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GLOBAL DEVELOPMENTS IN CLINICAL SUPERVISION

# Clinical supervision and counseling psychology in the Republic of Ireland

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**ABSTRACT**

Against the background of political, social, economic, and cultural factors, we present an overview of clinical supervision within counseling psychology in the Republic of Ireland (ROI). Clinical supervision has been an integral aspect of counseling psychology training in the ROI since its inception, and more recently it is being promoted as a professional support over the course of the counseling psychologist's career. Within this context, we discuss the current status of clinical supervision, including the major developments, key policies, and best practice principles. Recommendations regarding the future direction of clinical supervision in the ROI and globally are also offered.

**KEYWORDS**

Clinical supervision; counseling psychology; Republic of Ireland

## Cultural context of psychology in the Republic of Ireland

The island of Ireland is situated on the North Atlantic, Western Europe, and occupies an area of 32,575 square miles (Aughey & Oakland, 2013). The island is politically separated into two distinct countries, the largest of which is the Republic of Ireland (ROI) in the south of the island. Northern Ireland is part of the United Kingdom along with England, Scotland, and Wales, with a population in excess of 1.8 million, the marginal majority of whom identify as Protestant (Northern Ireland Statistics & Research Agency, 2014). The Republic of Ireland is a sovereign independent state with a population of approximately 4.8 million (12% of whom are non-Irish nationals representing 199 diverse nations and 0.6% of whom are members of the Irish Traveller Community—an indigenous minority group; Central Statistics Office, 2011). The official languages are Irish and English, with the majority of the population speaking English as their first language and identifying as Catholic, according to the last census (Central Statistics Office, 2011).

Irish history tells a complex story of centuries beset by conquest, colonization, rebellion, and conflict (O'Morain, McAuliffe, Conroy, Johnson, & Michel, 2012). The dominant rule of the United Kingdom lasted for 800 years until 1922 when independence was first determined and eventually followed by the legal establishment of the Republic of Ireland in 1948 (Brock, 2012).

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The partition of the country into two political entities, as mentioned earlier, had many consequences, most significantly, a 30-year (1968 – 1998) ethno-political conflict in Northern Ireland and the border areas of the Republic of Ireland (Coakley, 2004). A peace process was eventually initiated and culminated in signing a peace treaty, more commonly referred to as the "Good Friday Agreement," in 1998 (Aughey & Oakland, 2013). The separation between the North and South of the island saw two distinct health services develop on the same island and the discipline of psychology taking two different trajectories in its development and governance (MacIntyre, Moran, & Campbell, 2014).

Against this political background, along with other global events (e.g., World Wars in Europe), the economy in the Republic of Ireland was in a deep depression up to the 1960s, due in part to poor industrial development, the decline of agriculture, high unemployment, and emigration (Bielenberg & Ryan, 2013). In this context, there was little available funding to invest in state health or support services. Moreover, the Irish Catholic Church, which was a dominant influence in people's lives in the ROI, was the main benefactor of social and educational services up until the 1960s, but reportedly resisted developments in psychology, as it was perceived as a secular activity (Brock, 2012). Nevertheless, the first psychological service, in the form of a child guidance clinic, was established in 1955 under the direct patronage of the Catholic Church, and thus the foundation for the development of psychology, initially clinical psychology, was laid (Carr, 2015). Similarly, it was the early 1960s when formal counseling services were offered in the form of marriage guidance, again under the auspices of the Catholic Church (O'Morain et al., 2012). Gradually, university-based training programs began to develop, with the first qualification in counseling psychology becoming available in 1989 in Trinity College, Dublin, soon followed by a master's degree in 1991, which was replaced by a doctoral degree in 2008 (Connolly et al., 2014).

## Current status of counseling psychology

In contrast to the United Kingdom and Northern Ireland, currently there is no state regulation of psychology or counseling psychology in the Republic of Ireland. However, under the Health and Social Care Professionals Act (Department of Health, 2005), professional psychology will be state-regulated in the coming years. In the absence of such regulation, the Psychological Society of Ireland (PSI), a professional association established in 1970, has provided voluntary self-regulation (Swain, 2014). The PSI has a current membership of approximately 2,500 psychologists across the specialty domains (PSI, n.d.). As membership of PSI is voluntary, not all psychologists working in the ROI are represented in this number. The authors estimate that there are in excess of 500 counseling psychologists in the ROI; however, the actual number is unknown for this reason.

The PSI provides accreditation for all undergraduate and postgraduate psychology training in the Republic of Ireland that is recognized by major employers, such as the Irish statutory health service (Health Service Executive, or HSE). Akin to the American Psychological Association (APA), PSI has established divisions (e.g., Counseling Psychology) and special interest groups (SIG; e.g., Sexual Diversity and Gender Issues) for the advancement of psychology in Ireland. Each division and SIG organizes continuing professional development activities for its members. In addition, PSI has established a peer-reviewed journal, the *Irish Journal of Psychology*, and a newsletter, *The Irish Psychologist*, and organizes an annual conference (O'Leary & O'Shea, 2009), with the area of clinical supervision increasingly evident in the conference proceedings.

Considering the relatively recent arrival of counseling psychology in the Republic of Ireland, much progress has been achieved within that time frame. As with the development of the profession in other countries (e.g., United Kingdom), it has taken some time to consolidate a professional identity and one distinct from other mental health professions (e.g., counseling and psychotherapy; cf. Orlans & Scoyoc, 2009). Nevertheless, with the leadership of experts in the field and concerted efforts by the PSI Division of Counselling Psychology (DoCP; established in 1997), significant progress has been made in addressing this challenge by defining competencies of the specialty (currently under review), developing a doctoral training program, providing continuing professional development opportunities for counseling psychologists, and providing information to the public (Connolly et al., 2014). The development of clinical supervision has also been enhanced through the DoCP provision of workshops and seminars for supervisors.

In terms of the focus and scope of professional practice, counseling psychologists provide assessment, diagnosis, and psychological treatment for a range of presenting issues across the life span, including developmental issues, trauma, abuse, issues of identity, and so forth, with the aim of enhancing well-being and improving quality of life (PSI, n.d.). Qualified counseling psychologists work in a variety of settings (e.g., health services, hospitals, primary care services, prison services, university counseling centers, etc.), and also work in private independent practice. For instance, many counseling psychologists work within the National Counseling Service (NCS). This service was established by the Irish Health Service Executive (HSE) in 2000 to provide counseling for adults who are survivors of institutional abuse when, as children, they were in state care. Counseling psychologists may also provide clinical supervision in the aforementioned settings.

One of the significant challenges for counseling psychology has been achieving equal employment opportunities within the HSE (Connolly et al., 2014). Traditionally and currently, the HSE has supported clinical psychology through the funding of training and the direct provision of employment for

graduates. A consequence of this has been the restriction of psychology posts available to counseling psychologists in the HSE-designated psychological service areas (i.e., adult and child disability, adult mental health/older adult mental health, child and adolescent mental health; children, youth, and family services). With the exception of one area (primary care/community care adult services), counseling psychologists were deemed ineligible to apply for any of the others, due to the application criteria being based on qualification rather than on competencies (Connolly et al., 2014). The implications for counseling psychology supervisors have been difficult at times in terms of supporting professional identity development in a climate where parity of professional esteem and equality in the profession were unsupported by career opportunities in the statutory health service.

However, through many years of activism, advocacy, and statutory intervention, along with internal organizational restructuring, the HSE recently reviewed the eligibility criteria for the recruitment of psychologists in the HSE, the outcome of which saw the original eight service areas amalgamated to five (e.g., child disability, adult disability, adult psychology, child psychology, and life span primary care) and counseling psychologists are now eligible to apply for all HSE psychology positions in all service areas. Although the changes may perhaps have implications for the doctoral training curriculum (e.g., extending clinical experience in disability services), the changes have been, in general, welcomed. The question of funding for counseling psychology training remains an area for ongoing discussion and negotiation.

### *Counseling psychology training and qualification*

Within the context of counseling psychology, currently there is one training program available in Ireland and this is offered at the doctoral level (i.e., the Professional Doctorate in Counselling Psychology [DCounsPsych], Trinity College, Dublin, for which the second author is the Course Director and the first author is a faculty member). The doctoral program is a three-year full-time program; it is not possible to pursue this program on a part-time basis. Recruitment occurs annually (in the spring of each year) and, typically, 12 to 14 students commence their studies each September. Each cohort comprises an international group of trainees (for example, recent and current students are from Ireland, United Kingdom, Canada, United States, various European countries, South Africa, Australia, etc.), which provides for a diverse and rich learning environment.

Admission criteria require applicants to hold an honors degree in psychology (in which psychology needs to be the major subject undertaken) and be eligible to apply for graduate membership with the Psychological Society of Ireland (PSI). Program admission procedures comprise a formal application, an individual and group interview, along with two written

examinations, one related to research and one related to professional issues. In the absence of state funding or grant aid, trainees in counseling psychology self-fund their training.

In addition to the University's criteria for the award of a doctoral degree, PSI specifies program accreditation criteria (Psychological Society of Ireland, 2013). These criteria, directly informed by the principles of the PSI *Code of Professional Ethics* (Psychological Society of Ireland, 2010), relate to the academic content of the program and include guidelines on personal development, skills development, assessment, research, practice, and the provision of clinical supervision. In contrast to the United States, personal development is mandated for trainees (i.e., they are required to undertake 60 hours of personal individual therapy and 40 hours of group therapy with external accredited therapists over the duration of the program).

PSI (2013) guidance is also provided on assessment of competency procedures, program administration, management, staffing, admissions, and quality control mechanisms. To maintain PSI accreditation, the program needs to formally apply for accreditation every five years, demonstrating compliance with the specified criteria and the submission of a written report and supporting documentation (e.g., student handbooks). Thereafter, a formal review meeting is held with the Course Director, faculty, clinical supervisors, and students, along with department and college authorities.

With reference to clinical practice, PSI accreditation criteria require trainees to undertake a minimum of 450 hours of client contact under weekly individual clinical supervision at a ratio of 1 hour of supervision for every 5 hours of client work. Unlike the United States, where practica and internships differ somewhat in expectations of student involvement and are offered at different points in the developmental trajectory, doctoral trainees commence their supervised clinical placements (placement rather than practicum or internship is the term used) in the first semester of Year 1. This continues throughout their training for 30 months across the duration of their three-year program, at a minimum of two days per week, and with a maximum caseload of seven or eight clients at any given time. As part of their clinical experience, trainees must undertake clinical work with clients across all age ranges of the life span in a variety of settings (e.g., hospitals, prison services, family centers, health service, etc.). As stated by the PSI (2013), "students must gain client experience, including experience of diversity, in at least three settings, at least one of which should be in a health care setting" (p. 8). In addition, the PSI expects trainees to acquire varied clinical experience with clients who present with a range of psychological problems. It is the responsibility of the program to source, formally contract, and monitor appropriate clinical placements and clinical supervision for trainees.

The training approach of the doctorate endorses the scientist–practitioner model (Raimy, 1950) of training and subscribes to an integrative theoretical perspective, underpinned by humanistic principles, across the main approaches

of psychotherapy theories (e.g., psychodynamic, cognitive-behavioral therapy, humanistic/experiential including emotion-focused therapy). Trainees have opportunities to develop competency in individual, couple, family, and group therapy together with competency development in psychological assessment (e.g., cognitive, neuropsychological, and educational). The research component of the program requires trainees to undertake empirical research under the guidance of a research supervisor, submit a dissertation (40,000 words), and defend their dissertation in a viva voce examination at the end of their studies. As articulated in the program handbook (Doctorate in Counselling Psychology, 2015).

> The D.Couns.Psych. course aims to facilitate the integrative professional and academic development of ethically sensitive, critically reflective, emotionally aware, empathically responsive and research active scientist-practitioners who work collaboratively with their clients to provide high quality psychological services. It promotes evidence based psychological practice in the context of a therapeutic relationship characterised by trust, respect, and sensitivity to the phenomenological experience of the whole person and the uniqueness of the client within their cultural contexts. Furthermore, the course aims to develop and promote practice relevant research of a high international standard. (p. 2)

On successful completion of their doctoral degree, graduates are qualified to practice independently; further credentialing or licensing is not currently a requirement in the Republic of Ireland (Ellis, Creaner, Hutman, & Timulak, 2015). Although not a mandatory requirement, counseling psychologists may apply for registration status (i.e., to be included on the Register of Psychologists maintained by PSI). Although not currently a protected title, psychologists are then permitted to use the title "Registered Psychologist of the Psychological Society of Ireland" (Reg. Psychol. PsSI; PSI, n.d.). Requirements for registration for a counseling psychologist include a recognized postgraduate qualification, four years of supervised experience (years in training may be counted), and verification by a supervisor who is normally a PSI-registered counseling psychologist. For counseling psychologists who have gained their qualifications outside of the ROI, a process of review and validation is required to establish the equivalency of qualifications (cf. Gillon, Timulak, & Creaner, in press). This process is undertaken by the Department of Health in consultation with PSI. Similarly, counseling psychologists who qualify in the ROI and wish to practice in Northern Ireland (or the United Kingdom) are legally obliged to register with the Health and Care Professions Council (HCPC), which is the state regulatory body in that jurisdiction. However, there is a reciprocal relationship between the British Psychological Society (BPS) and PSI, with some psychologists holding dual membership, one of the many initiatives to enhance collaboration among psychologists in the ROI and the United Kingdom (MacIntyre et al., 2014).

## Clinical supervision practice in counseling psychology training

The PSI (2013) provides guidelines and criteria for program accreditation, including clinical supervision requirements. However, no supervisor

credentialing or specifications regarding supervision training are required to provide supervision in counseling psychology. Informed by PSI accreditation criteria, doctoral program requirements, and best practice principles, eligibility criteria have been established for the clinical supervision of counseling psychology trainees. The majority of supervisors for the doctoral trainees are typically qualified counseling psychologists with at least five years of post-training experience. Clinical psychologists and psychotherapists/counselors who meet the eligibility criteria may also undertake supervision of counseling psychology trainees; however, at least one of the clinical placements has to be supervised by a counseling psychologist. In reality, about 80% of the clinical placements in the counseling psychology program are supervised by a counseling psychologist, with the remainder of supervision typically being provided by clinical psychologists (this is also due to historical reasons, as clinical psychologists can be found in some settings that are relatively new to counseling psychology, such as psychiatric or other hospital settings).

Clinical supervisors are required to negotiate a written supervision contract with the supervisee and agree to a clinical placement contract provided by the program. As mentioned, they also need to agree to provide weekly face-to-face individual supervision at a ratio of 1:5 hours of client work. In acknowledgment of individual supervisor styles and approaches, no particular supervision model is specified by the program or by PSI, with the exception of a guideline referring to the need for developmentally appropriate supervision (PSI, 2013). Generally, these supervisors are also employees of the clinical placement agency (e.g., health service, university counseling centers) and as such provide supervisee induction to the service at the beginning of the clinical placement experience.

Clinical supervisors within counseling psychology training in the ROI have an explicit gate-keeping remit, and their key responsibilities are to facilitate and monitor supervisee professional development, ethical practice, and client welfare (Bernard & Goodyear, 2014). Optimally, clinical supervisors provide for the normative (e.g., quality control), formative (e.g., facilitating learning), and restorative (e.g., support) functions of supervision (Proctor, 1987). They prize a relational and collaborative supervisory alliance, congruent with the philosophy of counseling psychology (Creaner & Timulak, in press). It is expected that the clinical supervisors for the counseling psychology program subscribe to clear contracting and informed consent (Thomas, 2007); regular and quality feedback (Heckman-Stone, 2004); and the use of explicit criteria and due process in the trainee evaluation and overseeing documentation and record keeping (e.g., case notes, logs, and so forth) with the supervisee (Bernard & Goodyear, 2014). In facilitating the individual learning needs of supervisees and monitoring outcomes for clients, ideally, the supervisors will have a comprehensive repertoire of teaching and learning strategies (e.g., role play, discussion, modeling, outcomes measures, and so forth) on which to draw (Creaner, 2014; Creaner & Timulak, in press; Milne, Aylott, Fitzpatrick, & Ellis,

2008). Further supervisor responsibilities relate to the monitoring of client work (through supervisee self-report, case notes, reviewing digital recording of client sessions, etc.), psychological assessment, and all activities associated with the broader role of the trainee counseling psychologist (e.g., psychoeducational intervention) (Creaner & Timulak, in press).

Regarding evaluation, clinical supervisors are required to return two competency evaluation reports conducted in collaboration with the supervisees. One formative report is provided mid-way during each year of their placement and one summative annual evaluation at the end of the placement. An end-of-placement review meeting is conducted among a staff member, the supervisor, and the supervisee. In this meeting, the overall placement experience is reviewed, including the supervisee's competency development, professional conduct, and fitness to practice (e.g., case conceptualization, theoretical integration, skills development, ethical awareness, emotional awareness, case management, psychological assessment, multicultural competency, etc.). A formal evaluation of supervision is also conducted, and trainees complete a written review of how the supervision contract was fulfilled (e.g., frequency of supervision sessions, facilitation of competency development, adequacy of feedback, appropriate supervisory challenge and support). In acknowledgment of the need to empower supervisees, particularly in the relation to the power differential inherent in supervision (cf. Bernard & Goodyear, 2014; Ellis et al., 2015), this is discussed with the supervisee and supervisor at the end-of-placement review meeting. Trainees also have the opportunity to provide anonymous feedback each semester as part of their program evaluation.

In addition to individual supervision, trainees participate in adjunct group supervision within the program throughout the academic year. A clinical supervisor who is a core staff/faculty member facilitates this and the typical group size is seven supervisees. Group supervision is also subject to formal evaluation at the end of the year, and this is conducted individually with the supervisee outside of the group.

Where difficulties present for the supervisee or when fitness to practice issues or trainee impairment present in individual or group supervision, the clinical supervisor firstly discusses this with the supervisee. With regard to due process, the supervisor clearly indicates what competencies and program learning outcomes are not being met. The placement/field supervisor also informs the training program and normally a developmental plan is formulated in collaboration with the supervisee. The nature of the difficulty (e.g., skills deficit, serious ethical misconduct, criminal behavior) will determine the course of action (ranging from a development plan to dismissal from the program). The Fitness to Practice policy within the University ultimately determines how these issues are managed.

A further PSI (2013) accreditation criterion relevant to supervision refers to the provision of supervision training for trainees. As a result, during Year 3 of

the program, trainees undertake a total of 15 hours of introductory supervisor training, comprising supervision theory and practice (e.g., contracting, supervisor/supervisee roles and responsibilities, establishing a supervision relationship and alliance, feedback and evaluation, facilitating supervisee learning, and so forth). In contrast to many counseling psychology programs in the United States, ROI trainees do not provide supervision to other students on the doctoral program or allied programs.

## Clinical supervision practice in counseling psychology: Post-training

Attending post-training clinical supervision across the career life span is not currently a mandatory requirement in counseling psychology in the ROI (as it is for counseling psychologists in the United Kingdom [British Psychological Society, 2007]; and counselors/therapists, who are non-psychologists in the ROI [cf. Irish Association for Counselling and Psychotherapy, 2010]). Nonetheless, supervision is highly valued in the community, with many psychologists engaging in supervision and providing supervision post-training (McMahon & Errity, 2014). It is also recognized as a part of Continuous Professional Development activity, which is monitored by PSI. Generally, receiving supervision is considered as good practice and expected of counseling psychologists in the ROI (for instance, the doctoral training program emphasizes this as standard practice post-training).

Depending on the work setting (e.g., health service), attending supervision may be a condition of employment. For example, in 2015 the HSE introduced its first supervision policy—*HSE/Public Health Sector Guidance Document on Supervision for Health and Social Care Professionals.* The policy requires that all health and social care professionals, including counseling psychologists, engage in "regular, high quality, consistent and effective supervision that is appropriate to their profession" (HSE, 2015, p. 5). HSE also stated that professional supervision should continue across the career span of professionals working within their organization. In some instances, this may be line management or managerial supervision wherein the supervisor also holds a dual managerial responsibility. This form of supervision frequently presents as problematic regarding psychological safety and power differentials, and a number of authors and professional organizations have recommended a separation between line management and clinical supervision (e.g., McMahon & Errity, 2014; Psychological Society of Ireland, 2014).

### *Dominant supervision models in use in the Republic of Ireland*

Although professional guidelines and policies exist, the dearth of systematic inquiry and empirical evidence regarding the actual practice of supervision in counseling psychology in the ROI makes it impossible to determine what approaches and models are dominant. However, there have been a number of

specific influences from which some inferences may be made. For instance, the development of clinical supervision in the Republic of Ireland has been influenced by developments in the United Kingdom, with many supervisors pursuing training in the United Kingdom or experts in the field in the United Kingdom providing training in the ROI (e.g., Michael Carroll, Peter Hawkins, Robin Shohet, Sue Wheeler, Robert Bor, etc.). Thus, particular supervision models and approaches (e.g., Carroll, 1996; Hawkins & Shohet, 2012) have become accessible in the ROI. Most of these models are conceptual frameworks rather than empirically validated models and aim to provide guidance to supervisors in navigating the supervisory process. Gradually, a base of expertise has developed in the ROI (e.g., Creaner, 2014; Holton, 2010; McMahon & Errity, 2014; Moore, 2016; Morrissey, 2015), with several professionals involved in supervision research (see later discussion) and providing supervision training locally, both in the university setting, in private training contexts, and as continuing professional development (CPD) provision by professional organizations.

## Major developments in clinical supervision in the Republic of Ireland

As evident internationally, one of the major developments over the past decade is that clinical supervision is now understood as a distinctive professional activity warranting specific competencies (Falender et al., 2004) and awareness of best practice standards (Borders et al., 2014). Hence, supervision training opportunities are being provided (as discussed later), and supervision policies are being developed in the ROI, all of which will optimally influence supervision practice in counseling psychology. From this, a number of key initiatives have resulted in the promotion and development of clinical supervision in the ROI, some specifically in the context of counseling psychology and some in the broader service of clinical supervision across disciplines and professions.

### *Supervision policy development*

Initiated in 2008, a PSI draft supervision policy for all psychology specialties, including counseling, became available in 2014. The policy proposes career-long supervision attendance and standards for qualified psychologists working with the public. In summary, as a minimum, one hour of supervision (either individual or group) per month is recommended. In addition, for psychologists who wish to provide supervision, two years post-training experience along with 20 hours of formal supervision training is proposed (PSI, 2014). However, the nature of supervision training is not specified (e.g., if there is a professional practice component, assessment, etc.). The policy also includes specific guidelines for practice (e.g., the use of contracts) and ethical guidelines for supervision. As different specialties will have different requirements, the policy is currently under consultation across each PSI division.

### *Supervision research*

The past decade has seen a slow but steady growth in supervision research in the ROI. Three recent studies in particular help provide a glimpse into the landscape of supervision broadly within the ROI (note that studies do not pertain solely to supervision provided by or to counseling psychologists). The first study, by McMahon and Errity (2014), surveyed qualified professional psychologists ($N = 431$; the majority of whom were clinical [47%] and counseling [23%]) regarding their supervision practices and experiences. Results indicated that the majority of qualified psychologists received clinical supervision or line management supervision, generally on a monthly basis. Interestingly, one-half of the participants reported that they were very/quite satisfied, with approximately one-third reporting various levels of dissatisfaction with the support they received in supervision. Counseling psychologists reported the highest satisfaction and attended supervision more frequently, generally bimonthly, often with a supervisor external to the organization in which they worked. The key factor attributed to the level of satisfaction was the quality of the supervisory relationship, with participants noting the need for a psychologically safe, trustworthy, and nonjudgmental environment. Other factors identified by McMahon and Errity included an expressed need for clinical supervision and line management supervision to be separate professional activities, again referring to concerns about safety and feeling vulnerable with one's manger in the role of supervisor. As discussed by the authors, the supervisory relationship and the quality of that relationship was the main factor contributing to satisfaction with the supervisory experience. This study also investigated psychologists' confidence in providing supervision. Of note was that 70% of the participants provided clinical supervision, but only 16% of the participants had received formal training in supervision. Those who did undertake training and those who had engaged the longest in personal therapy felt more confident in the role of supervisor. A key recommendation of the study was the need for adequate supervision training.

The second study was a comparative cross-cultural study by Ellis and colleagues (2015), who investigated exceptional, inadequate, and harmful supervision (Ellis et al., 2014) in the Republic of Ireland (ROI) and the United States. The sample (ROI: $N = 149$; U.S.: $N = 151$) comprised supervisees in the mental health context (e.g., counseling, clinical psychology, counseling/psychotherapy, etc.). The ROI sample comprised trainee and qualified participants and the U.S. sample were trainees. In summary, the results indicated that 79.2% (ROI) and 69.5% (U.S.) of participants were currently receiving inadequate supervision and, at some point in their career, 92.4% (ROI) and 86.4% (U.S.) were deemed to have experienced inadequate supervision (e.g., 28.8% [ROI] and 48% [U.S.] did not have a supervision contract/informed consent in supervision). Regarding harmful supervision,

40.3% (ROI) and 25.2% (U.S.) were currently receiving harmful supervision; at some point in their career, 51.7% (ROI) and 39.7% (U.S.) said they received harmful supervision (e.g., 23% [ROI] and 11% [U.S.] did not feel safe from exploitation; one ROI participant reported feeling physically threatened by their supervisor). On a more positive note, just more than half of the supervisees reported receiving exceptional supervision from their current supervisors. The results further indicated that inadequate and harmful supervision is relatively frequent in the Republic of Ireland and the United States. The key recommendations offered by Ellis and colleagues related to the need for supervisor competency development, together with closer monitoring of supervision by training programs and supervisee education.

The third study, by Sweeney and Creaner (2014), was a qualitative inquiry with counseling psychologists ($N = 6$) in the ROI concerning their experiences of nondisclosure in supervision while in training. Findings indicated that power differentials, feeling psychologically unsafe, and feeling that the supervisor was not invested in the relationship or sufficiently experienced inhibited supervisee disclosure. Conversely, a safe supervision alliance where mistakes were seen as part of the learning process, where the supervisor disclosed appropriately and encouraged supervisee disclosure, were seen as facilitating factors. The key recommendations were the need for supervisor training and role induction for supervisees.

Across these three studies, whether as trainees or qualified practitioners, the participants/supervisees spoke to the key themes of needing psychological safety, a good supervisory relationship, and a competent supervisor. As mentioned earlier, the results do not speak directly to counseling psychology; nonetheless, these are recurrent themes in the literature, across all developmental levels, and accepted as best practice standards (e.g., Creaner, 2014).

## Supervisor education and training

A major development in support of supervision training and practice in the context of counseling psychology (and in related fields) was establishing one of the first ROI university-based qualifications in clinical supervision, namely, a Postgraduate Diploma in Clinical Supervision in Trinity College, Dublin, in 2004. The development of the Postgraduate Diploma was initiated in a conversation between the then Course Director of the MSc in Counselling Psychology, Dr. Rita Honan, and the first author regarding a need in the field for supervisor competency development. As the profession was still in its early days developmentally, few counseling psychologists had supervision training, due, in part, to the lack of systematic training programs available. The supervision program was also developed in awareness that supervision competency development required formal training (Falender et al., 2004). Successively, in recognition of the need for research to inform both practice

and the ongoing development of supervision, a master's degree in clinical supervision was developed in 2008.

The overall aim of the MSc is to provide formal graduate education and professional training for supervisors by drawing on the best practice principles and available research. The curriculum was initially developed by drawing on the resources available at the time; it is updated annually in collaboration with the external examiner, the course management committee, and feedback from students. For example, primary resources include training curricula guidelines and recommendations (e.g., Borders, 2010), supervision competency frameworks (e.g., Falender et al., 2004; Roth & Pilling, 2009), and training models (e.g., Watkins, 1993). Various professional organizations and practice standards also provide guidance in curriculum development (e.g., American Psychological Association, 2014). However, many of these, particularly those emanating from the United States, usually refer to supervisor training for the supervision of trainees, and the area of post-training supervision is, to date, largely unchartered territory (Creaner, 2014).

The MSc is a two-year part-time program. On successful completion of Year 1, there is an option to exit with a Postgraduate Diploma in Clinical Supervision. Regarding program admission, applicants are normally required to hold an honors degree in psychology or a related discipline, have some experience of receiving supervision, be a full member of a recognized professional body, subscribe to a code of professional ethics, and hold professional indemnity insurance for supervision. They are also required to attend an individual interview.

The MSc comprises six taught modules and a professional practice module in Year 1 with Year 2 focused on supervision research and dissertation. Course modules include the following:

- Module 1: Advanced Clinical Supervision, Theory, Skills, and Process
- Module 2: Clinical Supervision and Perspectives in Adult Learning
- Module 3: Advanced Peer and Group Supervision
- Module 4: The Reflective Practitioner
- Module 5: Professional Practice
- Module 6: Organizational Issues and Contexts
- Module 7: Research in Clinical Supervision
- Module 8: Clinical Supervision Dissertation (Year 2)

As part of the Professional Practice module, students are required to undertake 50 hours in the role of supervisor for which they contract for individual supervision of supervision with a program-approved external supervisor (at a ratio of 1 hour of supervision to 4 hours of supervision practice). Evaluation is provided by the external supervisor in the form of a mid-practice review and a summative evaluation at the end of their training. In addition, 25 hours of supervision practice is accommodated across modules in the form of peer supervision. Documentation and record keeping is part of this module

(supervision contracts, supervision logs, etc.). In Year 2, for the dissertation module, students conduct an empirical inquiry into an aspect of supervision and submit a 20,000-word dissertation. The program pedagogy aims to reflect the ethos of the program and is informed by humanistic principles and adult learning theory. Teaching and learning strategies span traditional didactic approaches, experiential learning, reflective groups, discussion, and presentations, written papers, video tutorials, role play, reflective teams, and peer supervision. Each module is individually assessed (e.g., written assignments, presentations, recorded skills practice) and regular feedback is provided.

Outside of the university setting, a number of private institutions offer professional training in supervision for the helping professions, and other training programs may be validated by an external university. Professional organizations (e.g., PSI) also organize supervision training, usually in the form of continuing development workshops and seminars. Depending on the nature of the supervision training provided (e.g., workshops, year-long programs), opportunities for professional practice with supervision may or may not be a feature.

Separate to counseling psychology and the psychology profession in the ROI, the Irish Association for Counselling and Psychotherapy (IACP) provides self-regulation for counselors and therapists in the form of accreditation for individual members, supervisors, and supervision training programs (Ellis et al., 2015). The IACP (2016) has developed a set of competency-based standards and standardized accreditation criteria for supervision training programs requiring 100 hours of systematic training, to include 25 hours of supervised external professional practice and 25 hours of course-facilitated practice. Hence, a number of programs have been developed to meet these standards and may apply to IACP for supervision training program accreditation. On completion of these programs, participants who are members of IACP may apply for accredited supervisor status with this organization.

Furthermore, a recent initiative in support of supervision training, research, and practice was the inaugural International Interdisciplinary Supervision Conference (2016) hosted by the Department of Psychotherapy in Dublin City University (organized by Aisling McMahon, Rita Glover, and colleagues). Likewise, the Supervisors Association of Ireland (SAI), founded by Geraldine Holton in 2005 to promote and support cross-professional supervision, offers training workshops, master classes, and supervision conferences (SAI, n.d.).

## Future directions

The imminent arrival of statutory regulation for counseling psychology in the ROI may have implications for standards and practices in clinical supervision, although what this will look like remains to be seen. Of pressing interest and

need is to develop a deeper understanding and a more accurate profile of clinical supervision in counseling psychology in the ROI and internationally, including the need to identify the unique aspects of supervision in this specialty and in comparison to the other professional activities of the counseling psychologist. Furthermore, process and outcome research with supervisors, supervisees, and their clients is a significant area of the supervision research agenda. As the ROI is becoming a more diverse society, further consideration to multicultural competence in supervision training and practice and how this competence is also facilitated for supervisee practice with clients is indicated. The area of supervision education and training and the needs of counseling psychologists in that regard necessitates systematic inquiry. More broadly, an evidence base is required for supervisor training to refine competencies development, assessment procedures, and support ongoing curriculum development with reference to the cultural contexts in which they are implemented. To move forward in a coherent and expeditious manner, there is a need to collaborate as a global supervision community in order to agree on a shared meaning of supervision, a set of standardized measures, and a research agenda that is meaningful to supervision researchers and practitioners, locally and globally.

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