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Competence in Competency-Based Supervision Practice: Construct and Application

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Providing competent clinical supervision is challenging for the practitioner both in determining supervisee competencies and in conducting the corresponding supervision. Competence, an ethical principle that informs the practice of psychology, refers to requisite knowledge, skills, and values for effective performance. Similar to other health care professions, psychology is increasingly moving towards competency-based approaches in education, training, and performance appraisal. In this article, the authors review perspectives on competence as a construct and define competency-based clinical supervision, with particular attention to the nature of ethical, legal, contextual, and practice issues that arise from the establishment of a standard of competency-based supervision practice. The authors conclude with a discussion of challenges faced in clinical supervision and recommendations for best practices.

Keywords: competence, metacompetence, competency, professional development, ethics

Competence is central among the constellation of principles and values that inform psychology as a profession. Psychologists are mandated to practice exclusively within the boundaries of their competence (American Psychological Association [APA], 2002) and regulatory and professional organizations; that is, individual state and provincial boards, the APA, the Association of State and Provincial Psychology Boards, and the American Board of Professional Psychology have established policies, guidelines, and standards to ensure the development, certification, and maintenance of competence. These efforts have produced criteria to establish the threshold of competence for independent practice and to encourage continued professional development; however, identification of a “gold standard” of competence in a psychologist has been difficult. As Roberts, Borden, Christiansen, and Lopez (2005) suggested, unlike other professionals such as basketball players (who measure success in balls dropped through the hoop), the obligations and standards of psychologists are more complicated to define and measure, particularly in light of the complexity of the

tasks involved and ever-present changes in health care. Kitchener (2000) concluded that

it may be easier to require psychologists [and supervisees] to be competent than it is to define what competence means, [and] competence is sometimes easier to identify in its absence than it is to specify what a proficient level of practical or scientific expertise involves. (pp. 154–155)

Despite these challenges, efforts to articulate and to apply the construct of competence are salient to the profession and particularly to supervision, because supervised clinical training provides the context for competence to be developed as well as for foundational attitudes and practices, which encompass professionalism, to be instilled. Skills practiced by the supervisor and supervisee provide the essential tools to achieve continuous development, which involve monitoring performance, maintaining perspective, evaluating metacompetence, and initiating learning and skill development. *Metacompetence*—the ability to assess what one knows and what one doesn’t know—holds a pivotal position in the development of competence and is required to address the complex responsibilities involved in maintaining competence throughout one’s career. Whereas during graduate school, competence can be identified within an articulated, sequential program of competency-based training in which built-in procedures of external evaluation complement self-assessment, professional development relies primarily on self-assessment and self-motivation and concerns the incorporation of new knowledge into existing competencies through individualized and often self-directed learning.

Clinical supervision is a significant activity of practicing psychologists and continues to be within the top five activities on which psychologists spend their time (Norcross, Hedges, & Castle, 2002; Peake, Nussbaum, & Tindell, 2002). However, less than 20% of supervisors have received formal training in supervision (Peake et al., 2002). The use of a competency-based approach provides supervisors with the means to identify the components that make up particular clinical competencies and establishes a model useful in initiating learning strategies for professional de-

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velopment. *Competency-based supervision* is defined as an approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion-referenced competence standards in keeping with evidence-based practices and requirements of the local clinical setting.

In this article, we review perspectives on competence as a construct and discuss competency-based clinical supervision, drawing particular attention to the nature of the learning process and the role of the supervisor. We conclude with a discussion of challenges often faced in clinical supervision, ethics, and recommendations for best practices.

Definition of Competence

Drawing on its 14th-century French roots, “to fall together, to coincide” (*Oxford English Dictionary*, 2006), *competence* can be understood as a state of sufficiency in a given context or in respect to a particular requirement. Within the professions,

competence refers to an individual’s capability and demonstrated ability to understand and do certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or specialty thereof (Kaslow, 2004, p. 775),

and as such, competence is an end point, representing a standard.

As applied to psychology, competence involves understanding and performing tasks consistent with one’s professional qualifications (often having involved specialized training), sensitive to cultural and individual differences, and anchored to evidence-based practices (APA Presidential Task Force on Evidence-Based Practice, 2006). Competence may be attributed when a person is

qualified, capable, and able to understand and do certain things in an appropriate and effective manner . . . (which) connotes that behaviors are carried out in a manner consistent with standards and guidelines of peer review, ethical principles and values of the profession, especially those that protect and otherwise benefit the public. (Rodolfa et al., 2005, pp. 348–349)

Most often, we think of competence in terms of “overall or integrated professional abilities (i.e., the quality of being adequately qualified)” (Kaslow et al., 2004); whereas in fact, many discrete competencies are required to perform most professional tasks. Competencies are measurable human capabilities involving knowledge, skills, and values, which are assembled in work performance (cf. Falender & Shafranske, 2004; Hoge, Tondora, & Marrelli, 2005, p. 517).

Core Competencies in Psychology

Whether viewed as all-around competence or as discrete capabilities, efforts have been made to identify core competencies and to designate inclusive categories in which clinical competencies might be organized. General categories have been articulated in APA accreditation guidelines (APA, Committee on Accreditation, 2005), and APA and other groups have sponsored initiatives, task forces, meetings, and programs to consider the specifics of professional competence; recently, for example, the APA Education Leadership Conferences and the Council of Chairs of Training

Councils Practicum Competencies Workgroup (Hatcher & Lasser, 2005). However, it was not until the Association of Psychology Postdoctoral and Internship Centers (APPIC) convened Competencies Conference 2002: Future Directions in Education and Credentialing in Professional Psychology (Kaslow, 2004; Kaslow et al., 2004)¹ that competencies relating to professional practice were defined and articulated. The work of the conference resulted in 12 position papers published in 2004 and 2005. Recently, APA’s Task Force on the Assessment of Competence in Professional Psychology (APA, 2006) reviewed the existing scholarship and produced a comprehensive report, which presents the societal influences, background, models, and challenges to the assessment of competence and competencies.

Although summarizing the descriptions of each clinical competency is beyond the scope of this essay, Epstein and Hundert’s (2000) widely used definition, derived from medicine, usefully informs our discussion. Professional competence involves “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (Epstein & Hundert, 2000, p. 227). This definition captures the essence of professional competence, upon which more refined and discrete analyses of specific clinical competencies can be undertaken. This definition not only incorporates “the language of enlightened humanists” (Leach, 2002, p. 243) but also articulates a perspective that is dynamic and goes beyond simple and time-limited demonstrations of skill-based competence, (i.e., “to know how”) to a performance-based orientation (i.e., “to do”; cf. Miller, 1990), which is a hallmark of professionalism. Competence in this view is not a static end state that one achieves but rather reflects the developmental and contextual nature of competence.

Although necessary, the act of declaring a clinician competent (whether operationally defined by possession of a doctorate in psychology, the license to practice psychology, or a standard separate from credentialing) may falsely convey a static quality to such status and obscure the fact that competence is continuously developed and in the actual practice is a dynamic, situation-specific phenomenon. The state of competence “is not an absolute, nor does it involve a narrow set of professional behaviors; rather competence reflects sufficiency of a broad spectrum of personal and professional abilities relative to a given requirement” (Falender & Shafranske, 2004, p. 5). In addition to the actual performance of clinical skill, “competence connotes motivation and action to achieve a level of qualification or capability” (Kaslow, 2004, p. 775) and is therefore essential to continuous professional development, which ensures competence. Further, a “deep vein of creativity that is constantly renewing itself” (National Center on Education and the Economy, 2006, p. 6) may be required that involves not just a countless repetition of professional procedures but flexible and problem-specific applications, combining old and new knowledge.

Consideration of competency is particularly apt in light of the rapidly expanding knowledge base in psychology (and in all of the sciences), which strains the limits of clinical competence of prac-

¹ The work of the APPIC conference resulted in 12 position papers published in 2004 and 2005; workgroup summaries can be obtained at http://www.appic.org/news/3_1_news_Competencies.htm

itioner and supervisor alike. The exponential rise in the scientific literature dates to the 18th century, and Wyatt (1991, 2001, cited in Brice, Palmer, & Bexon, 2005, p. 63) reported that the biomedical literature (which included 40,000 journals in 1991) has doubled every 20 years. Using a simple metric of citations by year in the *PsycINFO* database reveals a similar trend; in 1985 there were 47,909 citations, and in 2005, the number increased to 97,904 citations. The information explosion is likely to experience even greater increases, primarily because of the Internet; in 1993, there were only 130 Web sites, and in 2002 there were around 36 million Web sites (Brice et al., 2005, p. 64). This expansion of information led Dubin (1972) to estimate that the half-life of a psychologist's knowledge is between 10 and 12 years; 3 years later, Hebb (1975, cited in Flannery-Schroeder, 2005, p. 389) suggested the number to be about 5 years. If Hebb is correct, "half of the 'facts' in psychology are replaced within the span of a typical graduate school stint" (Flannery-Schroeder, 2005, p. 389). Beyond the sheer quantity of information lie other factors that may contribute to a disparity between supervisor and supervisee knowledge sets, which affect the clinical procedures available to be supervised and therefore performed. Advances in clinical applications, for example, empirically supported treatments, established through randomized controlled trials (which, according to Balas & Boren, 2000, take 17 years to incorporate randomized trial results into practice); policies, such as the recently approved APA Policy of Evidence-Based Practice in Professional Psychology (APA Presidential Task Force on Evidence-Based Practice, 2006); different training experiences, for example, in respect to multicultural competence; and motivation to learn and implement new approaches may create a mismatch between what the clinician-supervisor is prepared to perform, the supervisor is prepared to supervise, and the supervisee has been taught to do.

Competence, the Ethical Standard

The "Ethical Principles of Psychologists and Code of Conduct" (hereafter referred to as the Ethics Code; APA, 2002), specifically multiple subsections of 2.0 Competence, describe aspects of professional competence. Although the ethical standard provides parameters regarding the necessity of practicing within one's defined areas of competence, including multicultural and diversity competence, it does not provide guidance as to the definition of competence beyond having or obtaining "training, experience, consultation, or supervision." Supervisors must be competent in the clinical procedures that are being performed under the supervisor's direction (and license). In light of the evolving nature of clinical approaches and interventions, we might question how any supervisor would have obtained during graduate school and clinical training the breadth of experience to be competent in every assessment and treatment protocol, particularly those developed subsequent to such training.

There was a significant expansion of the means by which competencies could be developed between the 1992 (APA, 1992) and the 2002 (APA, 2002) versions of the Ethics Code. The present code (APA, 2002) contains broadened conceptions of competence that recognize alternative pathways to competence beyond areas in which one has had direct experience or training (D. Saccuzzo, personal communication, May 15, 2006). The present code (APA, 2002) added that "consultation and study"

could provide the basis for competence, and Section 2.01(d), which was new to the 2002 code, expanded competence to areas in which practitioners had had "closely related" prior training or experience and had made a "reasonable effort" to obtain competence through relevant research, training, consultation, or study. The assumption is that the psychologist knows what competence would be in those related areas of practice and how to design a plan to develop competence.

Supervisory responsibility regarding supervisee competence is more clearly spelled out in the 2002 Ethics Code: Supervisors are required to "see that such persons perform these services competently" (APA, 2002, Section 2.05 [3] Delegation of Work to Others). This statement brings the code to the standards addressed by the legal concept of *respondeat superior*, which states that the principal or employer is responsible for the actions of an employee or agent while acting within the scope of his or her employment or agency, or in this case, the supervisor is responsible for the actions of a supervisee while acting within the scope of the supervised professional activities. However, what is the threshold of competence for the supervisee, who by definition is in a state of learning and developing competence, rather than mastery?

Expectations of competence can be established, taking into consideration the present level of the supervisee's skill set, understood from a developmental perspective and related to the training rotation's requirements. A developmental trajectory, based on research by Dreyfus and Dreyfus (1986, 2004), is proposed, which is not necessarily anchored to a specific level of training (e.g., practicum student, predoctoral intern, and so on) but rather reflects emergent capacities to integrate existing knowledge and process information in the clinical setting, drawing on formal and informal learning (Shafranske & Falender, 2007). From this vantage, competence in professional functioning will look different at each stage of development and will follow a teleology in which detachment and rule-based behavior give way to greater immersion in situational aspects and produce context-based behaviors (cf. Leach, 2002, p. 243). In the beginner, competence will be assessed in terms of the ability to know and to apply rules in a consistent fashion, albeit in an unsophisticated and at times awkward manner. Later in development, we would expect a more nuanced application of rules, the ability to deal with increased confusion and greater ability to consider the varied situational aspects, which shape clinical work. In addition to assessing the supervisee's competence to engage in processes associated with skill acquisition, the supervisor must ensure competent care to the client, while acknowledging that the level of expertise (or competence) provided by a beginner and an expert will, by definition, be different.

Ensuring competence in client care may be usefully framed in terms of the supervisor's competence and the supervisee's entrustability. The supervisor bears the primary responsibility to ensure that competent service is provided and determines when "a trainee may be *trusted* to bear responsibility to perform a professional activity, given the level of competence he or she has reached" [emphasis added]; ten Cate, 2005, p. 1176). The measure of entrustability is an outcome of assessments obtained both formally and informally. Supervisors draw on their direct knowledge (obtained through observation and documentation) of a supervisee's capability, their trust in the supervisory alliance, and experience of the supervisee's ability to apply the guidance of the supervisor in determining the clinical responsibilities that they can entrust to the

supervisee. Although trust in the supervisee's motivation, integrity, willingness to learn, and so on are important, supervisory decision-making and practice ultimately rest on assessments of competence—evaluations of the supervisee's capability as well as the supervisor's own self-assessment—or metacompetence—of the ability to competently supervise the specific services to be provided to the patient and to effectively supervise and guide the supervisee's skill development. An explicit competency-based approach to supervision provides a framework to both effectively make such assessments and to develop competence.

Metacompetence

Metacompetence, or knowing what one knows and what one does not know, dates back to Spinoza (Weinert, 2001) and has been described by Hatcher and Lassiter (in press) as an organizing principle of great importance to the clinical training and development of competence of a psychologist. More clinically stated, metacompetence has been used to refer to the use of available skills and knowledge to solve problems or tasks and to determine which skills or knowledge are missing, how to acquire these, and whether they are essential to success.

A prerequisite to metacompetence is ability to introspect about one's personal cognitive processes and products and is dependent on self-awareness, self-reflection, and self-assessment (Weinert, 2001). Supervision plays an essential role in guiding the development of metacompetence. This is achieved by encouraging and reinforcing the supervisee's development of skills in self-assessment.

Competency-Based Clinical Supervision

The present focus on competency in psychology practice is in keeping with developments throughout the health professions (Accreditation Council for Graduate Medical Education, 2000; Institute of Medicine, 2001); in higher education, more generally (Voorhees, 2001); and in public policy (New Freedom Commission on Mental Health, 2003). This emphasis reflects the "responsibility to ensure via education, training, and ongoing life-long assessment that practicing psychologists and future generations of psychologists provide quality and safe psychological services" (APA, 2006, p. 3).

Clinical Competence

A presumption of clinical competence is implicit in supervision. The supervisor is presumed to be more competent than the supervisee in most areas, including the practice of supervision and the content areas supervised. Competencies for entry-level supervisors were devised by a workgroup of the APPIC Competencies Conference and were described in Falender, Cornish, et al. (2004). Competencies included knowledge and skills associated with developing a relationship with the supervisee, processes to support ongoing self-assessment by the supervisor, general knowledge and skills relating to the clinical context and all aspects of the client, as well as the interrelationships among supervisor, supervisee, and client(s) and appreciation for contextual factors.

By identifying core competencies and the specific knowledge, skills, and values that are assembled to form them, a standard is

established for the entry-level supervisor. Supervisors who do not meet these criteria are judged not to be functioning within the standard for supervision practice. Supervisor and supervisee behaviors can be identified and measured (Milne, in press); doing so influences the process and the effectiveness of supervision. Efforts have been made to obtain valid and reliable assessments of supervisory working alliance to augment subjective appraisals. It will be imperative to further develop, study, and enhance procedures to reliably assess the constituents of these competencies, each of which is believed to have an impact on the effectiveness of supervision (APA, 2006; Falender, Cornish, et al., 2004). In addition, empirical studies are needed to accurately assess the bidirectional influences of supervision process on therapeutic process and on the outcomes of treatment and supervision, as well as to investigate the effectiveness of education and training strategies involved in developing competence in supervision practice.

Competency-Based Approach to Enhance Competence

A competency-based approach offers methods consistent with these objectives and focuses on the ability to apply knowledge and skills in the real world, with performance outcomes or competencies as criteria for evaluating learners and training programs (Falender & Shafranske, 2004, in press). Rather than primarily examining the content of what is taught or trained (as found in evaluating curricula or training programs), emphasis is placed on what is learned and the specific outcome of that training. Approaches include task-analysis-specific; analysis of underlying processes such as problem-solving, clinical reasoning, learning, and self-assessment; and comparison with successful representatives of the profession in terms of technical and facilitative variables.

The identification of the specific competencies (e.g., listening skills, knowledge of diagnostic systems, and risk assessment), which are assembled or bundled to perform a specific clinical task (or competency) is undertaken in an attempt to "reduce measurement to definable units that contain sufficient granularity as to be unequivocal" (Bers, 2001, p. 29). Discrimination at the "molecular" level assists the supervisee to focus development on specific areas or skill sets that are required for performance of the clinical task. Feedback and self-assessment aimed at this level of refinement better target training objectives and encourage supervision activities to be adjusted to enhance learning and skill development in the areas most needing improvement. In contrast to global assessments of competence, which provide little explicit direction, evaluations of specific knowledge, skills, and values used more readily lead to identification of specific enhancement or remediation strategies. In this approach, attention is focused on the development of the specific components as well as on the competency or skill set as a whole. Also, in competency-based approaches, the supervisee is evaluated against a predetermined standard (i.e., criterion-referenced), rather than in comparison with others as found in norm-based assessment (i.e., comparing one supervisee to another; Falender & Shafranske, 2004).

A competency-based approach can be used to enhance supervisor and practitioner competence similar to its application in clinical training. An explicit framework and method are provided for initiating, developing, implementing, and evaluating the processes and outcomes of supervision. Through development of a schema of

supervisor competency, increased attention may be devoted to performance evaluation, supervisee and supervisor development, and the continuous quality improvement of the supervisor's skills, all of which will benefit the supervisees and their clients.

Caveats and Rejoinder

Although a competency-based approach offers a heuristic consistent with clinical performance and evidence-based practice objectives, implementing such an approach is not without its challenges or critics. One inherent difficulty in putting a competency-based approach into practice is identifying the essential competencies, that is, the knowledge, skills, abilities, and values needed to perform specific clinical functions and to determine how they can be reliably assessed (Elman, Illfelder-Kaye, & Robiner, 2005). Some researchers have argued that a competency-based approach, which emphasizes the serial completion of tasks, is a far cry from competence (Talbot, 2004, p. 588) and "fails to take account of the real character of professionalism on the one hand and the artistry of practice [in medicine] on the other" (Fish & de Cossart, 2006, p. 404). In our view, a competency-based approach does not reduce complexity or eliminate artistry from clinical or supervision practice. Rather, such an approach usefully articulates core competencies to be enhanced, which are uniquely assembled to perform specific clinical functions in individual cases. A competency-based approach, together with skills in metacompetence, provides the supervisor with an orientation to a developmental process that results in professionalism both at the point of entry into the profession and in continuous professional development.

A further challenge in implementing a competency-based approach is to ensure diversity infusion into each component of the competency and to be mindful of the context and the influence of power, privilege, and role in interactions with individuals. It is also acknowledged that the agenda of developing a competency-based approach and the entire conception of competence is in fact value- and culture-laden (Vargas, 2004).

Challenges Facing the Competent Practice of Clinical Supervision

Although clinical supervision as a whole requires further study, scholarly reflection, and empirical examination, we highlight six areas we find to be of particular importance in supervision competence: preparation to conduct clinical supervision, self-assessment, ethical competence, incompetence, diversity and multicultural competence, and professional development.

Preparation to Conduct Clinical Supervision

Clinical supervision, similar to other professional competencies, ideally requires a foundation of education and training, continuous self-assessment (leading to self-directed learning), and participation in professional development. Unlike other competencies, clinical supervision appears generally to be given short shrift in graduate education (Scott, Ingram, Vitanza, & Smith, 2000). Barriers may present unique challenges to accurate self-assessment, and limited professional growth opportunities exist for enhancing the specialized competencies involved in supervision.

Self-assessment. Self-assessment is at the heart of developing and maintaining competence (Belar et al., 2001; Kaslow, 2004), as an individual must identify areas of strength and weakness to establish priorities and to commit to learning strategies to ensure competent practice. In light of the dual competence requirements in supervision (competence in conducting clinical services and competence in providing supervision), the responsibilities to clients and to supervisees, and the variability in preparation in clinical supervision, self-assessment plays a particularly crucial role.

Conducting a self-assessment is novel and uncharted, and although models exist (Belar et al., 2001), applying them to an individual's practice area is an elaborate and lengthy task. Theoretical and personal factors may interfere with self-assessment activities as well as transform results of self-assessment into meaningful self-disclosure, which benefits the supervision process. Supervisor self-assessment and self-disclosure as well as supervisee self-assessment and self-disclosure play a crucial role in mutually identifying strengths and weaknesses influencing the supervisory process. Further, accurate self-assessment and self-disclosure performed by the supervisor model skills required of the supervisee and set the stage for the supervisor's use of herself or himself in supervision (Wells & Pringle, 2004).

In the area of clinical competence, supervisors must critically assess their capability to perform and supervise clinical activities conducted by their supervisees. It may be prudent to disclose the scope of their competence to ensure that supervisees clearly understand what services will be supervised in their training and the limits that may be imposed on practices that are outside the parameters of the rotation. Supervisors may feel uncomfortable with such disclosures, particularly when supervisees are more experienced and sophisticated in a particular clinical approach.

Ethical competence. Ethical competence is often narrowly construed, placing emphasis on behavioral outcomes related to correct or incorrect decisions, rather than directing attention to the underlying processes and values involved in ethical decision-making. Although one cannot extrapolate directly, a survey of all psychology ethics curricula in Australia revealed a "mainly slavish attention to professional and research ethics codes" and minimal assessment of ethical knowledge (Davidson, Garton, & Joyce, 2003). Overemphasis on "worst-case scenarios" involving ethical lapses or legal violations may obfuscate the perspective that "professional conduct always involves ethics" and that as a profession, psychology bears a particular responsibility for advancing ethics within its sphere of influence. Attention to ethical decision-making; to nontraditional areas of focus, such as cultural diversity (Johnson, Brems, Warner, & Roberts, 2006); as well as to character factors, such as integrity, balance ethical problem-solving with heightened awareness of the commonplace application of ethical principles, standards, and virtues. Self-assessment untethers ethical competence from the constraints of worst-case scenarios and expands focus on the everyday practice of ethics.

The practitioner and supervisor should be concerned not simply with judgment but with enhancing awareness of how one's actions affect others, the importance assigned to moral values in comparison with other competing values, and the clinician's perseverance, strength of conviction, and courage (Rest, 1994). Handelsman, Gottlieb, and Knapp (2005) suggested that becoming an ethical professional is substantially more complex than following a set of rules. Supervisors play a crucial role in modeling ethical practice

and guiding exploration of the application of ethics and professional standards throughout the clinical training experience. Self-reflection enables the supervisor to better understand the impact of personal morality on professional practice and supervision and to reconcile such faith commitments with the professional ethical codes. Because character virtues contribute to “the bedrock on which sustained professional competence rests” (Johnson, Porter, Campbell, & Kupko, 2005, p. 655), consideration of honesty, personal responsibility, and integrity are among the ethical factors that are considered. We agree with Pipes, Holstein, and Aguirre (2005) that “because the personal and the professional [factors] do so often become intertwined, a stance of self-reflection and self-knowledge should be fostered” encouraging behavior “that is consistent with broader aspirational principles” (p. 332). Consideration of the range of factors that influence ethical decision-making seems particularly important in light of the finding that a majority of licensed clinicians stated that legal and ethical principles should sometimes be violated on the basis of patient welfare or deeper values (Pope & Bajt, 1988) and that a majority of supervisees reported supervisor ethical violations (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). Ethical competence therefore requires not only an understanding of the Ethics Code, but also a broad-based understanding of the values affecting practice, the ethical decision-making model one uses, and post-conventional moral reasoning.

Incompetence. Any discussion of competence requires consideration of incompetence as well, which may be the result of a number of professional and personal factors. Haas and Hall (1991) differentiated *incompetence*, or a lack of skills or inability to perform, from *unethical judgment*, or acting in ignorance or planful violation of an ethical code, and both of those from *professional impairment*. Professional impairment relates to behaviors symptomatic of an underlying problem such as substance abuse, psychopathology, situation crises, or organic impairment. In practice, it is sometimes difficult to distinguish these, as ultimately each may present as incompetence or may not (Barnett & Hillard, 2001). But, care should be taken when using the term impairment because its use has a specific legal definition under the Americans with Disabilities Act (Falender, Collins, & Shafranske, in press). As a result, Elman and Forrest (in press) have suggested that “the terms problematic professional competence, professional competence problems, or problems with professional competence have been proposed as the language to replace impairment.” Sixty percent of practicing psychologist respondents reported working rarely to very often when too distressed to be effective (Pope, Tabachnick, & Keith-Spiegel, 1987). Metacompetence assists in distinguishing incompetence, unethical judgment, and impairment. Self-assessment and metacompetence assist the clinician or supervisor to be mindful of lapses in judgment, lack of current knowledge or skills, attitudinal or values issues such as lack of respect or value for a particular diversity group, or personal factors that impair performance. Resistance to or difficulty in performing self-assessment and metacompetence procedures or failure to remediate inadequacies points to either incompetence or impairment; both require immediate attention. Although the 2002 Ethics Code deleted 1.13 from the 1992 code (“psychologists have an obligation to be alert to signs of and to obtain assistance for their personal problems at an early stage in order to prevent significantly impaired performance”; APA, 1992), the practice of meta-

competence provides a means to assess factors such as “burnout” (Rupert & Morgan, 2005) or other risks of impairment that undermine clinical competence (O’Connor, 2001). Long-term effects may be great. Forty percent of medical residents who work with “impaired” supervisors suffered subsequent anxiety and depression (Igartua, 2000).

Diversity and multicultural competence. Among the ethical standards, multicultural competence is an area that requires particular attention in our self-assessment practice and commitments to development and training in light of the existing literature. Although multiple guidelines on multicultural practice have been published by APA—Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003c); Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 2003a); Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual clients (APA, 2000); Guidelines for Psychological Practice with Older Adults (APA, 2003b); and Guidelines for Psychological Practice With Girls and Women (APA, 2007).—studies suggest that further attention is required. For example, studies have found (a) discrepancies between what psychologists viewed as competent practice and how they actually performed (Hansen et al., 2006); (b) self-reports of psychotherapists treating diverse clients, whom they reported not feeling competent to treat (Allison, Echemendia, Crawford, & Robinson, 1996); (c) use of biased, inadequate, or inappropriate practices when treating gay and lesbian clients (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991); and (d) minimal attention in graduate study to disabilities, except those involving cognitive impairment, even though approximately 15% of the U.S. population is living with disabilities (Olkin, 2002). For supervisors, research has reported (a) inattention to culture and diversity in cross-cultural supervisory dyads (Burkard et al., 2006), (b) supervisors not as culturally competent as their supervisees (Constantine, 2001), (c) failure to acknowledge lack of cross-racial supervision experience (Duan & Roehlke, 2001), (d) failure to initiate discussion of cultural differences between supervisor and supervisee (Gatmon et al., 2001), and (e) failure to initiate diversity discussions in general even though this has been demonstrated to enhance alliance (Gatmon et al., 2001). The practice of metacompetence, enhanced self-awareness, and the use of an explicit competency-based approach provide a framework for diversity and cultural competency.

Professional development. Continuing education was conceived as a means to enhance professional competency (Association of State and Provincial Psychology Boards, 2001) and to protect the consumer. It was envisioned as facilitating reflection-in-action (Schön, 1987), a continuous process defining professional decisions, ends to achieve, and the means to do so. Competency-based approaches provide a template for self-assessment that can be translated into responsive plans for professional development both on the individual level and through collaborative efforts within professional organizations (e.g., sponsorship of workshops), specifically aimed at competency development. Professional development in clinical supervision can be enhanced not only through formal education and self-directed learning, that is, courses, workshops, reading, and directed studies, but also through collaborative activities such as individual and peer group consultation, including review of supervision videotapes, use of problem-solving role plays, and consultation with experts.

Competency-based approaches provide behavioral standards, which serve as the platform for evaluation throughout the course of training and beyond, and for construction of tasks to achieve standards and training objectives, which have not yet been attained. By clearly establishing behavioral expectations and performance standards as specific competencies (which can be observed, evaluated, and developed through supervision), supervisors, programs, and practitioners become better prepared to effectively perform training, including supporting remediation and fulfilling gatekeeping obligations. Further, a fully integrated competency-based approach is more responsive and able to more quickly identify strengths and weaknesses, including problematic professional competence; has a heuristic in place to remediate problematic behavior (or to fairly dismiss a supervisee); and furnishes the infrastructure to establish a culture of assessment, which we suggest contributes to the development of professional competence.

Recommendations for Competency-Based Supervision

The following recommendations will assist in implementation of competency-based supervision practice.

1. The supervisor *self-assesses* on clinical and supervision expertise and competency issues (Falender, Cornish, et al., 2004).
2. The supervisor *engages with the supervisee* to facilitate development of a viable supervisory relationship, leading to the emergence of a working alliance (Bordin, 1983; Falender & Shafranske, 2004).
3. The supervisor *commits* to the practice of supervision integrating the following superordinate values: integrity in relationship, ethical values-based practice, appreciation of diversity, and science-informed (better stated now as evidence-based) practice (Falender & Shafranske, 2004).
4. The supervisor *delineates* supervisory expectations, including standards, rules, and general practice (Falender & Shafranske, 2004; Vespia, Heckman-Stone, & Delworth, 2002).
5. The supervisor *identifies* setting-specific competencies the supervisee must attain for successful completion of the supervised interval. A competencies document (Hatcher & Lassiter, 2005) provides a prototype.
6. The supervisor *collaborates* with the supervisee in developing a supervisory agreement or contract for informed consent, ensuring clear communication in establishing competencies and goals, tasks to achieve them, and logistics (Falender & Shafranske, 2004; Falvey, 2002; Sutter, McPherson, & Geeseman, 2002).
7. The supervisor with the supervisee *links* the original competencies document to the contract or agreement and to the evaluation procedures so that expected competencies are stated and assessed and ongoing feedback is given on progress. A competencies document (Hatcher & Lassiter, 2005) provides a prototype.

8. The supervisor reviews supervisee work with audio or video review and supervisee case notes.
9. The supervisor *facilitates inquiry* leading to supervisee self-awareness and reflective practice as features of the evaluation process (Falender & Shafranske, 2004).
10. The supervisor *models and engages* the supervisee in self-assessment and development of metacompetence from the onset of supervision and throughout.
11. The supervisor *provides ongoing feedback*, verbal and written, and *encourages and accepts* feedback from supervisee.
12. The supervisor *maintains communication and responsibility* for observing problems in the supervisory relationship.

Concluding Comments

Professional ethics requires that psychologists perform their professional responsibilities in a competent manner. This involves not only establishing benchmarks of competence during development and at the point of entry into the profession but also necessitates continuous professional development beyond licensure. A competency-based approach provides a model to consider the means by which we, as clinicians and supervisors, identify and meaningfully apply our knowledge, skills, and values to go beyond what we were originally taught and to apply that foundation of expertise to the presenting and at times unknown situations. As supervisors, we model this commitment.

The starting point in this process is the acknowledgement that competence is a dynamic construct in which expertise, established on habitual forms of practice, requires accommodation to the continuous advance of knowledge in the field. This requires clinicians and supervisors to abandon the comfort afforded by the subjective experience of expertise and to commit to processes of self-assessment in which the limits of what one knows are confronted. The ability to self-assess and to identify discrete domains for development is complex and, while initiated in clinical training, requires intrinsic motivation to carry on throughout one's career.

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