Ethics and Clinical Supervision in an Era of Globalization

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Abstract

The sheer speed and magnitude of globalization coupled with increased mobility and diversity of clients, supervisees, and supervisors require new perspectives to address the diverse international worldviews. Added complexity arises from the surge of telehealth and telesupervision. Evidence suggests that international factors and complexity are either being overlooked in practice and in supervision or may clash. Through a review of the strategic literature, current international and cultural perspectives on ethical practice and training are described, and strategies are provided for effective and ethical clinical supervision in this era of globalization.

Keywords: clinical supervision; ethics; ethical clinical supervision; supervision; international supervision

The sheer speed and magnitude of globalization coupled with increased mobility and diversity of clients, supervisees, and supervisors require new perspectives to address the diverse international worldviews. Added complexity arises from psychological services provided through telehealth and telesupervision. Evidence suggests that international factors and complexity are regularly overlooked both in practice and supervision or if addressed, may clash. Through a review of the strategic literature, current international and cultural perspectives on ethical practice and training are described, and strategies are provided for effective and ethical clinical supervision in this era of globalization.

Although ethics is a pillar of clinical practice and clinical supervision, and there is international agreement that it is a cardinal supervision competency (Watkins, 2013), universal agreement does not exist on specific ethical codes (Leach & Harbin, 1997). It appears that ethical standards are far less likely to approach universal agreement than ethical principles, which could explain why universal agreement does not exist on specific ethical codes that describe standards of conduct. In a comparison of codes of ethics from 19 countries to the United States (U.S.) using the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (APA, 1992), Leach and Harbin (1997) found that the percentage of nations including each U.S. general standards

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ranged from 0 to 89% with a mean of 39.0%, whereas the percentage of nations including each APA ethical principle (namely, Principle A: Competence; Principle B: Integrity; Principle C: Professional & Scientific Responsibility; Principle D: Respect for People's Rights and Dignity; Principle E: Concern for Others' Welfare; and Principle F: Social Responsibility) ranged from 68 to 79% with a mean of 69.5%. It is posited that the future of psychological ethics will be grounded in an international framework (Leach, 2016) grounded in common, shared ethical principles.

Addressing ethics in clinical supervision through the lens of globalization requires harmonizing existing ethical rules or standards with professional ideals in the frame of cultural diversity (Kim & Park, 2007). Recognition of international ethical principles is imperative. Attitudes of cultural humility, openness and self-awareness, and other-orientation manifesting respect and curiosity, provide both structure and guidance for supervisors and supervisees (Falicov, 2014).

Guidance is provided in the framework provided by Kim and Park (2007) who described two types of globalization. At one extreme is a lens of enlightened globalization, associated with understanding, dialogue, and respectful supervisory practice that strives to serve the interests and perspectives of all peoples and persons. In contrast, unilateral globalization refers to a strong belief in the superiority of one's own culture, values and ideals, thus imposing a single valuative worldview on all cultures as a standard. While unilateral globalization is a modern form of oppressive colonialism imposing advantage of some over others; enlightened globalization provides the frame for respect, and recognition of the different values, beliefs, worldviews, and resources of the various cultures (Kim & Park, 2007).

Applied to supervision, one end of the spectrum is the unilateral imposition of behavioral expectations ("rules"), an assumption that these are equally valid to persons of all cultures. A supervisor using this method would not be open to feedback or perspectives from the supervisee or client or reflection on the cultural context of the client(s) and perspectives of each. In contrast, an enlightened approach first and foremost considers the ideals and ethical principles of the profession, and incorporates cultural worldviews of client(s), supervisees, and supervisors with openness, welcoming cultural discussion and proactive inclusion (Pettifor, Sinclair, & Falender, 2014). A likely result of unilateral globalization in supervision may be both therapeutic and supervisory alliance ruptures and harm, resulting from supervisees not feeling they have the power to address perceived ethical or practice infractions and multicultural intersections and thus not doing so. This result is reflected in significant numbers of reports by supervisees of inadequate or harmful supervision (e.g., Bautista-Biddle, Pereira, & Williams, 2021; Ellis et al., 2015; Hendricks and Cartwright, 2018), many with ethical and multicultural intersections.

Ethics codes began to be developed shortly after World War II. Currently, almost 60 countries have national ethics codes for their psychologists, but few efforts had been made prior to the Universal Declaration of Ethical Principles for Psychologists (2008) to develop ethics documents that reach beyond national boundaries. An example of the first of those was the Meta-Code of Ethics, a principle-based document developed by the European Federation of Psychologists' Associations (EFPA, 1995/2005) the aim of identifying what ethical principles and values each national Member Association should address in their codes of ethics, leaving to the Member Associations the responsibility to articulate those principles and values into the behavioral standards that would be included in their own specific codes. Another example is the Protocolo de Acuerdo Marco de Principios Éticos para el Ejercicio Profesional de los Psicólogos en el Mercosur y Paises Asociados [Protocol of the Framework Agreement of Ethical Principles for the Professional Practice of Psychology in the Mercosur and Associated Countries] (1997) developed as a regional declaration of ethical principles by the Comité Coordinador de Psicólogos del Mercosur y Paises

Asociados [Coordinating Committee of Psychologists of the Mercosur and Associated Countries] in South America. It was signed in 1997 by six southeast countries of South America that had formed in 1991 a common market called "Mercado Común del Sur" or "Mercosur": Argentina, Brazil, Paraguay and Uruguay as full members, with Chile and Bolivia as associated countries (see Gauthier, 2021 for an overview of the evolution of national, regional, and international ethics documents in psychology).

The Universal Declaration of Ethical Principles for Psychologists (hereinafter also referred to as the "Universal Declaration" and the "UD") (2008), developed with the collaboration and support of the global community of psychologists, is the product of a six-year process involving original research and broad international consultation led by an Ad Hoc Joint Committee working under the auspices of the International Union of Psychological Science and the International Association of Applied Psychology and in consultation with the International Association for Cross-Cultural Psychology . Based upon shared human values across culture (see Gauthier, 2020 for an overview of the development of the document), it provides a prototypic moral framework and a generic set of ethical principles that can be used as a foundation of psychological ethics to help psychologists worldwide to meet the ethical challenges of globalization. The structure and content of the document provide a conceptual frame for the four Universal Declaration principles.

The Universal Declaration of Ethical Principles for Psychologists (2008), includes a preamble followed by four sections, each relating to one of the following four ethical principles, formally labelled: (i) Principle I: Respect for the Dignity of Persons and Peoples; (ii) Principle II: Competent Caring for the Well-Being of Persons and Peoples; (iii) Principle III: Integrity; and (iv) Principle IV: Professional and Scientific Responsibilities to Society. Each section includes a statement defining the principle and outlining ethical values associated with the principle. In accepting the principle, psychologists also accept the values associated with that principle.

The stated purpose of the Universal Declaration (2008), as described in the second paragraph of the Preamble to the document, was to ensure psychology's universal recognition and the promotion of fundamental, shared, aspirational ethical principles grounded within common human values. Designed as a global template, it also provides guidance for development or revision of local codes of ethics factoring in ethical principles, definitions, and their related values, to identify standards of behavior. Rather than being prescriptive, it was designed to promote global understanding and cooperation, respecting cultural differences (Gauthier, Pettifor & Ferrero, 2010, p. 180).

The Universal Declaration (2008) purposefully avoided prescriptions of specific standards of conduct due to sensitivity to significant cultural variation in how principles are addressed. Evidence exists for the necessity for such guidance as supervisees perceive some supervisors to be functioning through the lens of unilateral globalization (e.g., Ellis et al., 2014; Pettifor et al., 2014).

Gauthier et al. (2010) caution that differences in meaning across cultures exist and identifying and addressing those is not always obvious or easy. Attitudes of cultural humility are in keeping with enlightened globalization, manifest in open, nondefensive, thoughtful and reflective approaches (Falicov, 2014; Hook et al., 2016). In response to culturally loaded queries or topics, supervisors and supervisees would show respectful curiosity, ability to question their own assumptions and beliefs in a cultural frame, while also attending to relational safety.

Supervisors should be mindful that the development of ethics of supervisees occurs through a process of integration of personal values and ethical positions with professional ethics, an intentional, systematic process; supported through supervision, to enhance their metacompetence (i.e., knowing what one

knows and doesn't know).

Agreement exists internationally on fundamental areas of ethical competence, including knowledge and skills in identifying and attending to matters of ethics relevant to the supervision endeavor (Watkins, 2013). Historically, common origin of all ethics principles and values exists deriving from the struggle to identify "right" behavior for professionals (Sinclair, 2012). However, codes of various countries vary. For example, countries that may be influenced by Confucian traditions (e.g., China and South Korea) value filial piety and attention to hierarchy and promoting harmony and saving face (Bang & Park, 2009; Quek & Storm, 2012) over Western valued collaborative practice. In most of Latin American, a more authoritative and patriarchal value system contrasts with collaboration (Fernandez-Alvarez et al., 2020).

In a comparison of ethics codes from 19 countries with APA's Ethical Principles of Psychologists and Code of Conduct (APA, 1992), Leach and Harbin (1997) found a relatively high level of agreement on a number of ethical principles and standards critical to clinical supervision. Sixty-eight percent of nations included the aspirational ethical principle of competence in their code; 68%, guidance about multiple relationships; 79%, informed consent for therapy; and 95%, maintaining confidentiality. Overall, ten specific standards were presented in common, occurring in more than 75% of the codes. At least 11 more countries had substantial ethical standards relating to supervision in their general code. Significant cultural issues arise internationally concerning the overlap between professional and nonprofessional relationships, including the normative values of interdependence of community and family, and individualistic versus collectivist values.

A sea change in supervisory practice, and the magnitude of the change toward a competency-based framework, have caught many supervisors by surprise (Gonsalvez & Calvert, 2014). Specific ethical supervisory practices (Barnett & Molson, 2014; Falender & Shafranske, 2014, 2021; Pettifor, McCarron, Schoepp, Stark, & Stewart, 2011) have been described. However, clinical supervision is generally not the subject of extended formal coursework during a psychologist's training nor is international practice or ethics attended to. Supervisors who have lesser formal training may supervise the same way they were supervised, through a process of osmosis or absorption of the practices of their supervisors. This process is fraught with peril for both ethics and practice. Furthermore, lesser value may be attached to the importance of clinical supervision by individuals who lack formal supervisory training (Rings, Genuchi, Hall, Angelo, & Cornish, 2009), and by training directors, who even urged that supervision instruction be eliminated from the training process (Stedman, Schoenfeld, & O'Donnell, 2013).

When supervisory training is offered, it may be through a psychotherapy-based or developmental model, which may not be systematic or include all the multiple components and dimensions of supervision (Falender, 2018; Falender & Shafranske, 2010). Specifically, psychotherapy models may not systematically address the supervisee's ethical knowledge and application, emotional reactivity, or multicultural diversity.

Contrary to the assumption that all supervisors meet the ethical standard of competence, supervisees report significant levels of less than adequate supervision, and training in clinical supervision is uneven (U.S., Falender, 2018; South Africa, Hendricks, Cartwright, and Cowden, 2021). Consensus exists across disciplines and international venues about what constitutes effective versus inadequate or harmful supervision. Harmful supervision has been defined as "the supervisor's actions or inactions resulting in psychological, emotional, or physical harm to the supervisee" (Ellis et al., 2014, p. 7), with implicit risk to the client(s). Inadequate supervision may not reach criteria as harmful, but poses significant risk, as it is characterized by failure to meet legal and ethical standards (e.g., competency, time, consistency, attention, multiculturally respectful behavior); supervisory

disinterest; lack of investment; failure to provide accurate and timely feedback and evaluation of supervisee competencies; or disrespect or disregard of supervisee input.

Studies in multiple countries also identify the incidence of inadequate and harmful supervisory practice: in the United States, Ellis et al. (2014, 2017) and Ladany, Mori & Mehr (2013); in Ireland, Ellis, Creaner, Hutman, & Timulak (2015); South Africa, Hendricks & Cartwright (2017); Australia, Lovell (2007); and South Korea, Bang & Goodyear (2014). Ladany and colleagues (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999) and studies conducted by our Pepperdine University research group (Hansell, 2018; Wall, 2009) found supervisees perception of ethical misconduct by their supervisors was associated with lower alliance ratings by supervisees with their supervisors. When supervisors allow use of treatment methods of which they have limited knowledge, or schedule supervision on an as-needed basis rather than providing regular supervision sessions, the consequences affect the alliance as well as the integrity of supervision, and ultimately the quality of client care. Both inadequate and harmful supervision constitute ethical breaches with significant impact upon both client and supervisee wellbeing.

Other studies identify ethical errors that supervisees perceive their supervisors to have committed. In a study of 151 beginning- to intern-level supervisees, 51% reported at least one ethical violation by their supervisors. Among the most frequently reported infractions were failure to provide supervisees with adequate performance evaluations, violating supervisee confidentiality, not working with alternative perspectives, disregard for session boundaries, and disrespectful behavior (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999).

To enhance ethical clinical supervision, a number of perspectives and objectives are required: (1) general parameters of ethical clinical supervsion; (2) international guidelines and codes for clinical supervision and ethics; (3) ethical standards importance in clinical supervision internationally; (4) cultural variants of ethical codes and particular aspects of ethics; (5) the trajectory of supervisee ethical development;and (6) summary discussion of ethical competence for supervisors provided.

Parameters of Ethical Clinical Supervision

There is significant international agreement on the ethical aspects of clinical supervision. The following are some of the premises:

1. Do no harm; act with beneficence.
2. Identify and attend to cultural identities and worldviews of client(s), supervisee, supervisor and to intersectional identities as they directly impact client assessment, diagnosis, and treatment as well as supervision.
3. Respect the Dignity of Persons and Peoples.
4. Clinical supervision does not include personal (supervisee) psychotherapy. That is, an individual who is providing clinical supervision holds power over the future of the supervisee. It is not appropriate for such an individual, the supervisor, to also conduct therapy with that supervisee.
5. Competence. Supervisors need to be competent both in the clinical services the supervisee renders and in the practice of clinical supervision. If either the clinical presentation or the supervision are beyond the competence of the supervisor, the supervisor is responsible for determining a course of action to ensure adequate supervision.
6. Informed consent. An informed consent agreement should cover expectations for the supervisee and the supervisory processes; contingencies in case of emergencies or cancellations; limits to the confidentiality of supervisee disclosures; jurisdictional legal and reporting regulations; recordkeeping; and specific information relevant to the entire setting. A written supervision contract formalizes the aspects and expectations for performance and successful completion of the supervisory sequence.

7. Boundaries and multiple relationships. Establishment of clear boundaries to allow both supervisor and supervisee to maintain objectivity is imperative. Some aspects of boundaries may be culturally variable (e.g., gift giving, aspects of multiple relationships). Given the power of the supervisor and the vulnerability of the supervisee, clarity of boundaries and a thoughtful approach to boundary crossings is essential.

8. Evaluation. Supervisors are responsible for providing ongoing feedback that is respectful, monitoring of client care and outcomes, and ensuring the progressive, strength-based growth of the supervisee. Feedback should be normative, ongoing, and frequent, ideally linked to behavior observed, or if that is not possible, through supervisee report. Direct observation is highly desirable to address the question of metacompetence, or whether the supervisee knows what he/she does not know or observe. Gatekeeping, present when a regulatory process exists, aims to ensure no unsuitable, less qualified individuals enter the profession or practice.

International Guidelines for Clinical Supervision and the Ethics of Clinical Supervision

Multiple countries and jurisdictions have developed guidelines for clinical supervision and/or the ethics of clinical supervision. Among those are: the APA's Guidelines for Clinical Supervision of Health Service Psychologists (APA, 2014, 2015); the Canadian Psychological Association's (CPA) Ethical Guidelines for Supervision in Psychology: Teaching, Research, Practice, and Administration (CPA, 2009/2017); the European Federation of Psychologists' Associations' (EFPA) Ethical Guidelines for Psychologists in the Role of Trainers, Supervisors and Teachers of Psychologists (EFPA, 2019); the Association of State and Provincial Psychology Boards' (ASPPB) Supervision Guidelines for Education and Training leading to Licensure as a Health Service Provider (ASPPB, 2015); the Australian Psychological Society's (APS) Ethical Guidelines on Supervision (APS, 2020); and the New Zealand Psychologists Board's Guidelines on Supervision (New Zealand Psychologists Board, 2021). The Universal Declaration of Ethical Principles for Psychologists (2008) also provides a common moral framework and ethical principles for psychologists.

There is a confluence of competencies (knowledge, skills, and attitudes) across many international venues, which share the following themes although specifics vary: (1) knowledge of the profession and areas under supervision; (2) ongoing behavioral assessment and feedback; (3) multicultural diversity – infusing diversity and worldview perspective of all participants; (4) reflective and respectful practice; (5) ethical and legal codes and standards; (6) supervisory relationship processes, including addressing emotional reactivity, strains, and ruptures; (7) ongoing assessment and feedback; and (8) ongoing attending to client progress (adapted from Falender & Shafranske, 2021; Watkins, 2013).

Specific Ethical Standards and Their Importance in Supervision Internationally

To frame the ethical issues in the training process and supervision, the following section considers several ethical aspects through an international lens, with a specific focus on their application to the supervisory process.

Boundaries and Dual and Multiple Relationships

There has been increasing attention directed to multiple relationships, including the inevitability of some, and the significant impact of culture upon the ethical standards. Many ethical codes state that not all multiple relationships are unethical, specifically, for example, in cases when they would not "reasonably be expected to cause impairment or risk exploitation or harm" (APA, 2017, 3.05 (a)). In some cultural contexts, avoiding dual relationships is actually considered disrespectful and insensitive. In the United States, Zur (2017) advocates a loosening of the standard, suggesting that multiple relationships may be an asset and enhance therapeutic acuity and outcome. Thus, supervisor and supervisee mindfulness

is encouraged of dimensions of autonomy and self-determination, community and family interdependence, and connections between persons that are highly valued in non-Western societies (Pettifor & Ferrero, 2012).

In clinical supervision, the power differential generally is significant, since the supervisor may serve as a gatekeeper (but not in all contexts; Falender et al., 2021), determining whether the supervisee may move into independent practice. The potential for strain and rupture in the supervisory relationship is great when the supervisor and supervisee slide into a quasi-friendship relationship that reverts to an evaluative one. Furthermore, due to the power differential, the supervisee generally cannot refuse a supervisor's request, even if the request is something that the supervisee is not comfortable with. Many ethics code indicate that multiple relationships of supervision by a spouse or other family members are inherently problematic.

Attentiveness to the potential for abuse of power, exploitation, and conflicts of interest are a supervisory responsibility. However, high value may be attached to seeking out therapy and supervision with someone known personally and respected due to the interdependence of community and family. Avoidance of dual relationships is sometimes actually viewed as disrespectful and insensitive (Deng et al., 2016). These issues may introduce ethical and worldview conflicts among supervisors, supervisees, and clients. Thomas (2014) concluded that it is difficult, and even undesirable, to have no connections or multiple relationships with supervisees, and that a thoughtful process is required in supervisor-supervisee relationships as well as in therapist-client ones. Ethical problem-solving is an effective tool (Gottlieb, Robinson, & Younggren, 2007).

Competence

Clinical supervision is a means for establishing and ensuring the competence of the supervisee. Maintaining competence generally is an international principle (Leach, 2016). In some countries supervisors are required to receive supervision training. In several jurisdictions, receiving supervision is a requirement throughout the professional trajectory (i.e., U.K. and Australia), and in Australia, the competence of supervisors is formally evaluated at intervals.

An essential aspect of enhancing and ensuring a psychologist's competence is feedback from the supervisor to the supervisee. That is, when supervisors perceive problems in the knowledge, skills, and/or attitudes of their supervisees, it is imperative they provide feedback, monitor the supervisee's practice, and ensure the protection of the client. Furthermore, supervisors bear responsibility for competence in all the areas they supervise. Particular aspects of supervisory practice such as feedback may not be culturally syntonic. For example, feedback is essential to the Western style of supervision and competency tracking – but the feedback may impact relationship, face, and be viewed as disrespectful, and thus be difficult to give in some non-Western cultures. However, there is some agreement on the necessity for competence, as shown, for example, by interest in the document, Competencies Benchmarks (Fouad et al., 2009), which has been translated in Taiwan and China.

The ability of the supervisee to give feedback and collaborate with the supervisor is also essential.

Multicultural discussions may not occur in clinical supervision. Multicultural competence requires consideration and discussion of the intersectional identities of the client, supervisee/therapist, and supervisor, their resultant worldviews, and the impact of all of those on the therapeutic relationship, assessment, and treatment (Falender, Shafranske, & Falicov, 2014). Resources which provide multicultural guidelines include An Ecological Approach to Context, Identity, and Intersectionality (APA, 2017).

These factors are of critical importance, and even more so in light of the half-life of psychological knowledge, i.e., the time it would take, in the absence of new learning, to become approximately

half as knowledgeable, which is generally a function of the development of new knowledge (Neimeyer, Taylor, Rozensky, & Cox, 2014). Average half-lives of knowledge in professional psychology are projected to decrease within the next decade from nearly nine years to just over seven years. The range of half-lives is currently from 19 years (psychoanalytic psychology) to 4.36 (clinical neuropsychology) to 3.63 (psychopharmacology).

Confidentiality

Since the time of Hippocrates, confidentiality has been considered a cornerstone of ethics in patient care. However, concepts of autonomy and individuality, collectivism, and family interdependence are relevant to such considerations. Clarity about the confidentiality of personal disclosures by supervisees is limited. Supervisees often assume confidentiality, but the supervisory responsibilities of protection for the client, and abiding by institutional, ethical, and legal regulations, gatekeeping, as well as duty to educational institutions, limit confidentiality (Falender & Shafranske, 2021).

Confidentiality issues in therapy may create ethical dilemmas in some countries. Exceptions to confidentiality – mandatory reporting laws for child abuse, for example – exist in some jurisdictions, although some are voluntary (Liu & Vaughn, 2019). Issues of privacy, family responsibility and loyalty, worldviews, and cultural factors all intersect with confidentiality exceptions and may be additional elephants in the supervision and therapy rooms (Pettifor et al., 2014).

Informed Consent

Articulated in many ethics codes and supervisory guidelines is the necessity for informed consent and clarity of expectations for clinical supervision. Also, the ethical imperative may exist that clients have informed consent that their therapist is a supervisee under supervision, and that all client sessions and data will be disclosed to and directed by the supervisor who holds responsibility for the clinical work. If audio or video recording is to occur (an increasingly common practice in some venues and required by accredited programs in the U.S.), informed consent from the client must also be obtained, with clarity about the use, storage, confidentiality, and process for erasure of the recordings.

Use of a written supervision contract such as one outlined in the APA's Guidelines for Clinical Supervision in Health Service Psychology (APA, 2014, 2015) is useful. It may include:

a. Content, method, and context of supervision – logistics, roles, and processes.

b. Clarity about the highest duties of the supervisor: protection of the client(s) and gatekeeping for the profession, while enhancing supervisee development and competence.

c. Roles and expectations of the supervisee and the supervisor, supervisee goals and tasks.

d. Criteria for successful completion and processes of evaluation.

e. Processes and procedures when the supervisee does not meet performance criteria, or reference to such if they exist in other documents.

f. Expectations for supervisee preparation for supervision sessions (e.g., video review, case notes, agenda preparation) and informing the supervisor of clinical work and risk situations.

g. Use of a multicultural frame that is internationalized to address identities, worldviews, and impact on client(s), supervisees, and supervisors.

h. Limits of confidentiality of supervisee disclosures, behavior necessary to meet ethical and legal requirements for client/patient protection, and methods of communicating with training programs regarding supervisee performance.

i. Expectations for supervisee disclosures, including personal factors and emotional reactivity, or countertransference and worldviews.

Ethical and legal parameters and compliance, such as informed consent, multiple relationships, limits of confidentiality, duty to protect and warn, and

procedures for emergency situations.

Processes for ethical problem-solving in the case of ethical dilemmas (e.g., boundaries, multiple relationships) (Adapted from APA, 2014, p. 24-25)

Supervisee Development and Ethical Acculturation

Understanding supervisee socialization and acculturation into ethical practice is essential. In some ethics acculturation models (Handelsman et al., 2005; Knapp, Vandecreek, & Fingerhut, 2017)), supervisors are cognizant of how supervisees progress developmentally to integrate their own personal ethics with professional ones. The four resultant quadrants of ethical behavior are: (1) marginalized, which is characterized by low personal and professional standards, and therefore potentially exploitative; (2) separated, which involves having adopted professional standards but lacking compassion, which makes the standards potentially rigid or legalistic; (3) assimilated, i.e., personal compassion is not restrained by professional ethics so there exists potential for overinvolvement; and (4) integrated with professionally informed practice and modulated by personal compassion. One supervisory task is to move the supervisee towards integrated ethical behavior, the highest level of development, and to monitor supervisee maintenance of objectivity in their clinical work.

Another supervisory responsibility for ethial practice is to be aware of metacompetence, both personally and for the supervisee. Metacompetence refers to awareness of what one knows and what one does not know. The latter is challenging to define, as we do not know what we do not know (Falender & Shafranske, 2007). A possible consequence of problems with a supervisee's metacompetence is he or she not recognizing their own behavior as deviating from their usual patterns, which may result in nondisclosure to their supervisor of their own countertransference or of clinical errors (although there are other reasons for nondisclosure, including an insecure supervisory relationship) (Ladany, Hill, Corbett, & Nutt, 1996; Wall, 2009).

Supervisors generally rely on supervisee self-disclosure rather than live or video observation and review of what transpired in a clinical session. However, supervisees may not know to identify clinically significant aspects of the client session or process, the ethical issues that arise, or general facilitators or impediments to treatment. Revised regulations for accreditation (APA CoA, 2018) in the United States directly addressed this by requiring each supervisor to conduct direct observation – live, video, or audio – to more effectively provide training and guide client care.

Ethical and Effective Supervision

Recognition that ethical supervision is a distinct professional practice that requires training is an essential first step. Supervisors hold responsibility for both client care and for their supervisees, and for understanding and integrating the worldviews and belief structures of the client(s), supervisees, and themselves. The supervisor models ethical behavior, thus providing a hidden curriculum that is supported by multiculturally competent ethical practice. Supervisors should self-assess their own supervisor knowledge, skills, and attitudes. Generally, the supervisor should be competent in the areas under his/her supervision, including understanding multicultural factors, modeling metacompetence, or considering what one does not know, and creating an environment in which communication and the supervisory and therapeutic relationships are facilitated. Knowledge and understanding of the Universal Declaration of Ethical Principles for Psychologists (2008), attention to principles of ethics, and assisting supervisees in intersectional consideration of ethical dilemmas in cultural frames are all essential. Acknowledging the limits of a supervisor's own competence and requisite ethical steps to address those limits are critical.

The supervisor provides informed consent to the supervisee regarding the multiple aspects of the supervisory relationship, expectations, and evaluation; this is codified in a supervision contract. Establishment of the supervisory relationship requires a respectful

process and collaboration in the competence assessment of the supervisee, as well as in the setting of goals and tasks. An emotional bond is developed, inviting trust, supervisee self-reflection and self-assessment, and reinforcing metacompetence. Developing an environment that enhances communication supports a supervisory working alliance while establishing and supporting clear boundaries that are articulated for the specific setting.

The supervisor's reflective process allows for monitoring and addressing the impact of relational dynamics and parallel processes, as well as the supervisee's emotional responses, reactivity, and countertransference, thus ensuring that the focus remains on the impact on the client and does not cross a line into personal psychotherapy with the supervisee. Ethical problem solving is an effective tool for assisting supervisees in identifying and determining action when supervisory and clinical dilemmas arise. Supervisors will find that supervisees' ethics training may have been focused primarily on risk avoidance and on ethics knowledge, sometimes rote knowledge of the ethics code, but not necessarily identifying ethical dilemmas within the expanse of the clinical presentation and setting. Supervisors must model positive ethics, ensuring that supervisees understand and promote the highest ethical conduct and aspirational principles.

The supervisors' ethical knowledge, skills, attitudes, and competence should be strong and continuously accrued. Supervisors model adherence to ethical principles and codes, as well as reflective practice. Supervisors are challenged to infuse recognition and attention to global and multicultural ethical aspects of clinical presentations and supervisee-client as well as supervisee-supervisor interactions, and to provide a respectful process that attends to the various approaches and problem-solving needed to ensure that supervisees learn and provide the best care, protecting and enhancing the outcomes for the clients they serve.

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