUPERVISEES’ PERSONAL AND PROFESSIONAL GROWTH

11. SEE’S Commitment to Ethical Standards and Professional Responsibilities
12. SEE’S Commitment to Supervision Time
13. SEE’S Willingness to Disagree in Supervision
14. SEE’S Investment in Their Own Learning and Growth as Counselors
15. SEE’S Personal Awareness and Reflections on Their Counseling Practices
16. SEE’S Personal Awareness and Reflections on Their Supervision Experience
17. SEE’S Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity
6. SEE’S Willingness to Be Open and Honest in Supervision

AREA 5. INCLUSION OF MULTICULTURAL CONSIDERATIONS

11. SEE’S Commitment to Ethical Standards and Professional Responsibilities
12. SEE’S Commitment to Supervision Time
13. SEE’S Willingness to Disagree in Supervision
14. SEE’S Investment in Their Own Learning and Growth as Counselors
15. SEE’S Personal Awareness and Reflections on Their Counseling Practices
16. SEE’S Personal Awareness and Reflections on Their Supervision Experience
17. SEE’S Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity
6. SEE’S Willingness to Be Open and Honest in Supervision

Note: SEE’S (Supervisees)
References


Bifarin, O., & Stonehouse, D. (2017). Clinical supervision: An important part of every nurse’s


Sexton, T., & ERIC Counseling Student Services Clearinghouse. (1999). *Evidence-based Counseling [electronic Resource] Implications for Counseling Practice, Preparation,
and Professionalism.


APPENDICES

Appendix A

ROUND 1

INSTRUCTIONS FOR THE GENERATION OF STATEMENTS

Focus Statement and Brainstorming Prompt

In the box below and based on your personal experiences as a supervisee, please generate AS MANY STATEMENTS AS POSSIBLE that describe what behaviors you should engage in as a supervisee to make the most out of your supervision experiences. You may consider your past and/or current experiences as a supervisee receiving supervision from your supervisors. Please focus on your INDIVIDUAL SUPERVISION experiences and be AS CLEAR AND CONCRETE AS possible.

One specific behavior I engage/could engage in supervision to make the most out of my supervision experience is:

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________

• ____________________________________________________
The second round of data collection will take place early in January, please select the option you consider would work better for you to be able to attend. Please let the researcher know if none of the options work for you.

January 15, 2020 _____

January 16, 2020 _____

January 17, 2020 _____

Please fill out the information below for the researcher to contact you about the date the second round of data collection will take place. Please indicate your preferred contact method (e-mail or phone). Your e-mail address or phone number will only be used to contact you about the second-round date.

Name: ______________________________

Email: ______________________________

Phone: ______________________________
Appendix B

INVITATION TO PARTICIPATE

Subject: Best Practices in Clinical Supervision: What Must Supervisees Do?

Dear students,

We are a research team of a faculty member and a doctoral student from the Old Dominion University Counseling Program. We are contacting you as we are starting a research study on supervisees’ behaviors in clinical supervision to make the most out of the supervision experience. It is our hope that this information can be used to inform supervisors, supervisees, and counselor education and supervision programs training counselors and supervisors, as well as to improve the clinical supervision experiences of both supervisors and supervisees, and enhance supervision outcomes. If you are currently receiving supervision or have received supervision within the last 1 year, and are currently taking or have taken COUN 670, COUN 846, and or COUN 868 within the last 1 year, we will appreciate your consideration to participate in this study.

In this study, we aim at exploring what supervisees perceive as their behaviors in supervision to make the most of their supervision experience. We will be using concept mapping as the study’s methodology. This study has been approved by the Institutional Review Board at Old Dominion University (IRB Protocol STUDY #).

About your participation:
If you volunteer to participate in this study, you are asked to read and sign a consent form, as well as complete a demographic questionnaire and a series of data collection procedures in three rounds: (1) generation of statements (30 minutes), (2) sorting of statements (60-90 minutes), and (3) an optional focus group session (90-120 minutes). All rounds of data collection will be in-person or online, will be held on different dates, and will take place in the New Education Building at ODU.

**Round 1:** In this data collection round, you will be asked to complete a demographic questionnaire form as well as a generation of statements form. After completing the two forms you will select one of the dates that better works for you for the second round of data collection. In case you want to participate in the second round, but you cannot attend in-person, the researchers will mail you a package containing the material to the mailing address provided by you.

**Round 2:** In this data collection round, you will receive a package containing the generated statements in round 1 and sorting instructions. At the end of the sorting instructions form, you will express your interest in participating in the last round of data collection, the focus group. Please complete this step individually and privately. Mailed packages should be returned to the researchers within the next two weeks after the initial contact. You will receive a couple reminders by the researchers about the completion of the task.
Round 3: In the focus group session, participants will interpret the results that emerged after the sorting of statements. The researchers will contact you regarding the time and the location of the focus group. If you agree to participate in the focus group sessions, you also are consenting to respect the privacy of other group members. You are agreeing to not ask for other group members’ names, and to keep identifying information and responses during the focus group session confidential, meaning that you will not discuss other participants or what is stated during the focus groups outside of this research study.

Compensation. You will be compensated for your participation in the current study. You will receive $10 for your participation in the first round of data collection, $20 for the second round, and $20 for the third round. In total, you will have the chance to receive $50 if you participate in all three rounds of data collection.

We appreciate your time and value your input as we strive to explore what supervisees perceive as their behaviors to make the most out of the supervision experience. We will greatly appreciate if you share your perceptions with us!

If you decide to participate, please read, sign, and email back the informed consent to the researchers.

Should you have any questions please do not hesitate to contact Dr. Gulsah Kemer at gkemer@odu.edu or Johana Rocha at jrocha@odu.edu.

Thank you for your consideration!

Sincerely,

Johana Rocha, Ph.D. Candidate, NCC
Graduate Student Investigator
Old Dominion University
jrocha@odu.edu

Gulsah Kemer, PhD, NCC, ACS
Responsible Principal Investigator
Old Dominion University
gkemer@odu.edu
Appendix C

INFORMED CONSENT

**PROJECT TITLE:** Best Practices in Clinical Supervision: What Must Supervisees Do?

**Principle Investigator:** Dr. Gulsah Kemer, Ph.D., NCC, ACS, Department of Counseling and Human Services, College of Education

**Graduate Student Investigator:** Johana Rocha, M.S.Ed., NCC, Doctoral Candidate in Counselor Education and Supervision, Department of Counseling and Human Services, College of Education

**DESCRIPTION OF RESEARCH STUDY**
In this study, the researcher will examine the supervisory behaviors in the clinical mental health field with a special focus on the supervisee (counselor trainee). Supervisees have a vital role in supervision, holding equal responsibility with their supervisors in the process, but having more of their investment influencing their own professional outcomes. However, despite being a critical party of the supervision process, supervisees are usually seen as passive learners, whose collaborative qualities are often times shadowed by the hierarchical nature of supervision. To date, no research and/or scholarly work has outlined supervisees’ behaviors in supervision. Therefore, this dissertation study will focus on exploring and understanding the supervisees’ behaviors in the clinical mental health supervision process, which may eventually result in a document offering the best practices for supervisees in clinical supervision.

If you volunteer to participate in this study, you are asked to complete a demographic questionnaire and a series of data collection procedures in three rounds: (1) generation of statements (30 minutes), (2) sorting of statements (60-90 minutes), (3) an optional focus group session (90-120 minutes). All rounds of data collection will be in-person or online and will be held on different dates. In-person meetings will take place in ODU’s New Education Building.

**INCLUSION CRITERIA**
You must be a counseling master’s student or a doctoral student in a counselor education and supervision program. Additionally, you must be (1) currently under supervision as a counselor trainee or resident in counseling, and/or have completed supervised clinical practice within the last 1 year, and (2) currently taking or have taken COUN 670 (Introduction to Counseling Supervision), COUN 846 (Advanced Counseling Supervision), and/or COUN 868 (Internship Supervised Supervision Practice) within the last 1 year.

**RISKS AND BENEFITS**
RISKS: If you decide to participate in this study you may face a risk of your identity being revealed to other focus group participants. Otherwise, your name will never be revealed. The researchers are ethically and legally bound to protect participants’ identities and responses in the focus groups. The researcher, however, cannot guarantee that other focus group participants will keep participants’ identities and responses confidential. The researchers will try to remove any risks by removing all linking identifiers, describing the confidential nature of this research to all the research participants, and keeping all paper documents in a locked safe at the principal
researcher’s office. And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

**BENEFITS:** The main benefit to you for participating in this study is you may increase your awareness regarding your behaviors as a supervisee. This study will have implications for supervisors, supervisees, and counselor education and supervision programs. The findings will advance our knowledge on supervision practices by obtaining an understanding of what supervisees must do in supervision to generate further personal and professional growth as well as supervisory outcomes.

**COSTS AND PAYMENTS**
The researchers want your decision about participating in this study to be voluntary. Your grade in COUN 670, COUN 846, or COUN 868 will not be influenced by your participation in the current study. The only cost to you from participating in this study is your time.

**NEW INFORMATION**
If the researchers find new information during this study that would reasonably change your decision about participating, then they will share it with you.

**CONFIDENTIALITY**
The researchers will take reasonable steps to keep all private information obtained in this study (e.g., demographic questionnaire, generated statements) confidential unless disclosure is required by law. Data will be entered into a password-protected, encrypted computer that only the research team members have access to. Also, the number of people who can access data will be restricted to the research team members. All paper documents will be kept in a locked safe at the principal researcher’s office. The data collected through this study will be kept for seven years following completion of this study. At the end of seven years, data on computer files will be completely erased and destroyed, and paper documents will be shredded. Only summarized data will be presented at meetings, in presentations, reports, and publications. However, the researcher will not identify you in these presentations. Only if your records are subpoenaed by court order or inspected by government bodies with oversight authority, will the data be shared with the necessary parties.

**WITHDRAWAL PRIVILEGE**
Even if you volunteer to participate in the current study, you are free to walk away or withdraw from the study at any time. Your decision will not affect your relationship with Old Dominion University, or otherwise cause a loss of benefits to which you might otherwise be entitled.

**COMPENSATION FOR ILLNESS AND INJURY**
If you volunteer to participate in the current study, your consent in this document does not waive any of your legal rights.

**INCENTIVES**
You will receive $10 for your participation in the first round of data collection, $20 for the second round, and $20 for the third round. In total, you will have the chance to receive $50 if you participate in all three rounds of data collection.
**VOLUNTARY CONSENT**
By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them.

If you have questions, concerns, or complaints, please contact the Responsible Project Investigator, Dr. Gulsah Kemer, at gkemer@odu.edu or 757-683-3225. This research has been reviewed and approved by the Old Dominion University Darden School of Education and Professional Studies IRB. You may contact Dr. Laura Chezan (lchezan@odu.edu), the current IRB chair, at 757-683-6696, or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

---

**INVESTIGATOR’S STATEMENT**
I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

---

**Subject's Printed Name & Signature**

__________  __________
Date

**Parent / Legally Authorized Representative’s Printed Name & Signature**

__________  __________
Date

**Witness’ Printed Name & Signature (if Applicable)**

__________  __________
Date

**Investigator Printed name and signature**

__________  __________
Appendix D

DEMOGRAPHICS QUESTIONNAIRE

Please answer the following questions in the spaces provided.

Participant ID (home address number [i.e., 1234]): ______

1. Age: _____

2. How do you identify your gender?
   _____ Female
   _____ Male
   _____ Non-binary
   _____ Other (please specify): ________________________________

3. How do you identify your racial/ethnic background?
   _____ African American/ Black
   _____ Asian/Pacific Islander
   _____ Hispanic/Latino(a)
   _____ Native American/ Alaska Native
   _____ White (non-Hispanic)
   _____ Multiracial
   _____ Other (please specify): ________________________________

4. Are you a master’s student?
   a. Yes____
   b. No____

5. If yes, what is your track?
   _____ Clinical Mental Health Counseling               _____ School Counseling

5. Are you currently in practicum? _______ or internship? _______
   a. If internship, what semester? _______

6. Are you a Doctoral student?
   a. Yes____
   b. No____

7. If yes, what is your semester? _______

8. How long ago (in months) did you obtain your master’s degree? _______

9. What counseling track? __________________________

10. As a counselor trainee/supervisee, how many approximate hours of supervision have you received up to this point? ________

11. Are you currently providing clinical supervision to a counselor trainee/s?
   a. Yes______
   b. No______

12. Have you provided supervision to a counselor trainee/s within the last 1 year?
   a. Yes______
   b. No______

13. How many supervisees have you worked with in your supervision practices so far? ____

14. How many supervision hours approximately have you provided to counselor trainees? _________

15. Please rank the following supervision modalities based on the frequency of your utilization in your supervision practices:
   a. individual ______
   b. triadic ______
   c. group ______
Appendix E

ROUND 2

INSTRUCTIONS FOR THE SORTING OF STATEMENTS

Dear participant,

Thank you for your continued participation in the current study. For the sorting task, please read the following instructions for the statements in the envelope labeled “Statements to Sort:”

1. Sort the statements into piles based on conceptual similarity.

2. Each statement must belong to 1 pile only. If a statement appears to fit several piles, then please select the 1 pile into which the statement best fits.

3. Please know that a statement can be a pile by itself.

4. Once you sort all the statements into piles, please place each pile separately into one of the small envelopes provided and write a word or short phrase on the envelope that you consider better describes the statements in the envelope.

Please fill out information below if you are interested in and available to attend the third round of the study, the focus group, on DATE (90 – 120 minutes). You will receive an additional $20 as a result of completing the focus group session.

Name: ______________________________

Email: ______________________________

Phone: ______________________________

☐ Yes, I am interested in attending the focus group.

If you have any questions regarding the focus group session, please re-enter your e-mail address below and I will contact you.

Email: ______________________________
In case you are not willing to attend the third round of data collection, the focus group session, you will receive $20 as a result of completing this second round of data collection. This money will be given to you in person at the end of today’s round or mailed to your address.
Appendix F

ROUND 3

AGENDA FOR THE FOCUS GROUP

1. Greeting

2. Review of the purpose of the study and the focus group

3. Summarization of the first Two Rounds of Data Collection

4. Introduction to the Third Round of Data Collection (task instructions)

5. Q & A

6. Presentation of Maps
   a. Point Map
   b. Cluster Map

7. Examination and Labeling of Clusters, regions, and dimensions

You will receive the $20 for your participation (in-person or online) in the focus group at the end of today’s round or mailed to your address.
Appendix G

Figure 1

Point Map
Appendix H

Figure 2

*Dendrogram*

Cluster Dendrogram

statements
clust(*, "ward.D")
Appendix I

FINAL CLUSTERS OF STATEMENTS

Table 1
Cluster 1: Supervisees’ Commitment to Ethical and Professional Responsibilities

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>s34</td>
<td>Dressing professionally at my internship site</td>
</tr>
<tr>
<td>s33</td>
<td>Dressing professionally for supervision</td>
</tr>
<tr>
<td>s78</td>
<td>Completing an agreement with my supervisor</td>
</tr>
<tr>
<td>s32</td>
<td>Being professional</td>
</tr>
<tr>
<td>s122</td>
<td>Presenting my client's information in a professional way</td>
</tr>
<tr>
<td>s157</td>
<td>Knowing my rights as a supervisee before going into the supervision relationship</td>
</tr>
<tr>
<td>s84</td>
<td>Logging direct and indirect hours daily</td>
</tr>
<tr>
<td>s90</td>
<td>Reviewing ACA Code of Ethics</td>
</tr>
<tr>
<td>s48</td>
<td>Advocating for my client/s</td>
</tr>
</tbody>
</table>

Table 2
Cluster 2: Supervisees’ Commitment to Supervision Time

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>s171</td>
<td>Being prompt</td>
</tr>
<tr>
<td>s1</td>
<td>Being dedicated to attend all supervision sessions when they are scheduled</td>
</tr>
<tr>
<td>s166</td>
<td>Being respectful of my supervisor's time and efforts</td>
</tr>
<tr>
<td>s3</td>
<td>Showing up on time for the supervision sessions</td>
</tr>
<tr>
<td>s2</td>
<td>Staying for the duration of each supervision session</td>
</tr>
<tr>
<td>s22</td>
<td>Paying attention in supervision</td>
</tr>
<tr>
<td>s4</td>
<td>Avoiding unnecessary absences from sessions</td>
</tr>
<tr>
<td>s109</td>
<td>Completing assigned tasks in supervision</td>
</tr>
<tr>
<td>s59</td>
<td>Keeping my commitments and not cancelling supervision unless it is necessary</td>
</tr>
<tr>
<td>s5</td>
<td>Letting my supervisor know ahead of time about scheduling conflicts and absences</td>
</tr>
</tbody>
</table>

Table 3
Cluster 3: Supervisees’ Active Engagement in Setting Learning Goals and Expectations

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>s17</td>
<td>Creating supervision goals/objectives for myself at the beginning of the semester</td>
</tr>
</tbody>
</table>
Making personal goals and striving towards them

Setting honest clinical goals (i.e., counseling skills) and making that a part of supervision

Having clear expectations of myself and my supervisor

---

**Table 4**

*Cluster 4: Supervisees’ Intentional Preparation for the Supervision Session*

<table>
<thead>
<tr>
<th>Code</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>s56</td>
<td>Reviewing counseling recordings and transcripts prior to supervision</td>
</tr>
<tr>
<td>s66</td>
<td>Bringing my planner in case my supervisor has to change our supervision date/time</td>
</tr>
<tr>
<td>s55</td>
<td>Bringing videos to every supervision session</td>
</tr>
<tr>
<td>s37</td>
<td>Bringing a written case presentation to supervision</td>
</tr>
<tr>
<td>s60</td>
<td>Completing paperwork on time</td>
</tr>
<tr>
<td>s28</td>
<td>Coming to supervision prepared ahead of time with all materials expected</td>
</tr>
<tr>
<td>s23</td>
<td>Coming to supervision with specific topics and questions (i.e., interventions to use with clients) on a regular basis, especially when needed.</td>
</tr>
<tr>
<td>s148</td>
<td>Being prepared to discuss treatment planning, goals, interventions, and techniques</td>
</tr>
<tr>
<td>s147</td>
<td>Being prepared to explain diagnoses I gave to my clients</td>
</tr>
<tr>
<td>s137</td>
<td>Being prepared with copies and knowledge of all necessary documents related to supervision</td>
</tr>
<tr>
<td>s80</td>
<td>Organizing end-of-semester paperwork in advance</td>
</tr>
<tr>
<td>s95</td>
<td>Bringing client files for case reviews</td>
</tr>
<tr>
<td>s63</td>
<td>Having a list of clients that I have seen since previous supervision session</td>
</tr>
<tr>
<td>s35</td>
<td>Taking notes during supervision to track and reflect on topics discussed and increase accountability</td>
</tr>
<tr>
<td>s81</td>
<td>Documenting concerns for discussion in supervision to prevent losing details</td>
</tr>
</tbody>
</table>

---

**Table 5**

*Cluster 5: Supervisees’ Positive Attitude and Investment in Supervision*

<table>
<thead>
<tr>
<th>Code</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>s151</td>
<td>Being flexible</td>
</tr>
<tr>
<td>s25</td>
<td>Being fully present in supervision</td>
</tr>
<tr>
<td>s107</td>
<td>Being willing and ready to do the supervision work</td>
</tr>
</tbody>
</table>
s9  Being kind in my supervision sessions
s115  Being respectful of client confidentiality during my supervision sessions
s61  Showing respect towards my supervisor
s168  Showing my appreciation to my supervisor
s135  Valuing supervision
s114  Developing my comfort level engaging in supervision
s106  Working on not getting distracted in supervision
s132  Having a professional mindset when in supervision
s38  Approaching supervision with a positive attitude
s121  Self-reporting my sessions in a more objective manner

Table 6

Cluster 6: Supervisees’ Willingness to Be Open and Honest in Supervision

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>s7</td>
<td>Being honest with my supervisor</td>
</tr>
<tr>
<td>s11</td>
<td>Being honest about my struggles</td>
</tr>
<tr>
<td>s13</td>
<td>Being honest about the challenges I face with clients</td>
</tr>
<tr>
<td>s14</td>
<td>Being honest about my weaknesses as a counselor</td>
</tr>
<tr>
<td>s15</td>
<td>Being honest about my doubts</td>
</tr>
<tr>
<td>s8</td>
<td>Being transparent in my supervision sessions</td>
</tr>
<tr>
<td>s16</td>
<td>Being open in supervision about personal reactions (i.e., feelings, thoughts, transference, countertransference) I experience while working with clients</td>
</tr>
<tr>
<td>s12</td>
<td>Being open about my failures with clients</td>
</tr>
<tr>
<td>s10</td>
<td>Being open with my supervisor</td>
</tr>
<tr>
<td>s130</td>
<td>Being open to supervisory interventions/techniques during supervision</td>
</tr>
<tr>
<td>s6</td>
<td>Being open to evaluation</td>
</tr>
<tr>
<td>s173</td>
<td>Being vulnerable</td>
</tr>
<tr>
<td>s113</td>
<td>Being willing to discuss new ideas</td>
</tr>
<tr>
<td>s164</td>
<td>Being willing to discuss things outside of counseling (in everyday life) that may be affecting my ability to provide counseling services efficiently</td>
</tr>
<tr>
<td>s152</td>
<td>Admitting when I don't understand something</td>
</tr>
<tr>
<td>s127</td>
<td>Communicating positive and negative aspects of my performance</td>
</tr>
</tbody>
</table>
### Table 7

**Cluster 7: Supervisees’ Comfort and Trust in the Supervisory Relationship**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>s45</td>
<td>Feeling comfortable with my supervisor</td>
</tr>
<tr>
<td>s44</td>
<td>Feeling comfortable working with my supervisor</td>
</tr>
<tr>
<td>s131</td>
<td>Being comfortable with conflict resolution with my supervisor</td>
</tr>
<tr>
<td>s153</td>
<td>Being genuine in the supervision relationship</td>
</tr>
<tr>
<td>s74</td>
<td>Being open to building the supervisory relationship</td>
</tr>
<tr>
<td>s105</td>
<td>Not being fearful of my supervisor</td>
</tr>
<tr>
<td>s139</td>
<td>Trusting that my supervisor has my best interest in mind</td>
</tr>
<tr>
<td>s146</td>
<td>Understanding and establishing good boundaries within the supervisory relation</td>
</tr>
</tbody>
</table>

### Table 8

**Cluster 8: Supervisees’ Active Participation in the Supervision Process**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>s52</td>
<td>Remaining committed to and actively engaged in supervision</td>
</tr>
<tr>
<td>s26</td>
<td>Preparing for and discussing termination of supervision with my supervisor</td>
</tr>
<tr>
<td>s156</td>
<td>Bringing research into supervision for discussion</td>
</tr>
<tr>
<td>s96</td>
<td>Addressing parallel process</td>
</tr>
<tr>
<td>s133</td>
<td>Following through with feedback</td>
</tr>
<tr>
<td>s144</td>
<td>Implementing counseling ideas discussed in supervision and bringing them up in the following supervision session</td>
</tr>
</tbody>
</table>

### Table 9

**Cluster 9: Supervisees’ Active Collaboration with Their Supervisor**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>s116</td>
<td>Reflecting on the supervision session with my supervisor</td>
</tr>
<tr>
<td>s67</td>
<td>Reflecting on my strategies/interventions with my clients and looking for other options with my supervisor</td>
</tr>
<tr>
<td>s65</td>
<td>Processing my counseling sessions with my supervisor (i.e., interventions used, clinical judgment)</td>
</tr>
<tr>
<td>s87</td>
<td>Collaborating with my supervisor about my professional development</td>
</tr>
<tr>
<td>s85</td>
<td>Collaborating with my supervisor to find resources for clients</td>
</tr>
<tr>
<td>s79</td>
<td>Discussing my theoretical orientation with my supervisor</td>
</tr>
</tbody>
</table>
s125 Engaging in the discussion process in supervision
s163 Putting effort into building a collaborative relationship with my supervisor
s86 Checking-in with my supervisor about my progress toward goals
s138 Briefly meeting with my supervisor throughout the day at the site
s83 Role playing in supervision to work on counseling skills
s98 Verifying the correctness of SOAP notes and other paperwork with my supervisor

Table 10
Cluster 10: Supervisees’ Communication of What They Need from Their Supervisor

<table>
<thead>
<tr>
<th>Index</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>s20</td>
<td>Expressing my needs to my supervisor in supervision</td>
</tr>
<tr>
<td>s24</td>
<td>Expressing any issues or concerns (i.e., within clinical work, at internship site) to my supervisor when they arise</td>
</tr>
<tr>
<td>s162</td>
<td>Being willing to ask for more help if I feel that I need it in certain areas</td>
</tr>
<tr>
<td>s68</td>
<td>Being open with the supervisor about my need for confidentiality so that I can feel safe in supervision</td>
</tr>
<tr>
<td>s101</td>
<td>Asking about possible referrals</td>
</tr>
<tr>
<td>s92</td>
<td>Asking about where I might find more information to answer a client's questions</td>
</tr>
<tr>
<td>s120</td>
<td>Asking for help on how to write better clinical notes</td>
</tr>
<tr>
<td>s31</td>
<td>Asking for help on how to correctly conceptualize my clients</td>
</tr>
<tr>
<td>s54</td>
<td>Asking my supervisor to watch my videos</td>
</tr>
<tr>
<td>s183</td>
<td>Asking for written feedback</td>
</tr>
<tr>
<td>s170</td>
<td>Asking for a pre-rating of my counseling skills and a post-rating (pre-supervision and post-supervision) to detect growth and development</td>
</tr>
<tr>
<td>s36</td>
<td>Asking questions about professional development (i.e., licensure process, residency, future supervisors)</td>
</tr>
<tr>
<td>s149</td>
<td>Asking questions about client statements and behaviors that I do not understand</td>
</tr>
<tr>
<td>s150</td>
<td>Discussing self-care practices</td>
</tr>
<tr>
<td>s72</td>
<td>Seeking for a collegial relationship with my supervisor as I do not want my supervisor to tell me what I must do, but to give me different options with rationales</td>
</tr>
<tr>
<td>s136</td>
<td>Seeking advice and consulting with my supervisor</td>
</tr>
</tbody>
</table>
| s53   | Requesting and advocating for consistent (i.e., same time and day) and continuous (i.e.,
weekly) supervision by a supervisor who attends to my individual needs

s71 Requesting guidance and support in client advocacy
s94 Requesting live supervision for challenging clients
s141 Requesting forms of supervision that help me (i.e., role play, creating a treatment plan)
s21 Requesting direct feedback from my supervisor on various topics (i.e., skills, case conceptualization, techniques of a given theory)
s118 Clarifying skills expected from me as a supervisee
s117 Clarifying tasks with my supervisor
s119 Clarifying counseling skills with my supervisor
s181 Clarifying the feedback with my supervisor
s70 Getting clarification about legal aspects of counseling to safeguard both myself and my clients in specific circumstances
s27 Consulting on ethical dilemmas with my supervisor regularly
s73 Ensuring my faculty supervisor and on-site supervisor communicate about my progress
s103 Inquiring about free continuing education
s43 Reaching out to my supervisor during crisis circumstances
s57 Showing my supervisor parts of taped sessions that I need help on
s47 Advocating for myself, specifically for my learning and needs as a supervisee

---

**Table 11**

*Cluster 11: Supervisees’ Receptiveness and Management of Feedback*

<table>
<thead>
<tr>
<th>Code</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>s190</td>
<td>Being open to positive feedback and constructive criticism from my supervisor</td>
</tr>
<tr>
<td>s46</td>
<td>Being open and willing to learn skills and new information from my supervisor</td>
</tr>
<tr>
<td>s191</td>
<td>Being open and willing to consider my supervisor’s perspectives and suggestions</td>
</tr>
<tr>
<td>s128</td>
<td>Being flexible with recommended interventions from my supervisor</td>
</tr>
<tr>
<td>s134</td>
<td>Being able to accept praise from my supervisor</td>
</tr>
<tr>
<td>s185</td>
<td>Being honest, but respectful, if feedback offends me (not holding negative feelings in)</td>
</tr>
<tr>
<td>s186</td>
<td>Not letting the negative feedback discourage me</td>
</tr>
<tr>
<td>s188</td>
<td>Learning from the negative feedback but not always taking it deeply</td>
</tr>
<tr>
<td>s182</td>
<td>Receiving feedback without taking personal offense</td>
</tr>
<tr>
<td>s184</td>
<td>Not getting defensive when receiving constructive feedback</td>
</tr>
</tbody>
</table>
Trying to believe in myself in spite of setbacks and negative feedback

### Table 12

**Cluster 12: Supervisees’ Willingness to Offer Feedback to Their Supervisor**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>s169</td>
<td>Providing feedback to my supervisor about supervision in the way I would like to receive feedback</td>
</tr>
<tr>
<td>s29</td>
<td>Providing my supervisor with feedback on what is and/or what is not working for me in our supervisory work</td>
</tr>
<tr>
<td>s30</td>
<td>Providing my supervisor with feedback on what is and/or what is not working for me in our supervisory relationship</td>
</tr>
<tr>
<td>s189</td>
<td>Telling my supervisor how I prefer to receive feedback</td>
</tr>
<tr>
<td>s58</td>
<td>Communicating my thoughts as clearly and specifically as possible to my supervisor</td>
</tr>
</tbody>
</table>

### Table 13

**Cluster 13: Supervisees’ Willingness to Disagree in Supervision**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>s51</td>
<td>Being willing to disagree with my supervisor</td>
</tr>
<tr>
<td>s123</td>
<td>Speaking up if I do not agree with an evaluation</td>
</tr>
<tr>
<td>s50</td>
<td>Communicating my disagreements with my supervisor</td>
</tr>
<tr>
<td>s97</td>
<td>Telling my supervisor when I am uncomfortable with their methods of supervision</td>
</tr>
<tr>
<td>s140</td>
<td>Not being afraid to challenge the supervisor's perspective on clinical work</td>
</tr>
</tbody>
</table>

### Table 14

**Cluster 14: Supervisees’ Investment in Their Own Learning and Growth as Counselors**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>s154</td>
<td>Doing my own research on different topics of practice outside of supervision (i.e., theories, techniques)</td>
</tr>
<tr>
<td>s155</td>
<td>Doing my own research on specific populations in which I will be working with outside of supervision</td>
</tr>
<tr>
<td>s99</td>
<td>Working with one or more counseling theories</td>
</tr>
<tr>
<td>s82</td>
<td>Researching my theoretical orientation</td>
</tr>
<tr>
<td>s89</td>
<td>Considering other theoretical orientations when appropriate</td>
</tr>
<tr>
<td>s100</td>
<td>Choosing appropriate interventions for client's needs</td>
</tr>
</tbody>
</table>
Being motivated to record session tapes
Conceptualizing clients according to my theoretical orientation
Refining my skills for assessments, diagnosis, and treatment planning
Reviewing steps for risk assessments
Having a case conceptualization for each client

Table 15
Cluster 15: Supervisees’ Personal Awareness and Reflections on Their Counseling Practice

<table>
<thead>
<tr>
<th>Code</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>s111</td>
<td>Being aware of personal aspects that might affect process in counseling</td>
</tr>
<tr>
<td>s49</td>
<td>Being willing to learn from my mistakes and successes</td>
</tr>
<tr>
<td>s40</td>
<td>Identifying and remaining aware of my strengths as a developing counselor</td>
</tr>
<tr>
<td>s41</td>
<td>Identifying and remaining aware of my areas of growth as a developing counselor</td>
</tr>
<tr>
<td>s69</td>
<td>Working on personal matters that might be impacting my clinical work</td>
</tr>
<tr>
<td>s39</td>
<td>Building on personal strengths</td>
</tr>
<tr>
<td>s110</td>
<td>Taking ownership of mistakes in order to learn</td>
</tr>
<tr>
<td>s62</td>
<td>Not assuming I know more than I do</td>
</tr>
<tr>
<td>s42</td>
<td>Developing my confidence as a counselor in training</td>
</tr>
<tr>
<td>s129</td>
<td>Engaging in critical thinking when reviewing session tapes</td>
</tr>
<tr>
<td>s172</td>
<td>Weighing differing opinions and synthesizing them into my practices</td>
</tr>
<tr>
<td>s143</td>
<td>Understanding that there is no &quot;perfect&quot; way of counseling</td>
</tr>
</tbody>
</table>

Table 16
Cluster 16: Supervisees’ Personal Awareness and Reflections on Their Supervision Experience

<table>
<thead>
<tr>
<th>Code</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>s77</td>
<td>Being prepared to have assumptions challenged by the supervisor</td>
</tr>
<tr>
<td>s126</td>
<td>Being comfortable talking about challenges</td>
</tr>
<tr>
<td>s112</td>
<td>Being aware of personal aspects that might affect process in supervision</td>
</tr>
<tr>
<td>s165</td>
<td>Trying not to be worried about what my supervisor thinks of me (if they think I am a good counselor or not)</td>
</tr>
<tr>
<td>s104</td>
<td>Working on managing my anxiety</td>
</tr>
<tr>
<td>s161</td>
<td>Remaining mindful that there are things my supervisor knows more about than I do</td>
</tr>
<tr>
<td>s75</td>
<td>Recognizing that supervisors have the intention of supporting counselors for purposes of</td>
</tr>
<tr>
<td>Cluster 17: Supervisees’ Willingness to Learn from Their Supervisor While Developing Their Own Counseling Style and Professional Identity</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>s167</strong></td>
<td>Learning from my supervisor's counseling style, while also working actively to create my own counseling style (not copying supervisor's style)</td>
</tr>
<tr>
<td><strong>s142</strong></td>
<td>Learning about my supervisor's theoretical perspective and preferred treatment modalities</td>
</tr>
<tr>
<td><strong>s159</strong></td>
<td>Being respectful of differences between my counseling style and my supervisor's counseling style</td>
</tr>
<tr>
<td><strong>s160</strong></td>
<td>Being respectful of supervisor's counseling experience</td>
</tr>
<tr>
<td><strong>s158</strong></td>
<td>Being respectful of supervisor's supervision/counseling style</td>
</tr>
<tr>
<td><strong>s91</strong></td>
<td>Observing my supervisor's style of supervision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster 18: Supervisees’ Willingness to Process Multicultural Considerations in Relation to Their Counseling Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>s177</strong></td>
</tr>
<tr>
<td><strong>s180</strong></td>
</tr>
<tr>
<td><strong>s175</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster 19: Supervisees’ Willingness to Process Multicultural Considerations in the Supervisory Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>s178</strong></td>
</tr>
<tr>
<td><strong>s174</strong></td>
</tr>
<tr>
<td><strong>s179</strong></td>
</tr>
<tr>
<td><strong>s176</strong></td>
</tr>
</tbody>
</table>
### Table 20
*By-Itself-Cluster 1*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>s76</td>
<td>Being cognizant of the gatekeeping functions of supervision</td>
</tr>
</tbody>
</table>

### Table 21
*By-Itself-Cluster 2*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>s145</td>
<td>Taking clinical risks in supervision and with clients</td>
</tr>
</tbody>
</table>
Appendix J

Figure 3

Two-dimensional cluster map with areas

**Note:** SEES’ (Supervisees)
CURRICULUM VITAE

JOHANA ROCHA, Doctoral Candidate/ABD, M.S.Ed., NCC, Resident in Counseling (VA)
1520 Hambledon Loop, Chesapeake VA, 23320
jrocha@odu.edu

<table>
<thead>
<tr>
<th>EDUCATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor of Philosophy, Counselor Education and Supervision</strong></td>
<td>May 2020 (anticipated)</td>
</tr>
<tr>
<td>Old Dominion University, Norfolk, Virginia</td>
<td>CACREP accredited program</td>
</tr>
<tr>
<td><strong>Master of Science in Education, Clinical Mental Health Counseling</strong></td>
<td>2017</td>
</tr>
<tr>
<td>Old Dominion University, Norfolk, Virginia</td>
<td>CACREP accredited program</td>
</tr>
<tr>
<td><strong>Bachelor of Arts, Psychology</strong></td>
<td>2013</td>
</tr>
<tr>
<td>UNAD, Ibagué, Colombia</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LANGUAGES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual in Spanish and English</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCHOLARSHIP</th>
<th></th>
</tr>
</thead>
</table>

**Publications in Progress**


**Book Chapters**

National Refereed Presentations


Rocha, J. (2019, October). You Don’t Practice What You Don’t Know: The Need for a Trauma Course in Counseling Master’s Program. Education session at the Association for Counselor Education and Supervision Conference, Seattle, WA.

State and Regional Refereed Presentations


AWARDS, PROFESSIONAL AFFILIATIONS, AND HONORS

Chi Sigma Iota - Omega Delta Chapter, Outstanding Research Award Fall 2019
Study: Structured Peer Feedback Exchange in Group Supervision of Beginning Supervisors

2019 Southern Association for Counselor Education and Supervision (SACES) Fall 2019
Research and Best Practice Grant Award
Darden College of Education and Professional Studies Dean’s Office Fall 2019
Travel Fund Award
Department of Counseling and Human Services’ Doctoral Student Professional Development Award Fall 2019
2019 Association for Counselor Education and Supervision (ACES) Research Grant Award Summer 2019
2019 Association for Assessment and Research in Counseling (AARC) Donald Hood Student Research Grant Award Summer 2019
ODU’s Darden College of Education and Professional Studies Doctoral Fellowship Award 2019-2020 Spring 2019
Chi Sigma Iota Travel Fund Award Spring 2019
Department of Counseling and Human Services’ Doctoral Student Professional Development Award Fall 2018
Darden College of Education and Professional Studies Dean’s Office Travel Fund Award Fall 2018
Integrated Behavioral Health with Children, Adolescents, and Youth Cohort Fellow Spring 2017
Chi Sigma Iota International Honor Society, Omega Delta Chapter Fall 2018 to Present
American Counseling Association Spring 2018 to Present
Association for Counselor Education and Supervision Spring 2018 to Present
Southern Association for Counselor Education and Supervision Spring 2018 to Present

PROFESSIONAL EXPERIENCE

Research Experience

**Doctoral Research Assistant** January to August 2019
Old Dominion University, Norfolk, Virginia
Supervisor: Dr. Emily Goodman-Scott
- Assisted with literature review research and transcription of interviews
• Collaborated on the creation of codebooks containing information of over 10 focus groups
• External auditor of data collection on different studies
• Collaborated on the creation of a textbook glossary

Research Project: A Structured Peer Feedback Exchange Intervention in Group Supervision of Beginning Doctoral Supervisors May 2017 to Present
Investigator- Coordinator
Responsible Project Investigator: Dr. Gulsah Kemer
• Collaborate in the writing of the proposal and other Institutional Review Board (IRB) materials
• Investigator and coordinator under the affiliation of Graduate Student responsible for project design, implementation, consent process, data collection, data analysis, manuscript write-up.

Research Project: Process and Outcome Instruments in Clinical Supervision Investigator August 2017 to Present
Responsible Project Investigator: Dr. Gulsah Kemer
• Collaborate in the revision of supervision measurements
• Investigator under the affiliation of Graduate Student responsible for revision of data analysis and manuscript write-up

Research Project: Supervisee Competencies in Supervision August 2017 to Present
Investigator
Responsible Project Investigator: Dr. Eric Baltrinic
• Contributed to the initial design of the project
• Collaborated in the creation of the data collection instrument
• Collaborated on the manuscript write-up

Old Dominion University Teaching

Co-Instructor:
COUN 670, Introduction to Supervision (Master’s level) Fall 2019
HMSV 341, Introduction to Human Services Spring 2019
HMSV 343W, Human Services Methods Fall 2018
HMSV 368, Field Observation in Human Services Summer 2018

Co-Instructor (online):
HMSV 449, Crisis Intervention Summer 2019
HMSV 452, Substance Abuse Treatment Summer 2019

Clinical Supervisor: Agency August 2019 to Present
• Conduct 1-hour weekly of individual supervision with two internship level counseling master’s students interning at Chesapeake Regional Healthcare
Clinical Supervisor: University

- Conduct 1-hour weekly of individual supervision with two practicum level supervisees in the counseling master’s program at ODU  
  **August 2019 to Present**
- Provided individual, triadic and group supervision to four students enrolled in COUN 634, Advanced Techniques at ODU  
  **Spring 2019**

Clinical Experience

Behavioral Health Services, Chesapeake Regional Healthcare, Chesapeake, VA
Intern  
**May 2019 to Present**

- Provide counseling services to English and Spanish speaking patients with a range of diagnosis in the Emergency Department, and the medical units to include the Clinical Decision Unit, the Progress Care Unit, and the Intensive Care Unit
- Conduct individual therapy at Chesapeake Regional Healthcare’s Cardiopulmonary Rehabilitation Center and Transitional Care Clinic with English and Spanish speaking patients with congestive heart failure and chronic obstructive pulmonary disease

Behavioral Health Services, Chesapeake Regional Healthcare, Chesapeake, VA
Intern  
**August 2016 to August 2017**

- Provided emotional support and applied basic and advanced helping skills as needed to patients with a range of diagnosis in the Emergency Department, and the medical units to include the Clinical Decision Unit, the Progress Care Unit, and the Intensive Care Unit
- Conducted therapy at the Transitional Care Clinic to patients with congestive heart failure, chronic obstructive pulmonary disease, no primary care provider, and/or no insurance
- Implemented stress management techniques, provided emotional support, and applied basic and advanced helping skills as needed to patients at the Chesapeake Regional Medical Center’s Out-patient Cardiopulmonary Rehabilitation Center
- Mentored practicum students in acclimating to the hospital’s site, systems, patient and family protocol, and care team procedures
- Facilitated a stress management support group at the Chesapeake Regional Medical Center’s Out-patient Cardiopulmonary Rehabilitation Center

Fleet & Family Support Center, U.S Naval Air Facility, Atsugi, Japan
Intern-Advocate  
**October 2012 to April 2013**

- Served on 24/7 crisis intervention team of 5 that responded to calls of domestic violence, marital rape, and child abuse and neglect
- Assisted clients as a companion through legal, medical, and clinical process
- Developed activities for the domestic violence awareness month making direct contact with members of the community
- Performed lethality assessments, informed the victims about resources, and assisted them in developing a safety plan
- Informed the victims about confidentiality and informed consent
Leadership and Service Experience

Proposal Reviewer

March 2020

2020 SACES Conference
- Reviewed 14 Master’s, Doctoral, and Faculty proposals
- Provided recommendations for accepting and/or rejecting proposals

Proposal Reviewer

November 2019

2020 VACES Graduate Student Conference
- Reviewed 12 Master’s and Doctoral proposals
- Provided recommendations for accepting and/or rejecting proposals

Associate Director of Behavioral Health Services

July 2019 to Present

Chesapeake Regional Healthcare
- Coordinate onboarding and offboarding procedures to include recruitment of potential interns, interviewing applicants, farewell rituals, and electronic medical records access
- Schedule and facilitate the orientation process
- Coordinate and lead the recruitment fair
- Identify gaps in, create, and modify policies and procedures, as necessary
- Identify gaps in and update the student handbook
- Provide weekly site supervision to two supervisees
- Participate in 1-hour weekly Supervision of Supervision meeting

Membership Chair

May 2019 to Present

International Honor Society Chi Sigma Iota, Omega Delta Chapter
- Email invitation to students encouraging them to join the organization
- Editor of the Chapter’s newsletter
- Organize and host initiation ceremony of new members
- Keep membership database up to date

Guest Lectures and Panels

Social and Cultural Issues in Counseling - COUN 655

April 2020

Guest lecturer in “Latinx People and Counseling”
Old Dominion University, Darden College of Education and Professional Studies, Counseling Department, Norfolk, VA

Doctoral Welcome Dean’s Office

August 2019

Stellar doctoral student guest panelist at the Dean’s Office Incoming Doctoral Students Welcome Darden College of Education and Professional Studies, Old Dominion University, Norfolk, VA

Doctoral Orientation for Incoming Students

August 2019

Doctoral guest panelist at the Counselor Education and Supervision Ph.D. Program Orientation Counseling and Human Services Department, Old Dominion University, Norfolk, VA

Faculty Summer Conference 2019

May 2019
Guest panelist on *Students’ Thoughts on Social Media Use in the Classroom*
Ted Convocation Center, Old Dominion University, Norfolk, VA

**Diversity Issues in Human Services - HMSV 346**
April 2019
Guest lecturer in Latino/Latina people and Human Services
Old Dominion University, Darden College of Education and Professional Studies, Human Services Department, Norfolk, VA

**Social and Cultural Issues in Counseling - COUN 655**
March 2019
Guest lecturer in “Latinx People and Counseling”
Old Dominion University, Darden College of Education and Professional Studies, Counseling Department, Norfolk, VA

**Diversity Issues in Human Services - HMSV 346**
April 2018
Guest lecturer in Latino/Latina people and Human Services
Old Dominion University, Darden College of Education and Professional Studies, Human Services Department, Norfolk, VA

**Social and Cultural Issues in Counseling - COUN 655**
March 2018
Guest lecturer in Latino/Latina people and Counseling
Old Dominion University, Darden College of Education and Professional Studies, Counseling Department, Norfolk, VA

---

**RELATED PROFESSIONAL EXPERIENCE**

**Operation Smile Short Documentary Demonstration**
January 2018 to April 2019
Team Member
Old Dominion University, Darden College of Education and Professional Studies, Counseling and human Services Department, Product and Outcome Research Laboratory, Norfolk, VA
- Contributed to the planning of the project
- Utilize the Perception Analyzer Software as part of the delivery tool of the project
- Assist with the logistics of the event

**Advanced Group Counseling – COUN 844**
Fall 2018
Group Facilitator
Old Dominion University, College of Education, Counseling Department, Norfolk, VA
- Facilitated an interpersonal relationship group that consisted of six human services students
- Practiced group facilitation skills learned in my advanced group counseling course COUN 844

**Human Services Internship Coordinator**
Fall 2018
Graduate Assistant to the Internship Coordinator
Old Dominion University, Darden College of Education and Professional Studies, Counseling and human Services Department, Norfolk, VA
• Assisted the internship coordinator in processing human services students’ internship applications

Clinical Observation and Recording System CORS  
Spring 2018
Coordinator
Old Dominion University, Darden College of Education and Professional Studies, Counseling  
Department, Norfolk, VA
• Scheduled counseling practices sessions for master’s students taking COUN 634
• Scheduled doctoral supervision sessions for doctoral students taking COUN 846
• Collaborated with the counseling office manager in assigning and scheduling the rooms for counseling and supervision sessions

Product and Outcome Research Laboratory  
May 2017 to Present
Member – Investigator
Old Dominion University, Darden College of Education and Professional Studies, Counseling  
Department, Norfolk, VA
• Contribute to the development of several projects related to supervision
• Collaborate on the submission of IRB applications for some projects related to supervision
• Collaborate on manuscript’s write-ups

Counseling and Psychotherapy - COUN 633  
Fall 2017
External Reviewer of Mock Counseling Sessions
Old Dominion University, College of Education, Counseling Department, Norfolk, VA
• Provided written feedback to students taking (COUN 633) on the use of their basic counseling skills during their mock sessions

Integrated Behavioral Health with Children, Adolescents, and Youth Cohort  
Spring 2017
Intern-Fellow
Old Dominion University, Darden College of Education, Counseling Department, Norfolk, VA
• Participated in the creation of one additional content area to be included in section one or two of the SAMHSA document on integrated care for children and youth, and served as a behavioral health consultant to the students in the College of Health Sciences on the benefits of counseling for the client experiencing chronic pain
• Attended the “Interprofessional Education (IPE): Healthcare Professional Roles/Responsibilities & Values/Ethics” day at the Ted Constant Convocation Center
• Attended and presented with students of the College of Health Sciences at the IPE poster presentation day on the topic of “The Effect of an Interprofessional Registered Nurse-Physical Therapist Team on Reducing Prescribed Opioid Dependence in Patients with Chronic Lower Back Pain”
• Collaborated with College of Health Sciences students to develop a group care plan for a session at Eastern Virginia Medical School and a website that focused on the treatment of a patient with different co-morbidities
• Attended the one-day Simulation and Immersive Learning workshop held at EVMS Sentara and participated in the workshop with an assigned interprofessional team using motivational interviewing through face to face and telehealth encounters
### Professional Filming for Graduate Recruitment
Ph.D. student guest on *what it is like to be a Ph.D. student at ODU*
Old Dominion University, Counseling Department, Norfolk, VA

### University Marketing Photo Shoot
Old Dominion University, Strategic Communication & Marketing, Norfolk, VA

### PROFESSIONAL DEVELOPMENT

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can VR simulations be an effective tool in training mental health clinicians?</td>
<td>April 2020</td>
</tr>
<tr>
<td>Mursion Webinar</td>
<td></td>
</tr>
<tr>
<td>Counseling and Human Services, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Telehealth for Mental Health Professionals: 2-Day Distance Therapy Training</td>
<td>April 2020</td>
</tr>
<tr>
<td>PESI Digital Seminar</td>
<td></td>
</tr>
<tr>
<td>Using 21st Century Contracts as a Tool for Building Egalitarian Supervisory Relationships</td>
<td>April 2020</td>
</tr>
<tr>
<td>Southern Association for Counselor Education and Supervision (webinar)</td>
<td></td>
</tr>
<tr>
<td>Mental Health Counselors’ Perceptions on Preparedness in Integrated Behavioral Healthcare in Underserved Areas</td>
<td>April 2020</td>
</tr>
<tr>
<td>Dissertation Defense</td>
<td></td>
</tr>
<tr>
<td>Counseling and Human Services Department, Old Dominion University, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Supervising Students with Disabilities: Raising Awareness &amp; Cultural Competence</td>
<td>March 2020</td>
</tr>
<tr>
<td>The Supervision and Training Section, Division 17 of APA in association with the Practice Advisory Board (webinar)</td>
<td></td>
</tr>
<tr>
<td>Darden College of Education and Professional Studies, Old Dominion University, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Did I Hear (Do) That?: A Process for Addressing Microaggressions in Counseling Education Programs</td>
<td>October 2019</td>
</tr>
<tr>
<td>Association for Counselor Education and Supervision, Seattle, WA</td>
<td></td>
</tr>
<tr>
<td>Politics: Are We as Counselor Educators as Unbiased as We Think?</td>
<td>October 2019</td>
</tr>
<tr>
<td>Association for Counselor Education and Supervision, Seattle, WA</td>
<td></td>
</tr>
<tr>
<td>Counseling Supervision at Integrated Behavioral Health (IBH) Settings</td>
<td>October 2019</td>
</tr>
<tr>
<td>Association for Counselor Education and Supervision, Seattle, WA</td>
<td></td>
</tr>
<tr>
<td>A Multidimensional Framework for Teaching Sexuality Counseling</td>
<td>October 2019</td>
</tr>
</tbody>
</table>
Association for Counselor Education and Supervision, Seattle, WA

Counselor Trainees’ and Supervisors’ Roles, Responsibilities, & Needs in IBH Settings
Counseling and Human Services, Old Dominion University, Norfolk, VA September 2019

CHS Research Days: Brown Bag Series
Phenomenology
Process and Outcome Research Lab (PORL), Old Dominion University, Norfolk, VA April 2019

CHS Research Days: Brown Bag Series
Autoethnography
Process and Outcome Research Lab (PORL), Old Dominion University, Norfolk, VA February 2019

CHS Research Days: Brown Bag Series
Concept Mapping
Process and Outcome Research Lab (PORL), Old Dominion University, Norfolk, VA January 2019

Laughing with Your Clients: Humor and Therapy
Virginia Counseling Association Conference, Norfolk, VA November 2018

Building Resiliency after Sibling on Sibling Sexual Abuse
Virginia Counseling Association Conference, Norfolk, VA November 2018

Integrating Bilateral Stimulation into Treatment of Trauma to Increase Client Resilience and Affect Management
Virginia Counseling Association Conference, Norfolk, VA November 2018

Writing Your Research Question
Old Dominion University, Norfolk, VA October 2018

Small Object Use in Supervision: An Exploratory Study
Virginia Association for Counselor Education and Supervision Conference, Lynchburg, VA February 2018

Lived Experiences of First-Generation Doctoral Students of Color
Virginia Association for Counselor Education and Supervision Conference, Lynchburg, VA February 2018

What Supervisors Can Do to Help Supervisees to Talk More in Supervision: A Review of 20 Years of Literature
Virginia Association for Counselor Education and Supervision Conference, Lynchburg, VA February 2018

Empathy 101: You don’t know what you don’t know
Virginia Association for Counselor Education and Supervision Conference, Lynchburg, VA February 2018

Graduate Teaching Assistant Instructors’ Institute (GTAI Institute)
Old Dominion University, Norfolk, VA January 2018
<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simulation and Immersive Learning workshop</td>
<td>April 2017</td>
</tr>
<tr>
<td>EVMS Sentara, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Inter-professional Education Day: Healthcare Professional Roles/Responsibilities &amp; Values/Ethics</td>
<td>March 2017</td>
</tr>
<tr>
<td>Old Dominion University, College of Health Sciences, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Building Bridges: Trauma Informed Care Training</td>
<td>March 2017</td>
</tr>
<tr>
<td>South Norfolk Memorial Library, Chesapeake, VA</td>
<td></td>
</tr>
<tr>
<td>Military Culture and Deployment-Related Mental Health Issues Affecting Veterans and their Families</td>
<td>Sept 2016</td>
</tr>
<tr>
<td>The Barry Robinson Center, Virginia Beach Tidewater Community College, Virginia Beach, VA</td>
<td></td>
</tr>
<tr>
<td>Discovering Invisible Privilege</td>
<td>May 2016</td>
</tr>
<tr>
<td>Old Dominion University, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Child Sexual Abuse Prevention Training</td>
<td>April 2016</td>
</tr>
<tr>
<td>Norfolk Department of Human Services, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Gay-Straight Alliance Leadership Workshop</td>
<td>April 2016</td>
</tr>
<tr>
<td>The LGBT Center of Hampton Roads, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Diversability Training</td>
<td>March 2016</td>
</tr>
<tr>
<td>Old Dominion University, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>The Cost of Caring: Compassion Fatigue Education and Treatment Training</td>
<td>April 2015</td>
</tr>
<tr>
<td>Virginia Beach Coaching &amp; Counseling, Chesapeake, VA</td>
<td></td>
</tr>
<tr>
<td>Domestic Violence Victim Advocate Training</td>
<td>November 2012</td>
</tr>
<tr>
<td>The U.S. Department of Defense and the Fleet and Family Support Center, Atsugi, Japan</td>
<td></td>
</tr>
</tbody>
</table>

**VOLUNTEER EXPERIENCE**

<table>
<thead>
<tr>
<th>Experience</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Counseling Association</td>
<td>November 2018</td>
</tr>
<tr>
<td>Represented the Counselor Education and Supervision Doctoral Program at the booth Hilton at Norfolk, Norfolk, VA</td>
<td></td>
</tr>
<tr>
<td>Chesapeake Regional Medical Center</td>
<td>August 2017 – December 2017</td>
</tr>
<tr>
<td>Volunteer at Cardio-Pulmonary Rehabilitation Center</td>
<td></td>
</tr>
<tr>
<td>Chesapeake, Virginia, USA</td>
<td></td>
</tr>
<tr>
<td>The Program of Domestic Abuse Victim Advocate</td>
<td>April 2013- April 2014</td>
</tr>
<tr>
<td>Advocate</td>
<td></td>
</tr>
<tr>
<td>Naval Air Facility, Atsugi, Japan</td>
<td></td>
</tr>
</tbody>
</table>