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# Providing Competency Training to Clinical Supervisors Through an Interactional Supervision Approach

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## Abstract

Training in supervisory competencies is essential to effective clinical practice and helps address the current national crisis in the behavioral health workforce. Interactional supervision, the approach used in the current study, is well established in clinical social work and focuses the task of the supervisee on the interpersonal exchanges encountered in clinical practice. This study examines the feasibility of supervisory competency training and associated gains in competencies among 81 clinical supervisors. Three types of competencies are assessed before and after training and at a 3-month follow-up—managing supervisory relationships, managing job performance, and promoting professional development. The results show that competency training is a feasible and potentially effective approach and is associated with supervisor satisfaction and stress management. The training employed is compatible with skills-based and intervention-specific supervisor training common among evidence-based treatments and is appropriate for use with clinical social workers, counseling and clinical psychologists, and psychiatric nurses.

## Keywords

supervisor competencies, interactional supervision, stress, satisfaction, workforce development

A recent consensus report by the independent Annapolis Coalition on the Behavioral Health Workforce identified several workforce challenges facing America's behavioral health system: a shortage and diminished pipeline of trained professionals, inadequate supervision, and the lack of workforce diversity and cultural competence (Hoge et al., 2007; Hoge et al., 2009; Stuart, Hoge, Morris, Adams, & Daniels, 2009). Similar concerns had been raised by the President's New Freedom Commission (2003) in its earlier report of "serious" problems in the nation's behavioral health workforce, including professional shortages and a lack of essential "education, training, or supervision."

In addition to mobilizing a call to action for behavioral health workforce development (Hoge et al., 2009; Stuart et al., 2009), these national reports draw on a growing empirical and professional literature that has identified the lack of training in supervision as a critical factor in increased supervisor stress and turnover, decreased supervisor work satisfaction, inadequate accountability of supervisees, and an inconsistent or diminished quality of care (Bruce & Austin, 2000; Butterworth, Bell, Jackson, & Pajnikihar, 2008; Hoge & Morris, 2002; Ladany, Ellis, & Friedlander, 1999; Powell & Brodsky, 2004; Shulman, 1991; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001; Tsui, 2005). A particular concern is the association between a lack of clinical supervision with supervisor stress and satisfaction (Knight, Broome, Edwards, & Flynn, 2009; Spence et al., 2001). Increased supervisor stress can disrupt the

supervisor-supervisee working alliance (Nelson, Barnes, Evans, & Triggiano, 2008; Sterner, 2009), is associated with staff burnout (Barling, Kelloway, & Frone, 2005; Knudsen, Ducharme, & Roman, 2008), and can lead to decreased supervisor satisfaction and increased turnover (Knight et al., 2009; Sterner, 2009).

We define supervision as a supportive professional relationship in which one individual has responsibility for and authority over the work and work life of another. This definition assumes that a positive and constructive supervisor-supervisee working relationship is critical to clinical practice and organizational accountability (Bernard & Goodyear, 1998; Bradley & Ladany, 2001; Shulman, 2005, 2011). It is also consistent with Kadushin's (1976) emphasis on a positive supervisor-supervisee relationship in social work practice as essential for carrying out "administrative, educational, and supportive" functions in supervision.

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With increased national recognition of the dearth in clinical supervision training, there is a growing consensus in the behavioral health field that relationship-centered supervision, while valuable, must be supplemented with training in supervisory competencies (Falender & Shafranske, 2004; Hoge et al., 2009; Schultz, 2008). Competency-based supervision “explicitly identifies the knowledge, skills, and values” that are combined to form a clinical expertise (Falender & Shafranske, 2007). Supervision training that emphasizes competencies encourages the development of “learning strategies and evaluation procedures” to ensure that supervision meets local standards of practice and accountability (Falender & Shafranske, 2007).

Almost 20 years ago, Shulman (1991, 1993) described a social work supervision approach he termed “interactional supervision.” Interactional supervision is relationship-centered and is based on the theory that the positive working relationship between supervisor and supervisee is the medium of supervisory influence (Shulman, 1991). Supervisory functions are understood through the various interactional contexts that the supervisee encounters in practice, such as interactions with the supervisor, others in the agency, clients, and individuals as collateral contacts (Shulman, 2005, 2011). Interactional supervision is now widely used in social work practice (Shulman, 2011), in part because it focuses supervisors on helping their supervisees develop practical competencies in managing key interactional contexts relevant to practice. Although previous research on interactional supervision has shown it to be a promising approach to supervision (Shulman, 1991, 1993), thus far, training in this approach has not been examined for its impact on supervisory competencies.

The current study reports on an initial test of training in core supervisory competencies through the use of an interactional supervision approach (Shulman, 1993, 2005, 2011). In addition, specific supervisory competencies are examined in relation to key factors associated with supervisor satisfaction and stress. This work is part of a broader transformation initiative in a northeastern state that seeks to provide clinicians in the adult mental health system with training in supervision to improve clinical practice.

### **Supervisory Competencies**

Three types of supervisory competencies are examined in this study: (a) managing supervisory relationships, which involves supervisory contracting and the creation of an agenda for each session; (b) managing job performance, which includes conveying clear expectations to the supervisee, conducting effective evaluations of supervisee performance, and assisting the supervisee to achieve compliance with agency requirements and adherence to agency standards; and (c) promoting professional development, which emphasizes establishing staff development plans in conjunction with the supervisee.

A growing literature has identified the components of each of these competencies as essential to effective clinical supervision. Evidence from a number of sources has indicated that

contracting is a critical component of competency-based supervision (Kavanagh, Spence, Wilson, & Crow, 2002; Kilminster, Cottrell, Grant, & Jolly, 2007; Shulman, 1993; Sutter, McPherson, & Geeseman, 2002; Thomas, 2007). Shulman (1991, 1993, 2011) and Kavanagh et al. (2002) show that sessional agendas and verbal contracts between the supervisor and supervisee facilitate the management of roles and expectations in the supervisor–supervisee relationship, and Thomas (2007) likens contracting to providing informed consent for clinical services. Sutter et al. (2002) further notes that contracting makes it more likely that legal and ethical standards are adhered to in both supervision and clinical care. Finally, several investigators (Manuel, Mullen, Fang, Bellamy, & Bledsoe, 2009; Stern, Alagia, Watson, & Morton, 2008) note that supervisor–supervisee contracting is essential in monitoring effective evidence-based social work practice.

In addition to monitoring practice, written or verbal contracting between the supervisor and supervisee provides a basis for measuring supervisee work progress and providing evaluative feedback (Shulman, 2011; Tsui, 2005), which is central to managing supervisee job performance. This is especially the case when goals are specified and operationalized and when evaluations are conducted in a timely, clear, and systematic manner (Lehrman-Waterman & Ladany, 2001; Tsui, 2005). Implementation of a competency-based evaluation approach is also related to positive reports of supervision by supervisees, such as reports of an effective working alliance, self-efficacy, perceptions of supervisor responsiveness and support, and satisfaction (Ladany et al., 1999; Lehrman-Waterman & Ladany, 2001; Nelson et al., 2008; Shulman, 1991, 2011; Stern et al., 2008).

Finally, the development of individualized professional development plans is associated with building effective supervisory relationships (Blackwell, Strohmer, Belcas, & Burton, 2002; Culbreth, 2001; Heckman-Stone, 2003; Powell & Brodsky, 2004; Thielsen & Leahy, 2001; Tsui, 2005). Such plans serve as a foundation for measuring work progress (Powell & Brodsky, 2004; Tsui, 2005), support supervisee achievement of learning goals (Fischetti & Lines, 2004; Herrin & Spears, 2007; Pintar, Capuano, & Rosser, 2007), and foster a positive supervisor–supervisee working relationship (Lehrman-Waterman & Ladany, 2001).

In recent years, there has been more of an emphasis on competency-based supervision (Falender & Shafranske, 2007; Kilminster, Jolly, & van der Vleuten, 2002), in part because of the growth of evidence-based treatments that require specific supervisee competencies when implementing services (Manuel et al., 2009; Palinkas et al., 2009; Stern et al., 2008). With a few exceptions (e.g., McMahon & Simons, 2004), supervision programs developed separately from evidence-based interventions have not been subjected to rigorous empirical test for their feasibility of implementation and the extent to which identified competencies were enhanced following training (e.g., Britton, Goodman, & Rak, 2002; Hancox, Lynch, Happell, & Biondo, 2004; Kaiser & Kuechler, 2008; Riess & Herman, 2008).

The current study reports on the feasibility and longitudinal impact of competency-based training in interactional supervision.

Although previous empirical work showed that this approach to supervision holds considerable promise in promoting supervisory competencies (Shulman, 1991), to date, there has been no empirical test of the impact of training in interactional supervision on such competencies.

Supervisor training is intended to provide the basis for subsequent, rigorous comparative trials and to allow for the incorporation of evidence-based practice models into the training. In this study, supervisor training is based on Shulman's interactional theory of clinical supervision in social work practice (1993, 2005, 2011) that specifies how the relationship between the supervisor and supervisee forms the basis for a positive working relationship with the client (Shulman, 1991, 1993, 2011). This approach is readily applicable to other behavioral health professionals such as counseling or clinical psychologists and psychiatric nurses (e.g., Bernard & Goodyear, 1998; Nelson, Gray, Friedlander, Ladany, & Walker, 2001; Spence et al., 2001).

In this study, assessments of self-reported supervisor competencies are made before and immediately after delivery of a 7-month supervisor competency training program and then at a 3-month follow-up. This is intended to demonstrate the feasibility of the training and the extent to which its longitudinal impact is consistent with expectations, an approach that draws on the stage model of intervention development in which direct variable relationships among interventions and intended outcomes are examined in an initial test of an intervention model (Carroll & Nuro, 2002; Rounsaville, Carroll, & Onken, 2001). In the current study, competencies are also examined for their relationship to supervisor satisfaction and stress management, factors that have been well established to be related to supervisory turnover (Kavanagh et al., 2003; Knight et al., 2009; Spence et al., 2001).

## Method

### Supervision Training

Supervision training consisted of 5 days (approximately 28 hours) delivered across a 7-month period. Supervisors initially completed 2 days of consecutive training, followed by a third day of training approximately 1 month later. Two training review days were also provided at 4 and 7 months after the initial training. One of the study authors (L.S.), a recognized expert in the use of interactional supervision in social work practice, conducted the training but was not involved in the administration of the measures to assess the training.

The focus of training was to strengthen the skill sets of supervisors in interactional supervision (Shulman, 1993, 2005, 2011). Training emphasized the importance of a positive supervisor-supervisee relationship characterized by trust and support (i.e., providing reassurance, fostering autonomy and self-esteem, and helping to manage stress) and the completion of key supervisory tasks. Training content was organized around four phases of supervision: (a) preliminary (or "tuning in")—before the initial supervisory meeting the

supervisor empathizes with the position of the supervisee; (b) beginning—development of a verbal or written contract that defines the purpose, roles, and responsibilities for supervision; (c) middle—use of the contract to guide supervision sessions; and (d) ending/transitions—if either the supervisee or supervisor leaves an agency or has work reassigned, effective termination with clients and staff, and completion of administrative requirements. A detailed description of the content for each day of supervisor training is provided in Table 1.

Four core supervisory functions were demonstrated across each phase: (a) practice (how the supervisee actually works with clients); (b) job management (how the supervisor helps the supervisee complete their daily work); (c) staff development (fostering supervisee competencies and providing evaluation and feedback); and (d) professional impact (helping a supervisee develop skills to make a professional contribution towards change within their own agency or others). Within these four core supervisory functions, the training leader illustrated essential skills in supervision, such as communication, relationship building, and group leadership, and encouraged participants to share their own experiences. Further discussion centered on how to supervise defensive staff members, manage staff apathy and resistance to change, understanding of the supervisor's role as teacher, and feeling "caught in the middle" between staff and administration. Finally, content focused on both individual and group supervision, and on core competencies essential to clinical supervision, such as managing supervisory relationships and supervisee job performance, and promoting professional development.

### Participants

A total of 81 supervisors participated in the training. Supervisors were employed in a state-operated facility and in three private nonprofit behavioral health agencies in a northeastern state. Characteristics of the sample are shown in Table 2. Most participants were female (76%) and currently licensed in their discipline (65%), with the majority licensed clinical social workers. Participants reported supervising about 8 supervisees per week for a total of 6.6 mean hours and reported that they spent more than two thirds (69%) of their supervision time providing individual supervision. Supervisors also reported about 16 years of direct service experience and 8 years of supervisory experience.

### Procedure

As is standard in a rigorous Stage 1 clinical trial (Carroll & Nuro, 2002; Rounsaville et al., 2001), the current study used a pre/post/follow-up design to assess training feasibility and impact. Thus, no comparison group was selected as the study was intended to (a) examine the feasibility of implementing the training as designed and (b) determine whether the impact of the training was consistent with expectations. As noted earlier, additional longitudinal analyses were conducted to assess expected relationships of supervisory competencies with

**Table 1.** Program Description

Method: The trainings, which were based on the approach to clinical supervision developed by Shulman (2011), integrated didactic and experientially based learning and included presentations, analysis of supervision examples, and discussions of case examples generated by the presenter and supervisors.

Day 1 Topics:

- Initiative and program purpose
- Overview of four phases of work
- Preliminary phase
- Beginning phase
- Middle phase
- Ending/Transitions phase
- Four core supervisory functions
- Practice
- Job management
- Staff development
- Professional impact
- Preliminary/Tuning In
- Being a new supervisor
- Beginning phase of supervision
- Stages of change
- Working with challenging staff members

Day 2 Topics:

- Middle/work phase
- Boundaries/ethical issues
- Role of supervisor as intermediary between front-line staff and administration
- Working with other supervisors and agencies

Day 3 Topics:

- Group supervision, issues of leadership, and managing group dynamics
- Dealing with issues of trauma (within agency or community) and the impact on practice

Day 4 Topics:

- Review of previous material and case examples
- Managing issues of diversity in supervision and client care
- Educational role of supervisor
- Discussion of evidence-based practice concepts in relation to supervisor's role/responsibilities

Day 5 Topics:

- Ending/Transitions
- Supervision of direct practice staff on issues of professional impact related to case management
- Working effectively with other professionals
- Follow up on case examples
- Identification of future areas of work

supervisor satisfaction and stress management in order to provide further support for this approach.

Surveys to assess training outcomes were conducted immediately before the training began (pretest/baseline), after the fourth day of training (posttest), and immediately after the last day of review training (follow-up). Participants in the trainings completed surveys developed specifically by the authors to evaluate the impact of this initiative. To ensure anonymity, respondents created a unique five-digit code that could be matched from one survey administration to another. The survey protocol was approved by the university institutional review board (IRB) in which the research took place.

**Table 2.** Characteristics of Supervisors (N = 81)

	%
Gender (Female)	76
Highest degree obtained	
<BA	4
BA/BS	14
Masters	75
PhD/MD	7
Licensed—All professions	65
LCSW	59
	M (SD)
Direct service (years)	16.05 (8.1)
Supervisory exp. (years)	7.98 (6.6)

### Measures

**Demographics.** The survey included items about respondents' gender, professional degree, years of supervisory and direct care experience, and the type and amount of supervision provided/received.

**Supervisory competencies.** Table 3 provides sample items used in a 14-item measure designed to assess self-perceived supervisor competencies. As shown in the table, supervisor competencies assessed were (a) managing supervisory relationships (developing a supervisory contract, developing an agenda for each session; 4 items; Cronbach's  $\alpha = .65$ ); (b) managing job performance (conveying clear expectations, conducting effective evaluations, achieving compliance with requirements, and achieving adherence to standards; 8 items; Cronbach's  $\alpha = .54$ ); and (c) promoting professional development (supporting staff development plans; 2 items; Cronbach's  $\alpha = .57$ ). For each item, respondents were asked to indicate their level of agreement on a scale from 1 (*Strongly disagree*) to 7 (*Strongly agree*); items were balanced and reverse-coded to reduce response bias. A summed composite score for each of the three competencies was created, with higher scores indicating greater self-perceived competencies.

**Satisfaction with supervision.** Satisfaction with supervision was measured using 3 items: "I am satisfied with my work as a supervisor," "I am satisfied with the amount of the supervision that I provide to direct care staff," and "I am satisfied with the quality of the supervision that I provide to direct care staff." For each item, respondents indicated their level of agreement on a scale from 1 (*Strongly disagree*) to 7 (*Strongly agree*). Scores on the 3 items were summed to create a satisfaction total score; with higher scores indicating greater satisfaction with supervision. Cronbach's alpha for this scale was .81.

**Management of supervisory stress.** Management of supervisory stress was measured using 2 items developed by Shulman (1991): "My job as a supervisor is manageable virtually all of the time" and "Being a supervisor causes me a great deal of stress." For each item, respondents indicated their level of agreement on a scale from 1 (*Strongly disagree*) to 7 (*Strongly agree*).

**Table 3.** Sample Items for Supervisor Competencies

Managing Supervisory Relationships	
Develop supervisory contract	I generally do not have a contract for supervision with my supervisees that guides our work.
Develop session agenda	My supervisees and I rarely have an agenda when we begin our supervision sessions.
Managing Job Performance	
Convey clear expectations	I routinely convey performance expectations to my supervisees.
Conduct effective evaluations	I complete detailed performance evaluations with my supervisees.
Achieve compliance with requirements	Supervisees' adherence to paperwork and administrative requirements is not very important.
Achieve adherence to standards	I try to make sure that my supervisees and I review whether they are adhering to practice models/standards.
Promoting Professional Development	
Support staff development plans	I encourage supervisees to identify their own goals for professional development.

agree). Scores on the 2 items were summed to create a supervisor stress management total score (the second item was reverse-coded); with higher scores indicating greater self-perceived ability to manage stress related to supervision. Cronbach's alpha for this scale was .69.

**Satisfaction with trainings.** On the final day of training, supervisors were asked to rate their satisfaction with the training from 1 (*Unsatisfactory*) to 5 (*Outstanding*) in four areas: (a) content; (b) readings, materials, and visual aids; (c) teaching ability of the trainer; and (d) overall.

### Data Analyses

Descriptive statistics were conducted to summarize demographic characteristics of the sample, and Pearson correlations were then computed to examine the relationships among all continuous variables. In order to evaluate the effects of the supervision training, a repeated measures, linear mixed-effects model was used (Cnaan, Laird, & Slasor, 1997). Also known as an individual growth model (Singer, 1998), this method of analysis is implemented with longitudinal data by allowing individual intercepts and slopes to vary across persons and modeling the between-person variance or by assuming that individual intercepts and slopes are constant and modeling the within-person error covariance structure (Gueorguieva & Krystal, 2004; Singer, 1998). The latter approach was chosen for the current analysis to allow time to be treated as a categorical factor and comparisons between time points to be made,

similar to what is done with traditional repeated measures analysis of variance. However, unlike repeated measures analysis of variance (ANOVA), this approach allows for the incorporation of correlated and incomplete data as well as unequal variances (Gueorguieva & Krystal, 2004). For the current analyses, estimated marginal means were calculated at each time and compared as in a traditional repeated measures analysis. To examine the effect of the training on supervisory competencies, a linear mixed-effects model was used to compare the three supervisor competency scores at each time point (baseline, posttest, and follow-up), and results were expressed as effect sizes to allow for direct comparison of scores. Statistical package for the social sciences (SPSS) was used to compare Cohen's *d* for these analyses (PASW, 2010).

A second set of analyses was then conducted to examine how changes in supervisor competencies impacted supervisor job satisfaction and supervisor stress management. In this second linear mixed-effects model, time was treated as a continuous variable to allow for an estimate of the rate of change per month in supervisor job satisfaction and supervisor stress management. This analysis first uses an unconditional growth model to determine the average monthly rate of change in the outcome (i.e., supervisor job satisfaction and supervisor stress management) without including other covariates in the model. Next, a conditional growth model is estimated where time varying covariates (i.e., the three supervisor competencies) are included in the model as predictors of supervisor satisfaction and supervisor stress management. SPSS was also used in these analyses with effect sizes shown as regression coefficients.

### Results

A total of 45 supervisors completed pre- and posttest surveys (56% retention rate) and 34 supervisors completed all three administrations of the survey over the 7-month study period (42% retention rate). Attrition analyses indicated that the group of supervisors who completed all three trainings consisted of a slightly higher proportion of females (82% vs. 76%), individuals with master's degrees (88% vs. 75%), and licensed supervisors (85% vs. 65%); but no significant differences in pretest supervisory competencies scores were observed. Licensed clinical social workers were able to obtain continuing education credits for participating in all 5 days of the training, perhaps, accounting for the differential participation rates over the 7-month study period.

Overall, supervisors' ratings of their satisfaction with the training sessions indicated moderate-to-high satisfaction with training. Mean (and standard deviation) scores in each of the four areas assessed were positive: (a) content, 3.37 (.76); (b) readings, materials, and visual aids, 3.07 (.83); (c) teaching ability of the trainer, 3.83 (.79); and (d) overall rating for the training, 3.50 (.82). One half of the participants (50%) rated the *overall training* as excellent or outstanding and 90% rated it as good to outstanding.

As shown in Table 4, correlational analyses revealed significant positive relationships among all three competencies

**Table 4.** Correlations and Descriptive Statistics for Study Variables (*N* = 81)

Variables	<i>M</i> ( <i>SD</i> )	1	2	3	4	5
Managing Supervisory Relationships	4.61 (1.10) [4.37, 4.85]	—				
Managing Job Performance	5.57 (.68) [5.42, 5.72]	.57*** [.41, .71]	—			
Promoting Professional Development	5.17 (1.15) [4.92, 5.42]	.32** [.11, .50]	.46*** [.28, .62]	—		
Satisfaction with Supervision	4.62 (1.12) [4.38, 4.86]	.55*** [.38, .69]	.44*** [.25, .60]	.27** [.05, .46]	—	
Supervisor Stress Management	4.01 (1.40) [3.71, 4.31]	.28** [.07, .47]	.08 [−.14, .29]	.05 [−.17, .27]	.32** [.11, .50]	—

Note. Numbers in brackets are 95% confidence intervals; the left column shows confidence intervals for means and the remaining columns show confidence intervals for correlations.

\*\* *p* < .01.

\*\*\* *p* < .001.

assessed (managing supervisory relationships, managing job performance, and promoting professional development). There was also a significant positive relationship between supervisors' satisfaction with supervision and all three competencies assessed. Management of supervisory stress was significantly and positively related only to managing supervisory relationships but not the other two competencies. Furthermore, there was a significant positive correlation between management of satisfaction with supervision and the management of supervisory stress.

**Effects of Training on Supervisor Competencies**

Table 5 displays the means, standard deviations, changes in mean scores, and the effect sizes of the training. These values were obtained from unconditional growth models for the three supervisory competencies using the covariance pattern method. An unstructured within-person error covariance matrix was determined to have the best goodness of fit by the Akaike's Information Criteria. As shown, there is a statistically significant increase in supervisors' competencies from baseline (Time 1) to follow-up (Time 3) in all areas assessed: managing supervisory relationships, managing job performance, and promoting professional development. Examination of the means and standard deviations over time revealed substantial changes in effect sizes in these competencies. The effect size from Time 1 to Time 3 for managing supervisory relationships was large (.67) and the effect sizes for managing job performance (.42) and promoting professional development (.40) for the same period were moderate. The table also shows minimal to small effect sizes from Time 2 to Time 3 that were not statistically significant, but moderate and statistically significant changes were observed for managing supervisory relationships (.52) and managing job performance (.42) from Time 1 to Time 2.

**Factors That Predict Change in Satisfaction With Supervision and Supervisor Stress Management**

A linear mixed-effects model was also used to examine how changes in supervisor competencies across the 7-month study period impacted supervisor job satisfaction and supervisor stress management. Results for unstandardized mean-

centered predictors are reported in Table 6. The first column (No Predictors) represents regression coefficients from an unconditional growth model that illustrates the average change in supervisor satisfaction and supervisor stress management. The average monthly increase in satisfaction was significant and approached a value of almost .05 units (.046), while the average monthly increase in the management of supervisory stress was highly significant and was almost .07 units (.067). This shows that as supervisors' competencies increase, satisfaction with supervision and supervisor stress management, respectively, also increase. Next, the factors that predicted change in supervisor satisfaction and supervisory stress were examined through a conditional growth model. Column 2 (Predictors) indicates that increases in supervisor competencies are associated with increased supervisor satisfaction and supervisor stress management. Specifically, managing supervisory relationships and managing job performance significantly predict increases in supervisor satisfaction about equally (.344 and .340, respectively), but an increase in supervisor satisfaction is not related to promoting professional development. Finally, only managing supervisory relationships significantly predicts increases in supervisor stress management (.223). Managing job performance and promoting professional development are not related to changes in supervisor stress management.

**Discussion and Applications to Practice**

The current study summarizes results of competency training for clinical supervisors using an interactional supervision approach. The results provide evidence to support: (a) the feasibility of the training model employed, (b) the stability and growth of perceived competencies gained over a 7-month period, and (c) the relationship of competencies to increases in supervisor satisfaction and supervisor stress management. As hypothesized, training in interactional supervision was associated with significant increases in supervisors' perceived ability to manage supervisory relationships, manage supervisee job performance, and promote the professional development of their supervisees. The largest gains following training were observed 7 months after the training program began, with large effect sizes found for managing supervisory relationships and moderate effects sizes found for managing job performance

**Table 5.** Mixed-Model Effects of Supervision Training on Supervisors ( $N = 81, 45, 34$ )

Components	Time 1: Pretest Mean (SD) [95% CI]	Time 2: Posttest Mean (SD) [95% CI]	Time 3: Posttest 2 Mean (SD) [95% C.I.]	Effect Size (d) Time 1–Time 2	Effect Size (d) Time 2–Time 3	Effect Size (d) Time 1–Time 3
Managing Supervisory Relationships	4.61 (1.10) [4.37, 4.85]	5.15 (0.94) [4.90, 5.41]	5.33 (0.99) [5.03, 5.63]	.52***	.19	.67***
Managing Job Performance	5.57 (0.68) [5.42, 5.73]	5.84 (0.57) [5.68, 6.00]	5.85 (0.66) [5.64, 6.07]	.42**	.02	.42*
Promoting Professional Development	5.17 (1.15) [4.91, 5.42]	5.37 (1.25) [5.00, 5.73]	5.60 (0.91) [5.31, 5.90]	.17	.21	.40**

Note. Numbers in brackets are 95% confidence intervals for means.

\*  $p < .05$ .

\*\*  $p < .01$ .

\*\*\*  $p < .001$ .

**Table 6.** Mixed-Model Repeated Measure Regression Coefficients for Satisfaction With Supervision and the Supervisor Stress Management, Times 1–3 ( $N = 81$ )

Variable	No Predictors B (Unstandardized $\beta$ )	Predictors B (Unstandardized $\beta$ )
Satisfaction with Supervision		
Initial Status	4.56*** [4.32, 4.81]	4.70*** [4.50, 4.91]
Months	0.05* [0.01, 0.08]	0.01 [–0.02, 0.04]
Managing Supervisory Relationships		0.34*** [0.19, 0.50]
Managing Job Performance		0.34** [0.09, 0.60]
Promoting Professional Development		0.06 [–0.08, 0.19]
Supervisor Stress Management		
Initial Status	4.00*** [3.69, 4.30]	4.06*** [3.75, 4.36]
Months	0.07*** [0.03, 0.10]	0.05* [0.01, 0.09]
Managing Supervisory Relationships		0.23* [0.02, 0.43]
Managing Job Performance		0.08 [–0.25, 0.42]
Promoting Professional Development		–0.12 [–0.29, 0.06]

Note. Numbers in brackets are 95% confidence intervals for regression coefficients.

\*  $p < .05$ .

\*\*  $p < .01$ .

\*\*\*  $p < .001$ .

and promoting professional development, respectively. One explanation for the increased gains in competencies over time is that as supervisors had more opportunity to use the skills they were taught in the training program, their perceived competencies increased.

Another important finding from this study was the extent to which the competencies assessed were significantly related to increases in supervisor satisfaction and supervisor stress management, two factors previously shown to be related to supervisor turnover (Knight et al., 2009; Ladany et al., 1999; Sterner, 2009) and staff burnout (Barling et al., 2005; Knudsen et al., 2008). Managing supervisory relationships (i.e., supervisory contracting and creating agendas for each session) was related to increases in supervisor satisfaction and the management of supervisor stress, a finding consistent with previous research (Kavanagh et al., 2002; Kilminster et al., 2007; Sutter et al., 2002). Another competency, managing job performance (i.e., conveying clear performance expectations, conducting effective evaluations, and ensuring

compliance with agency and professional standards) was related only to increases in supervisory satisfaction. Although this finding was consistent with the literature (Blackwell et al., 2002; Nelson et al., 2008; Tsui, 2005), the lack of a significant relationship between managing job performance to increases in supervisor stress management is a departure from previous work (Falender & Shafranske, 2004; Tsui, 2005). Finally, a surprising finding was the lack of association observed between the promotion of professional development in one's supervisee and either supervisor satisfaction or stress management. Although previous research had shown that promoting professional development is critical to supervisees (Fishetti & Lines, 2004; Herrin & Spears, 2007; Pintar et al., 2007; Powell & Brodsky, 2004), this study suggests that doing so may not be related to increases in supervisor satisfaction and stress management. One possible reason for this finding is that the study period may have been too brief for supervisees to participate in and demonstrate gains from professional development activities.



### Study Limitations and Directions for Future Research

One limitation of the current study was the lack of a control or comparison group that would allow one to rule out threats to internal validity. Importantly, however, Phase I feasibility trials typically do not include a comparison group (Carroll & Nuro, 2002; Rounsaville et al., 2001) because the primary research objectives are to determine (a) whether it is feasible to implement the intervention as designed and (b) whether its primary effects are consistent with theoretical expectations and sustained over time. On each of these objectives, the current study was successful. Nevertheless, it is conceivable that implementation of a placebo or no-intervention group could also have yielded increases in supervisory competencies, although perhaps not as dramatic as the gains observed. Future research must determine whether the gains in competencies observed are sustained in a new sample, whether they remain as strong when examined in relation to a control or comparison group, and whether aspects of the implementation and its evaluation (e.g., testing, recruitment, etc.) may have contributed to the effects observed.

Two measurement limitations of the current study is that supervisor self-reports were used to assess competencies and that reliability estimates for two of the supervisor competencies scales—managing job performance (.54) and promoting professional development (.57)—were modest. The use of self-reports reveals that gains observed were in *perceived* supervisor competencies, which may not be identical to observed competencies. Since supervisors had invested considerable time and effort to attend the trainings and had also obtained release time from their employers to do so, it is possible that their self-ratings may have been inflated. This limitation should be examined in future research, perhaps, by having supervisors complete vignettes aligned with the training material that are rated for skill acquisition or by having supervisees rate their supervisors on various competencies before and after training, a practice consistent with fidelity monitoring in evidence-based interventions (Manuel et al., 2009; Palinkas et al., 2009; Tebes, Kaufman, & Connell, 2003). Modest reliability estimates for two of the supervisor competency scales may have been due to too small a pool of items upon which these assessments were based. Future research should expand the number of items used to assess supervisor competencies to increase reliability.

Another limitation of the current study is that the relative importance of specific training components remains unknown. In this study, 5 days of training were provided over a 7-month period and all substantive new training was completed by the fourth month. To what extent would a different configuration or timing of training have altered the results? Previous research has suggested that training over a longer period (e.g., Sundin, Ogren, & Boethius, 2008) or more intensive training (e.g., McMahon & Simons, 2004) are also successful supervisor training strategies that may be useful to examine in future research.

Despite these limitations, the current study has several notable strengths: (a) the intervention was based on a theoretically based approach to clinical supervision that is well established in social work practice; (b) the measures employed were sensitive to perceived changes in supervisory competencies emphasized in the training; (c) the design examined changes in competencies and related variables at three points in time; and (d) the data analyses took into account missing data so as to utilize sample responses at any point in the training, thus, providing a robust test of the study hypotheses.

### Implications

This study has several implications for practice. First, it examines a relatively brief, empirically promising approach for training clinical social workers in competencies essential to providing clinical supervision and consultation. Such training is consistent with National Association of Social Workers (NASW) clinical standards (NASW, 2004) and may be particularly useful for social workers who are relatively new to clinical supervision.

A second practice implication is that supervisor competency training in interactional supervision is compatible with training provided for a wide range of evidence-based treatments (e.g., Trauma-Focused Cognitive Behavioral Therapy [CBT], Multi-Systemic Therapy, etc.). An interactional supervision approach can be readily aligned with other, more skills-based empirically supported treatments because its primary focus is on the supervisor–supervisee relationship and not on the specific content of clinical practice. Thus, it may serve as a bridge for the integration of evidence-based practice into clinical social work training programs, a development that some have argued is essential for the continued survival of the field (McNeece & Thyer, 2004). Further training in interactional supervision can also help address the concern identified by Bledsoe et al. (2007) that less than 40% of graduate programs in social work currently provide training in evidence-based treatments. One barrier to implementing evidence-based treatments is that supervisory approaches must be compatible with supervision that focuses on skills-based content (Stern et al., 2008) while also integrating relationship-centered supervision, that latter approach being common in most clinical practice fields (Vanderploeg, Franks, Plant, Cloud, & Tebes, 2007). Competency training in interactional supervision provides a framework for providing supervisees with ongoing relationship-centered support while allowing for skills-based and intervention-specific supervision common in evidence-based practice.

Finally, the current study lays the empirical foundation for future research on the utility and effectiveness of competency training for clinical supervisors using an interactional supervision approach. Such training would be examined in a Phase II trial that would include a control or comparison group and utilize vignettes and supervisee ratings to provide independent assessments of supervisor competencies.

## Conclusion

Competency training for clinical supervisors using interactional supervision is a feasible and potentially effective approach for supervisor training. The training provided emphasized three supervisory competencies—managing supervisory relationships, managing supervisee job performance, and promoting professional development—that complement the more skills-based and intervention-specific supervisor competencies essential to a variety of evidence-based treatments. Although the supervisor competency training examined in this study is well established in clinical social work, it is also appropriate for use in counseling or clinical psychology and psychiatric nursing.

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