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Supervision of Primary Care Behavioral Health Trainees: A Survey of Current Practices

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by

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We, the undersigned committee,
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"Supervision of Primary Care Behavioral Health Trainees:
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Abstract

Supervision of Primary Care Behavioral Health Trainees:
A Survey of Current Practices
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The current study surveyed 39 supervisors of primary care (PC) psychology trainees at the practicum, internship, and postdoctoral levels regarding various aspects of training, including structure and techniques used, expected competencies, perceived barriers, and their own supervision training received. These results provide a descriptive analysis of current practices of the sampled PC psychology supervisors, which are intended to inform development of best practices in supervision of PC psychology trainees. No statistically significant group differences between training levels regarding the number of competencies trainees were expected to achieve prior to program entry were found; however, sample size was a limitation. Implications for current trainers and supervisors in PC psychology are offered, in the context of precepting as a useful technique and approach to supervision of PC psychology trainees.

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Acknowledgments

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"Mentoring is a brain to pick, an ear to listen,
and a push in the right direction." -John C. Crosby

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Introduction

Lightner Witmer, born in 1867, is considered to be the founding father of clinical psychology. Initially a strictly experimental psychologist, trained at the University of Pennsylvania (Penn) and in Leipzig under William Wundt's tutelage, Witmer went on to become a founding member of the American Psychological Association (APA) in 1892. In this academic year (1892 – 1893), Witmer became a professor of psychology at the University of Pennsylvania. In 1893, Penn began developing a curriculum offering continuing education courses to local public school teachers on evenings and weekends. Witmer, being a part of this curriculum, further explored his professional interest in child psychology, and in 1896, his career experienced "a shift from an exclusive commitment to psychology as a pure science – experimental psychology – to a parallel, and eventually stronger, commitment to psychology as a practical, helping profession" (McReynolds ,1997, p. 71). During this year, Witmer established a "psychological clinic" at the University of Pennsylvania, which was the world's first of its kind as a "facility that had not existed before but that a half century later would be commonplace" (p. 71). A cultural milieu of an appreciation for practical and pragmatic endeavors, plus the inception of pediatrics as a medical specialty and the rise of developmental psychology, Witmer's clinic's first case was a boy who had a learning disorder, which would later be considered *dyslexia*. Witmer began to receive more child patients at his clinic that had problems of learning or general developmental

disorders, which he spent several hours with weekly to "train these children" (p. 77). An interesting development, which will have great relevance in a later section of this current study, was Witmer's publication of an editorial piece in the new journal *Pediatrics* in 1896 titled "The Common Interests of Child Psychology and Pediatrics," in which he argued precociously for a collaborative approach between psychologists and physicians. The term precocious is used here because clinical, or applied professional, psychology was yet to be recognized as a separate helping profession on par with medicine.

Around 1904, Witmer was emphasizing the need to begin training students for this "new profession," that of "practicing psychological expert" (McReynolds, 1997, p. 122), and in 1907 he published an article, "Clinical Psychology," in his edited journal *The Psychological Clinic,* which served to formally name the profession, require of it a doctoral level education, compare it to medicine, sociology, and pedagogy, and engender in it interest from potential students. Witmer's use of the term, the first American use of this terminology, "was conceived precisely to delineate a distinct new professional area, and it is from this terminological beginning that the present, many-faceted profession and discipline has grown" (p. 132). Within the first ten years of the Psychological Clinic (1896 – 1907), McReynolds (1997) noted that Witmer had "no master mentor or clinical supervisor, because none existed" (p.120), as it was Witmer who created the profession himself without any previous formal definition for or recognition of it.

However, McReynolds also reported Witmer's likely use of consultation with physicians, teachers, school principals, and other budding psychologists.

Thus, the roots of modern-day clinical psychology arose from the zeitgeist of early 20th century America and the professional pursuits of a classically educated experimental psychologist with a passion for practical application of education and research. During the period of time between 1915 – 1940's, the Department of Psychology at Penn, with Witmer as the heading faculty,

> had been the largest producer of trained clinical psychologists…since the origins of the profession…[and] was the only program anywhere to offer what would later come to be accepted as the full panoply of clinical psychological training, that is, basic courses in scientific psychology, a variety of clinical courses specifically designed to prepare the graduate for direct practice, and an extensive supervised clinical experience, all organized within a standard doctoral program. (p. 189)

The structure of this program was largely in place by 1915, which demonstrates the integral nature of clinical supervision in the graduate training of a clinical psychologist. Falender and Shafranske (2004) described the nature of the supervisory relationship as an "experiential foundation for the psychologist's knowledge, skills, and values to be consolidated and applied" (p. 3). Essentially, they purport, supervision is the point of synthesis or coalescing of the entire professional identity for a future psychologist, a role which arguably makes

supervision an indispensable element of training programs. Given the gravity of this training modality, scholarly attention is highly warranted in this area from various perspectives (conceptual, theoretical, and research-oriented) to promote the effective, competent, and ethical practice of supervision.

The current study aims to further theory and research efforts in psychological supervision, specifically for psychologists in the integrated primary care (medical) setting by exploring the supervisory practices of professionals currently in the field. This research is needed because relatively little is officially known about supervision in this specialty area, partially because research of supervision in general received little attention until very recently within psychology, and partially because this specialization is relatively new and, therefore, evolving in terms of the professional demands and expectations. However, before discussing supervision in such a specific context, the next few sections will provide a historical account of supervision in clinical psychology, including its function and roles, as necessary context for the aim of the current research.

Review of the Literature

What Is Supervision?

As the founder of the field, Lightner Witmer and colleagues created the first training curriculum for clinical psychology graduate students from the ground up. These individuals likely drew from what was known of the supervisory methods in similar professions, such as medicine, social work, and psychiatry. Naturally, the name alone – *supervision* – denotes the basic function and structure of the practice. *Supervise*, according to Online Etymology Dictionary (n.d.), has Medieval Latin roots (*supervisus*, *supervidere*) meaning "to oversee and superintend the work or performance of others." However, this simple dictionary definition hardly encapsulates or explains the vast array of responsibilities, expectations, and the methods used by supervisors within clinical psychology to fulfill the role. A better comparison is the concept of apprenticeship in which an expert oversees a novice's acquisition and development of required skills within a specialized guild or trade. This relationship at least alludes to a teacher-learner aspect of the relationship. Because supervision in clinical psychology began with an emphasis on the authority of the supervisor, the structure and function of supervision naturally followed the course of a master-apprentice-style relationship. According to Falender and Shafranske (2004), since its beginnings and until the late 1950's supervision's main function and concern was with the functioning and dynamics of the patient. However, around 1960, the practice began to evolve from a

predominant or sole focus on the supervisee's patient to inclusion of the psychology of the supervisee in terms of both the content and process of supervision. This shift marked an important point in the evolution of the field as it greatly expanded the function and goals of supervision, both for the supervisor and supervisee. Before examining those aspects of supervision, it would be helpful to provide a definition of the practice within the helping professions. Bernard and Goodyear (2009) offered a very broad definition of supervision as

> an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship 1) is evaluative and hierarchical, 2) extends over time, and 3) has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for those who are to enter the particular profession. (p. 7)

This definition was proposed by them in 1992, but it has remained virtually unchanged because it is general enough (i.e., applicable to various professions), yet descriptive enough (i.e., addresses the critical elements of mode, structure, time, and goals) to stand the test of both time and interdisciplinary application. Alternatively, Falender and Shafranske (2004) offered a slightly more specific definition of supervision in psychology as:

> a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involves observation, evaluation, feedback, the facilitation of supervisee self-assessment, and the acquisition of knowledge and skills by instruction, modeling, and mutual problem solving. In addition, by building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy. Supervision ensures that clinical consultation is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large. (p. 3)

The current study proposes a third rendering that combines and slightly modifies the two interpretations above for a more comprehensive working definition of the practice of supervision as it occurs today within clinical psychology. The modification involves focusing on the expectations of each of the individuals (supervisor and supervisee) within the relationship. From this angle, supervision can be seen as a collaborative relationship forged over time between a more experienced member of the profession (supervisor) and a less experienced member of the profession who usually lacks full credentials (supervisee). This relationship is intended to be the theater in which the supervisor transmits professionally relevant knowledge and skills to the supervisee to ensure competent

provision of clinical services from supervisee to patient. This process is expected to protect and promote the welfare of current and future clients, the profession, and society at large as well as promote the growth and development of the supervisee in order to eventually render him/her an *effective, independent* practitioner (i.e., gatekeeping). To reach these goals, the supervisor is generally expected to engage in practices that promote the professional development of the supervisee to include observation, evaluation, feedback, instruction, modeling, support, problem-solving, and appropriate scaffolding (resulting from accurate identification of supervisee's strengths and weaknesses). Meanwhile, the supervisee is expected to be observed and evaluated, receive instruction and feedback, witness modeling, mutually problem-solve, and practice self-evaluation in terms of relevant strengths and weaknesses in order to continually build professional knowledge and skill necessary to eventually *independently* maintain a competent, science-informed practice (i.e., self-supervise). This definition is lengthy, but likely helpful in terms of the pragmatics of the practice, particularly considering that the recommended custom is to start the relationship with an explicit contract between each member as to the scope and expectations of the working relationship (Corey et al., 2010).

Functions, goals, and roles of supervision. Today's supervision has evolved to include various functions and goals way beyond the original singular focus on patient dynamics. Corey et al. (2010) proposed four distinct goals, or purposes, of supervision in the helping professions. The first goal, which many

supervisors see as their primary one, is to promote supervisee growth and development. The supervisory techniques are all aimed at teaching the supervisee how to effectively provide clinical psychology services, whether psychotherapy, assessment, consultation, etc. However, beyond solely clinical competence, this goal also addresses socialization to the profession in the fullest sense to include cultivation of professional values and identity as well as career goals and commitments (Corey et al., 2010; Falender & Shafranske, 2004).

Corey et al.'s (2010) second goal of supervision is to protect the welfare of the client. The requirement that all unlicensed professionals receive a minimum level-specific amount of supervision is to ensure the safety of all current and future clients. Supervisors are expected to monitor supervisees' work with clients to confirm they are providing a competent and professional service. If at any point the appropriate standard of care is not being met by the supervisee, the supervisor is expected to intervene in whatever way necessary to prevent or correct any inappropriate treatment. Falender and Shafranske (2004) identified the "quality assurance" function of supervision as paramount to all others (educative, training and evaluative), ostensibly due to the ethical, legal, and reputational implications for the supervisor and profession at large.

Supervisors are also expected to monitor and assess the supervisees' performance in order to operate as a gatekeeper for the profession. Supervisors evaluate clinical competence as well as other personal qualities of the supervisee to

determine suitability for the profession. There is an awareness of the potential for damage that can be caused by an unsupervised mental health professional who possesses certain harmful traits and/or lacks certain important qualities or competencies. Intra- and interpersonal dynamics, capacity for professionalism, and clinical proficiency are all important factors in determining whether an individual is capable of becoming an ethical and competent *independent* practitioner. Therefore, gatekeeping is an ethical imperative as it protects future clients/patients, while also preserving the integrity of the field. If a supervisee is identified as a trainee with problems of professional competence (TPPC), the supervisor will likely have a role in the remediation and/or dismissal of the individual. Because of the close level of overseeing by supervisors, they are usually the first and most likely point of discovery of TPPC, which makes gatekeeping, while not the primary function of supervision, an indispensable one (Bodner, 2012; Corey et al., 2010).

Lastly, Corey et al. (2010) stated supervision's fourth goal is to empower the supervisee to self-supervise and effectively operate with increasing independence and confidence. Indeed, an extremely important and expected outcome of supervision is internalization of the practice, or the ability to self-supervise. Supervisors assist the supervisee in fostering the necessary skills, awareness, and resources to be able to effectively self-monitor and self-evaluate. Through this process and the various techniques supervisors may implement to achieve this goal, the supervisee grows more confident in his/her ability to

effectively solve problems and make decisions related to their professional roles. The nature of the profession is such that it is impossible to completely separate the quality of service provided by a professional psychologist from the personal functioning of that individual. Indeed, the primary "instrument" of the profession, especially in the case of psychotherapy, is the self of the psychologist. Therefore, self-exploration and self-discovery are natural, and arguably necessary, processes in accomplishing this goal of supervision, which speaks to the personal, as well as professional, growth that supervision can foster. Again, not the paramount purpose of supervision, but one that occurs simultaneously alongside all other functions and, if met, will indicate that all other goals have been well-achieved. Corey et al. (2010) explained that

> a competent professional will be able to monitor his or her own performance, be aware of the limits of his or her competence, be able to identify how personal issues affect professional practice, and know when and how to seek consultation and additional supervision as a self-supervisor. (p. 7)

Thus, *successful* empowerment of the supervisee promotes the protection of client welfare, enables continuation of professional (and personal) growth and development, and meets gatekeeping obligations (i.e., all the other important purposes of supervision).

In carrying out these functions and aiming for these goals, which usually are accomplished simultaneously, rather than hierarchically or sequentially, supervisors may wear many hats as they address the supervisory needs moment to moment. Corey et al. (2010) identified eleven roles a supervisor in a helping profession might take on even within a single supervision session – teacher/coach, mentor, consultant, counselor, sounding board, adviser, administrator, evaluator, recorder/documenter, empowerer, and advocate. Factors, such as the setting of clinical work and supervision, level of training of the supervisee, and objectives of the supervision, determine which roles the supervisor is more or less likely to execute within the relationship.

Types of supervision. Within clinical psychology, there are two general types, or categories, of supervision that can be provided – clinical and administrative (Corey et al., 2010). Clinical supervision focuses on the quality of the clinical service being rendered, such as technical proficiency and related ethical matters. Administrative supervision is concerned with a supervisee's responsibilities as an organization's employee, such as personnel matters, time keeping, documentation, etc. Administrative issues versus clinical issues are even difficult to fully tease apart as a practitioner since each category can have bearing on the other. Likewise, the distinction may seem like an unnecessary, and difficult, one to make in terms of supervision, especially since they are both commonly provided by the same individual and overlap one another. However, the delineation

is important because sometimes these two types of supervision are provided to the same supervisee by different individuals or entities, and sometimes administrative supervision (e.g., staff meetings and administrative oversight) is mistaken for clinical supervision. While important and usually necessary, administrative supervision alone is not sufficient for the supervision needs of a psychologist in training and, if not provided, is a serious deficiency in the training curriculum. An omission of this nature could occur, for example, if the primary supervisor has not received sufficient training in supervision and is operating beyond his/her scope of competence.

Approaches to Supervision in Clinical Psychology – A Brief Overview

Falender and Shafranske (2004) described four distinctly different general approaches to supervision in psychology – psychotherapy-based approach, developmental approach, process-oriented approach, and competency-based approach.

Psychotherapy-based models. Psychotherapy-based approaches are considered "extensions of psychotherapy" (p. 9), since the original and early methods of supervision were largely rooted in psychotherapy practices themselves rather than created solely and distinctly for the purpose of supervision. Eventually, from this approach, supervision models were outlined by contributors within many of the major theoretical orientations of psychotherapy, including psychodynamic, cognitive and cognitive-behavioral, client-centered and existential-humanistic,

intersubjective/constructivist, and systemic and family systems. Naturally, these psychotherapy-based approaches influence the type of client data observed and reported as well as the significance of and interpretation of that information, which extends to supervision within that therapeutic model. For example, affective reactions and subjective experiences are likely of more importance than thought and behavior patterns to a supervisor of psychodynamic psychotherapy, while the opposite is likely true for a supervisor of cognitive-behavioral psychotherapy. Similarly, interventions specific to each theory-based model of psychotherapy have certain associated skills, which a supervisee must learn and practice, which naturally affect the course of supervision. To that end, psychotherapy-based approaches often oblige the supervisee to apply such interventions to him/herself and/or to the supervisory relationship. For example, cognitive therapy supervisees may be asked to dispute their own irrational thoughts within the context of supervision and the supervisor may model this as well; systemic supervisors will consider the functions and roles of the entire system as they conduct supervision; and narrative supervisors are likely to explore the supervisee's constructed reality of the relationships between supervisor, supervisee, and client. Additionally, some strategies that have proven helpful in the treatment context may be adapted and incorporated into supervisory practices, such as a cognitive-behavioral supervisor being likely to utilize agenda-setting and homework in supervision. Certainly, a theoretical orientation contributes to and shapes one's worldview and beliefs about

best practices for learning. Thus, some incorporation of psychotherapy theory, interventions, techniques, and strategies is inevitable in supervision (Bernard & Goodyear, 2009). Falender and Shafranske (2004) pointed out the advantage that psychotherapy-based approaches offer, such as providing real-life context for modeling and experiencing the theoretical model in action and for providing seamless consistency and reinforcing theoretical concepts, which foster learning. However, they also caution that pure psychotherapy-based approaches are too narrow in focus in terms of the broad range of the goals of supervision, especially since psychotherapy and supervision have distinctly different purposes.

Developmental models. While a psychotherapy-based approach was the popular default in terms of supervision for many decades, alternative approaches emerged with the recognition that supervision as a mere echo of psychotherapy is too limited to accomplish all of supervision's growing goals. Developed specifically for the dynamics and purposes of the supervisory relationship itself, the developmental approach is metatheoretical (i.e., applicable to supervision within the context of any psychotherapy model). The most comprehensive of this approach is the integrated developmental model (IDM), originally credited to Stoltenberg (1981) and refined by Stoltenberg and others since, which outlines a probable progression over time of beginner supervisees in terms of their needs, motivations, anxieties, skills, challenges and differential attributes as they progress through supervision training (Stoltenberg & McNeill, 1997).

The IDM provides supervisee prototypes at each level of professional development, from total beginner to a well-developed professional on the verge of fully independent practice. In this approach, supervisors use three overriding structures to monitor supervisee development – Self and Other Awareness (Cognitive and Affective), Motivation, and Autonomy – through various domains of clinical training at three levels (Level 1, Level 2, and Level 3). This model outlines the developmental issues common to each level and markers that indicate resolution or mastery of those issues and progression to the next level. For example, according to the IDM, a beginner supervisee is relatively a novice practitioner with high motivation to learn but also high performance anxiety, and thus, high dependence on the supervisor for guidance, with limited self-awareness and a high focus on self. At Level 2, motivation to learn new techniques is likely to wane once they are operating comfortably with initial techniques. Confidence is higher but likely to vacillate greatly depending upon the responsibilities, and the supervisee is able to function with more independence, and can shift focus more toward the client. By Level 3, supervisee motivation is stable, doubts are not crippling, and focus can effectively be devoted to total professional identity and therapist role. Level 3 supervisees have a confidence in their own ability to practice autonomously and seek consultation when necessary, and are able to attend to both client and self, utilizing self as a therapeutic tool. Of course, this description is a brief snapshot to exemplify the IDM, which in its depth goes much further into the

process at each level, including a supervisee's likely challenges at the transition points between levels, consideration of the supervision environment, and prescriptive guidance for the supervisors of each level supervisee, etc. There are also similar models for *supervisor* development that, similarly, are metatheoretical, sequential, and progress to a fixed endpoint (Hess, 1986; Stoltenberg, McNeill, & Delworth, 1998; Watkins, 1993; Rodenhauser, 1994).

Falender & Shafranske (2004) acknowledged the benefits of developmental models of supervision for reasons such as clarifying expectations of each role and providing guidance for the supervisor to meet various supervisees' needs. However, while these models tend to resonate with the intended audience due to experiential congruence, the authors note that these models have largely failed to establish strong empirical support. They also pointed out that homogeneity of supervisees can be rare in certain training settings in terms of various characteristics (age, background, personality, etc.) and training orientations (e.g., group supervision may include clinical and counseling psychology students and interns, marriage and family trainees, social work trainees, master and doctoral level, etc.), which makes application of the model complex, perhaps even clunky, for any one supervisor. They also noted that some developmental models do not address certain important aspects of supervisee competence, such as integration of empirical research in treatment planning, development of assessment strategies, and multicultural considerations in conceptualization.

Process-based models. The third set of general approaches to supervision are process-based, according to Falender and Shafranske (2004), though they may also be considered social role supervision models or even integrative models (Corey et al., 2010). These approaches were developed to describe the typical roles, tasks, and processes within supervision in order to uniformly discuss, explicate, and research the relationship and its outcomes. Two of the most popular process-based models are the Discrimination Model (DM), developed by J. M. Bernard (1997), and the systems approach to supervision (SAS), developed by Holloway (1995).

Bernard's (1997) DM developed from a need she perceived supervisors to have for a "map to direct their teaching efforts" (p. 310), which led her to create a "technically eclectic," though parsimonious and versatile, model. So-named, the model's intention is that supervisors, upon assessment of each supervisee's needs, will tailor their supervision accordingly. In this model, the supervisor should attend to three foci of supervision – the supervisee's intervention skills, the supervisee's conceptualization skills, and the supervisee's personalization skills (personal style as a therapist) – areas in which they will assess each supervisee. The supervisor can then use three different roles – teacher, counselor, or consultant – across the foci to foster the supervisee's progress toward the supervision goals. Many consider the model helpful and useful, based on professional experience, but some critiques include: 1) the lack of consideration of theoretical orientation and how it will inevitably influence supervisors, possibly preventing them from being flexible

enough to *fully* utilize the DM; 2) the model focuses solely on the interactions occurring during the supervision meetings, lacking direct address of the "behind the scenes" supervisory actions of evaluator and monitor; and 3) research of supervision that tests roles of supervisors is very limited (Bernard & Goodyear, 2009).

With motivation similar to Bernard, Holloway (1995) developed the SAS to serve as a guide for supervisors in their practices and teaching of trainees. Also similar to the DM, the SAS does not subscribe to a theoretical orientation, though it provides a conceptualization of the supervision process. This model proposes five specific goals: 1) the supervisee will learn a wide range of professional attitudes, knowledge, and skills, 2) a mutual, professional relationship provides the context for supervision, 3) this relationship is the driving force that engages the supervisee in accomplishing goals of supervision, 4) within this relationship, both content and process are important to instructional approaches, and 5) the supervisee is ultimately empowered through acquiring knowledge and skills (Holloway, 1997). Holloway also denoted seven dimensions that form the basis of supervision, the first three of which are the supervisory relationship, supervision tasks, and supervision functions plus four "contextual factors": the supervisor, the supervisee, the client, and the institution or agency. A more complex model than the DM, Holloway's SAS model describes how the interaction of these seven components affect the supervision process as it unfolds within the foundational supervisory

relationship. The SAS outlines the progression of this relationship through three phases (developing, mature, and terminating), which is a progression similar to results of research on friendship. The SAS model provides a substantial guide as a framework and a language for supervisory practice and teaching.

Supervision has grown up. Therapy alone is a complex task. Providing supervision to trainees who are learning to do therapy work is even more complex. Understandably, the field had a need for guidance to those fulfilling the role of supervisor, out of which these various approaches and models arose. They each somewhat similarly and somewhat uniquely describe, guide, predict, and explain the interactions and events likely to occur in the context of supervision. While some approaches tend to focus on supervision techniques that are congruent with the model of therapy the supervisee is learning, some models focus on outlining a supervisee's progression and development over time in terms of clinical competence and professional identity. Others focus on the process of supervision within the context of the supervisory relationship from an integrative perspective. Yet, all of these have an underlying intention to increase supervisee competence in clinical practice. Thus, not surprisingly, a competency-based approach to supervision is the most recent development within the practice of supervision. However, before discussing this approach in the context of supervision specifically, some discussion of the evolution of the forces within psychology that led to a focus on competence is warranted.

Competency Movement in Clinical Psychology

In 1976 the National Council of Schools and Programs of Professional Psychology (NCSPP) was founded with a goal of fostering the development of quality graduate training programs in professional psychology. By the mid-1980s this organization produced a competency-based core curriculum guide for schools of psychology (Rubin et al., 2007). Since this early effort to provide a standard, the last few decades have seen a significant interest in defining competence and ensuring competency-based standards in education, training, and credentialing programs. Beginning in the 1990s, psychology accrediting bodies in the United States and Canada utilized an "outcomes-based" (Rubin et al., 2007, p. 454) model to determine program accreditations, quite similar to the competency-based approach soon to follow. A 2005 APA publication, *Guidelines and Principles for Accreditation of Programs in Professional Psychology*, from the Committee on Accreditation, outlined requirements of doctoral, internship, and postdoctoral training programs to demonstrate educational and training practices related to each of several core competencies in psychology, including student outcomes in each domain. In 2006, the Final Report from the APA Task Force on the Assessment of Competence in Professional Psychology stated, "it is timely for professional psychology to embrace not only a culture of competence, but also a culture of the assessment of competence" (American Psychological Association [APA], 2006, p. 3). Rubin et al. (2007) noted that "there is a national zeitgeist focusing on

competencies and their assessment" (p. 453). Indeed, efforts dedicated specifically to the task have included the APA Task Force on the Assessment of Competence in Professional Psychology, the Assessment of Competency Benchmarks Workgroup, and APA Education Leadership Conferences, among others.

Defining competence. *Competence* was defined by Epstein and Hundert (2002) as "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" and is considered strongly related to an individual's "attentiveness, critical curiosity, self-awareness, and presence" (p. 227). Rubin et al. (2007) explained *competence* as a professional's "overall suitability for the profession," that is captured by the individual's "knowledge, skills, and attitudes, and their integration," which they noted is "developmental, incremental, and context dependent" (p. 453). Shallcross, Johnson, and Lincoln (2010) noted that Elman, Illfelder-Kaye, and Robiner (2005) consider the process of moving from incompetence to competence to be precisely what is meant by professional development. Competence, however, is a broad and evolving construct, at both an individual level and a conceptual one, and "implies a meta-capacity" (p. 507), as noted by Shallcross et al. (2010). Some have bemoaned the case that it seems much easier to identify incompetence than to precisely characterize competence (Shallcross et al., 2010; Koocher & Keith-Spiegel, 1998).

Competence vs. competencies. As a means of operationalizing and assessing such a construct, *competencies* are considered to be the more basic components or elements of competence, which are integrated and dynamically interact in practice to form the basis of competence. In a sense, competence can be thought of as not only having the requisite competencies, but also having the ability to effectively leverage and integrate those competencies to fulfill the duties and responsibilities of one's professional role. Derived from the definitional components above (knowledge, attitudes, skills), Kaslow (2004) stated competencies should always be observable, measurable, containable, practical, and flexible. While competence has some global elements across the profession, considered core or foundational competencies, other elements are more context-dependent and related to specific clinical/professional requirements (Falender & Shafranske, 2004; Kaslow, 2004; Shallcross et al. 2010). It is the variance in specific competencies that likely inspired the ethical standard related to *boundaries* of competence. Indeed, it is possible to be competent in one professional setting/capacity within the field of psychology and lack competence in another. For example, a psychologist may be highly competent in treating anxiety and depression, but may lack competence in treating borderline personality disorder or comorbid substance use disorders. Likewise, a psychologist may be highly competent in the traditional outpatient setting providing long-term psychotherapy, but may largely lack competence in the integrated primary care setting providing

short-term behavioral health intervention in a team approach alongside the patient's medical providers.

Competence as an ethical obligation. *Competence* was granted its own section in the APA Ethics Code in 2002 which addressed: a) boundaries of competence, b) providing emergency services, c) maintaining competence, d) bases for scientific and professional judgments, e) delegation of work to others, and f) personal problems and conflicts (Fisher, 2012). In 2002, this new section was a response to and a continuation of the movement toward competency-based approaches within professional psychology. The standard regarding boundaries of competence speaks to the discrete nature of competencies in which individual practitioners may have competence in some areas of psychological service but not in others, while the standard concerning maintaining competence highlights the dynamic and evolving nature of the field and the necessity to frequently reevaluate competencies.

The Competency Movement Meets Supervision

Though it has been one of the standard training modalities in clinical psychology since its inception, clinical supervision received relatively little attention in the academic literature in terms of its practice until several decades after its first use. In 1950, Orval H. Mowrer wrote an article titled, *Training in Psychotherapy*, in which he specified a distinct difference between what psychotherapy patients should receive as treatment and what students of clinical

psychology should receive as training. He confessed, "…it is not as yet entirely clear what status we should accord [students] and what experiences we should try to provide for them" (p. 274). At that time, psychoanalytic students were expected to undergo extensive "didactic analysis," fundamentally equivalent to psychoanalytic treatment, while other academic psychologists held an opposite opinion that students did not need in-depth training or particular credentials as long as they had command of a few key "rules" of psychotherapy. Written shortly after the Boulder Conference of 1950, Mowrer's article identifies the seeds of the later competency movement within clinical psychology. Mowrer discussed a need for a means of evaluating "personal maturity" of clinical psychology students and certain requirements of these students (an "active interest in the process and goals of therapy" and "conceptual sophistication") in order to be considered fit for the profession. Prior to this time, beyond classroom performance and supervisor opinion, clinical psychology had no *standardized* means of evaluating the proficiency of its students as future psychologists. Rubin et al. (2007) noted the Boulder Conference of 1950 as the beginnings of the eventual field-wide movement toward competency standards and means of evaluation. Because supervision was the training modality in which a clinical psychology student's proficiency as a psychotherapist could be most closely observed, evaluated and shaped, it is not surprising that the questions of competency raised at the Boulder Conference led to papers that addressed supervision specifically, such as

supervision of clinical psychology trainees in various types of facilities (Brewer, 1950; Carp, 1950) and supervision procedures and methods for interns (Anderson, 1950). Before this conference and the academic thought and publications it spurred, very little attention had been given to these issues.

Yet, it was another few decades before the move toward competency and evaluation standards of graduate training in clinical psychology became sufficiently defined, organized, and published. This is not to say that prior to this time psychologists who were training their students were not concerned with issues of competence, as surely they were, but they did not yet have any authoritative consensus on guidelines to follow. As Watkins put it as recently as 1995, "it seemingly is a process that is learned on the job or through some sort of osmosis; through witnessing countless hours of supervision – usually by several different supervisors or by undergoing one's own supervision" (p. 573). Naturally, the competency movement sparked a realization that the field of clinical psychology had been making an assumption for quite a long time that therapist knowledge and skills naturally translated to supervisory knowledge and skills (Falender & Shafranske, 2004). This glaring deficit within the profession inspired the theoretical and practical efforts discussed above in *Approaches to Supervision*, as well as the competency-based approach discussed below.

The competency-based approach to supervision. As the competency movement within professional psychology was gaining momentum, supervision

itself was formally recognized as a competency in the 1990s. Yet, it was still another decade or so before the competency-based approach to supervision developed. Indeed, Shallcross et al. (2010) referenced the work of Bernard, Goodyear, Falender and Shafranske when they wrote, "the theoretical base for supervision has only recently begun to solidify" (p. 504). Falender and Shafranske (2004, 2008) are the main proponents of this approach to supervision because they believe it complements supervision's goals and easily lends itself to empirical study more so than some other models that have been proposed. Falender and Shafranske (2008) pointed out that psychology has long been concerned with competence in various domains, but it was not until the 2002 Competencies Conference: "Future Directions in Education and Credentialing in Professional Psychology" that specific competencies were delineated, and a product of this effort was a description of supervisor competencies.

One general definition of supervision, presented above, came from Falender and Shafranske (2004). In addition to defining supervision, they also describe supervision as having three foundational "pillars" (Falender & Shafranske, 2008, p. 5) they refer to as the supervisory relationship, inquiry, and educational praxis. This *supervisory relationship* is an alliance between supervisor and supervisee in which their individual and mutual responsibilities will help achieve the goals of supervision. *Inquiry* points to the processes that stimulate the supervisee to gain awareness of self and think critically about all aspects of the therapeutic process.

Educational praxis refers to the use of a variety of educational modalities that can serve to increase supervisee knowledge and skill. These foundational aspects of supervision synergistically work to either enhance or undermine the outcomes of supervision. Falender and Shafranske also describe four superordinate values that permeate throughout the entire supervisory relationship and process – integrity-in-relationship, ethical values-based practice, appreciation for diversity in all its forms, and science-informed practice. Between this definition, the pillars, and the superordinate values, Falender and Shafranske (2008) have presented what they consider to be the essential basis of the best practices for supervision:

> From here and more specifically, they (2007) define *competency-based* supervision 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. (p. 233)

Falender and Shafranske (2004) acknowledge that a goal of any approach to supervision is to develop competence, but they distinguished their competency-based approach as supervision that has an "explicit framework and method to initiate, develop, implement, and evaluate the processes and outcomes of supervision" (p. 20). The implication here is that this approach, regardless of any particular model of supervision that may be employed or therapeutic orientation

adopted, will always clearly identify expected competencies to be achieved, employ interventions and other procedures to facilitate the attainment of these competencies, and have concrete ways by which to assess these competencies in supervisees. The reason this approach to supervision did not exist when the other approaches were brewing in the collective academic consciousness is because the committees and meetings (mentioned above) during which competent practice was articulated and delineated had not yet occurred (Task Force on the Assessment of Competence in Professional Psychology, Assessment of Competency Benchmarks Workgroup). There were no "competencies" yet to inform or guide a supervisor's approach to supervision. Certainly, prior to this time, supervisors were largely effectively facilitating supervisee's training and helping to produce competent practitioners. However, the ability to refer to collectively established competencies was missing until the competency movement gained momentum within the discipline, informing accreditation of training programs, and creating a general "sea change" (Falender & Shafranske, 2008, p. 3) within the field.

In Kaslow and Bell's chapter in *Casebook for Clinical Supervision* (2008), they discuss supervision by exemplifying all the hallmark elements of a competency-based approach as delineated by Falender and Shafranske. Competency-based supervision is integrative in nature, drawing upon several models of psychotherapy and supervision as relevant, including multicultural considerations. Often, the competency-based approach to supervision is

developmentally informed because the supervisee must be met at the appropriate point in their level of training for best growth. The competency-based approach also functions best within a collaborative supervisory relationship. Collaboration is key for the self-assessment called for by this approach, which is to be conducted by both supervisor and supervisee. Likewise, formative and summative feedback is provided by supervisor to supervisee and vice versa. Both individuals work together in this approach to increase competence in both parties (for the supervisee to become a better clinician and for the supervisor to continue to improve supervisory competence).

Why a competency-based approach to supervision makes sense. Cynthia Belar stated, "We also must be aware that all health professionals are being held more accountable for education and training for competence in evidence-based practice" (Dittmann, 2003, p. 16). Indeed, just as evidence-based practice is about requiring professionals to utilize empirically supported interventions and formally assess patients' response to treatment, the competency-based approach is about requiring supervisors and other educators to use educational practices that have scholarly precedent and to obtain evidence that the training is developing level-appropriate competencies in trainees. The nature of a competency-based approach is to provide concrete evidence that a particular trainee has reached expected benchmarks in competence and, thus, possesses important knowledge, skills, attitudes, and the ability to effectively integrate them. More and more emphasis is

being placed on competence in professional practice by consumers, regulators, and policy makers alike (APA, n.d.a). To address this issue, in 2007, the Assessment of Competency Benchmarks Workgroup (ACBW) built upon work that not only identified and defined competencies, but also operationalized them with "behavioral anchors" in order to move toward formalized, objective assessment. McDaniel et al. (2014) defined behavioral anchors as "observable, measurable examples of how the essential components might be demonstrated…[that are] examples, so they vary by the model of service delivery being used, the population being seen, and the system of care" (p. 414).

The most current conceptualization and organization of these competency benchmarks was revised in 2011 by APA. In that defining document, core competencies are delineated as *foundational* or *functional*, and are organized in thematic clusters. Table 1 outlines the organization of these competency benchmarks from that APA document.

The Supervision section of this Competency Benchmarks document (Education cluster, Supervision competency from Table 1), endorsed by APA, can be found in Table 2, which includes elaboration with examples of behavioral anchors (APA, 2011b). This document also outlines competencies according to developmental level of the clinician (Readiness for Practicum, Readiness for Internship, Readiness for Entry to Practice) and is one of several resources offered

on APA's website under the heading of "Benchmarks Evaluation System." This webpage states,

> The benchmarks evaluation system, just like the benchmarks document, was designed as a resource, not as a mandate, for training programs. Programs are free to modify the examples … and identify additional examples or competencies that relate to their specific program goals and outcomes and to select the specific clusters they wish to use (APA, 2011c, para. 2).

Background of Health Psychology

Health psychology mushroomed in the mid-1970s and grew into one of the largest domains within psychology. Suggested reasons for this great expansion of health psychology include 1) the insufficiency of the biomedical model to explain health and illness, 2) increasing life expectancy lead to concerns about quality of life and prevention of chronic illness, 3) chronic illness was found to be related to lifestyle factors and was, by then, the larger challenge in medicine rather than infectious disease, 4) research in the behavioral sciences had become more sophisticated as psychological theories (e.g., learning theory) were successfully applied to explain disease etiology and health behavior, and 5) increased healthcare costs led to more effort to find alternative (and less costly) treatment modalities than traditional medicine. New professional groups sprang up to address this growing professional domain including the Academy of Behavioral Medicine, Society of Behavioral Medicine, APA Division 38 Health Psychology, and the

Journal of Behavioral Medicine, all of which were founded in 1978. The journal *Health Psychology* began publication four years later and by 1994 the *International Journal of Behavioral Medicine* came out as the behavioral health movement went global. By the mid-1980s, the American Board of Health Psychology was established and has been fully affiliated with the American Board of Professional Psychology since 1993 (Belar & Deardorff, 1995).

Psychologists' affiliation with medicine dates back to the early 20th century when psychologists could be found teaching medical students. Physiological psychology (i.e., experimental psychology) flourished as well around this time. However, psychology was yet to be applied to the problems and challenges within the healthcare system specifically. World War II led to a great increase in clinical psychologists, though they were primarily focused on mental disorders and intellectual assessment. The research literature contains a few early forays by psychologists who studied psychological factors of medical patients, such as overutilizers of the healthcare system, psychosomatic disorders, and psychological preparation for surgery. However, the role that psychologists could play in the delivery of health services became apparent by the late 1960s, which ushered in the behavioral health movement as it is known today (Belar & Deardorff, 1995).

Belar & Deardorff (1995) explained how ingrained mind-body dualism was in the thinking of medical professionals, and even many psychologists. This dualist view was so entrenched that it even expressed itself in the administrative choices

made at that time (and still often made today) in which mental healthcare facilities were (and are) in different departments and even different buildings than the corresponding medical services. Of course, certain types of psychological disorders had clear medical implications, such as eating disorders, and thus, necessitated a treatment team approach that logically included providers of medical and mental healthcare services. Aside from specialty treatments like these, psychologists were not standard members of the general healthcare services in this country. However, times are surely changing, and though there is still a long way to go before it is the norm, psychologists are becoming more and more prevalent as providers at the primary care level of patient healthcare, including co-location of services, and collaborative and team-based care.

Not unrelated to psychologists' recent increased presence in primary-level healthcare is the growing trend in patient-centered medical homes (PCMH). According to the federal government's Agency for Healthcare Research and Quality (AHRQ, n.d.), a PCMH is a model for how primary care is organized and delivered that is expected to transform and improve primary healthcare delivery in the U.S. Based on the "work of a large and growing community," the AHRQ defines a medical home as a medical facility that delivers specific "core functions" to patients (Agency for Healthcare Research and Quality [AHRQ], n.d.). These core functions and characteristics include: 1) comprehensive care, 2) patient-centered care, 3) coordinated care, 4) accessible services, and 5) quality and safety.

The "comprehensive care" component states "the PCMH is accountable for meeting the large majority of each patient's physical *and mental health care* needs, including prevention and wellness, acute care, and chronic care [italics added by the current author for emphasis]," which makes mental health providers crucial members of staff at a PCMH (AHRA, n.d., para. 2). The "patient-centered" trait of a PCMH is described as "relationship-based with an orientation toward the *whole* person [italics added by current author for emphasis]," which is helping to reform the problematic dualistic view of mind-body mentioned earlier that paves the way for mental health professionals to join physicians side-by-side in primary care. As the PCMH continues to evolve and increase in prevalence, mental health professionals, including psychologists, should gain an even greater presence in primary level healthcare.

In addition to the cultural/organizational shifts occurring in U.S. healthcare, such as the PCMH, the epidemiological research bears out the rationale for bringing mental health services into the primary care setting. For example, Robinson and Reiter (2007) noted that "the average [primary care provider] PCP will see the full spectrum of mental health disorders, from depression and anxiety to substance abuse to psychotic disorders within a week of practice" (p. 5). They also referenced a statistic from Gatchel & Oordt (2003) which states that up to 70% of PC medical appointments are for problems resulting from psychosocial issues. Additionally, the shift in psychopharmacological treatment that enabled not only

specialty mental health providers, but also PCPs, to prescribe a majority of psychiatric medications also further normalized the PCP as a go-to resource for mental health concerns. Not only do the majority of patients go to their PCP with obvious mental health concerns, they also present with somatic problems that are likely to have psychological underpinnings and implications, such as irritable bowel syndrome, tension headaches, insomnia, and chronic nonspecific pain. These types of complaints tend to be related to a patient's perceived stress. So, the need for psychologists' involvement in primary care is real. A broader description of these new medical facilities, of which PCMHs are a specific type, is a model for integrated primary care (IPC) that promotes inclusion of mental health providers in primary care medical centers, seeking to normalize mental health issues in primary care and improve patient outcomes (Vogel et al., 2012). Admittedly, the collaboration between psychologists and medical professionals goes back several decades, such as teaching at medical schools and pediatric treatment teams, but the truly integrated primary care practice that co-locates and integratively utilizes the services of medical professionals and psychologists is relatively recent and continuing to evolve.

This distinction is that of *collaborative* care versus *integrated* care. Various other models for integrated services exist with the common element of psychologists working alongside the medical professionals and administrative staff to address and treat the mental health needs of patients in-house. Various issues are

referred to a primary care psychologist in an integrated care setting, and the psychologist intervenes with the intention of improving the overall, broad functioning of the patient (while more severe mental health problems are usually referred to specialty care).

Vogel et al. (2012) argued that the "recent surge of interest in IPC necessitates an evaluation of the workforce needed to implement this model of care" because, they point out, "…the primary care environment is a unique setting that many traditionally trained psychologists find daunting" (p. 272). Indeed, the generalist training of psychologists does not typically include elements that are essential to the job functions of a psychologist in integrated primary care, such as regular collaboration and consultation with medical physicians and nursing staff, extensive and working knowledge of basic biomedicine, expertise in the vast array of psychologically relevant presenting problems of patients and common reasons for referral from PCPs, real-time and rapid chart documentation, and an ability to be flexible and adaptive to a fast-paced medical environment (Vogel et al., 2012; Bray, 2004).

Some postdoctoral fellowships are specifically designed to educationally and experientially equip a psychologist to work in an IPC setting, such as at the University of Massachusetts Medical School (Blount & Miller, 2009) and Genesys Regional Medical Center in Michigan (Vogel et al., 2012). Such sites have been pioneers of the cultural and structural changes necessary within two long-standing

professions (medicine and clinical psychology) to become a functionally optimized IPC facility. The result of these programs – "lessons learned," including practical issues, and future recommendations – are a boon to the field. However, these well-established IPC training facilities are relatively rare and the demand for psychologists in IPC settings is expected to exceed the supply of professionals who are adequately trained for work in this setting (Blount & Miller, 2009; Bray, 2004; Vogel et al., 2012). With so many differences in practice for a psychologist in primary care versus a more traditional setting, coupled with a growing need for primary care psychologists, the issue of training for professionals to work in an IPC setting is highly pertinent. Certainly, the earlier in training that psychologists can be exposed to practice in an IPC, the better, in order to meet the growing demand and expedite the creation of other practicing and training IPC sites around the country.

However, the biggest question about any IPC training program for psychologists, especially those that are training practicum-level students, is – how do training directors and supervisors maintain the necessary elements of good psychology supervision and training while incorporating the appropriate elements of the medical model (i.e., merge the culture of psychology and medicine) to properly train psychologists to work at the intersection of these two domains and on the "front lines" (primary level) of patient care. This question begets another

equally important question – are there enough supervisors sufficiently trained to provide "state of the art," competent supervision in primary care?

McDaniel et al. (2014) presented the product of a 16-person interorganizational workgroup on competencies for primary care psychology practice. The clusters and competency groups according to McDaniel et al. are presented in Table 3. This workgroup identified competencies, essential components, and behavioral anchors within each cluster. The resulting product within the supervision competency of the education cluster is presented in Table 4. McDaniel et al. (2014) noted that the essential components are defined or determined by the knowledge, skills, and attitudes applicable to that domain of practice. The behavioral anchors above are non-exhaustive, mutable examples of the essential components of the competency.

A notable item in Table 4 is one of the ways in which supervision can occur – *precepting*. This article does not define the term specifically. However, it was clearly borrowed from the medical disciplines, which makes sense considering PC psychologists have to adapt their traditional training to fit the unique demands and conditions of a primary care setting. Since precepting is not defined yet considered important enough to list it as one of the "ways" in which PC psychologists can supervise, the current study turns to the medical literature for an understanding of precepting.

Preceptorship in Medicine

The term *preceptorship* was first used in 1974 to describe the method of nursing training that actually began in the 1960s and served to induct the novice nursing graduate into clinical practice (Billay & Yonge, 2004; Tan, Feuz, Bolderston, & Palmer, 2011). After examining the various definitions of preceptorship in the literature, Tan et al. (2011) determined that the commonalities across definitions included its "establishment …for a defined period of time where learning occurs from an experienced, competent, role model and most importantly, is education focused" (p. 17). However, Tan et al. mentioned that the variability in definitions is usually due to the specific needs and the environment in which it is used. They also identified purposes of a well-structured/defined preceptorship experience to include: 1) easing the transition from the educational to the service setting; 2) closing the theory-practice gap for new practitioners by consolidating knowledge and increasing practical competence; 3) and socializing the new practitioner into the profession. Billay and Yonge (2004) consolidated the necessary functions and behaviors of the medical doctor-preceptor to include a) teaching, b) providing feedback, c) being clinically competent and knowledgeable, d) serving as a role model, e) having good communication skills, f) understanding teaching principles, g) providing favorable, real-life experiences, and h) linking theory with practice. In many ways, the functions and expectations are quite similar to those of clinical supervision in psychology.

Inducting the new professional into the medical practice setting via a preceptorship has several benefits. The relationship provides the novice with supportive, one-on-one teaching and learning from a clinical expert. The relationship is also believed to guide the novice in integration of previous education and learning with real-world practice, which increases clinical confidence and knowledge of clinical reality. This confidence is linked to increases and improvements in assertiveness, communication skills, and problem-solving and overall empowerment of the new practitioner (Tan et al., 2011). The term seems to be most often used in nursing, though other allied health professionals use it as well (e.g., physician assistants; radiologists; primary care, family medicine, and OB-GYN students). There appears to be no single determined criteria for preceptorship within medicine; rather, each institution or organization structures a preceptorship in its own way. However, the distinction between a preceptorship versus clerkship, internship, residency, etc. seems to be that a preceptorship offers a *community-based* educational experience for the learner that is more personalized and serves to broaden the learner's exposure to *real-world* clinical practice at the *level of community health* (e.g., private practices, community health centers, local primary care or family medicine clinics) (Neutens, 2006).

As an example, the Stanford University School of Medicine has a Primary Care Associate Program (PCAP) for training physician assistants (PAs) in order to meet the community needs for primary-level healthcare. This program includes a

preceptorship experience which is critical to its mission to "educate PAs for clinical practice in primary care and medically underserved communities in California" because the preceptorship provides the community-based, real-world training that primary care professionals require (Stanford University School of Medicine Primary Care Associate Program [PCAP], 2015, para 2). These PA trainees complete the preceptorship to receive a *Certificate of Clinical Proficiency*. As an example of the roles and responsibilities of a preceptor, see Appendix A, which is an excerpt from PCAP's Primary Preceptor Manual. In this program, in addition to the primary preceptor, there is a clinical coordinator, faculty advisor, site visitor, preceptor administrative assistant, and a potential assistant preceptor for each student. Students spend the bulk of their clinical experience (46 weeks of a 21-month accelerated program) under the supervision of their primary preceptor. Preceptors in this program are also provided with supplementary sources of support for their role, such as online evaluations, learning assessment tools, teaching guidance, goals and expected competencies to be achieved by preceptees, etc. As additional incentive/compensation, preceptors and assistant preceptors can receive CME credit for their participation (PCAP, 2011).

Another example is the University of Washington School of Medicine (UW Medicine), which offers preceptorships to matriculated medical students. Their website describes the preceptorship as an 8-week training experience occurring during the first two years of medical school that is

> a mentoring experience in which a practicing physician volunteers to give personal instruction, training, and supervision to a medical student during the second year of medical school. Preceptorships offer the preclinical student an opportunity to follow a patient over time, to get to know the particular clinical field and to experience a clinical setting. Students report that preceptorships can be an excellent way of preparing for board examinations and clinical training (University of Washington School of Medicine [UW Medicine], 2015, *About Preceptorships* section).

The language that identifies different training experiences in the medical field itself continues to be somewhat vague, as exemplified above. The Canadian Nurses Association (CNA) (2004) acknowledged that mentorship and preceptorship are often used synonymously in the international community, as it seems UW Medicine has done. However, the CNA is solidifying the distinction between the two approaches. The CNA explained the similarities are that "both approaches [preceptorship and mentoring] depend upon effective role modeling in one-to-one relationships, self-directed learning, providing a safe environment for critical reflection and practice, the acts of advising, counseling, guiding, advocating, recognizing strengths and providing constructive feedback" (p. 13). Tan et al. (2011) delineate the differences of each as

> Mentorship seems to be a nonforced, dynamic, reciprocal relationship and occurs on a voluntary basis for both parties. It is used more for the purpose

> of career development and professional socialization. A mentorship agreement is a supportive and nurturing relationship that does not involve any type of [formal] evaluation process … In contrast, preceptorship focuses more on the transfer of practical skills, orientation, and socialization of new team members to a unit, acting as a role model and evaluator of the preceptee's progress. (p. 16)

Based on this distinction, Stanford's PCAP program appears to be a true preceptorship due to the lengthy rules and responsibilities placed on their selected preceptors, who also engage in performance evaluation of preceptees in collaboration with the student's faculty educators. UW Medicine's "preceptorship" seems better classified as a *mentorship*, according to CNA and Tan et al., because there does not appear to be any evaluative functions required of the hosting physicians.

The Association for Professors of Gynecology and Obstetrics (APGO) also supports preceptorships and mentoring and provides several resources including a 12-module primer, APGO Effective Preceptor Series written and published by the APGO Undergraduate Medical Education Committee, to provide preceptors with practical tools for teaching and evaluating preceptees. Some topics covered in this series include providing feedback, how to prepare for a preceptee, using micro-skills to improve teaching, using the electronic medical record (EMR) to precept, and cultural competence. The CNA also developed a guide to preceptorship and

mentoring titled, *Achieving Excellence in Professional Practice.* This guide offers a thorough source of information regarding definitions, characteristics, costs, benefits, and examples of mentoring versus preceptorship; how to develop each type of program; competencies of each type; and suggested assessment instruments for formative and summative feedback (CNA, 2004).

Preceptorship training methods can inform psychology supervision. Obviously, practicing medicine in any capacity (doctor, nurse, etc.) is fundamentally different in many ways than practicing as a psychologist, even a psychologist within an integrated primary care team. However, aspects of medical training, specifically of preceptorships, seem highly applicable to psychologists in primary care as they continue to adapt their practice and training to the system, culture, roles, and goals of the primary care setting. Medical preceptorship offers meaningful application precisely because it is a main training approach for medical students in *the primary care setting*. Many more examples of the current practice of preceptorship within the medical fields could be provided. However, the focus here is not as much on the specifics of preceptorship in medicine, but rather the elements of the preceptorship approach to training that can be extrapolated to inform clinical psychology supervision in the PC setting, which is likely what McDaniel et al. (2014) were referring to when they mentioned “precepting” as one of the various ways the PC psychology supervisors can train their supervisees.

In clinical psychology, the traditional style of training alone does not prepare students to competently work in the primary care setting because, as mentioned above, there are various differences in the roles, responsibilities, and functioning of a primary care psychologist. The competency movement in psychology seeks to be "responsive to the changing healthcare landscape and evolving opportunities for psychology within collaborative and comprehensive healthcare" (McDaniel et al., 2014, p. 427). McDaniel et al.(2014) warn that

> Graduate and postdoctoral education in professional psychology must change if it is to ensure that psychologists have the necessary competencies to take their rightful place in integrated interdisciplinary PC. Failure to make this change will leave psychologists out of mainstream 21st-century health care; the void will certainly be filled by other mental health providers. (p. 427)

What does precepting mean for psychology? Researchers established personal correspondence with some of the writers of McDaniel et al. (2014) about their definition of precepting in primary care psychology. The participants in the conversation included Susan McDaniel, Terry Stancin, Catherine Schuman, Catherine Grus, and Kristi Van Sickle (December 10, 2015). Interestingly, there was not initially consensus or clarity among these individuals about what precepting is in primary care psychology. This lack of congruence speaks to the need for clarification of the term and the technique within the context of

supervising in primary care psychology. From this conversation with experts, the best definition provided is that precepting is a means of teaching and modeling the skills and knowledge necessary for providing primary care mental health treatment in the clinical setting in real time with real cases. This method of training allows practical experience for supervisees and provides supervisors more opportunities to evaluate trainee competencies.

As discussed above, precepting has long been a highly important and common experience of medical training, and as such, a concept with which medical and nursing students are familiar. As psychology continues to expand its services to the realm of primary care, by co-locating with primary care medical providers and integratively collaborating on patient treatment teams, utilizing similar approaches to training, such as precepting, seems prudent and likely to be highly effective. Such training techniques would be expected to foster the integration of mental healthcare into the primary care domain and may even be a necessary adaptation that clinical psychology must make to successfully establish and maintain its place in primary care. Given the relatively limited knowledge of precepting that psychologists currently seem to have, gaining a solid sense of current supervisory practices among primary care psychologists will provide a good starting point for continuing the effort to enhance training and increase competency for psychologists in this special setting.

Statement of Purpose

The current study is in line with APA's suggestion to modify supervision resources as needed to meet the unique training goals specific to certain settings. Indeed, as the competency-based movement has been going strong for a few years within the general field of clinical psychology, a question arises as to the implications of this training approach in various subdisciplines of clinical psychology and how the competency-based approach will be similar or different in its application within those different areas of practice. One of the most recent settings practitioner psychologists have entered, and the focus of the current study, is the primary care setting, where psychologists have slowly made a place for themselves since the growth of the subdiscipline of health psychology. By beginning the process of understanding the current state and practice of supervision in primary care, this research can eventually inform the field about the best ways to supervise in primary care based on actual current practices and issues faced now by supervisors in primary care psychology. One of the underlying impetuses of the current survey is to determine ways in which psychologists in primary care can continue to successfully adapt their functions to this relatively new setting, which has several major differences compared to the generalist training and traditional practice of clinical psychologists. The results of the current study are expected to inform the development of primary care supervision competencies, competency

benchmarks, and specific methods of training that will support supervisors and supervisees to best meet the full range of competencies in practice.

This survey is exploratory, so data will largely be collected for the purposes of providing a descriptive analysis of current practices in the training of primary care psychologists. However, the following hypotheses about current practices, based on the supervision literature, can be made:

1) The structure of supervision (individual, group, precepting) provided will differ by level of training program (practicum, internship, post-doctoral).

2) The characteristics of supervision (e.g., structure and time) provided will differ by APA classification of the training program (major area of training, emphasis, experience, exposure).

3) The competencies expected to be achieved by supervisee prior to entry into the program will differ by level of trainee (practicum, internship, post-doctoral), with greater competency expected at higher levels of training.

Method

Design

This cross-sectional survey study was designed to examine the current supervision practices being utilized today in training psychology students within integrated primary care settings and other issues relevant to training. This study was reviewed and approved by the Institutional Review Board of Florida Institute of Technology.

Participants

This study used a convenience sample of subjects who voluntarily responded to an email request for participation. Due to the specific nature of the study, participants were required to be supervising trainers of primary care behavioral health trainees (predoctoral, internship, and/or postdoctoral levels). These participants were recruited from the APA's Directories of Doctoral (44 programs), Internship (140 programs), and Postdoctoral (72 programs) Training Opportunities in Primary Care Psychology. These databases were cross-referenced for duplicate entries and then each original point of contact from these directories was invited to complete the survey or to direct the survey to the appropriate individual within their organization for completion. Approximately 260 potential participants were emailed for recruiting. An exact number of potential recruits cannot be provided for several reasons: 1) some emailed contacts were inappropriate for the survey (i.e., not supervisors in primary care), 2) some

forwarded the survey request on to other supervisors, and 3) some emails no longer worked and alternate addresses could not be determined.

Participation included completion of the survey questions online. Eligibility criteria for participation included adults who identified as supervisors or trainers of primary care behavioral health trainees. Participants were informed that participation was voluntary and collected data would be anonymous. No incentive for participation was offered. The consent form can be found in Appendix B. Participants' names and other identifying information were not included in the study's survey data collection. However, participants who wished to receive the results of the survey were asked to submit an email address in a separate survey. Therefore, identifying information was kept separate from their questionnaire responses as to maintain anonymity of the data.

Due to the voluntary nature of the survey, participation is biased to those who self-selected to complete the survey. Ideally in any study, random sampling would be used to ensure participants were representative of relevant demographic subgroups. However, as data was needed from a specialized population, with relatively small numbers in total, the APA databases were utilized as the most accessible and comprehensive known source from which to recruit participants within this special population.

Procedure

The primary instrument for data collection in the current study was an original survey designed to collect information about the individual supervisor, the training program, and the training experiences offered to various levels of psychology trainees working in the primary care setting. This survey included 41-60 questions (see Appendix C for full survey); the survey length varied because participants were able to provide answers that prompted further inquiry. Some sub-questions were only asked if the previous answer indicated their relevance to the specific participant. For example, if a participant indicated they had not received training in supervision in primary care, they were not prompted to answer further questions about that training experience. Data collection began February 11, 2016, when the survey was activated on Qualtrics and promoted via the above methods. Data collection ended April 11, 2016.

Results

Sample Characteristics

Forty-six participants attempted the survey, while 39 respondents completed the survey (a completion rate of 84.8%; 15.2% attrition rate). Based on analysis of the incomplete surveys, attrition may have been largely attributable to participants' realization that they were not appropriate for the study (e.g., not supervisors of *primary care* trainees). Using the total number of entries in the APA databases used for recruitment of participants, the response rates for each program type are: approximately 13.6% for doctoral programs, 14.3% for internship programs, 18% for postdoctoral programs, and 15.2% for the entire sample (all programs). It should be noted that the actual number of potential participants reached via email recruiting is minimally different than these total numbers due to outdated entries, new entries, and second-hand recruitment (e.g., email forwarding). Also, many of the programs (82%) offered more than one training program (e.g., internship and postdoctoral training; see Table 7). However, the survey forced respondents to choose only one program on which to base their responses. Responses per program may have been greater if participants were allowed to respond based on more than one level of training program. A limitation of the current study is the low response rate. For each subsample, at a 90% confidence level and a margin of error of ±10%, the following response rates were required: practicum N = 27 (actual N = 6), internship N = 46 (actual N = 20), postdoctoral N = 36 (actual N = 13). Therefore,

the current results cannot be considered fully representative of the population of supervisors of primary care psychology trainees and primary care psychology training programs. However, because this survey was exploratory, trends in the data can provide useful insights and directions for further study.

Participant Demographics

The demographics of the supervisors and programs are displayed in Tables 5-7 for the entire sample and the three subsamples (practicum, internship, and postdoctoral) when applicable. The subsamples in this study (by level of training program) were distributed very similarly to their population distribution (with population ratio of approximately 6:19:10 vs. sample ratio of 6:20:13, practicum, internship, and postdoc, respectively), with the majority of participants representing internship programs (51.3%). Ninety-five percent (n = 37) of the participants identified as "Clinical Psychologist," while two participants identified as "Counseling Psychologist." Over half of all participants reported being licensed for 6-20 years, and 41% of the entire sample reported being a clinical supervisor for over 10 years. In the primary care (PC) setting specifically, 38.5% (sample mode) of participants reported 6-10 years of supervisory experience. An equal percentage (38.5%) reported working at their current PC setting for 3-5 years, while 43.5% of participants reported working in the current setting for 6 or more years.

Programs

Table 7 provides frequencies of various characteristics of the sites represented by the survey participants. The sample was heavily represented by Veteran's Affairs (VA) hospitals (46.2%), followed by Community Health Centers (25.6%), Public or Private Hospitals (20.5%) and Private Practice Primary Care (7.7%). The sample favored sites that were defined by APA as having a primary care "Major" or "Emphasis," with 79.4% (n = 31) of the sample sites categorized in one of these two classifications (53.8% and 25.6%, respectively). This distribution suggests that responses were more likely to come from those who are particularly invested in primary care training, reflective of the phenomenon that individuals are more likely to voluntarily participate in an activity that has greater salience for them. These highly invested individuals may also have been more motivated to participate based on the option to receive results of the study upon completion. In terms of the PC model utilized in the sample, 77% of the sites were classified as "Officially recognized PCMH/PACT" (46.2%) or "integrated care" (30.8%) and 17.9% as "co-located and collaborative" care model. Although each participant was required to choose only one level of training program to base their responses on, data was collected regarding which levels of training they offer. Sixteen sites (41%) in the sample offered all three levels (practicum, internship, and postdoc), 2.6% (one site) offered internship only. All survey responses based on a practicum program came from sites that offered only the practicum experience. When

participants had the option to answer based on their practicum training program vs. internship or postdoc program (n = 22, 56.4%), they chose to answer based on a more advanced training level. No sites within the sample offered *only* a postdoc training program.

Supervision Model

The single supervision model that predominantly guides primary care psychology training within each program in the sample is represented in a pie chart (whole sample only - see Figure 1) and in Table 8 (for a breakdown by training program type). Forty-one percent (n = 16) of the sample identified as using the Competency-based Approach, while 28.2% (n = 11) predominantly use the Developmental Approach, 10.3% (n = 4) predominantly use a Medical Model/Preceptorship, 5.2% (n = 2) mainly use a Psychotherapy-based Approach, and 15.4% (n = 6) use an "Other" approach. Of note, no participants identified the predominant supervision model guiding primary care psychology training as the Process-based Approach. Fifty percent (n = 3) of the practicum program respondents selected Competency-based Approach, followed by Medical Model/Preceptorship (33.3%, n = 2). Of internship programs, the Development approach (40%, n = 8) and the Competency-based Approach (35%, n = 7) were most popular.

Services Offered by Trainees

For detailed results, see Table 9. Of the entire sample (n = 39), 100% of primary care psychology training programs supervise trainees who provide the service of brief treatment for patients, 97.4% of programs supervise trainees providing individual treatment, 89.7% of programs supervise trainees providing screenings to patients, 84.6% offer warm hand-offs (i.e., same-day visit with behavioral health), 82.1% offer crisis intervention, 69.2% offer group treatment, 61.5% offer family and couples treatment. Fifty-nine percent offer psychological evaluations and 41% of programs offer traditional psychotherapy. The services provided by the fewest number of training programs included telemedicine (23.1%) and case management (23.1%). "Other" services (12.8%), which included after-hours telephone operation, assistance with injections, and unspecified services, were offered only by trainees at the postdoctoral programs.

All sampled practicum programs (n = 6) offer brief treatment and individual treatment that is provided by practicum level trainees, while 83.3% offer screenings, same-day visits, and crisis intervention. Only one practicum program offers telemedicine and psychoeducational groups. None of the practicum programs offered case management provided by practicum level trainees.

Among internship programs, 100% (n = 20) offer brief treatment, while 95% offer individual treatment and 90% offer screenings that are provided by

interns. The least popular services provided by interns included telemedicine (35%) and case management (25%).

Among postdoctoral programs, 100% (n = 13) offer individual treatment, brief treatment, and crisis intervention. Screenings are offered by trainees at 92.3% of the sampled postdoctoral programs, and same-day visits are provided at 84.6% of those sites. The least popular services offered by postdoc trainees included case management (30.8%), telemedicine (7.7%) and "Other" (23.1% - as elaborated above).

Training Opportunities Provided to Trainees besides Direct Patient Care

Among the entire sample, 97.4% (n = 38) of programs provide training in consultation/collaboration/liaison (100% of practicum (n = 6) and postdoctoral programs (n = 13) and 95% (n = 20) of internship programs). The one participant who did not report this opportunity was from an "integrated care" internship program site, so this data point may be due to software user error (i.e., misreported by participant), especially considering integrated care is driven and defined by collaboration between medical and behavioral care team members. Staff training/PCP education opportunities are provided to trainees at 74.4% (n = 29) of all programs (50% of practicum, 70% of internship, and 92.3% of postdoctoral programs). Quality improvement opportunities are offered by 61.5% of entire sample followed by program development by 56.4% of programs. Research in primary care is a less common training opportunity among the sampled programs

with 46.2% (n = 18). Few programs (7.7%, n = 3) offer trainees the opportunity to teach academic courses (16.7% of practicum, 0% of internship, and 15.4% of postdoctoral programs). See Table 10 for full breakdown of results. See Discussion section for more commentary.

Who Attends Group Supervision with Trainees?

Full results are reported in Table 11. Of the entire sample, 23.1% reportedly did not offer scheduled group supervision to trainees. A licensed psychologist was present for group supervision in 80% (n = 24) of the sampled programs that conduct group supervision (n = 30). Following, 20% (n = 6) of the programs with group supervision include social worker/mental health counselor, 6.7% (n = 2) include PCPs, and 3.3% (n = 1) include case manager in the supervision. Five programs (16.7%) reported including "Other" members, which were reported as psychiatrist, nurse, social work externs, and psychiatric clinical nurse specialist.

Among the practicum programs, 100% (n = 6) conduct scheduled group supervision, 83.3% include a licensed psychologist in supervision, while 16.7% (n = 1) include a postdoctoral fellow and none report including PCPs or case managers. Sixteen of the 20 internship programs conduct group supervision (80% of the intern programs represented in the sample – subsequent percentages are based on a total of 16 programs). A licensed psychologist participates in 81.3% (n = 13) of internship programs that provide group supervision; 43.8% of such internship programs include postdoc trainees, and 31.3% include practicum

trainees. Eight of the 13 postdoc programs reported conducting group supervision (61.5% of the postdoctoral programs represented in the sample – subsequent percentages are based on a total of 8 programs). Seventy-five percent of postdoctoral programs that provide group supervision include a licensed psychologist, 62.5% include intern trainees, 25% include PCPs, and 12.5% include practicum trainees, social worker/mental health counselor, and case manager.

Communication Methods Used Between Supervisor and Trainee

Across the entire sample (n = 39), 94.9% of programs utilize office drop-ins (83.3% among practicum, 100% among internship, and 92.3% among postdoctoral programs). Phone communication is used by 84.6% of all the programs, followed by 79.5% using e-mail, 66.7% using text messaging, and 48.7% using EMR (electronic medical record) messages. Reflecting a shortcoming of the survey, 41% of the entire sample (n = 16) use an "Other" method, which included instant messaging systems, video conferencing, paging, and precepting (including in-vivo, between patient encounters, and at point of care/rounds). See Table 12 for the breakdown of communication methods used within each training level.

Nature of Unscheduled Supervision

The entire sample (n = 39, 100%) reported use of unscheduled supervision with trainees. Thirty-six programs (92.3%) reported that unscheduled supervision can occur upon trainee's request (whether crisis/urgent or non-urgent issue). Thirty-four programs (87.2%) reported that unscheduled supervision often occurs in real

time regarding patient care (i.e., occurring while patient is present within the clinic). Three programs (7.7%) reported unscheduled supervision was the primary form of *individual* supervision provided to their trainees, all of which were practicum programs (50% of practicum programs in the sample). None of the internship or postdoctoral programs indicated that unscheduled supervision was the primary form of individual supervision provided to trainees, which may be due to accreditation requirements of those programs, because all internship and postdoctoral programs in the sample provide a minimum of two days/month of scheduled individual supervision up to daily. Among practicum programs, 83.3% conduct unscheduled supervision at trainee's request and in real-time. Among internship programs, 95% and 85% conduct unscheduled supervision at trainee's request and in real time, respectively. Among postdoctoral programs, 92.3% conduct unscheduled supervision at the trainee's request and often in real-time. See Table 13 for detailed results.

Why Do Primary Care Psychology Supervisors Consult with PCPs?

Within the entire sample, six participants (15.4%) reported that primary care psychology supervisors at their primary care site do not consult with PCPs regarding trainees or trainees' cases. Twenty-four programs (61.5% of entire sample) consult regarding patient recommendations, 21 (53.8%) consult regarding medication issues, 19 (48.7%) regarding diagnostic information, and 11 (28.3%) regarding trainee-specific issues. Six participants (15.4%) reported they consult

with PCPs for "Other" reasons which included: use of joint supervision/co-treatment, providing psychoeducation to PCP/explain interventions used by trainee, providing PCP feedback on cases, maintaining clinic relationships, familiarizing trainee with medical culture and with PCPs, and consulting only at time of formal evaluation.

All six practicum programs (100%) reported the PC psychology supervisor consults with PCPs, the most common reasons, each occurring at 4 programs (66.7%), include patient recommendations, medication issues, and diagnostic information. Among internship programs, three (15% of subsample) reported they do not consult with PCPs. Thirteen (65%) consult for patient recommendations and 11 (55%) do so for medication issues. Among the postdoc programs, 3 (23.1% of subsample) of the programs reported supervisors do not consult with PCPs regarding trainees or trainees' cases. Seven programs (53.8%) consult for patient recommendations and for trainee specific issues. For a full report of frequencies, see Table 14.

Do Programs Offer Their Trainees Supervision Experience and What Are the Associated Responsibilities?

Of the entire sample, 18 participants reported their primary care psychology training program does not offer the experience of supervision to trainees whereby the trainee supervises less experienced trainees (e.g., postdoc trainees supervise practicum trainees), referred to as "trainee-supervisor." The following percentages

are based on a total of 21 programs (53.8% of entire sample) that reported offering this training experience: 20 (95.2%) of programs have their trainee-supervisors model conducting patient visits with supervisees (i.e., are shadowed by supervisees). Trainee-supervisors conduct individual supervision at 15 sites (71.4%) and 13 sites have trainee-supervisors review notes (61.9%). Three sites (14.3%) have trainee-supervisors engage in "Other" activity which included: providing summative feedback to supervisees, a Journal Club, and giving direct skills development instruction (e.g., motivational interviewing techniques).

Among the four (of six) practicum sites that offer this experience, 100% have their trainee-supervisors attend group supervision with their supervisees and have them model patient visits, and 75% of these practicum programs have trainee-supervisors review notes and conduct individual supervision. Among internship sites, only 7 programs (35%) offer this type of experience to its trainees. Of these seven internship programs, 85.7% have trainee-supervisors model patient visits and 71.4% have them review supervisees' notes. Among postdoc programs, 10 sites 76.9% of subsample offer their postdocs the experience of trainee-supervisor. Of the 10 sites that have their postdocs supervise, 100% have their trainee-supervisors model patient visits to supervisees and 80% have their trainee-supervisors conduct individual supervision. For the full breakdown of frequencies across all subsamples, see Table 15.

Didactic Training Offered in Training Programs

For the full results of this survey question, see Table 16. Only one program within the entire sample, a postdoc program, indicated it does not offer any didactic training to its trainees. Across the sample, the most popular topic of didactics in 35 programs (89.7%) covered the topic of common behavioral health (BH) patient presentations in PC, followed by 82% covering the understanding and adapting of evidence-based treatment in PC, and 79.5% covering introduction to PCBH and covering motivational interviewing. Some programs offer several "Other" topics as part of didactic training, including: testifying in court, cultural issues (e.g., religious and aging issues), behavioral health issues related to HIV/AIDS, play therapy, family therapy Acceptance and Commitment Therapy, healthcare policy/financial stability, leadership, functional assessment, geriatric primary care, screening, suicide prevention and risk assessment, and rapid assessment.

Among practicum training programs, 100% cover common BH presentations in PC and the second two most popular topics are covered by 83.3% of practicum programs, which are understanding and adapting evidenced-based treatment and motivational interviewing. Among internship programs, 90% cover common BH presentations in PC, followed by 85% covering understanding and adapting evidence-based treatment, and 80% covering both introduction to PCBH and motivational interviewing. Among the postdoctoral programs, 84.6% cover common BH presentations in PC as well as introduction to PCBH. Equally

common at 76.9% are topics covered by postdoc programs that include understanding and adapting evidence-based treatment, motivational interviewing and pharmacological interventions and their impact on BH. This latter topic is most commonly covered in didactics offered in the postdoctoral sites of the current sample of PC training programs.

Who Provides Written Feedback for Trainees

Across all programs sampled, the clinical supervisors at all sites provide written feedback to trainees (100%). At 10 sites (25%), written feedback is provided by the trainee-supervisor. PCPs contribute to written feedback to trainees at only 8 sites (20.5%), and only 10.3% of sites solicit written feedback from RNs, Administrative Staff, and "Other." Participants provided the following responses for this latter category including: onsite clinical director gives feedback to postdoc leadership team, psychology training council, interprofessional partners, and other primary care rotation supervisors. One site, a postdoctoral program, incorporates written feedback from peers. For a complete breakdown of this data, see Table 17.

What Competencies Do PC Psychology Training Programs Expect Trainees to Achieve During the Course of the Program?

For elaboration of the competency categories, see survey question #28 in Appendix C. For full results of this data, see Table 18. Thirty-eight programs (97.4%) expect their trainees to gain competence in Clinical Practice Knowledge & Skills. The single participant that did not select this option was representing a

postdoctoral program. This same participant reported the site expects their postdoctoral trainees to enter the program with this competency achieved. Thus, that particular program would not be targeting this competency as a training goal for their trainees, because they are expected to be beyond that level of training at the start. Similarly, all sites except one internship site (97.4%), expect trainees to achieve Consultation Skills during the course of the program. This competency is not a focus during the program because it is expected to already be achieved by a trainee at the start of the program. All sites except one practicum program (97.4%) expect trainees to achieve Documentation Skills during the course of the program. Thirty-six programs (92.3%) expect trainees to achieve Practice Management Skills and to achieve Team Performance Skills. Administrative Knowledge & Skills are expected by 87.2% of all programs, followed by 35.9% for Supervision Skills. This relatively low frequency is related to whether the program even offers that training opportunity to trainees. Two participants (5.1%) selected the "Other" category and added basic clinical skills and teaching residents.

The most common competencies to be achieved among practicum programs, expected by 100% of the subsample, include Clinical Practice Knowledge & Skills, Consultation Skills, and Practice Management Skills. The most common competences to be achieved among internship programs, expected by 100% of the subsample, are also Clinical Practice Knowledge & Skills and Documentation Skills, followed by 95% that expect Consultation Skills to be

achieved. Among the postdoctoral programs, all programs (100% of subsample) expected most of the competencies to be achieved during their training program (Consultation Skills, Documentation Skills, Practice Management Skills, Team Performance Skills, and Administrative Knowledge & Skills). This high rate of postdoctoral programs that expect trainees to achieve many of the competencies assessed in the study is likely related to postdoctoral training being the "last chance" to hone skills while under supervision to ready a trainee for independent practice. Not surprisingly, these programs focus the trainee on achieving competency in a variety of important skills for practice in the PC setting.

PC Competencies Trainees Are Expected to Have Achieved Prior to Program Entry

Among the entire sample, twenty-three participants (59%) reported their programs did not expect trainees to enter with any competencies already achieved other than basic clinical skills. Of the other competencies, answers were provided on a binomial (Yes/No) choice. Fifteen programs (38.5%) expected trainees to enter with competencies achieved in Clinical Practice Knowledge & Skills, nine programs (23.1%) expected trainees to enter with competency in Documentation Skills, and five programs (12.8%) expected trainees to enter with competency in Practice Management Skills and in Team Performance Skills. Two programs (5.1%) expected trainees to enter their program with competency achieved in Consultation Skills, and one program expected trainees to enter with

Administrative Knowledge and Skills; these two programs were postdoctoral. For all frequencies of each competency broken down by training level, see Table 19.

Do Expected Entry-Level Competencies Differ by Training Level?

It was hypothesized that significant group differences existed in the number of competencies expected across training levels prior to program entry. More specifically, the hypothesis was that more competencies would be expected at higher levels of training, with the least expected for practicum students and the most expected for postdoctoral fellows. The dependent variable was measured by totaling the number of up to seven competencies selected by each participant when asked to select all the competencies trainees were expected to have upon beginning their training program. This variable is referred to as TCE (Total Competencies Expected). Initially the plan was to test the hypothesis with a one-way ANOVA. A one-way ANOVA test assumes six characteristics about the data being tested (Laerd Statistics, 2015). The first three assumptions were not violated: 1) the dependent variable is continuous, 2) the independent variable is categorical, and 3) independence of observations between groups. However, the fourth assumption was violated: there should be no significant outliers in the groups of independent variables with respect to the dependent variables. Visual inspections of the boxplots of this data showed two outliers within the internship group and one outlier in the postdoctoral group. The option to statistically correct these outliers exists. However, because the sample size is smaller than ideal, that option was declined. A

fifth assumption of the one-way ANOVA test was also violated by the current data: the dependent variable should be approximately normally distributed for each group of the independent variable. The Shapiro Wilk test of normality revealed that the TCE score was normally distributed for the practicum group ($p > .05$). However, the internship and postdoctoral groups were not normally distributed ($p < .05$). With a small sample size and two violations of assumptions of the one-way ANOVA test, the decision was made to test the hypothesis with the Kruskal-Wallis H test. This test is the nonparametric alternative to the one-way ANOVA that can be utilized when data characteristics do not meet the assumptions of the one-way ANOVA.

A Kruskal-Wallis H test was conducted to determine if there were differences in Total Competency Expected (TCE) scores between the groups of three training levels: practicum (n = 6), internship (n = 20), and postdoc (n = 13). Values are mean ranks unless otherwise stated. Distributions of TCE scores were not similar for all groups, as assessed by visual inspection of a boxplot. TCE scores increased from internship (17.83), to postdoc (20.42), to practicum (26.33). However, the differences were not statistically significant, x^2 (2) = 3.287, p = 0.193. Lack of statistical significance in this analysis may be due to small sample size. However, the trend suggested by the mean rank values indicates, counter to expectation, that the lowest training level has the highest expected competencies.

Possible explanations of this observation are addressed in the Discussion section below.

Do Expected Entry Level Competencies Differ by APA Classification of Training Program?

A Mann-Whitney U test was run to determine if there were significant differences in TCE scores between programs based on APA classification. Two groups were formed by grouping the two classifications with the greatest amount of time spent training in the primary care setting (Major/Emphasis; n = 31) and comparing them to the two classifications with the least amount of time spent training in the primary care setting (Experience/Exposure; n = 7). Distributions of the TCE scores for these two groups were not similar, as assessed by visual inspection of plotted data. TCE scores for programs classified as Major/Emphasis (mean rank = 19.84) and for programs classified as Experience/Exposure (mean rank = 18.00) were not statistically significantly different, $U = 98$, $z = -.449$, $p = .653$. In this test also, the lack of statistical significance may be attributable to small sample size (Laerd Statistics, 2015).

What Type of Training in Supervision Did Participants Receive?

Three participants, all of whom represented an internship program (7.7% of entire sample) reported they did not receive any formal training in supervision in psychology. The most common type of training in supervision reported by participants was didactic seminars, received by 82.1% of entire sample.

Supervision of supervision was received by 69.2% of the entire sample. Skills workshop was received by 51.3% of the sample. Participants at 33.3% of the sites selected "Other" training and provided several types of training they received in supervision including: graduate course(s), practicum experiences as a trainee-supervisor, continuing education, and independent study/reading. The high frequency of participants who selected "Other" indicates a shortcoming of the current survey. Research should incorporate these possibilities into any future surveys assessing training in supervision. Because they were not explicitly listed as options in the current study, their actual numbers may be higher. For full results, see Table 20.

What Model(s) Was This Supervision Training Based On?

The following percentages are based on a total of only those participants who reported receiving formal supervision training. By far, the two most common models that participants were exposed to during their supervision training are the Developmental Approach (n = 22, 61.1%) and the Competency-based Approach (n = 19, 52.8%). Seven participants (19.4%) received training based on a psychotherapy-based approach (which included CBT, Integrative, Psychodynamic, Interpersonal, and Client-centered/Rogerian, listed in descending order of frequency). Six participants (16.7%) reported they received supervision training based on a Medical Model/Preceptorship. For a full frequency distribution of these results, see Tables 21-22.

What Type of Training in Supervision *Specific to the PC Setting* Did Participants Receive?

Formal supervision training for the PC setting is uncommon among the current sample. The majority of respondents (84.7%) indicated they had never received any formal training for conducting supervision in the PC setting specifically. Five participants (12.8% of entire sample) reported receiving didactic seminar training for providing supervision within the PC setting and four participants (10.3% of entire sample) reported receiving supervision of supervision specific to the PC setting. For full results, see Table 23.

What Barriers Do Supervisors in the PC Setting Perceive As Preventing Ideal Supervision?

Nineteen participants (48.7% of entire sample) reported they do not perceive any barriers to provision of ideal supervision to their trainees. All of these participants came from the internship and postdoctoral programs. All the practicum program participants indicated one or more barriers. The most common barrier among the sampled programs was a lack of supervisor's time (85% of those participants who reported one or more barriers). Seven participants reported that trainees' time was a barrier (35% of those participants who reported one or more barriers). Five participants reported that inability to bill for their time was a barrier (25% of those participants who reported one or more barriers). Three participants perceived lack of space as a barrier to supervision. Two participants reported

"Other" barriers and provided these issues: "coddling" and "drive time to PCMH." All six practicum program participants indicated that a lack of supervisor's time was a barrier to ideal supervision. The full frequency distribution for this data is displayed in Table 24.

How Much Time Is Spent in Supervision Addressing Various Practice and Trainee-Related Issues?

These results are based on survey question #26 (See Appendix C). Each participant was able to identify their own open-ended estimation (up to 100%) of how much time was spent on any particular category within supervision. Results are based on a sample size of 38, due to one strong outlier case being removed. The data displayed within a pie graph in Figure 2 show the average value participants estimated spending in supervision in the PC setting with their trainees. The ranges and standard deviations are reported below the figure. Some categories have a wide range, such as patient care/case discussion (range = 0-90, SD = 19.1), while others had a relatively smaller range, such as diversity and multicultural issues (range = 0-15, SD = 3.7). On average, the largest amount of time estimated as spent on supervision topics was that of patient care/case discussion (41.9%), followed by the next activity (learning practical techniques and evidence-based intervention) estimated at 16.1%. On average, the least amount of time estimated as spent on supervision topics was "Other" activities that included program evaluation/development and research (1.1%). Pie graphs for the same results but

broken out by training level (practicum, internship, and postdoc) are displayed in the subsequent figures (3 – 5).

What Diversity Issues Do Supervisors Encounter in Supervision in the PC Setting?

Table 25 displays the full results of this survey question. Race/ethnicity was the most common aspect of diversity that supervisors reported they encountered (n = 38, 97.4%) when supervising within the PC setting. Religion/spirituality was the second most common diversity issue reported as experienced by 36 participants (92.3%). Also, gender issues and sexual orientation issues were relatively common, 87.2% and 84.6% respectively. Fourteen participants (35.9%) identified "Other" diversity issues they encountered within supervision. These "other" issues included: socioeconomic status (including education), ability/disability status (including medical and psychiatric conditions and with respect to functional impairment), veteran culture, immigration status, access to and experience with technology, aging issues, and political views. The high frequency of endorsement of "other" diversity issues signifies a shortcoming in the current survey and future research should accommodate respondents with the options. Table 26 reports data regarding the type of formal training the participants received related to working with diversity issues in supervision.

Which Techniques Are Considered "Essential" to Training/Supervision by Supervisors in Primary Care?

Survey question #40 (See Appendix C) addressed the question of essential techniques for supervision and training of primary care psychology trainees. For elaboration of the definition of these techniques, also see survey question #40. Table 27 reports the full results of this question to participants, including the breakdown by training level. The training practice most frequently endorsed by participants as being both utilized by them in the PC setting and considered "essential" was didactic trainings (n = 37, 94.9%). Closely following was individual case discussion in individual supervision and shadowing of supervisor (within the discipline), both endorsed by 36 participants (92.3%). Providing formative feedback to trainee and making expected competencies clear to trainee were endorsed by 35 participants (89.7%). Precepting and direct observation were endorsed by 32 participants (82.1%). Videotaping was by far the least endorsed technique by participants with only three participants (7.7%) selecting use of videotaped patient visits.

Relatively Speaking, How Important To Training in the PC Setting Is Each Technique?

To assess this question, participants were asked to rank order the techniques they indicated they used and considered essential to supervision and training within the PC setting. Average ranked values were calculated for each technique, across

the entire sample and with training levels. Tables 28 – 31 display these full results. It should be mentioned that missing values were transformed to data for this measure. Because participants were only able to rank those techniques they selected as essential in the previous question, some participants were able to rank many more techniques than other participants. For example, some participants may have had the option to rank 12 techniques, while others may have ranked only 8 techniques. To represent these missing values, the decision was made to provide a rank value for each participant on all 15 techniques. This missing value was replaced with the value of the average ranked value for all missing values within a particular case. For example, if a participant only ranked 8 techniques (8-15, 15 representing the most valuable technique) then the missing values of the remaining unranked items are necessarily 1-7. The average rank of these missing values would be 4. To deal with missing values for this item, unranked item missing values were replaced with the average rank of the unranked items. This decision was made because when missing ranks were not included, the data appeared to be misrepresented. For example, raw scores for videotaping produced an average ranked value within the top three most valuable techniques. However, when the participants who did not rank videotaping were provided an opportunity to rank whether it was valuable, even if they did not use it, most participants did not select videotaping as valuable. Thus, filling in missing values with the average of

unranked items appeared to provide a more accurate picture of the relative rank for each technique.

These results were based on 32 participants' scores because 7 participants' responses for this particular survey item were not recorded, apparently due to a survey software malfunction or user error. The average ranks, relative ranks, ranges and standard deviation scores are displayed in Tables 28-31 for the whole sample and each training level. The whole sample results showed precepting and case discussion within individual supervision were tied as the most important techniques. This can be contrasted to the most important techniques by average rank within the practicum programs being direct observation and case discussion within group supervision. The top techniques for internship programs mirrored those of the entire sample (precepting and case discussion (individual)), and within postdoctoral programs, case discussion (individual), precepting, and shadowing within the discipline were the top techniques. Videotaping received the lowest average rank across all training levels. Also ranked higher across all levels were formative feedback and making expected competencies clear during training and summative feedback. Summative feedback was generally ranked relatively low across groups.

Perceived Value of Unused Supervision and Training Techniques

One survey question (#41, Appendix C) showed participants the techniques they did *not* select when asked which techniques they use and consider "essential"

to training in PC and asked participants if they considered any to be techniques that they believe would be valuable to training if they were in a position to incorporate them into training. This highly exploratory variable was designed to show which techniques some programs are not using, but would like to use if time, space, funding, etc. did not pose barriers. While only 5.5% of 36 participants reported they use videotaping as part of their training practices, 38.9% of 36 participants reported they consider it valuable enough to incorporate into training if conditions allowed, and 55.6% did not see value in the practice regardless of their ability to incorporate it. For several techniques, of the participants who are not currently using them, this group was often split almost evenly between considering unused techniques valuable versus not valuable. For example, regarding the technique of having the trainee shadow outside of the discipline (medical team members), of the 25% of participants who did not currently use the technique, 56% believed it would be valuable for training, while 44% believed it would not be valuable. Regarding the practice of making expected competencies clear for trainees during training, of the 11.2% of participants who do not use this technique, 50% of those believed it would make a valuable contribution to training, while 50% did not. The full results of these survey items are displayed in Table 33.

Discussion

The purpose of the current study was to explore the supervisory practices used in training behavioral health trainees in the primary care (PC) setting at the practicum, internship, and postdoctoral levels and other factors related to training. Thirty-nine clinical and counseling psychologists who supervise primary care psychology trainees in practicum, internship, or postdoctoral programs around the country completed a survey designed for this current study. This survey assessed the training approaches used by these supervisors, including the structure of training/supervision, techniques, issues related to training (barriers, diversity, etc.), and supervisors' own training backgrounds.

One surprising result of the study was related to the hypothesis that expected competencies prior to training would be greater for higher training levels, with postdoctoral programs expecting more prior competence than internships and practicum programs expecting the least amount of competence. While the Kruskal Wallis H test did not yield significant results in terms of group differences, the lack of statistical significance may be attributable to the small sample size. And, though not significant, the trend of the ranked means suggests that the practicum programs of the current sample expect more competence prior to program entry than the two higher training levels.

One possible reason for this finding is that practicum programs tend to draw from students from a specific university, which enables the practicum program to

have highly accurate knowledge of the specific competencies students are developing within their training prior to practicum entry. This knowledge enables the supervisors at these practicum sites to know what competencies they can expect in their applicants, which enabled these participants to make more definitive selections in terms of expected competence. Another explanation is captured in one participant's comment,

> We evaluate the overall status of each trainee in reviewing applications and in face to face interviews. Experience in some or all of these areas is a plus; but we do not expect any to have been fully achieved prior to the postdoc year.

This explanation suggests that the data may have portrayed a different picture if the competence variables were assessed on an ordinal scale, rather than dichotomous, providing participants with the ability to select a particular level of competence within each competency domain. Ordinal responses may yield different results.

However, another factor in explaining the current results is that, in this context, these competencies are largely specific to primary care psychology. Programs may not be able to expect more from trainees in primary care, regardless of the program's level of training, because PC psychology is a relatively young field. Expecting applicants to have more than minimal PC psychology competencies would reduce their pool of viable applicants far too much. Postdoctoral programs in primary care, for example, might rule out too many

applicants if they require certain, or too many, PC competencies to be obtained prior to beginning their program, which could slow the growth of psychologists in this setting. Likely, in this growing specialty area – primary care psychology – training programs of all levels are probably wise to have a willingness to "start from scratch" in fostering PC-specific exposure and competencies in their trainees.

The two hypotheses related to the structure of supervision differing between training level groups and between APA classification groups were not tested in the current analysis. There are a few reasons for this decision. One reason for forgoing testing of these hypotheses with the current data is because the results, whether significant or not, would not likely be highly informative. Many programs sampled, if not all, are accredited. Accredited programs have certain requirements stipulating the type and amount of supervision that trainees should receive to ensure comparable training experiences. Also, some programs have factors that confound this variable, such as having only one trainee, which would, for example, prohibit group supervision entirely. Therefore, these hypotheses were not tested with the current survey and results.

However, the study explored expected competency differences between groups based on APA classification (major, emphasis, experience, exposure). Using the same measure of competency – Total Competency Expected (TCE) scores – utilized to test prior expected competency between training program levels, the sample was split into the two more intensive and the two less intensive

classifications (major/emphasis vs. experience/exposure). These results were also not significant, likely because of the small sample size. The ranked means of each group suggest a trend in the hypothesized direction (more expected competencies at more intensive training programs), but are not significantly different in the current sample.

The survey results are intended to inform further research on the topic of training and supervision of primary care psychology trainees and possibly provide training committees and PC psychology supervisors with helpful information that may inform their current training techniques and practices. This survey also assessed the amount and type of training participants have received regarding supervision in psychology and supervision in PC psychology, which can indicate qualifications and areas of need in the field.

This survey was a pilot project that was partially intended to provide the groundwork for future research in the area of supervision in primary care psychology. One expectation was the survey would help identify lessons learned in terms of ways to improve future survey design. One such lesson is the attention needed toward design of survey questions to adequately accommodate participants who may be representing a training program with multiple sites and/or rotations that trainees may elect or are required to do and also rotations that last for semester(s), quarter(s), year, etc. The following participant comment illustrates this point in the current survey: “You're assuming only one rotation/experience; we

have multiple rotations that interns elect and that fill ALL the above categories." This participant was unable to answer the narrow question regarding the primary care model used at their site. A prudent alteration may involve separating surveys designed to evaluate the characteristics of a training program versus the characteristics of a supervisor/supervision, particularly when some training programs have multiple supervisors/sites who may each have a good deal of leeway in their approach to training.

The current survey inquired about several program and supervision/training factors. In addition to the topics addressed in this section above, the survey also evaluated the following aspects: types of patient services trainees provide, non-service training opportunities, the structure of individual, group, and unscheduled supervision, communication methods between supervisor and trainees, reasons for consultations by supervisor with PCP, trainee-supervisor experience, didactic trainings, nature of feedback to trainees, type of training in general supervision and PC supervision participants have received, barriers to supervision in PC, ways in which supervision time is spent, diversity issues in supervision in PC, and "essential" techniques for supervision in PC.

A specific focus of exploration was on the training method of precepting as a technique/model of medical training that is relevant to PC psychology training (Billay & Yonge, 2004; Tan, Feuz, Bolderston, & Palmer, 2011; McDaniel et al., 2014). While only 10.3% of the sample indicated their supervision model in

training PC psychology trainees was predominantly medical model/preceptorship, the technique of precepting (see p. 47 and for a definition) received an average relative rank of 1 (out of 15, with 1 being most important) among the entire sample in terms of importance of the technique to training psychology trainees *specifically in the PC setting*. The competency-based approach was the most common approach endorsed by participants, followed by the developmental approach. As discussed in the Review of the Literature, a preceptorship incorporates elements of developmental and competency-based approaches. Hence, these results suggest the likelihood that primary care psychology training could easily adopt the terminology and techniques of the medical fields' preceptorship approach to training without losing the characteristics that define it.

Furthermore, because a medical preceptorship is intended to be a competency-based, developmentally appropriate, individually customized approach to training, PC psychology would be able to adopt the model of preceptorship while still incorporating important elements of its training (developmental, competency-based) under the label of preceptorship. For example, a training program could identify as a CBT-informed PC psychology preceptorship or an integrative PC psychology preceptorship. This type of approach to training could further the mission of PC psychology to integrate with medical culture and its provision of primary care services.

In terms of the argument for the value of psychologists in primary care, a common assertion is that psychologists are trained experts on program development and quality improvement. An APA article titled, *Psychologists and Primary Care Providers: How We Can Work Together*, states one of the ways that psychologists can work for the benefit of patients and families is to "design and use evaluation methods, such as continuous quality improvement measures and patient satisfaction surveys" (APA, n.d.b, para. 5). Additionally, in a previously referenced article by McDaniel et al. (2014) regarding competencies specific to psychology practice in primary care, they wrote

> The second competency area in the Science cluster [referenced in Table 3 of the current document] requires competence in research and program evaluation applied specifically to the PC setting. Distinct competencies include functioning as leaders on interdisciplinary research projects, evaluating clinical programs, fully participating in quality improvement assessments, and developing practice standards. Evaluating the effectiveness of screening or prevention programs used in the PC setting is a behavioral example of the essential component of applying research skills to evaluate practice, interventions, and programs. (p. 414)

However, as Table 10 shows, among the current sample, only 61.5% of all programs evaluated reported they offer trainees experience in quality improvement (33% of practicum sites, 55% of internship sites, and 85% of postdoctoral sites).

Also, training in program development was reported as offered by only 56.4% of the entire sample (33% of practicum sites, 55% of internship sites, and 69% of postdoctoral sites). With program development and quality improvement being one of the unique skill sets that psychologists (compared to mental health counselors or social workers, for example) can bring to a medical setting, these survey results indicate an area for growth in supervisory practices in PC psychology. For example, while quality improvement training is offered at many of the sampled postdoctoral sites, fewer offer it at the internship level and even fewer at the practicum level. If this competency is to be a unique and solid contribution that psychologists in the PC setting have to offer, training in this area is best begun at the practicum level and certainly at the internship level. Early introduction to this competency will provide trainees with ample experience to strongly develop this skill set by the time they are new psychologists entering the field of primary medical care.

Integration of care continues to be challenging in some primary care sites, as the following open-ended response from one participant illustrates. Regarding the PC model that best describes their site, a participant noted, "Our primary care ideally operates in PACT [Patient Aligned Care Team], however that is not functionally what happens. PCMHI [Primary Care Mental Health Integration] is collocated and strives to work with PC in a collaborative way, though PC struggles with the model." In terms of increasing integration of psychology and medicine in

the PC setting, having similar training methods (i.e., “preceptorships” in both PC medicine and PC psychology) would likely foster this process. Some locations appear to be thriving within the integrated PC model, while others struggle. Future research in PC psychology and training could seek to understand which specific administrative, practice and/or training factors of the medical and psychological domains of a site affect level of integration between them in the PC setting.

The relative ranked value of supervision and training techniques used in the training programs provides insight into what is being used and what is the perceived value of that technique. Some ways in which the programs differed in their relative rankings include practicum programs average ranking of case discussion in group supervision as 1 while internship and postdoc programs ranked it 9 and 8, respectively. However, 9 of the 33 internship and postdoctoral sites do not provide scheduled group supervision during the PC psychology training, while 100% of practicum program sites provide group supervision, which certainly would affect this ranking. Conversely, case discussion in individual supervision has an average relative rank of 7, while it ranks 1 with internship and postdoctoral sites of the sample. Again, a smaller proportion of the practicum programs of the sample utilize scheduled individual supervision, which is related to this difference in ranking. The top six average rankings across the entire sample belong to precepting, case discussion (individual supervision), direct observation, shadowing within the discipline, making expected competencies clear to trainee, and providing

formative feedback throughout training. All of these techniques are commonplace within a medical preceptorship.

However, the average ranking scores have potential limitations. The rater's unfamiliarity with some techniques could inaccurately lead to low rankings, not due to participant's opinion of the value of the technique, but due to inability to fairly or adequately compare the technique with others. Also, the procedure used to replace missing values, discussed in Results, was not ideal and made assumptions about participants' rankings that may also be inaccurate. The rankings are merely intended to be a starting point for further research into the value and use of training and supervision techniques PC psychology programs offer to its trainees. In future research and survey design, participants should be allowed to rank all evaluated techniques regardless of whether they utilize them in their practice to avoid the problem of missing values.

There are some overall limitations to the current survey study, including the use of convenience sampling, volunteer participants, and a low sample size. As previously discussed, low sample size may account for the lack of significant findings in group comparisons. The low sample size also means the data cannot be guaranteed to be an accurate depiction of the population it has attempted to evaluate, so conclusions drawn from the current study should be made with caution.

Despite these limitations, this study has some strengths. For example, it is the first study researchers know of that has evaluated certain supervision and training practices and issues specific to PC psychology training programs. The data provide a unique comparison among certain variables between practicum, internship, and postdoctoral programs. This study is also unique in its definition of and exploration of precepting as used with PC psychology training. This study, as discussed above, provides direction for future research in this area in terms of improvement of survey design. The study also begins the discussion within the field regarding precepting as both a technique and an entire approach to training psychology trainees within the PC setting. This study was able to highlight the ways in which precepting complements the competency-based and developmental approaches to training that are currently strong movements within the field. The study also generally provides current supervisors and training program developers with a comparative sample of the structure, techniques, and issues facing other PC psychology supervisors. Additionally, this study indicates the possible lack of *formal* training current PC psychology supervisors have received specifically covering training and supervision within the PC setting, as only 15.3% of the entire sample indicated they had received such training. Comparing this finding with the 92.3% of participants who reported they received formal training covering supervision and training within psychology in general suggests the need for more training opportunities (i.e., continuing education, convention seminars, skills

workshops or didactic training, etc.) to address the unique aspects of psychology training specific to the PC setting.

In addition to improved survey design, future research should seek to include a larger number of participants for more generalizability of findings. Future research could also evaluate trainees in terms of their experience of these training techniques and their usefulness. Finally, research regarding the issues primary care sites are having when they are struggling with integrating psychological/behavioral services with medical services is another area that could provide invaluable information for improving psychology training in the PC setting.

References

Agency for Healthcare Research and Quality (AHRQ). (n.d.) *Defining the PCMH.* Retrieved from https://pcmh.ahrq.gov/page/defining-pcmh.

American Psychological Association (APA). (n.d.a). *Culture of the assessment of competence: Introduction*. Retrieved from http://www.apa.org/ed/graduate/introduction.pdf

American Psychological Association (APA). (n.d.b) *Psychologists and primary care providers: How we can work together.* Retrieved from http://www.apapracticecentral.org/business/collaboration/primary-care.aspx

American Psychological Association. (2006). *APA task force on the assessment of competence in professional psychology: Final report*. Retrieved from http://www.apa.org/ed/resources/competence-report.aspx.

American Psychological Association. (2011a). *Competency Benchmarks in Professional Psychology*. Retrieved from http://www.apa.org/ed/graduate/competency.aspx

American Psychological Association. (2011b). *Competency Benchmarks in Professional Psychology: Appendix (i.e., Items with examples).* Retrieved from http://www.apa.org/ed/graduate/benchmarks-evaluation-system.aspx?tab=1.

American Psychology Association. (2011c). *Benchmark Evaluation System*. Retrieved from http://www.apa.org/ed/graduate/benchmarks-evaluation-system.aspx?tab=1

Anderson, G. L. (1951). Procedures and methods in supervising clinical interns. *Journal of Consulting Psychology, 15(4),* 267.

Belar, C. (2008). A competency-based approach to supervision. In Falender, C. A., Shafranske, E. P. (Eds.). *Casebook for clinical supervision: A competency-based approach* (197-209). Washington, DC: American Psychological Association.

Belar, C., & Deardorff, W. W. (1995). *Clinical health psychology in medical settings: A practitioner's guidebook* (Rev. ed.). Washington, DC: American Psychological Association.

Bernard, J. M. (1997). The discrimination model. In E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (310-327). New York: Wiley.

Bernard, J.M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). New York: Pearson.

Billay, D. B., Yonge, O. (2004). Contributing to the theory development of preceptorship. *Nurse Education Today, 24,* 566-574.

Blount, F. A., & Miller, B. F. (2009). Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings, 16, 113-119.*

Bodner, K. E. (2012). Ethical principles and standards that inform ethical gatekeeping practices in psychology. *Ethics &* Behavior, *22(1)*, 60-74.

Bray, J. H. (2004). Training primary care psychologists. *Journal of Clinical Psychology in Medical Settings, 11(2),* 101-107.

Brewer, J. E. (1951). Procedures and methods in supervising clinical interns. *Journal of Consulting Psychology, 15(4),* 268-270.

Canadian Nurses Association. (2004). *Achieving excellence in professional practice: A guide to preceptorship and mentoring.* Retrieved from https://www.cna-aiic.ca/en/download-buy/preceptorship-and-mentorship

Carp, A. L. (1951). Procedures and methods in supervising clinical interns. *Journal of Consulting Psychology, 15(4),* 271-273.

Corey, G., Haynes, R., Moulton, P., & Muratori, M. (2010). *Clinical supervision in the helping professions* (2nd ed.). Alexandria, VA: American Counseling Association.

Dittmann, M. (2003, February). Conference focused on competencies in professional psychology. *Monitor, 34*, 16.

Elman, N. S., Illfelder-Kaye, J., & Robiner, W. N. (2005) Professional development: Training for professionalism as a foundation for competent practice in psychology. *Professional Psychology: Research and Practice, 36,* 367-375.

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association, 287*, 226-285.

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

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

Falender, C. A., & Shafranske, E. P. (2008). Best practices of supervision. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (3-15). Washington, DC: American Psychological Association.

Falender, C. A., & Shafranske, E. P. (Eds.). (2008). *Casebook for clinical supervision: A competency-based approach.* Washington, DC: American Psychological Association.

Fisher, C. B. (2012). *Decoding the ethics code: A practical guide for psychologists*. Los Angeles, CA: Sage.

Gatchel, R. J., & Oordt, M. S. (2003). *Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration.* Washington, DC: American Psychological Association.

Hess, A. K. (1986). Growth in supervision: Stages of supervisee and supervisor development. *The Clinical Supervisor, 4,* 51-67.

Holloway, E. L. (1995). *Supervision: A system approach*. Newbury Park, CA: Sage.

Kaslow, N. J. (2004). Competencies in professional psychology. *The American Psychologist, 59(8),* 774-781.

Kaslow, N. J., & Bell, K. D. (2008). A competency-based approach to supervision. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (17-38). Washington, DC: American Psychological Association.

Koocher, G. P., & Keith-Spiegel, P. (1998). *Ethics in psychology: Professional standards and cases*. New York, NY: Oxford University Press.

Laerd Statistics. (2015). *Statistical tutorials and software guides.* Retrieved from https://statistics.laerd.com/

McDaniel, S. H., Grus, C. L., Cubic, B. A., Hunter, C. L., Kearney, L. K., Schuman, C. C. … Johnson, S. B. (2014). Competencies for psychology practice in primary care. *American Psychologist, 69(4),* 409-429.

McReynolds, P. (1997). *Lightner Witmer: His life and time*. Washington, DC: American Psychological Association.

Milne, D. (2008). A competency-based approach to supervision. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (211-233). Washington, DC: American Psychological Association.

Mowrer, O. H. (1951). Procedures and methods in supervising clinical interns. *Journal of Consulting Psychology, 15(4),* 274-277.

Neutens, J. J. (2006). The effective preceptor series: Introduction to preceptorship & preceptors. *Association for Professors of Gynecology and Obstetrics Effective Preceptor Series*, 1, 1-4.

Primary Care Associate Program. (2011). *Primary preceptor manual.* Retrieved from http://pcap.standford.edu/curriculum/PreceptorManual.pdf

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

Robinson, P. J., & Reiter, J. T. (2007). *Behavioral consultation and primary care: A guide to integrating services.* New York, NY: Springer.

Rodenhauser, P. (1994). Toward a multidimensional model for psychotherapy supervision based on developmental stages. *The Journal of Psychotherapy Practice and Research, 3(1),* 1-15.

Rubin, N. J., Bebeau, M., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S., … Kaslow, N. J. (2007). The competency movement within psychology: An historical perspective. *Professional Psychology: Research and Practice, 38(5),* 452-462.

Shallcross, R. L., Johnson, W. B., & Lincoln, S. H. (2010). Supervision. In J. C. Thomas & M. Hersen (Eds.), *Handbook of clinical psychology competencies* (501-548). New York, NY: Springer.

Stanford School of Medicine Primary Care Associate Program with Foothill College. (2015, November). *Primary Care Associate Program: Overview*. Retrieved from http://pcap.stanford.edu/

Stoltenberg, C. D., & McNeill, B. W. (1997). Clinical supervision from a developmental perspective: Research and practice. In E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (184-202). New York: Wiley.

Stoltenberg, C. D., McNeill, B. W., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco, CA: Jossey-Bass.

Stoltenberg, C. D. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology, 28(1),* 59-65.

supervise. (n.d.). *Online Etymology Dictionary*. Retrieved June 13, 2015, from Dictionary.com website: http://dictionary.reference.com/browse/supervise

Tan, K., Feuz, C., Bolderston, A., & Palmer, C. (2011). A literature review of preceptorship: A model for the medical radiation sciences? *Journal of Medical Imaging and Radiation Sciences, 42,* 15-20.

University of Washington School of Medicine. (2015). *Preceptorships for Second Year Students.* Retrieved from http://www.uwmedicine.org/education/md-program/current-students/curriculum/preceptorships

Vogel, M. E., Kirkpatrick, H. A., Collings, A. S., Cederna-Meko, C. L., & Grey, M. J. Integrated care: Maturing the relationship between psychology and primary care. *Professional Psychology: Research and Practice, 43(4),* 271-280.

Watkins, C. E., Jr. (1993). Development of the psychotherapy supervisor: Concepts, assumptions, and complexities of the Supervisor Complexity Model. *Journal of Psychotherapy, 47,* 58-64.

Watkins, E. (1995). Psychotherapy supervision in the 1990s: Some observations and reflections. *American Journal of Psychotherapy, 49,* 568-581.

Appendix A

The following information was excerpted verbatim from the Primary Preceptor Manual of the Primary Care Associate Program 2011-2013 offered at Stanford University. The manual is provided with free access online via http://pcap.standford.edu and at the following contact: 1215 Welch Road, Modular G, Palo Alto, CA 94305-5408, (650) 725-6959. This specific example is provided because of its well defined structure and good description of the preceptorship experience in a medical discipline.

Primary Preceptor

The Primary Preceptor is a physician who is the clinical mentor of the PA student. Each student must have a Primary Preceptor who provides a clinical "home" for part of the student's training. Preferably the Primary Preceptor will be a Family Medicine physician. The student can train with an Internal Medicine physician but will need to complement it with clinical sites in pediatric, obstetric/ gynecological and other sites to complete their required clinical training.

The responsibilities of the Primary Preceptor are:

- Provide a physical location, adequate clinical space, and provide or help arrange a variety of patient encounters necessary for a primary care learning experience for the PA student

- Remain on-site at all times when the student is on-site for training
- Precept only one PA student at a time
- Contact the Preceptor Administrative Assistant as needed to receive a copy of the PCAP student portfolio of vaccines and pre-clinical preparation which is on file in the PCAP office. Should an individual clinic or facility have additional requirements or safety orientation (drug screening, background check, etc.), Primary Preceptors are responsible for ensuring that students are aware of and fulfill those requirements
- Review the student clinical requirements (e.g. for variety of patients including pediatrics, women's health, and geriatrics) to insure that the clinical requirements are realizable in the preceptor's practice site. If not, the preceptor will inform the student so that he/she can make other arrangements for their completion
- Provide the required number of hours for the student to perform clinical activities in order to develop the student's skills and to insure proper patient care
- Supervise, demonstrate, teach, and observe the student in clinical activities in order to develop the student's skills and to insure proper patient care

- Provide gradually increasing levels of responsibility in clinical identification of problems and in clinical patient management as the student's clinical competence develops
- Review with the student the "Goals and Objectives" section of the curriculum (distributed to the students each quarter) in order to identify the problem areas and provide specific teaching demonstrations for the student or other instructions to resolve these problems areas.
- Allow student to utilize the problem-oriented medical record system notations and problem lists in record keeping. Students may use electronic medical records for charting or hand written notes. Preferably the notes will be inserted into the actual patient chart. If this is not allowed, the student will write a note and keep it in a separate portfolio.
- Sign each note written by the student, preferably within 24 hours of the patient encounter. . Signatures are required whether the note is in the actual patient chart or in the student's portfolio.
- Assistant Preceptors must have the responsible supervising physician sign the student note within 7 days of the patient encounter

- Within HIPAA guidelines support the student in maintaining their records in an electronic system (EValue) with diagnoses for all patients seen by the student. As well, the preceptor will allow the student to maintain a clinical log with HIPAA-appropriate patient identifiers listed in each system or disease category
- Maintain malpractice and liability insurance that provides coverage for the Primary Preceptor and his/her employees
- Participate in the evaluation of the student's clinical skills and didactic knowledge base through the following mechanism:
  - o Direct supervision, observation, and teaching in the clinical setting
  - o Student oral presentation to the preceptor
  - o Dialogue with faculty during site visits to evaluate student's progress and to assist the student's learning process
  - o Chart audits of student progress notes and history and physical write-ups on patients seen
  - o Quarterly formal written evaluation reports to the central program office
  - o Facilitate relations between the student and the office staff in the practice site, as well as with other health professionals in the medical community

- Notify the program should any problems arise that would prevent the preceptor from accomplishing the above items or diminish the training experience for the student. It is the program's intention to have a complete open faculty-colleague relationship with the preceptor. Early notification of problems will facilitate early problem solving and will improve the training experience for the student.

Additional Preceptors

Assistant Preceptor: The Primary Preceptor may allow a Nurse Practitioner (NP) or a Physician Assistant (PA) that works with him/her to act as teaching assistant in instructing the PA student. The Primary Preceptor needs to be on site and he/she needs to co-sign all the student's chart notes. The Assistant Preceptor will be required to undergo the program's review and approval of their credentials. The Primary Preceptor has the ultimate responsibility for the PA student's clinical training.

Secondary or Supplemental Preceptor: A physician who has agreed to precept a student for a given period of time in a specific area of medicine (e.g., obstetrics and gynecology, pediatrics, orthopedics, dermatology).

Appendix B

Dear Participant,
The purpose of this study is to determine the supervisory and training practices currently in use by supervisors of psychology trainees in the primary care setting and other related aspects of supervision. These results will inform the establishment of best practices for primary care psychology training and are part of ongoing research in this area.
Instructions:
1. Please read all information presented and answer accordingly.
2. You must provide a response to each question to proceed to the next question. However, you are able to use the 'back' button to change an answer if necessary.
3. Your responses will be saved for several days if you need to stop and resume the survey at a later time.
4. The end of the survey will automatically redirect you to a separate link in which you may enter your email address to be eligible to receive a copy of the study's results.

NOTE: Email addresses are collected in a secondary form to ensure participants' identifying information is separate and responses on the survey are kept confidential.

Your completion of these instructions and continuation beyond this page will be considered your consent to participate in this study. Participation in this study is strictly voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. All information that you provide will be kept entirely confidential. There are no foreseeable risks involved in participating in this study. Benefits of participating in the study may include gaining awareness of supervisory practices currently in use by supervising psychologists at other primary care training sites.
Please feel free to contact me, kbranch2011@my.fit.edu, or my supervisor, kvansickle@fit.edu, with any questions or feedback regarding the study.

Regards,
Karly A. Branch, M.S.

Appendix C

1) What is your age? [Drop-down menu options 21-85]

2) What is your gender?
- Male
- Female
- Gender Non-conforming/Gender fluid
- Other, Self-identify _____

3) What is your profession?
- Clinical Psychologist
- Social Worker
- Physician
- Psychiatrist
- Nurse Practitioner
- Mental Health Counselor
- Other, Self-identify

4) How long have you been licensed?
- 0-2 years
- 2-5 years
- 6-10 years
- 11-20 years
- More than 20 years

5) How long have you worked in (or with) mental healthcare <u>in the primary care setting</u>?
- 0-2 years
- 3-5 years
- 6-10 years
- 11-20 years
- More than 20 years

6) Some sites offer more than one level of training experience (doctoral, internship, postdoctoral).
FOR EXAMPLE: Your organization may provide practicum experience for doctoral students AND an internship training program OR you provide an internship training program AND a postdoctoral fellowship training.

Please select the statement below that is true for your site:

- My site offers ONLY ONE training experience.
- My site offers two or more levels of training experience.

6.1a) [If first option selected for #6] Which single training experience does your site offer?

- Doctoral Level (Practicum)
- Internship
- Fellowship/Postdoctoral

6.1b) [If second option selected for #6] Which training experiences does your site offer? (select all that apply)

- Doctoral Level (Practicum)
- Internship
- Fellowship/Postdoctoral

6.1b.1) You indicated your site offers two or more types of training experiences.
We ask that you choose below ONLY ONE of these training experiences on which to base the remainder of your survey responses.
Which training experience will you be basing your survey responses on?

- Doctoral Level (Practicum)
- Internship
- Fellowship/Postdoctoral

6.2) [For respondents who are answering based on their "Doctoral Level (Practicum) training program]
At what year in their academic program are students able to start at your facility? (select all that apply)

- 1st
- 2nd
- 3rd
- 4th or later

PROMPT: [Depending on respondents answer to question #6.1a or #6.1b.1, they received the appropriate prompt] The remainder of this survey frequently uses the term "trainee." In your case, please interpret this term to refer only to the [practicum/intern/postdoctoral] trainees at your primary care site.

In other words, please base the remainder of your survey responses **exclusively** on this [**doctoral level (practicum)/internship/postdoctoral] training experience offered at your primary care site**.

7) Use these criteria from APA to answer the following question:
Major = Two or more major rotations (16-40 hours per week) in primary care
Emphasis = One major rotation (16-40 hours per week) in primary care
Experience = One or more minor rotations (1 day a week) in primary care
Exposure = Limited introduction (1-4 hours per week) to primary care

How is your primary care psychology training program classified in terms of level of training experience provided?

- Major
- Emphasis
- Experience
- Exposure
- I'm unsure of the program's current classification

8) What type of facility do these students work in (pick the option that best describes)?

- Private primary care practice (includes independent, group, pediatric, family, adult, geriatric)
- Community Health Center (e.g., Federally Qualified Health Center, rural health center, Indian Health Center, patient-centered medical home)
- Veteran's Affairs Medical Center
- Private or Public Medical Hospital (includes academic health centers)
- School/University Clinic (serving student body)
- Public Health Department
- In none of the above options fit, please list facility type here

  _____

9) What primary care model best describes how your site operates?

- Co-located care
- Co-located *and* collaborative care
- Integrated care (e.g., PCBH (primary care behavioral health model), team-based)
- *Officially recognized* patient-centered medical home (PCMH) / PACT (patient-aligned care team)
- If no option above fits, please write description here

  _____

10) What patient services are offered by trainees at your site? (Select all that apply)
- Intervention/Treatment (Brief)
- Intervention/Treatment (Group)
- Intervention/Treatment (Telemedicine)
- Intervention/Treatment (Individual)
- Intervention/Treatment (Family/Couples)
- Intervention/Treatment (Children/Adolescents)
- Case Management
- Psychoeducational Groups
- Screenings
- Psychological Evaluations/Testing (e.g., for surgery candidacy) – does NOT include brief screenings
- Crisis Intervention
- Warm-handoff/same-day triage
- Please list any others here _____

11) In addition to patient services, what other training opportunities does your program offer to its trainees? (please select all that apply)
- Collaboration/Consultation/Liaison (with medical team members)
- Staff Training/PCP Education
- Research in primary care
- Opportunities to supervise less experienced trainees (trainee-supervisor)
- Teaching academic courses
- Program Development
- Quality Improvement
- Please list any others here _____

12) How many on-site supervisors of primary care psychology trainees are involved in training at your facility?

13) What is the total number of hours/week in the clinic for supervisors of primary care psychology trainees (total of all individuals' hours)?
For example, if your site has one full-time supervisor who works 40 hours/week and one part-time supervisor who is on site for 20 hours/week, then your answer would be 60 hours/week regardless of whether their time at the facility overlaps. Type your answer below. _____

14) What is the total number of [practicum/intern/postdoctoral] trainees your site has per semester:

15) What is the total # of hours/week in the clinic for the trainees?
For example, if your site has 3 same-level trainees, each working in the clinic for 15 hours/week, your response would be 45.
Please write the total of all trainees' hours below. _____

16) What is the frequency of scheduled group supervision for trainees at your site?
- No scheduled group supervision occurs
- 1 day/month
- 2 days/month
- 1 Day/week
- 2 Days/week
- 3 Days/week

16.1) [If applicable] Typically, how long are the scheduled group supervision meetings?
- 1 hour
- 1.5 hours
- 2 hours
- 3 or more hours
- If it varies, please elaborate here. _____

16.2) [If applicable] Who attends your scheduled group supervision sessions? (Please check all that apply.)
- Doctoral Trainees
- Intern Trainees
- Fellows/Postdoctoral residents
- Licensed Psychologist(s)
- Licensed Social Worker/Mental Health Counselor(s)
- Case Manager(s)
- PCP(s)
- Please list any others here _____

17) What is the frequency of **scheduled** individual supervision per trainee?
- No scheduled individual supervision occurs
- 1 day/month
- 2 days/month
- 1 day/week
- 2 days/week
- 3 days/week
- 4 or more days/week

17.1) Typically, how long is each scheduled individual supervision meeting?
- Less than 1 hour
- 1 hour
- 1.5 hours
- 2 hours
- 2.5 or more hours

18) Does **unscheduled** individual supervision occur with trainees?
- Yes
- No

18.1) [If applicable] What communication methods are used between supervisor and trainee outside of scheduled supervision? (select all that apply)
- Text Messaging
- Phone Calls
- Messaging within EMR (electronic medical record)
- Email
- Office Drop-ins
- Please list any other methods here _____

18.2) What is the nature of unscheduled supervision? You may choose more than one answer (select all that apply):
- Only for crisis or urgent issues
- At trainee's request (for crisis and non-crisis issues, urgency not required)
- This is the primary form of individual supervision provided
- Often occurs in real time regarding patient care (i.e., while patient is present in the clinic)

19) What is the average frequency of supervisor consultations with PCP regarding trainee and/or trainees' cases?
- Less than 1 time/week
- 1 time/week
- 2 times/week
- 3 times/week
- 4+ times/week

20) What is the purpose of supervisors' consultations with PCP on trainees' cases (select all that apply)?
- Does not occur

- Medication issues
- Diagnostic information
- Patient Recommendations
- Trainee-specific issues
- Other, please list_____

21) Do trainees have the opportunity to supervise less experienced trainees?
- Yes
- No

PROMPT: If yes, the following few questions will refer to this role as "trainee-supervisor" defined as a trainee (doctoral, intern, or postdoc) who is supervising one or more less-experienced trainees.

21.1) [If applicable] Please select all of the trainee-supervisors' responsibilities below:
- Review Notes
- Conduct individual supervision with supervisees
- Attend group supervision meetings of supervisees
- Provide PCP education
- Modeling of conducting patient visits (trainee-supervisor is shadowed by supervisee)
- Please list any other responsibilities here _____

21.2) [If applicable] Do your trainee-supervisors receive supervision of supervision?
- Yes
- No

21.3) [If applicable] Do your trainee-supervisors receive training that addresses supervising in the primary care setting specifically (besides supervision of supervision)?
- Yes
- No

22) What is the frequency of didactic trainings (on any/all topics) offered to trainees at your primary care site?
- N/A - None offered
- Weekly
- Monthly
- Other: _____

22.1) [If applicable] Please select all the topics these trainings have covered (select all that apply):
- Introduction to Primary Care Behavioral Health
- Motivational Interviewing
- Common behavioral health presentations in primary care
- Understanding and adapting evidenced-based treatment in primary care
- Understanding pharmacological interventions and their impact on behavioral health
- Please list any others here

_____

23) Which one supervision model predominantly guides primary care psychology training in your program?
- Medical Model/Preceptorship
- Psychotherapy-based approach
- Developmental approach (e.g., IDM (Integrated Developmental Model))
- Process-based approach (e.g., DM (Discrimination Model), SAS (Systems Approach to Supervision))
- Competency-based approach
- If none of the above apply, please list your model here

_____

23.1) [If applicable] You selected "psychotherapy-based approach." Based primarily on what therapy model?
- Cognitive-Behavioral
- Psychodynamic
- Rational/Emotive
- Interpersonal
- Feminist
- Client-Centered/Rogerian
- Integrative
- If no option above fits, please list response here

_____

24) At any point in training, do trainees shadow supervisors conducting patient visits?
- Yes
- No

25) At any point in training, do trainees shadow PCPs/nurses?
- Yes
- No

26) During supervision, what is the estimated percentage of time spent on each category below? Please answer so that all numbers total 100%. If a category does not apply, enter '0.'
- Learning practical techniques and evidence-based interventions
- Administrative activities
- Consultation skills
- Documentation
- Patient care/case discussion
- Reviewing video recording of patient consultations
- Trainees' intrapersonal process issues
- Diversity and multicultural issues
- Other _____
- Other _____

27) Do you provide trainees with formal, written feedback on performance at the end of the term?
- Yes
- No

27.1) Who directly contributes to trainees' formal evaluative feedback at your primary care site (select all that apply)?
- Clinical supervisor
- Primary care physicians
- Nursing staff
- Administrative staff
- Peer (same-level trainees) feedback
- Trainee-supervisor
- Please list any other contributor(s) here

_____

28) Which of the following are competencies to be achieved by trainees at your site (select all that apply)?
- Clinical Practice Knowledge and Skills (e.g., role definition, problem identification, assessment, problem focus, population-based care, biopsychosocial approach, use of empirically-supported interventions, intervention design, multi-patient intervention skills, pharmacotherapy)

- Practice Management Skills (visit efficiency, time management, follow-up planning, intervention efficiency, visit flexibility, triage, case management, community resource referrals)
- Consultation Skills (referral clarity, curbside consultations, assertive follow-up, PCP education, recommendation usefulness, value-added orientation
- Documentation Skills (concise and clear charting, prompt PCP feedback, appropriate format)
- Administrative Knowledge and Skills (IPC policies and procedures, risk-management protocols, coding documentation, program development and quality improvement)
- Team Performance Skills (fit with primary care culture, knows team members, responsiveness, availability)
- Supervision Skills
- If any other, please list here

  _____

29) Are trainees expected to enter your site's program with any competencies already achieved? Which ones? (select all that apply)
- None expected
- Clinical Practice Knowledge and Skills (e.g., role definition, problem identification, assessment, problem focus, population-based care, biopsychosocial approach, use of empirically-supported interventions, intervention design, multi-patient intervention skills, pharmacotherapy)
- Practice Management Skills (visit efficiency, time management, follow-up planning, intervention efficiency, visit flexibility, triage, case management, community resource referrals)
- Consultation Skills (referral clarity, curbside consultations, assertive follow-up, PCP education, recommendation usefulness, value-added orientation
- Documentation Skills (concise and clear charting, prompt PCP feedback, appropriate format)
- Administrative Knowledge and Skills (BHC policies and procedures, risk-management protocols, coding documentation, program development and quality improvement)
- Team Performance Skills (fit with primary care culture, knows team members, responsiveness, availability)
- Supervision Skills
- If any others, please list here _____

30) Who is responsible for determining supervisee competencies to be achieved during the training experience?
- Supervisor only

- Supervisor and supervisee in collaboration
- Other, list here _____

31) As a supervisor, how much formal training have you received about providing supervision in general (in any setting)?
- 0 Hours/None
- 1-2 Hours/Minimal
- 3-5 Hours/Moderate
- 6+ hours/Substantial

31.1) How were you trained in supervision (select all that apply)?
- Supervision of supervision
- Skills Workshops
- Didactic Seminars
- Please list any other here _____

31.2) Regarding your training in supervision, generally speaking, how useful was it to you?
- Not useful
- Somewhat useful
- Very useful

31.3) What theoretical model(s) was the supervision training based on?
- Medical Model/Preceptorship
- Psychotherapy-based approach
- Developmental approach (e.g., IDM (Integrated Developmental Model))
- Process-based approach (e.g., DM (Discrimination Model), SAS (Systems Approach to Supervision)
- Competency-based approach
- If response not above, please write in choice here _____

31.3.1) [If applicable] You answered "psychotherapy-based approach." Based primarily on what therapy model(s)?
- Cognitive-Behavioral
- Psychodynamic
- Rational/Emotive
- Interpersonal
- Feminist
- Client-Centered/Rogerian
- Integrative

- If options above do not apply, please list response here ___

31.4) Did you receive any supervision training specific to integrated primary care settings?
- Yes
- No

31.4.1) How much formal training have you received about providing supervision in the primary care setting specifically?
- None
- 1-2 Hours/Minimal
- 3-5 Hours/Moderate
- 6+ Hours/Substantial

31.4.1.1) What type of supervisor training in primary care did you receive? (select all that apply)
- Supervision of supervision
- Skills Workshop(s)
- Didactic Seminar(s)
- Please list any others here

_____

31.4.1.2) Generally speaking, how useful was the primary care supervision training you have received?
- Not useful
- Somewhat useful
- Very useful

32) What do you feel are some of the barriers to providing adequate supervision at your facility? (check all that apply)
- No perceived barriers
- Supervisor Time
- Trainee Time
- Lack of space
- Inability to bill for related time
- Pleas list any other barriers here _____

33) How much supervisory experience do you have in your current setting?
- Less than a year

- 1-2 years
- 3-5 years
- 6-10 years
- Over 10 years

34) How long have you been a clinical supervisor in total?
- Less than a year
- 1-2 years
- 3-5 years
- 6-10 years
- Over 10 years

35) How often do diversity issues arise in supervision?
- Never
- Rarely
- Sometimes
- Often

36) What types of diversity issues have you encountered in supervision?
- Race/Ethnicity
- Religion/Spirituality
- Gender
- Sexual Orientation
- Please list any other diversity issues encountered here
  _____

37) Did you receive training on how to deal with diversity issues in supervision?
- Yes
- No

  37.1) What type of training did you receive (select all that apply)?
  - Academic (Graduate class)
  - Supervision of Supervision
  - Didactic Seminar
  - Skills Workshop
  - Please list any other here _____

38) During the course of a semester, how much of your supervision time is devoted to addressing issues related to diversity?
- 5-20%
- 21-40%

- 41-60%
- 61-80%
- 81-100%

39) Of supervision time spent on addressing issues related to diversity, please estimate what percentage is spent on each of these areas.
Please provide answers that total to 100%. You may use '0' if that area is not applicable.
   - Patient diversity issues
   - Trainee diversity issues
   - Staff/team diversity issues

40) Please check all the items below that you consider to be essential techniques you intentionally use to supervise trainees in the primary care setting. (In other words, techniques that you employ regularly with trainees.)
   - Precepting – a means of teaching and modeling the skills and knowledge necessary for providing primary care mental health treatment in the clinical setting in real time with real cases (i.e., supervision that is integrated throughout the regular work day, not necessarily involving direct observation)
   - Direct Observation – supervisor is in the room with trainee, real-time
   - Video tape – Observation of videotaped patient visits
   - Case Discussion – in a group supervision setting
   - Case Discussion – in an individual supervision setting
   - Interprofessional Feedback – feedback from other members of treatment team
   - Feedback on EMR notes – feedback on written patient notes
   - Summative feedback – feedback that rates/compares supervisee to an expected standard or benchmark
   - Formative feedback – ongoing feedback intended to shape and improve supervisee's learning and growth
   - Shadowing within discipline– trainee shadows you or other experienced mental health provider in primary care setting
   - Shadowing outside discipline – trainee shadows practitioners specifically from other health disciplines (i.e., interprofessional training that helps supervisee acclimate to the primary care culture)
   - Expected competencies to be achieved are made clear and reviewed at beginning of supervisory relationship
   - Trainee provides formal feedback regarding training experience
   - Trainee conducts self-assessment of competency

- Trainee receives didactic training experiences – readings, seminars, workshops, etc.

40.1) The items you selected on the previous page are listed below. Please think about how important you believe each is to training in terms of being most helpful in honing the trainees' skills for the primary care setting **specifically**. Please rank them (by clicking and dragging) in the order of importance with the top item being the most helpful/important to the last item being least important in preparing the trainee for competency specifically in primary care.

- [Items choices are those selected in the previous question.]

41) Of the items you did not select (techniques that you do not use regularly when supervising trainees), which one or more do you believe could be most valuable to your trainees if incorporated into their training?
Please select all that you wish you could incorporate into the training program if resources (funding, time, space, etc.) were not an issue.
If you do not feel that any of them would be helpful techniques you would like to incorporate, select "None of these" from the list below.

- None of these
- [Other item choices are those NOT selected in question #41]

Table 1

Clinical Psychology Clusters and Associated Competencies

Foundational Clusters	Competency Groups
Professionalism	Professional Values and Attitudes Individual and Cultural Diversity Ethical Legal Standards and Policy Reflective Practices/Self-Assessment/Self-Care
Relational	Relationships
Science	Scientific Knowledge and Methods Research/Evaluation
Functional Clusters	
Application	Evidence-Based Practice Assessment Intervention Consultation
Education	Teaching Supervision
Systems	Interdisciplinary Systems Management-Administration Advocacy

Source: APA, 2011a

Table 2

Supervision Competencies Elaborated with Examples of Behavioral Anchors

13. Supervision: Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others.		
READINESS FOR PRACTICUM	**READINESS FOR INTERNSHIP**	**READINESS FOR ENTRY TO PRACTICE**
13A. Expectations and Roles		
Demonstrates basic knowledge of expectations for supervision Examples: • Demonstrates knowledge of the process of supervision • Articulates components of effective supervision such as the working alliance	**Demonstrates knowledge of, purpose for, and roles in supervision** Examples: • Identifies roles and responsibilities of the supervisor and supervisee in the supervision process • Demonstrates understanding of supervisor and supervisee roles in relation to client • Demonstrates understanding of vicarious liability of the supervisor	**Understands the ethical, legal, and contextual issues of the supervisor role** Examples: • Articulates a model of supervision and reflects on how this model is applied in practice, • Integrates contextual, legal, and ethical perspectives in supervision vignettes • Writes supervisory contract that accurately reflects roles and expectations of supervisor and supervisee

Table 2 (cont.)

READINESS FOR PRACTICUM	READINESS FOR INTERNSHIP	READINESS FOR ENTRY TO PRACTICE
13B. Processes and Procedures		
No expectation at this level	**Identifies and tracks progress achieving the goals and tasks of supervision; demonstrates basic knowledge of supervision models and practices** Examples: • Presents goals and related tasks of supervisee's growth and development • Demonstrates ability to monitor and communicate progress on goals	**Demonstrates knowledge of supervision models and practices; demonstrates knowledge of and effectively addresses limits of competency to supervise** Examples: • Prepares supervision contract (cont. next page) • Assesses supervision competency • Constructs plans to deal with areas of limited competency • Articulates range of supervision methods available and the utility of such methods • Demonstrates knowledge of the scholarly literature on supervision • Identifies the basic tenets of specific model of supervision

Table 2 (cont.)

READINESS FOR PRACTICUM	READINESS FOR INTERNSHIP	READINESS FOR ENTRY TO PRACTICE
13C. Skills Development		
Displays interpersonal skills of communication and openness to feedback Examples: • Completes self-assessment (e.g., Hatcher & Lassiter, 2006) • Integrates faculty/supervisor feedback into self-assessment	**Demonstrates knowledge of the supervision literature and how clinicians develop to be skilled professionals** Examples: • Successfully completes coursework on supervision • Demonstrates formation of supervisory relationship integrating theory and skills including knowledge of development, educational practice	**Engages in professional reflection about one's clinical relationships with supervisees, as well as supervisees' relationships with their clients** Examples: • Articulates how supervisory relationships may enhance the development of supervisees and their clients • Elicits evaluation from supervisee about supervisory relationship and uses feedback to improve quality of supervision

Table 2 (cont.)

READINESS FOR PRACTICUM	READINESS FOR INTERNSHIP	READINESS FOR ENTRY TO PRACTICE
13D. Supervisory Practices		
No expectation at this level	**Provides helpful supervisory input in peer and group supervision** Examples: • Identifies core skills on which to provide feedback to peers • Demonstrates ability to provide constructive criticism to peers	**Provides effective supervised supervision to less advanced students, peers, or other service providers in typical cases appropriate to the service setting** Examples: • Helps supervisee develop evidence based treatment plans • Directs supervisee to literature that may inform case • Provides supervision input according to developmental level of supervisee • Encourages supervisee to discuss reactions and helps supervisee develop strategies to use reactions in service of clients • Presents supervisor of supervision with accurate account of case material and supervisory relationship, seeks input, and utilizes feedback to improve outcomes

Source: APA, 2011b

Table 3

Primary Care Psychology Clusters and Associated Competencies

Clusters	Competency Groups
Science	Science related to the biopsychosocial approach Research/evaluation
Systems	Leadership/administration Interdisciplinary systems Advocacy
Professionalism	Professional values and attitudes Individual, cultural, and disciplinary diversity Ethics in primary care Reflective practice/self-assessment/self-care
Relationships	Interprofessionalism Building and sustaining relationships in primary care
Application	Practice management Assessment Intervention Clinical consultation
Education	Teaching Supervision

Source: McDaniel et al., 2014

Table 4

Competency Domain – Supervision

Essential Components	Example Behavioral Anchors
Understands the ethical, legal, and contextual issues of the supervisor role in PC	• Ensures that PC psychology training program meets all accreditation requirements • Outlines competency expectations for PC psychology and regularly provides feedback to trainees on progress
Applies a range of methods to the supervision of psychology trainees	• Supervises in a variety of ways, including case discussion, direct observation, and precepting • Creates opportunities for psychology trainees to receive supervision from colleagues from other disciplines

Source: McDaniel et al., 2014

Table 5

Demographic Characteristics of Sample

	WS		P		I		PD	
	n	%	n	%	n	%	n	%
Gender								
Female	26	66.7	4	66.7	14	70.0	8	61.5
Male	13	33.3	2	33.3	6	30.0	5	38.5
Total	39	100.0	6	100.0	20	100.0	13	100.0
Profession								
Clinical Psychologist	37	94.9	6	100.0	20	100.0	11	84.6
Counseling Psychologist	2	5.1	0	0	0	0	2	15.4
Total	39	100.0	6	100.0	20	100.0	13	100.0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs. (cont. on next page)

Table 6

Professional Experience of Participants

	WS		P		I		PD	
	n	%	n	%	n	%	n	%
Time Licensed								
0-2 Years	3	7.7	0	0	2	10.0	1	7.7
3-5 Years	8	20.5	0	0	4	20.0	4	30.8
6-10 Years	11	28.2	2	33.3	7	35.0	2	15.4
11-20 Years	11	28.2	1	16.7	6	30.0	4	30.8
>20 Years	6	15.4	3	50.0	1	5.0	2	15.4
Total	39	100.0	6	100.0	20	100.0	13	100.0
Time as Supervisor								
Less than 1 Year	0	0	0	0	0	0	0	0
1-2 Years	5	12.8	0	0	4	20	1	7.7
3-5 Years	9	23.1	1	16.7	4	20	4	30.8
6-10 Years	9	23.1	1	16.7	5	25	3	23.1
Over 10 Years	16	41.0	4	66.7	7	35	5	38.5
Total	39	100.0	6	100.0	20	100	13	100.0
Time in a PC Setting								
0-2 Years	5	12.8	0	0	5	25.0	0	0
3-5 Years	10	25.6	1	16.7	4	20.0	5	38.5
6-10 Years	15	38.5	3	50.0	9	45.0	3	23.1
11-20 Years	9	23.1	2	33.3	2	10.0	5	38.5
Over 20 Years	0	0	0	0	0	0	0	0
Total	39	100.0	6	100.0	20	100.0	13	100.0
Time in Current PC Setting								
Less than 1 year	1	2.6	0	0	1	5	0	0
1-2 Years	6	15.4	0	0	4	20	2	15.4
3-5 Years	15	38.5	2	33.3	8	40	5	38.5
6-10 Years	10	25.6	3	50.0	4	20	3	23.1
Over 10 Years	7	17.9	1	16.7	3	15	3	23.1
Total	39	100.0	6	100.0	20	100	13	100

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.

Table 7

Program Characteristics

	WS		P		I		PD	
	n	%	n	%	n	%	n	%
APA Classification (N = 39)								
Major	21	53.8	2	33.3	10	50.0	9	69.2
Emphasis	10	25.6	2	33.3	7	35.0	1	7.7
Exposure	4	10.3	2	33.3	1	5.0	1	7.7
Experience	3	7.7	0	0	2	10.0	1	7.7
Unknown	1	2.6	0	0	0	0	1	7.7
Type of Facility (N = 39)								
VA Medical Hospital	18	46.2	0	0	11	55.0	7	53.8
Community Health Ctr.	10	25.6	4	66.7	4	20.0	2	15.4
Private or Public Hospital	8	20.5	2	33.3	4	20.0	2	15.4
Private Primary Care Practice	3	7.7	0	0	1	5.0	2	15.4
Primary Care Model (N = 39)								
Officially recognized PCMH/PACT	18	46.2	3	50.0	7	35.0	8	61.5
Integrated care	12	30.8	1	16.7	8	40.0	3	23.1
Co-located and collaborative	7	17.9	2	33.3	3	15.0	2	15.4
Co-located	1	2.6	0	0	1	5.0	0	0
Other/Multiple sites	1	2.6	0	0	1	5.0		
Programs Offered (N = 39)								
Practicum, Internship, & Postdoc	16	41.0	0	0	10	50.0	6	46.2
Internship & Postdoc	10	25.6	0	0	4	20.0	6	46.2
Practicum Only	6	15.4	6	100.0	0	0	0	0
Practicum & Internship	5	12.8	0	0	5	25.0	0	0
Practicum & Postdoc	1	2.6	0	0	0	0	1	7.7
Internship Only	1	2.6	0	0	1	5.0	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.

Table 8

Predominant Supervision Model Used within Each Program

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Competency-based Approach	16	41.0	3	50.0	7	35.0	6	46.2
Developmental Approach	11	28.2	0	0	8	40.0	3	23.1
Medical Model/ Preceptorship	4	10.3	2	33.3	0	0	2	15.4
Psychotherapy-based Approach								
CBT	1	2.6	0	0	1	5.0	0	0
Integrative	1	2.6	0	0	1	5.0	0	0
Rational/Emotive	0	0	0	0	0	0	0	0
Interpersonal	0	0	0	0	0	0	0	0
Feminist	0	0	0	0	0	0	0	0
Client-Centered/ Rogerian	0	0	0	0	0	0	0	0
Other								
Unspecified/Various	3	7.7	0	0	2	10.0	1	7.7
Medical Model/ Psychotherapy- based Combo	1	2.6	1	16.7	0	0	0	0
Indigenous Psychology Mentorship Model	1	2.6	0	0	1	5.0	0	0
Reflective Supervision	1	2.6	0	0	0	0	1	7.7
Process-based Approach	0	0	0	0	0	0	0	0
Total	39	100	6	100	20	100	13	100

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was required to select only one option.
The percentages shown represent the portion of the sample (indicated below) that selected each item. Figure 1 displays the equivalent WS data in pie chart form.
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)

Table 9

Patient Services Offered by Trainees in the Programs

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Brief Treatment	39	100.0	6	100.0	20	100.0	13	100.0
Individual	38	97.4	6	100.0	19	95.0	13	100.0
Screenings	35	89.7	5	83.3	18	90.0	12	92.3
Warm Hand-off/Same-day	33	84.6	5	83.3	17	85.0	11	84.6
Crisis Intervention	32	82.1	5	83.3	14	70.0	13	100.0
Group Treatment	27	69.2	3	50.0	15	75.0	9	69.2
Family & Couples	24	61.5	4	66.7	14	70.0	6	46.2
Psychological Evaluations	23	59.0	2	33.3	15	75.0	6	46.2
Psychoeducational Groups	22	56.4	1	16.7	12	60.0	9	69.2
Child & Adolescents	17	43.6	4	66.7	8	40.0	5	38.5
Traditional Psychotherapy	16	41.0	2	33.3	9	45.0	5	38.5
Telemedicine	9	23.1	1	16.7	7	35.0	1	7.7
Case Management	9	23.1	0	0	5	25.0	4	30.8
Other	3	12.8	0	0	0	0	3	23.1

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable.
The percentages shown represent the portion of the sample (indicated below) that selected each item.
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: after-hours telephone on call, assistance with injection administrations, and unspecified

Table 10

Other Training Opportunities Offered to Trainees in the Programs

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Collaboration/Consultation/ Liaison	38	97.4	6	100.0	19	95	13	100
Staff Training/PCP Education	29	74.4	3	50.0	14	70	12	92.3
Quality Improvement	24	61.5	2	33.3	11	55	11	84.6
Program Development	22	56.4	2	33.3	11	55	9	69.2
Supervision of Less Advanced Trainees	20	51.3	3	50.0	8	40	9	69.2
Research in PC	18	46.2	3	50.0	6	30	9	69.2
Teaching Academic Courses	3	7.7	1	16.7	0	0	2	15.4

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable.
The percentages shown represent the portion of the sample that selected each item.
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)

Table 11

Group Supervision Attendees

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Licensed Psychologist	24	80.0	5	83.3	13	81.3	6	75
Doctoral Trainees	N/A		--	--	5	31.3	1	12.5
Interns	N/A		0	0	--	--	5	62.5
Postdoc Trainees	N/A		1	16.7	7	43.8	--	--
Social Worker/ MH Counselor	6	20.0	2	33.3	3	18.8	1	12.5
Other	5	16.7	1	16.7	2	12.5	2	25
PCPs	2	6.7	0	0	0	0	2	25
Case Manager	1	3.3	0	0	0	0	1	12.5

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 30 (9 sites (23.1% of entire sample) do not conduct scheduled group supervision). Above percentages are based on n = 30.
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 16 (4 of 20 internship sites (20% of subsample) do not conduct scheduled group supervision). Above percentages are based on n = 16.
[d]Number of Participants Responding = 8 (5 of 13 internship sites (38.5%) do not conduct scheduled group supervision). Above percentages are based on n = 8.

Table 12

Communication Methods Used between Supervisor and Trainee

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Office Drop-in	37	94.9	5	83.3	20	100	12	92.3
Phone	33	84.6	4	66.7	18	90	11	84.6
Email	31	79.5	3	50.0	18	90	10	76.9
Text Messaging	26	66.7	3	50.0	14	70	9	69.2
EMR Messages	19	48.7	2	33.3	10	50	7	53.8
Other	16	41.0	4	66.7	6	30	6	46.2

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: instant messaging (Lync, Google, etc.), video conference, paging, precepting (in-vivo, between patient encounters, at point of care/rounds)

Table 13

Nature of Unscheduled Supervision

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
At Trainees' Request (Crisis and Non-crisis issues)	36	92.3	5	83.3	19	95	12	92.3
Often in real-time re: patient care (occurring while patient is present in clinic)	34	87.2	5	83.3	17	85	12	92.3
The primary form of individual supervision provided	3	7.7	3	50.0	0	0	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)

Table 14

Purpose of Supervisors' Consultations with PCP

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Patient Recommendations	24	61.5	4	66.7	13	65.0	7	53.8
Medication Issues	21	53.8	4	66.7	11	55.0	6	46.2
Diagnostic Information	19	48.7	4	66.7	9	45.0	6	46.2
Trainee-specific Issues	11	28.3	2	33.3	2	10.0	7	53.8
Other	6	15.4	1	16.7	3	15.0	2	15.4
Does not consult with PCP	6	15.4	0	0	3	15.0	3	23.1

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: joint supervision occurs, co-treatment, provide psychoeducation to PCP about psychological interventions used by trainee, provide PCP feedback, maintain clinic relationships, familiarize trainee with medical culture/PCPs, only at time of formal evaluation

Table 15

Supervision Duties of Trainees (for supervision of less advanced trainees)

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Modeling of conducting patient visits (shadowed by supervisee)	20	95.2	4	100.0	6	85.7	10	100
Conduct Individual Supervision with Supervisees	15	71.4	3	75.0	4	57.1	8	80
Review Notes	13	61.9	3	75.0	5	71.4	5	50
Attend Group Supervision Meetings of Supervisees	11	52.4	4	100.0	2	28.6	5	50
Provide PCP Education	9	42.9	1	25.0	3	42.9	5	50
Other	3	14.3	1	25.0	1	14.3	1	10

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 21 (18 sites (46.2% of entire sample) do not offer trainees the opportunity to supervise). Percentages above are based on n = 21.
[b]Number of Participants Responding = 4 (2 of 6 practicum sites (33.3%) do not offer trainees the opportunity to supervise). Percentages above are based on n = 4.
[c]Number of Participants Responding = 7 (13 of 20 internship sites (65%) do not offer trainees the opportunity to supervise). Percentages above are based on n = 7.
[d]Number of Participants Responding = 10 (3 of 13 postdoctoral sites (23.1%) do not offer trainees the opportunity to supervise). Percentages above are based on n = 10.
Participants offered the following additions in the "Other" category: provide summative evaluation of supervisees, Journal Club, direct instruction (e.g., teaching motivational interviewing techniques)

Table 16

Didactics Offered in the Training Program

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Common BH Presentations in PC	35	89.7	6	100.0	18	90	11	84.6
Understanding & Adapting Evidence-Based Tx in PC	32	82.1	5	83.3	17	85	10	76.9
Introduction to PCBH	31	79.5	4	66.7	16	80	11	84.6
Motivational Interviewing	31	79.5	5	83.3	16	80	10	76.9
Understanding Pharmacological Interventions & their impact on BH	27	69.2	4	66.7	13	65	10	76.9
Other	6	15.4	0	0	2	10	4	30.8
Does not offer didactic training	1	2.6	0	0	0	0	1	7.7

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: Testifying in Court, Religious Issues in Treatment, HIV/AIDS, Cultural issues, Play Therapy, Family Therapy, Acceptance and Commitment Therapy (ACT), Healthcare Policy/Financial Sustainability, Leadership, Functional Assessment, Geriatric Primary Care, Screening, Assessing Capacity, Suicide Prevention and Risk Assessment, Rapid Assessment

Table 17

Contributors to Written Feedback for Trainee

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Supervisor	39	100.0	6	100.0	20	100	13	100
Trainee-Supervisor	10	25.6	2	33.3	5	25	3	23.1
PCPs	8	20.5	1	16.7	4	20	3	23.1
RNs	4	10.3	0	0	1	5	3	23.1
Administrative Staff	4	10.3	0	0	2	10	2	15.4
Other	4	10.3	0	0	0	0	4	30.8
Peers	1	2.6	0	0	0	0	1	7.7

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable.
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: on-site clinical director gives feedback to postdoc leadership team, psychology training council, interprofessional partners, other primary care rotation supervisors.

Table 18

Competencies to Be Achieved by Trainees during Program

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Clinical Practice Knowledge & Skills	38	97.4	6	100.0	20	100	12	92.3
Consultation Skills	38	97.4	6	100.0	19	95	13	100
Documentation Skills	38	97.4	5	83.3	20	100	13	100
Practice Management Skills	36	92.3	6	100.0	17	85	13	100
Team Performance Skills	36	92.3	5	83.3	18	90	13	100
Administrative Knowledge & Skills	34	87.2	4	66.7	17	85	13	100
Supervision Skills	14	35.9	3	50.0	4	20	7	53.8
Other	2	5.1	0	0	1	5	1	7.7

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs. For definition of terms, see Appendix C, question #28. Each participant was able to select multiple options as applicable.
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: teaching residents, basic clinical skills

Table 19

Competencies Trainees Are Expected to Have Achieved Prior to Program Entry

	WS[a]		P[a]		I[a]		PD[a]	
	n	%[b]	n	%[c]	n	%[d]	n	%[e]
None Expected	23	---/ 59.0	1	---/ 16.7	14	--- / 70	8	---/ 61.5
Clinical Practice Knowledge & Skills	15	93.7/ 38.5	4	80/ 66.7	6	100/ 30	5	100/ 38.5
Documentation Skills	9	56.3/ 23.1	2	40/ 33.3	3	50/ 15	4	80/ 30.8
Practice Management Skills	5	31.2/ 12.8	1	20/ 16.7	2	33.3/ 10	2	40/ 15.4
Team Performance Skills	5	31.2/ 12.8	1	20/ 16.7	2	33.3/ 10	2	40/ 15.4
Consultation Skills	2	12.5/ 5.1	0	0	0	0	2	40/ 15.4
Administrative Knowledge & Skills	1	6.2/ 2.6	0	0	0	0	1	20/ 7.7
Supervision Skills	0	0	0	0	0	0	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable. For definition of terms, see Appendix C, question #28.
[a]Number of Participants Responding = see below
[b]First % is based on n = 16 (23 sites of entire sample (59.0%) had no competency expectations of incoming trainees beyond basic clinical skills); Second % is based on n = 39.
[c]First % is based on n = 5 (1 of 6 practicum sites (16.7%) of subsample had no competency expectations of incoming trainees beyond basic clinical skills); Second % is based on n = 6.
[d]First % is based on n = 6 (14 of 20 internship sites (70%) of subsample had no competency expectations of incoming trainees beyond basic clinical skills); Second % is based on n = 20.
[e]First % is based on n = 5 (8 of 13 postdoctoral sites (46.2%) of subsample had no competency expectations of incoming trainees beyond basic clinical skills); Second % is based on n = 13.

Table 20

Type of Formal Supervision Training Received by Participants

	WS[a]		P[b]		I[c]		PD[d]	
	n	%[e]	n	%	n	%[f]	n	%
Didactic Seminar	32	88.9/ 82.1	6	100.0	13	76.5/ 65	13	100
Supervision of Supervision	27	75.0/ 69.2	4	66.7	12	70.6/ 60	11	84.6
Skills Workshop	20	55.6/ 51.3	3	50.0	7	41.2/ 35	10	76.9
Other	13	36.1/ 33.3	2	33.3	7	41.2/ 35	4	30.8
Did not receive formal training	3	---/ 7.7	0	0	3	---/ 15	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = see below
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = see below
[d]Number of Participants Responding = 13 (100% of subsample)
[e]First % is based on n = 36 (3 participants of entire sample (7.7%) reported receiving no formal training); Second % is based on n = 39.
[f]First % is based on n = 17 (3 of 20 internship participants (15%) reported receiving no formal training); Second % is based on n = 20.
Participants offered the following additions in the "Other" category: graduate course(s), practicum experiences as a trainee-supervisor, Continuing Education, and independent study/reading.

Table 21

Model(s) of Supervision in Which Participants Were Formally Trained

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Developmental Approach	22	61.1/ 56.4	2	33.3	11	64.7/ 55	9	69.2
Competency-based Approach	19	52.8/ 48.7	3	50.0	10	58.8/ 50	6	46.2
Psychotherapy-based Approach	7	19.4/ 17.9	3	50.0	3	17.6/ 15	1	7.7
Medical Model/ Preceptorship	6	16.7/ 15.4	1	16.7	3	17.6/ 15	2	15.4
Process-based Approach	4	11.1/ 10.3	1	16.7	2	11.8/ 10	1	7.7
Other	4	11.1/ 10.3	0	0	1	5.9/ 5	3	23.1
None received	3	---/7.7	0	0	3	---/ 15	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 39 (3 participants reported they did not receive formal training in supervision). First percentage based on n = 36. Second percentage based on n = 39.
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (3 internship supervisors reported they did not receive formal training in supervision). First percentage based on n = 17. Second percentage based on n = 20.
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: Reflective supervision, unspecified (including training occurring 30 years ago prior to development of supervision models)

Table 22

Psychotherapy-Based Approaches in Which Participants Were Formally Trained

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
CBT	5	71.4	2	66.7	2	66.7	1	100
Integrative	4	57.1	2	66.7	2	66.7	0	0
Psychodynamic	3	42.9	2	66.7	1	33.3	0	0
Interpersonal	3	42.9	2	66.7	1	33.3	0	0
Client-centered/Rogerian	1	14.3	0	0	1	33.3	0	0
Feminist	0	0	0	0	0	0	0	0
Rational/Emotive	0	0	0	0	0	0	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 7 (32 participants (82.1% of sample) either did not receive any formal training or received training based on a different type of approach). Percentages based on n = 7.
[b]Number of Participants Responding = 3 (50% of subsample – 50% received training based on a different type of approach). Percentages based on n = 3.
[c]Number of Participants Responding = 3 (15% of subsample – 85% received training based on a different type of approach). Percentages based on n = 3.
[d]Number of Participants Responding = 1 (7.7% of subsample – 92.3% received training based on a different type of approach). Percentages based on n = 1.

Table 23

Type of Supervision Training Participants Received Specifically for the PC Setting

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Did not receive formal training	33	---/ 84.7	5	---/ 83.3	18	---/ 90	10	---/ 76.9
Didactic Seminar	5	83.3/ 12.8	1	100.0/ 16.7	1	50/ 5	3	100/ 23.1
Supervision of Supervision	4	66.7/ 10.3	0	0	2	100/ 10	2	66.7/ 15.4
Skills Workshop	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable.
[a]First % is based on n = 6 (33 participants (84.7% of sample) reported they did not receive any formal training in supervision *specific to the PC setting*); Second % is based on n = 39.
[b]First % is based on n = 1 (5 participants of the subsample (83.3%) reported they did not receive any formal training in supervision *specific to the PC setting*); Second % is based on n = 6.
[c]First % is based on n = 2 (18 participants of the subsample (90%) reported they did not receive any formal training in supervision *specific to the PC setting*). Second % is based on n = 20.
[d]First % is based on n = 3 (10 participants of the subsample (76.9%) reported they did not receive any formal training in supervision *specific to the PC setting*). Second % is based on n = 13.

Table 24

Perceived Barriers to Providing Ideal Supervision

	WS[a]		P[b]		I[c]		PD[d]	
	n	%[e]	n	%	n	%[f]	n	%[g]
No Barriers	19	---/ 48.7	0	0	11	---/ 55	8	---/ 61.5
Supervisor's Time	17	85.0/ 43.6	6	100.0	8	88.9/ 40	3	60/ 23.1
Trainees' Time	7	35.0/ 17.9	3	50.0	3	33.3/ 15	1	20/ 7.7
Inability to Bill for Time	5	25.0/ 12.8	3	50.0	2	22.2/ 10	0	0
Lack of Space	3	15.0/ 7.7	2	33.3	0	0	1	20/ 7.7
Other	2	10.0/ 5.1	0	0	1	11.1/ 5	1	20/ 7.7

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable.
[a]Number of Participants Responding = see below
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = see below
[d]Number of Participants Responding = see below
[e]First % is based on n = 20 (19 participants (48.7% of entire sample) did not perceive any barriers to supervision); Second % is based on n = 39.
[f]First % is based on n = 9 (11 participants (55% of subsample) did not perceive any barriers to supervision); Second % is based on n = 20.
[g]First % is based on n = 5 (8 participants (61.5% of subsample) did not perceive any barriers to supervision); Second % is based on n = 13.
Participants offered the following additions in the "Other" category: "coddling," drive time to PCMH

Table 25

Diversity Issues Encountered During Supervision

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Race/Ethnicity	38	97.4	6	100.0	19	95	13	100
Religion/Spirituality	36	92.3	6	100.0	17	85	13	100
Gender	34	87.2	5	83.3	18	90	11	84.6
Sexual Orientation	33	84.6	6	100.0	16	80	11	84.6
Other	14	35.9	2	33.3	6	30	6	46.2

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)
Participants offered the following additions in the "Other" category: socioeconomic status (including education), ability/disability status (including medical and psychiatric conditions and with respect to functional impairment), veteran culture, immigration status, access to and experience with technology, aging issues, political views).
See Figure 6 for another view of estimated percentage of time spent on diversity issues in PC supervision.

Table 26

Types of Diversity Training Received by Participants

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Didactic Seminars	22	75.9/ 56.4	3	100/ 50.0	9	60/ 45	10	90.9/ 76.9
Academic course	19	65.5/ 48.7	1	33.3/ 16.7	10	66.7/ 50	8	72.7/ 61.5
Supervision of Supervision	14	48.3/ 35.9	1	33.3/ 16.7	9	60/ 45	4	36.4/ 30.8
Skills Workshop	12	41.4/ 30.7	0	0	4	26.7/ 20	8	72.7/ 61.5
Other	1	3.4/ 2.6	1	33.3/ 16.7	0	0	0	0
Did not receive formal training	10	---/ 25.6	3	---/ 50	5	---/ 25	2	---/ 15.4

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable.
[a]First % is based on n = 29 (25.6% (10) of entire sample reported receiving no formal training specifically regarding diversity issues in supervision); Second % is based on n = 39.
[b]First % is based on n = 3 (50% (3) of entire subsample reported receiving no formal training specifically regarding diversity issues in supervision); Second % is based on n = 6.
[c]First % is based on n = 15 (25% (5) of subsample reported receiving no formal training specifically regarding diversity issues in supervision); Second % is based on n = 20.
[d]First % is based on n = 11 (15.4% (2) of subsample reported receiving no formal training specifically regarding diversity issues in supervision); Second % is based on n = 13.
Participants offered the following additions in the "Other" category: Reading.

Table 27

Techniques Used by Participants and Deemed "Essential" to Training/Supervision in the Primary Care Setting

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Trainee Receives Didactic Trainings	37	94.9	4	66.7	20	100	13	100
Case Discussion (Individual)	36	92.3	3	50.0	20	100	13	100
Shadowing within Discipline	36	92.3	5	83.3	18	90	13	100
Formative Feedback	35	89.7	6	100.0	18	90	11	84.6
Expected Competencies Made Clear	35	89.7	3	50.0	20	100	12	92.3
Trainee Gives Feedback on Training Experience	34	87.2	3	50.0	19	95	12	92.3
Precepting	32	82.1	4	66.7	17	85	11	84.6
Direct Observation	32	82.1	4	66.7	18	90	10	76.9
Feedback on EMR Notes	30	76.9	4	66.7	16	80	10	76.9
Shadowing Outside Discipline	30	76.9	5	83.3	15	75	10	76.9
Trainee Self-Assesses Competence	29	74.4	3	50.0	14	70	12	92.3
Interprofessional Feedback	26	66.7	3	50.0	15	75	8	61.5
Case Discussion (Group)	25	64.1	6	100.0	12	60	7	53.8
Summative Feedback	25	64.1	3	50.0	14	70	8	61.5
Videotaping	3	7.7	1	16.7	2	10	0	0

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable.
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)

Table 28

Supervision Techniques Ordered by Average Ranked Value (Whole Sample)

	n	$\bar{x}$	RR	Range	SD
Precepting	32	11.1	1	2-15	4.43
Case Discussion (Individual)	32	11.1	1	4-15	2.98
Direct Observation	32	10.9	3	2-15	4.68
Shadowing within Discipline	32	10.5	4	3-15	3.26
Expected Competencies Made Clear	32	10.3	5	2-15	4.03
Formative Feedback	32	10.1	6	2.5-15	3.42
Feedback on EMR Notes	32	8.2	7	2.5-14	3.51
Trainee Receives Didactic Trainings	32	7.9	8	2-13	3.29
Case Discussion (Group)	32	7.5	9	1.5-15	4.47
Interprofessional Feedback	32	6.1	10	1.5-14	3.34
Trainee Self-Assesses Competence	32	5.9	11	2-14	3.14
Trainee Gives Feedback on Training Experience	32	5.8	12	2-14	2.96
Shadowing Outside Discipline	32	5.8	12	2-13	2.92
Summative Feedback	32	5.7	14	1-11	2.85
Videotaping	32	3.3	15	1-15	3.22

Note. RR = Relative Rank.
Mean, range, and standard deviation is based on 15 as highest rank and 1 as lowest rank. Seven participants' responses for this survey question were not recorded, apparently due to a survey software malfunction. Their data was unable to be included in the results. See Table 32 for ease of comparison. For definition of terms, see Appendix C, question #40.

Table 29

Supervision Techniques Ordered by Average Ranked Value (Practicum Programs Only)

	n	$\bar{x}$	RR	Range	SD
Direct Observation	5	12.2	1	4-15	4.6
Case Discussion (Group)	5	12.2	1	9-15	2.59
Shadowing within Discipline	5	11.4	3	8-13	2.07
Precepting	5	10.6	4	4-15	6.02
Feedback on EMR Notes	5	10.2	5	4-14	3.77
Formative Feedback	5	9.8	6	8-12	1.48
Case Discussion (Individual)	5	7.4	7	9-15	2.59
Trainee Receives Didactic Trainings	5	7.4	7	2-13	4.62
Shadowing Outside Discipline	5	7.4	7	4-12	3.13
Expected Competencies Made Clear	5	6.2	10	2-11	3.70
Interprofessional Feedback	5	6.2	10	4-11	3.58
Trainee Self-Assesses Competence	5	4.8	12	3-8	1.92
Trainee Gives Feedback on Training Experience	5	4.8	12	4-8	1.79
Summative Feedback	5	4.8	12	1-9	3.56
Videotaping	5	4.2	15	2-7	1.79

Note. RR = Relative Rank.
Mean, range, and standard deviation is based on 15 as highest rank and 1 as lowest rank. One participant's response for this survey question was not recorded, apparently due to a survey software malfunction. Their data was unable to be included in the results. See Table 32 for ease of comparison. For definition of terms, see Appendix C, question #40.

Table 30

Supervision Techniques Ordered by Average Ranked Value (Internship Programs Only)

	n	$\bar{x}$	RR	Range	SD
Case Discussion (Individual)	16	11.8	1	8-15	2.02
Precepting	16	11.4	2	3-15	3.84
Expected Competencies Made Clear	16	11.3	3	4-15	3.61
Direct Observation	16	11.2	4	3-15	4.01
Formative Feedback	16	10.7	5	3.5-15	3.19
Shadowing within Discipline	16	10.0	6	3-15	4.08
Trainee Receives Didactic Trainings	16	7.9	7	2-13	3.12
Feedback on EMR Notes	16	7.4	8	2.5-14	3.26
Case Discussion (Group)	16	6.5	9	1.5-12	4.41
Trainee Self-Assesses Competence	16	6.3	10	2-14	3.74
Interprofessional Feedback	16	5.8	11	1.5-11	3.15
Trainee Gives Feedback on Training Experience	16	5.7	12	2-13	2.72
Summative Feedback	16	5.5	13	1-10	2.50
Shadowing Outside Discipline	16	4.9	14	2-10	2.44
Videotaping	16	3.7	15	1-15	4.33

Note. RR = Relative Rank.
Mean, range, and standard deviation is based on 15 as highest rank and 1 as lowest rank. Four participants' responses for this survey question were not recorded, apparently due to a survey software malfunction. Their data was unable to be included in the results. See Table 32 for ease of comparison. For definition of terms, see Appendix C, question #40.

Table 31

Supervision Techniques Ordered by Average Ranked Value (Postdoctoral Programs Only)

	n	$\bar{x}$	RR	Range	SD
Case Discussion (Individual)	11	11.8	1	7-15	2.14
Precepting	11	10.9	2	2-15	4.89
Shadowing within Discipline	11	10.9	2	6-14	2.3
Expected Competencies Made Clear	11	10.5	4	4-15	3.91
Direct Observation	11	9.7	5	2-15	5.73
Formative Feedback	11	9.4	6	2.5-15	4.36
Feedback on EMR Notes	11	8.4	7	2.5-13	2.37
Case Discussion (Group)	11	6.8	8	2-14	4.12
Trainee Gives Feedback on Training Experience	11	6.5	9	2.5-14	3.70
Interprofessional Feedback	11	6.4	10	1.5-14	3.77
Summative Feedback	11	6.3	11	2-11	3.14
Shadowing Outside Discipline	11	6.2	12	2-13	3.30
Trainee Receives Didactic Trainings	11	5.8	13	2-12	3.21
Trainee Self-Assesses Competence	11	5.8	13	2-11	2.71
Videotaping	11	2.3	15	1-4	0.96

Note. RR = Relative Rank.
Mean, range, and standard deviation is based on 15 as highest rank and 1 as lowest rank. Two participants' responses for this survey question were not recorded, apparently due to a survey software malfunction. Their data was unable to be included in the results. See Table 32 for ease of comparison. For definition of terms, see Appendix C, question #40.

Table 32

Combined Results of Ranked Training Techniques

	WS			P			I			PD		
	n	$\bar{x}$	RR	n	$\bar{x}$	RR	n	$\bar{x}$	RR	n	$\bar{x}$	RR
Precepting	32	11.1	1	5	10.6	4	16	11.4	2	11	10.9	2
Case Discussion (Individual)	32	11.1	1	5	7.4	7	16	11.8	1	11	11.8	1
Direct Observation	32	10.9	3	5	12.2	1	16	11.2	4	11	9.7	5
Shadowing within Discipline	32	10.5	4	5	11.4	3	16	10.0	6	11	10.9	2
Expected Competencies Made Clear	32	10.3	5	5	6.2	10	16	11.3	3	11	10.5	4
Formative Feedback	32	10.1	6	5	9.8	6	16	10.7	5	11	9.4	6
Feedback on EMR Notes	32	8.2	7	5	10.2	5	16	7.4	8	11	8.4	7
Trainee Receives Didactic Trainings	32	7.9	8	5	7.4	7	16	7.9	7	11	5.8	13
Case Discussion (Group)	32	7.5	9	5	12.2	1	16	6.5	9	11	6.8	8
Interprofessional Feedback	32	6.1	10	5	6.2	10	16	5.8	11	11	6.4	10
Trainee Self-Assesses Competence	32	5.9	11	5	4.8	12	16	6.3	10	11	5.8	13
Trainee Gives Feedback on Training Exp.	32	5.8	12	5	4.8	12	16	5.7	12	11	6.5	9
Shadowing Outside Discipline	32	5.8	12	5	7.4	7	16	4.9	14	11	6.2	12
Summative Feedback	32	5.7	14	5	4.8	12	16	5.5	13	11	6.3	11
Videotaping	32	3.3	15	5	4.2	15	16	3.7	15	11	2.3	15

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs; RR = Relative Rank. Data extracted from Tables 28 – 31 and combined for ease of comparison.

Table 33

Frequencies of Use and Perceived Value of Unused Supervision Techniques

	WS		P		I		PD	
	n	%	n	%	n	%	n	%
Trainee Receives Didactic Trainings								
Already In Use	34	94.4	3	60	19	100	12	100
Not Used/Valuable	1	2.8	1	20	0	0	0	0
Not Used/Not Valuable	1	2.8	1	20	0	0	0	0
Case Discussion (Individual)								
Already In Use	33	91.6	2	40	19	100	12	100
Not Used/Valuable	1	2.8	1	20	0	0	0	0
Not Used/Not Valuable	2	5.6	2	40	0	0	0	0
Formative Feedback								
Already In Use	33	91.6	5	100	17	89.4	11	91.7
Not Used/Valuable	2	5.6	0	0	1	5.3	1	8.3
Not Used/Not Valuable	1	2.8	0	0	1	5.3	0	0
Shadowing within Discipline								
Already In Use	33	91.6	4	80	17	89.5	12	100
Not Used/Valuable	2	5.6	0	0	2	10.5	0	0
Not Used/Not Valuable	1	2.8	1	20	0	0	0	0
Expected Competencies Made Clear								
Already In Use	32	88.8	2	40	19	100	11	91.7
Not Used/Valuable	2	5.6	2	40	0	0	0	0
Not Used/Not Valuable	2	5.6	1	20	0	0	1	8.3

Table 33, continued

Trainee Gives Feedback on Training Experience								
Already In Use	31	86.1	2	40	18	94.7	11	91.7
Not Used/Valuable	3	8.3	1	20	1	5.3	1	8.3
Not Used/Not Valuable	2	5.6	2	40	0	0	0	0
Precepting								
Already In Use	29	80.6	3	60	16	84.2	10	83.3
Not Used/Valuable	4	11.1	2	40	2	10.5	0	0
Not Used/Not Valuable	3	8.3	0	0	1	5.3	2	16.7
Direct Observation								
Already In Use	29	80.6	3	60	17	89.4	9	75.0
Not Used/Valuable	4	11.1	2	40	1	5.3	1	8.3
Not Used/Not Valuable	3	8.3	0	0	1	5.3	2	16.7
Shadowing Outside Discipline								
Already In Use	27	75.0	4	80	14	73.7	9	75.0
Not Used/Valuable	5	13.9	0	0	3	15.8	2	16.7
Not Used/Not Valuable	4	11.1	1	20	2	10.5	1	8.3
Feedback on EMR Notes								
Already In Use	27	75.0	3	60	15	78.9	9	75.0
Not Used/Valuable	2	5.6	0	0	1	5.3	1	8.3
Not Used/Not Valuable	7	19.4	2	40	3	15.8	2	16.7
Trainee Self-Assesses Competence								
Already In Use	26	72.2	2	40	13	68.4	11	91.7
Not Used/Valuable	7	19.4	3	60	4	21.1	0	0
Not Used/Not Valuable	3	8.3	0	0	2	10.5	1	8.3
Interprofessional Feedback								
Already In Use	24	66.7	2	40	14	73.7	8	66.7
Not Used/Valuable	7	19.4	3	60	3	15.8	1	8.3
Not Used/Not Valuable	5	13.9	0	0	2	10.5	3	25.0

Table 33, continued

Summative Feedback								
Already In Use	24	66.7	3	60	13	68.4	8	66.7
Not Used/Valuable	5	13.9	2	40	1	5.3	2	16.7
Not Used/Not Valuable	7	19.4	0	0	5	26.3	2	16.7
Case Discussion (Group)								
Already In Use	23	63.9	5	100	12	63.1	6	50.0
Not Used/Valuable	7	19.4	0	0	3	15.8	4	33.3
Not Used/Not Valuable	6	16.7	0	0	4	21.1	2	16.7
Videotaping								
Already In Use	2	5.5	0	0	2	10.5	0	0
Not Used/Valuable	14	38.9	3	60	5	26.3	6	50
Not Used/Not Valuable	20	55.6	2	40	12	63.2	6	50

Note. Above statistics are the combined results of two questions to participants. The first question assessed how many participants utilize the particular training practice. The second question assessed the participant's perceived value in any techniques the participant did not currently use. For the specific questions, see Appendix C, questions #40 and #41. The percentages are based on WS (n = 36), P (n = 5), I (n = 19), PD (n = 12) because three participants' responses for this survey question were not recorded, apparently due to a survey software malfunction. For definition of terms, see Appendix C, question #40.

Table 34

Use of Intra- and Interprofessional Shadowing During Training

	WS[a]		P[b]		I[c]		PD[d]	
	n	%	n	%	n	%	n	%
Shadow Supervisor	39	100.0	6	100.0	20	100	13	100
Shadow PCP and/or Nurses	29	74.4	4	66.7	13	65	12	92.3

Note. WS = Whole Sample; P = Practicum Programs; I = Internship Programs; PD = Postdoctoral Programs.
Each participant was able to select multiple options as applicable
[a]Number of Participants Responding = 39 (100% of sample)
[b]Number of Participants Responding = 6 (100% of subsample)
[c]Number of Participants Responding = 20 (100% of subsample)
[d]Number of Participants Responding = 13 (100% of subsample)

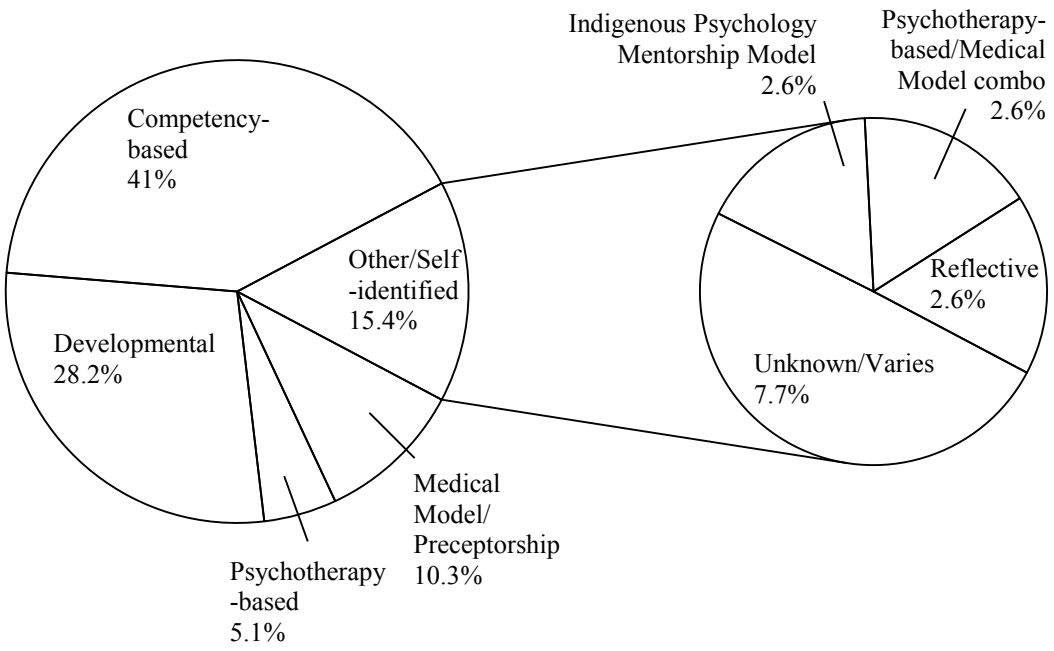

Figure 1. Which supervision model *predominantly* guides PC training? Two responses composed the psychotherapy-based category: Integrative and CBT. N = 39.

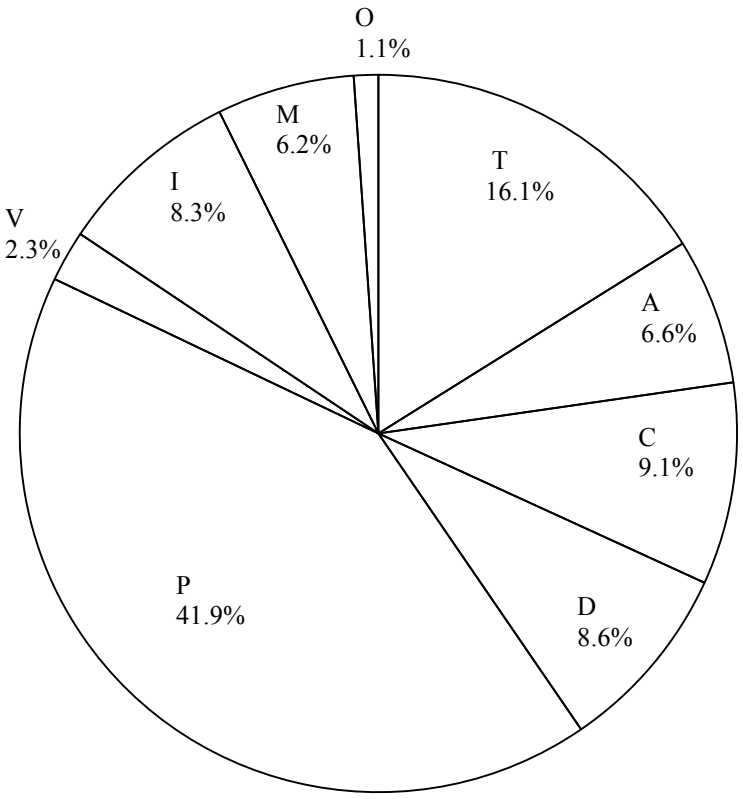

Figure 2. Average estimated percentage of supervision time spent on various aspects of training among supervisors of all programs. N = 38 (one response was removed due to outlier status). Arranged below in descending order of above values.

P – Patient care/case discussion: 41.9%; SD = 19.1; Range = 0-90%
T – Learning practical techniques and evidence-based interventions (includes role-playing and modeling): 16.1%; SD = 11.4; Range = 0-55%
C – Consultation skills: 9.1%; SD = 7.4; Range = 0-40%
D – Documentation: 8.6%; SD = 6.9; Range = 0-30%
I – Trainees' intrapersonal process issues (includes professional development): SD = 8.3%; 7.6; Range = 0-35%
A – Administrative activities: 6.6%; SD = 5.5; Range = 0-30%
M – Diversity and multicultural issues: 6.2%; SD = 3.7; Range = 0-15%
V – Viewing session recordings of patient consultations (includes direct observation): 2.3%; SD = 4.9; Range = 0-20%
O – Other (includes participant-added items of program evaluation/development, and research): 1.1%; SD = 5; Range = 0-30%

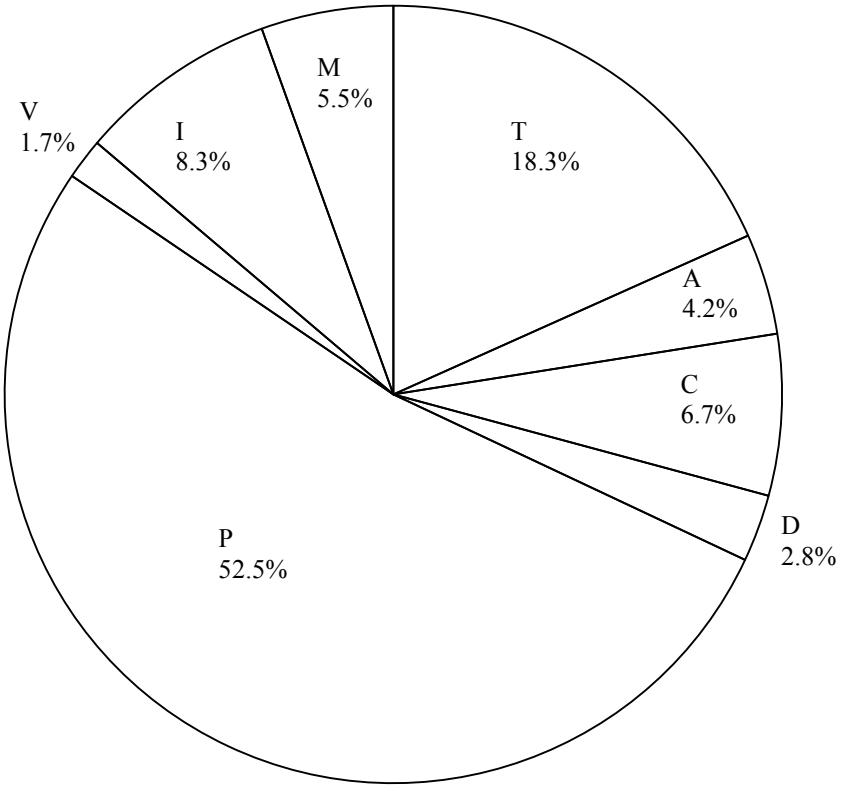

Figure 3. Average estimated percentage of supervision time spent on various aspects of training among the supervisors of the practicum programs. N = 6. Arranged below in descending order of above values.

P – Patient care/case discussion: 52.5%; SD = 15.7; Range = 30-75%
T – Learning practical techniques and evidence-based interventions (includes role-playing and modeling): 18.3%; SD = 10.8; Range = 5-30%
I – Trainees' intrapersonal process issues (includes professional development): 8.3%; SD = 8.8; Range = 0-25%
C – Consultation skills: 6.7%; SD = 6.8; Range = 0-20%
M – Diversity and multicultural issues: 5.5%; SD = 3.9; Range = 0-10%
A – Administrative activities: 4.2%; SD = 3.8; Range = 0-10%
D – Documentation: 2.8%; SD = 2.5; Range = 0-5%
V – Viewing session recordings of patient consultations (also includes live observation of sessions): 1.7%; SD = 2.6; Range = 0-5%

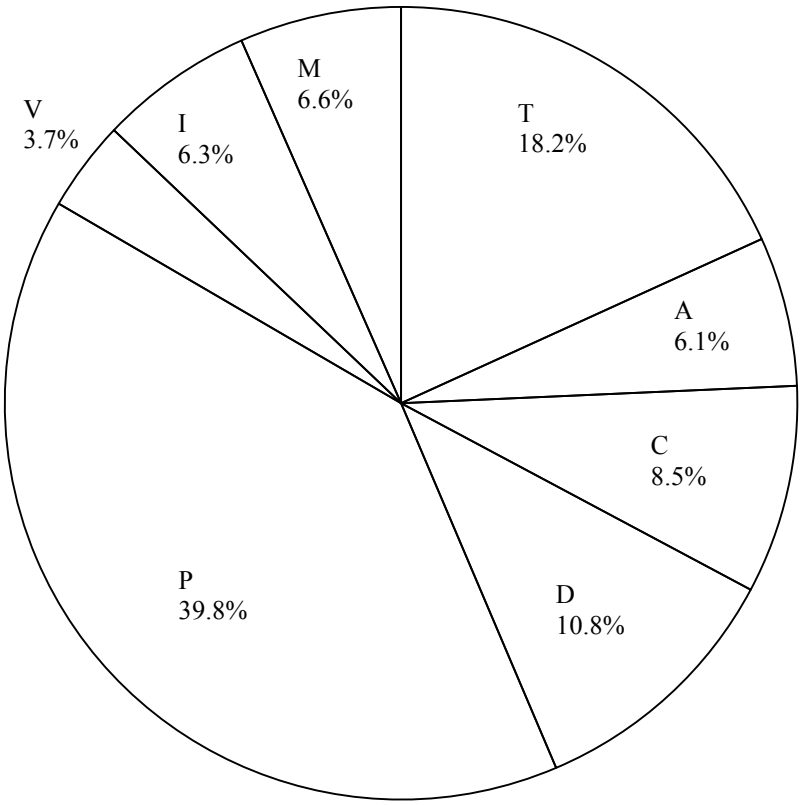

Figure 4. Average estimated percentage of supervision time spent on various aspects of training among the supervisors of the internship programs. N = 19 (one response was removed due to outlier status). Arranged below in descending order of above values.

P – Patient care/case discussion: 39.8%; SD = 12.5; Range = 0-55%
T – Learning practical techniques and evidence-based interventions (includes role-playing and modeling): 18.2%; SD = 4.3; Range = 0-15%
D – Documentation: 10.8%; SD = 8.0; Range = 0-30%
C – Consultation skills: 8.5%; SD = 4.6; Range = 2-20%
M – Diversity and multicultural issues: 6.6%; SD = 3.7; Range = 0-15%
I – Trainees' intrapersonal process issues (includes professional development): SD = 6.3%; 4.9; Range = 0-15%
A – Administrative activities: 6.1%; SD = 4.3; Range = 0-15%
V – Viewing session recordings of patient consultations (also includes live observation of sessions): 3.7%; SD = 6.4; Range = 0-20%

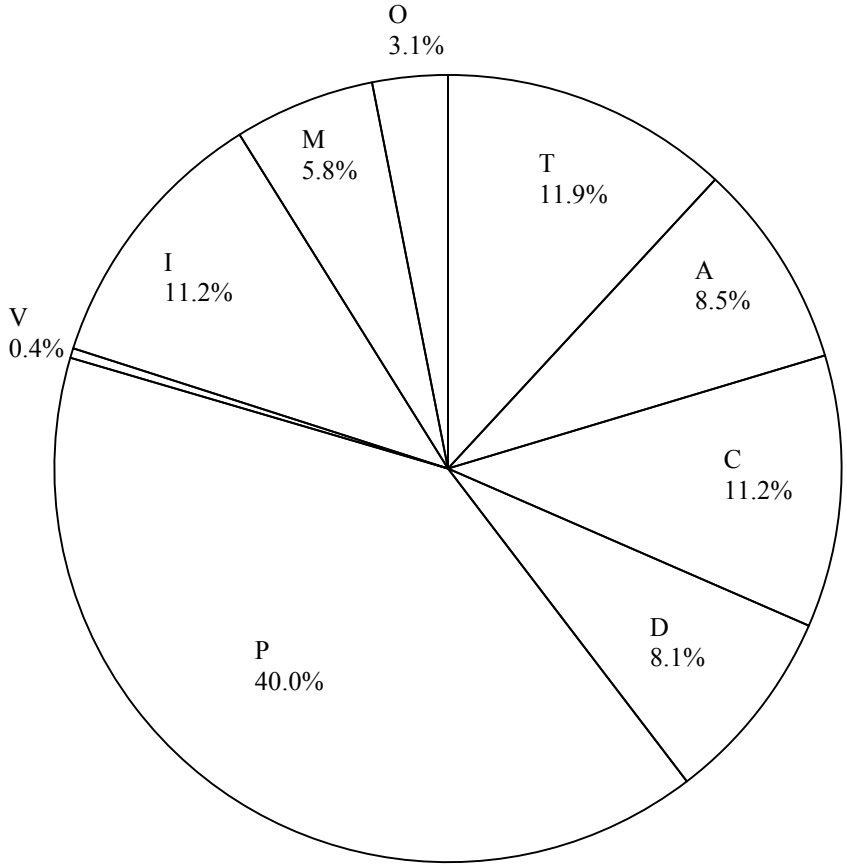

Figure 5. Average estimated percentage of supervision time spent on various aspects of training among the supervisors of the postdoctoral programs. N = 13. Arranged below in descending order of above values.

P – Patient care/case discussion: 40.0%; SD = 22.7; Range = 0-90%
T – Learning practical techniques and evidence-based interventions (includes role-playing and modeling): 11.9%; SD = 9.5; Range = 0-30%
C – Consultation skills: 11.2%; SD = 10.4; Range = 0-40%
I – Trainees' intrapersonal process issues (includes professional development): 11.2%; SD = 9.6; Range = 0-35%
A – Administrative activities: 8.5%; SD = 7.2; Range = 0-30%
D – Documentation: 8.1%; SD = 4.8; Range = 0-20%
M – Diversity and multicultural issues: 5.8%; SD = 4.0; Range = 0-10%
O – Other (includes program evaluation, program development, and research): 3.1%; SD = 8.3; Range = 0-30%
V – Viewing session recordings of patient consultations (includes direct observation): 0.4%; SD = 1.4; Range = 0-5%

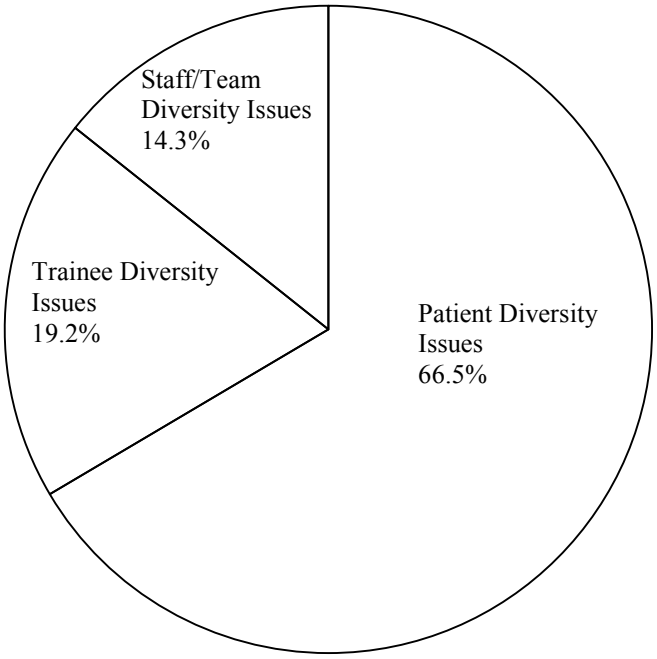

Figure 6. Average estimated percentage of types of diversity issues addressed during supervision time. N = 39

Patient Diversity Issues: 66.5%; SD = 20.9; Range = 25-100%
Trainee Diversity Issues: 19.2%; SD = 13.7; Range = 0-50%
Staff/Team Diversity Issues: 14.3%; SD = 15.1; Range = 0-50%