

Facilitating and evaluating trainee clinical competencies in Ireland

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This article, divided into three sections, first briefly considers the clinical competency set that psychologists in clinical training (hereafter referred to as 'trainees') aspire to, and then focuses on how these can be facilitated and evaluated while on clinical placements.

COMPETENCE IS CONSIDERED to be achieved when the learner 'attains a predetermined and clearly articulated level of competence in a given domain' (Kaslow, 2004, p.777) with each domain comprising certain knowledge, skills and (professional) attitudes or values. While moving beyond competency to proficiency is the ultimate goal, the British Psychological Society (BPS, 2010) outlines the domains within which trainees must achieve clinical competence in order to graduate with a Doctorate in Clinical Psychology (DClinPsych; Table 1). The American Psychological Society (APA) distinguishes between foundational and functional core competency domains. Attainment of competency in each domain across four developmental levels (e.g. 'readiness for entry to practice' level as health care providers) can be defined by specific behavioural anchors (Fouad et al., 2009).

Facilitating clinical competencies

The Psychological Society of Ireland (PSI, 2009) still uses a structural model of core (i.e. adults, children and adolescents, and people with intellectual disability) plus specialist placements when accrediting doctoral programmes in clinical psychology. Within this 'core placement' model, trainees need to work a minimum total of 390 clinical days (over a period of three years) and a minimum of 60 days in each core and specialist placement, and they are assessed on whether they 'pass' each placement. In contrast, and partially due to placement constraints, the BPS (and APA) have moved away from the latter approach and have adopted a more

flexible competency-based model that focuses on specific learning outcomes that facilitate a unique and improved training path for each trainee (Fleming & Steen, 2004). However, the two models are not mutually exclusive. The Irish training programmes could continue to use the structure of core placements yet place more emphasis on trainees developing specific competencies.

Clinical placement supervision needs to ensure maximum possible learning for trainees given that more than half of their learning may occur while on placements (Falender & Shafranske, 2004). Within a context of initial contracting and functional supervisory activities, such learning can accrue but supervision also needs to be both developmentally informed and dual-focused.

Developmentally informed supervision

Trainees learn best when their supervisors are sensitive to their evolving learning needs as they progress through their individual and sequenced placements. Supervision practice is therefore ideally needs-led in that it matches the developmental level of trainees. For example, supervisors may adopt Stoltenberg's (2005) Integrated Developmental Model (IDM) of supervision whereby trainees are classified as being at 1 of 4 graduated levels of dependence/independence (across each competency domain), with each level requiring a different supervisory response.

Dual-focused supervision

While Stoltenberg's model is only one of many approaches to supervision, such models fall into two broad categories: those

Table 1: Core competencies

British Psychological Society	American Psychological Association	
	<i>Foundational</i>	<i>Functional</i>
Transferable skills	Reflective practice/Self-assessment/Self-care	Assessment
Psychological assessment	Scientific knowledge & methods	Intervention
Psychological formulation	Relationships	Consultation
Psychological intervention	Individual & cultural diversity	Research/evaluation
Evaluation	Ethical-legal standards & policy	Supervision
Research	Inter-disciplinary systems	Teaching
Personal and professional skills		Management-administration
Communicating and teaching		Advocacy
Service delivery		

rooted in psychotherapy (e.g. CBT and psychodynamic theory) and those that were developed solely for use in supervision (i.e. process models). As of yet, no supervisory model has emerged as the clear favourite (Fleming & Steen, 2004), with the chosen model often reflective of supervisors' theoretical perspective and/or how one was supervised (Falender & Shafranske, 2004). However, regardless of orientation, supervisors need to focus on both the technical aspects of clinical work (i.e. content, evidence-based practice) and the processes therein (e.g. emotional impact of work on trainees; Milne, Scaife & Cliffe, 2009).

Initial contracting

Supervisor-trainee dyads need to identify trainee baseline levels of each clinical competence by breaking them down into knowledge, skills and attitudes (e.g. novice, intermediate, advanced). As detailed in a placement (or learning) contract, they then need to outline realistic competency goals complete with a learning plan (and strategy) for achieving these (e.g. weekly and uninterrupted supervision) along with the evaluation procedures to be employed (Falender &

Shafranske, 2004). Contracts also need to outline the rules and regulations specific to the service-delivery setting, the duties and responsibilities of both the supervisor and trainee, and preferably the supervisor's scope of practice and style of supervision.

Functional supervisory activities

Reflective of the academic literature, and as utilised in the observational tool Teachers' Process Evaluation of Training and Supervision (PETS; Milne & James, 2002, p.58), Table 2 details best-practice functional supervisory activities. Supervisors may use different mixes of these activities depending upon trainees' developmental level and learning needs. Obvious as it may seem, given that much of trainees' learning occurs in the moment-to-moment dialogue that occurs during supervision sessions, supervisors need to listen intently to trainees during these sessions.

To optimise learning, supervisors need to cultivate a psychologically safe space or environment (Milne et al., 2009) whereby trainees believe that they can disclose their clinical struggles (e.g. difficulty using a theoretical model) and can openly request feed-

back without fear of ridicule or negative evaluation. In lowering the threshold for admitting professional limitations and for seeking help, and in turn reducing clinical risk, learning behaviour can be maximised. Hence, for example, supervisors need to provide support to trainees and opportunities for them to express their anxieties and worries. The latter can also be normalised to a degree by disclosure by supervisors of their own anxieties (Falender & Shafranske, 2004). However, building trust and fostering psychological safety does not include false performance-related reassurances.

In order to focus supervision dialogue on the areas that need attention, supervisors need to first ask specific questions (i.e. 'scaffolding') and then provide temporary support (or 'platforms') such as summaries or supportive feedback that facilitates trainees working through their clinical concerns. While feedback may be ongoing (i.e.

formative) or at placement end (i.e. summative), some supervisors may find it difficult to be supportive and affirmative, while also having to give negative evaluative feedback. They need to take the lead and agree with trainees to have (potentially) unpleasant conversations relating to trainee performance.

Guided experiential learning involves the 'acquisition of skills and understanding' through reflection, 'conceptualisation, planning and practical experience, within a structured learning environment' (Kolb as cited in Milne & James, 2002, p.57). Kolb proposed that teachers (or supervisors in this context) must facilitate learning in their students through interactive learning processes (e.g. educational role playing), a process that trainees perceive as augmenting their learning (Milne & James, 2002). Trainees also need opportunities to observe their supervisors working with service users and to be observed, especially during the initial

Table 2: Functional supervisory activities (summarised from Milne & James, 2002 and printed with their permission)

	Supervisory activity	Example of
1	Managing	<ul style="list-style-type: none"> Organising & managing the flow of a supervision session
2	Listening	<ul style="list-style-type: none"> Active listening, silent attention
3	Supporting	<ul style="list-style-type: none"> Reassurance – verbal & non-verbal
4	Summarising	<ul style="list-style-type: none"> Summarising information to clarify links & improve understanding
5	Gathering information	<ul style="list-style-type: none"> Seeking out information
6	Checking theoretical knowledge base	<ul style="list-style-type: none"> Evaluating competence (e.g. what homework task would you assign?..)
7	Feedback	<ul style="list-style-type: none"> Provision of specific verbal or written feedback
8	Challenging	<ul style="list-style-type: none"> Encouraging learner to rethink or reason their view
9	Informing	<ul style="list-style-type: none"> Providing educational data to learner
10	Guided experiential learning	<ul style="list-style-type: none"> Modelling, role-play Developing competencies through situational role-play
11	Self-disclosing	<ul style="list-style-type: none"> Sharing relevant information (e.g. 'I find these cases difficult to handle')
12	Disagreeing	<ul style="list-style-type: none"> Verbal correction or shaking of the head
13	Video observation	<ul style="list-style-type: none"> Watching taped therapy session involving supervisee & service user
14	Other	<ul style="list-style-type: none"> Social chat, jokes, light conversation

weeks of their placements. Such observation can normalise trainee self-expectations and facilitate learning of effective therapeutic strategies. Observing trainees can also highlight problematic issues that trainees have not yet identified (e.g. a lack of empathy during therapeutic sessions). Such observation can be conducted 'live' (e.g. sit in on sessions or observe through a one-way mirror) or through audio/visual recordings.

Evaluating clinical competencies

While essential to the learning process, evaluation of clinical competencies is the least embraced supervisory task by supervisors. The ultimate responsibility for passing and failing trainees in their placements lies with the training institution. Such a structure provides a degree of psychological safety for trainees to discuss areas of tension and/or protect them from inadequate supervisory practices. However, supervisors' reports are 'a major part of the assessment' (PSI, 2009, p.17).

The difficulty with competence assessment lies in how to specifically evaluate if a competency has been achieved. The APA provides detail on the identified components of each competence; takes into account the developmental level of the trainee and, importantly, provides details on how to assess each competency. A summary of specific assessment tools designed to evaluate whether sufficient knowledge, skill-level and attitude have been reached for a competency are included in Table 3 (Falender & Shafranske, 2004). A trainee must reach a certain level of knowledge, skill and attitude (appropriate to his/her developmental stage) in any given competency domain in order to pass a placement.

Rather than being perceived as distressing and worrisome, the evaluation process needs to be viewed as an essential part of the learning process that helps to remediate problematic behaviour. The first step in competency-based evaluation is to compile a report highlighting the strengths and developmental points of a trainee based on his/her previous academic or work experience (Falender & Shafranske, 2004). Once the competencies that need to be achieved are identified, each competency can be bro-

Table 3: Toolkit for assessing competencies

	Assessment method
1	Rating of live/recorded performance
2	Structured clinical examination
3	Portfolio review
4	Performance in role play
5	Self assessment/reflection
6	Structured oral exams
7	Standardised service user interviews
8	360 degree evaluations

ken down into core components (e.g. administering psychometric batteries can be broken down into knowledge of psychometric theory, ability to choose appropriate measures, administer and score them, and interpret findings). Goals related to achieving these core components need to be specific, feasible within the context of the placement, challenging and flexible.

Ongoing (or formative) feedback (to trainees) needs to be clear and specific. Ideally in written form, it needs to detail progress towards specific goals or lack of progress and a management plan to address same (Falender & Shafranske, 2004). Regarding end-of-placement (or summative) feedback, this can only relate to problems that have been highlighted during placement. Supervisors need to recognise that all trainees will struggle with developing at least some competencies and that it is their responsibility to support trainees over an adequate period of time to pro-actively achieve these in a goal-oriented manner.

There are many reasons as to why evaluation within a supervisor-trainee relationship may be challenging. There may be rater bias towards overly-positive evaluation due to supervisors wanting to be protective of, or nice towards, trainees. There may also be what might be termed 'political' considerations. Failing a trainee on placement and necessitating repeating a similar placement has the potential to rupture relations with the sponsoring agency (that may incur extra

Table 4: Recommendations for supervisors

	Principle	Recommendation
1	Integration of competency-based training & evaluation	Identify behavioural indicators of threshold competency performance levels, formulate strategies to achieve these & evaluate same using multiple methods (see Table 3).
2	Developmentally informed supervision	Remain sensitive to trainees' developmental needs e.g. provide more structure for novice trainees but more flexibility to more advanced trainees.
3	Dual-focused supervision	Focus on both the technical aspects of clinical work & the processes therein.
4	Initial contracting	Detail competency learning goals & associated behavioural indicators, & other placement expectations.
5	Functional supervisory activities	For example, ensure mutual observation, role plays, formative & summative evaluation (see Table 2) to create a psychologically safe & rich learning environment.

salary expenses) and/or the training programme (especially if programme re-accreditation is imminent). A negative evaluation may also impair relationships with trainees and subsequent chances of attracting them to apply, post-graduation, for local posts. Supervisors may also not want to imply, through failing trainees, that their supervisory practice is less than adequate.

The PSI guidelines (2009, p.16) note that the formulation of 'procedures and criteria for assessment including criteria for pass/failure' of each competence (e.g. clinical, research) 'will be at the discretion of each psychology department concerned'. Pertaining also to evaluative supervisory practices, this lack of direction allows each training program to differ significantly in how they evaluate their trainees when on placement. Hence, there may be inconsistencies between programmes regarding what levels of competence are deemed adequate.

While a multi-rater approach to evaluation in supervision may be optimum (Falender & Shafranske, 2004), information from other stakeholders (e.g. service users, peers and colleagues) may be biased. For example, evaluation based on service user progress is problematic given that their lack of progress may not necessarily reflect trainee incompetence. Similarly, evaluation based on service user satisfaction measures may also pose dif-

ficulties given that some may resent being appropriately challenged during intervention and consequently poorly rate a more-than-adequate service from a trainee.

Conclusion

This article is intended to be a useful reference for supervisors who wish to improve their supervision of trainees. Following the lead of both the BPS and APA, all stakeholders in Ireland (e.g. the PSI, training programmes, supervisors, and trainees) may profit from considering a more competency-based model of training. This cultural shift could still be achieved within the context of the existing 'core placement' model once supervisors place adequate emphasis on developing and assessing specific competencies in trainees (see Table 4).

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Working with Empathy: From Neuroscience to Relationship

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- 09:30 – 10:00 Registration and refreshments
- 10:00 – 11:00 Dr Giles Yeates, Community Head Injury Service, NHS: Mirror neuron on the wall.... uses & abuses of the neuroscience of empathy
- 11:00 – 12:00 Dr Aikaterini Fotopoulou & Colleagues, Kings College London: Pain, empathy & relationships: neuroscientific perspectives
- 12:00 – 12:15 Discussion with morning speakers
- 12:15 – 13:15 Lunch (provided)
- 13:15 – 14:15 Mary Wilkinson, Private Practice: Systemic Approaches to Empathy
- 14:15 – 15:15 Gail Palmer, Ottawa Couple & Family Institute: Empathy & Attachment: Perspectives from Emotion-Focussed Couples Therapy (EFT)
- 15:15 – 16:15 Susanna Abse, Tavistock Centre for Couples Relationships: The generation of empathy between intimate partners - Gesture and recognition or identity diffusion?
- 16:15 – 16:30 Plenary Discussion
- 16:30 Finish

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