Group Supervision Attitudes: Supervisory Practices Fostering Resistance to Adoption of Evidence-Based Practices

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Abstract

The focus of this study was to qualitatively evaluate worker's attitudes about clinical supervision. It is believed that poor attitudes toward clinical supervision can create barriers during supervision sessions. Fifty-one participants within a social services organization completed an open-ended questionnaire regarding their clinical supervision experiences. Results suggest four key areas which appear to be strong factors in workers' experiences and attitudes regarding group supervision: a. facilitator's skill level; b. creativity; c. utilization of technology; and d. applicability. For organizations interested in overcoming potential barriers to adopting best practices, effectively addressing workers' negative attitudes toward group supervision would be a worthy endeavor.

Keywords

Group Supervision, Evidence-based Practices, Worker Attitudes, EBP adoption, Phenomenology

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The focus of this study was to qualitatively evaluate worker's attitudes about clinical supervision. It is believed that poor attitudes toward clinical supervision can create barriers during supervision sessions. Fifty-one participants within a social services organization completed an open-ended questionnaire regarding their clinical supervision experiences. Results suggest four key areas which appear to be strong factors in workers' experiences and attitudes regarding group supervision: a. facilitator's skill level; b. creativity; c. utilization of technology; and d. applicability. For organizations interested in overcoming potential barriers to adopting best practices, effectively addressing workers' negative attitudes toward group supervision would be a worthy endeavor. Key Words: Group Supervision, Evidence-based Practices, Worker Attitudes, EBP adoption, Phenomenology.

With the push from funding sources, whether mandated or not, to incorporate best practices into social services (NIH, 1999), clinical supervision plays an increasingly important role in sound clinical procedures toward adopting best practices within agencies. Evaluating and monitoring these clinical practices through specific clinical supervision activities should be at the forefront of any agency. Attention to factors which augment workers' resistance to the adoption of new practices could likely make the bridge from research to practice an easier path to cross. In this study, an internal, mixed model self-administered survey collected workers' attitudes about supervision from 51 participants. The qualitative data were analyzed using Moustakas' adaptation of the Stevick-Colaizzi-Keen method of analysis of phenomenological data (Moustakas, 1994).

Background

Because little research has been devoted to supervision in the bio-psychosocial services field (Spence, Cantrell, Christie, & Samet, 2002), a breakdown between assimilation and successful implementation of EBPs could exist resulting from the lack of effective clinical supervision processes. Cleary and Freeman (2005) describe nurses' passive resistance to clinical supervision in mental health settings as attributable, in part, to a perception that sufficient supervision is contained within continuing education

licensure requirements. Few articles outlining specific worker-reported attitudinal barriers to the adoption of EBPs appear in the published literature. Fewer transfer this data to group supervision practices which may improve workers' assimilation of important EBPs. Of interest to organizations seeking to improve service quality through the implementation of EBPs would be specific, no-cost measures supervisors could take to reduce workers' attitudinal resistance to the adoption of EBPs through the group supervision methods already in place.

In addition to general organizational change-resistance described in professional mental health settings, there have been other hypotheses to explain why EBPs often fail to transition from research to practice. For example, organizational culture and climate factors are beginning to be linked with barriers to implementation and adoption of EBPs (Aaron, 2005; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hemmelgarn, Glisson, & Dukes, 2001; Hemmelgarn, Glisson, & James, 2006; Nadler & Tushman, 1997; Rogers, 1995; Rousseau, 1997). Other primary care clinicians, such as general practitioners, have noticed a movement away from supervision of any type–an independence mindset which often seems fitting in a fast-paced and busy work environment (Launer, 2007). This project expands on the knowledge learned from organizational research and targets those internal structures which possibly impede EBP implementation; specifically, the lack of informed, structured, and effective clinical supervision activities. While there are many EBPs available to human services organizations, there seems to be a gap between empirically-based best practices and the implementation of these clinical practices throughout community-based organizations (Hoagwood, Burnas, Kiser, Ringeisen, & Schoenwald, 2001; Weisz & Jensen, 1999). If community-based organizations remain capable of providing clinical supervision to their workers by strategically overcoming organizational cost constrains or lack of matched supervisor and worker educational training (see, Berger & Mizrahi, 2001; Gibelman & Schervish, 1997), there is still little known about workers' attitudes toward supervision in general, how these attitudes might create barriers to adopting best practices, and the adaptive clinical group supervision practices which could be used.

While there could be many reasons for favoring a specific form of clinical supervision, 65% to 75% of community-based organizations chose group supervision over individual (Power, Bogo, & Litvack, 2005; Riva & Cornish, 1995). With a majority of organizations utilizing group supervision, understanding attendees' attitudes and experiences associated with the group process could lead to future studies connecting supervision attitudes with attitudes toward EBPs adoption. Without the professional and personal support which should develop during group supervision, workers may cultivate a negative attitude toward supervision which could result in a lack of needed support when considering an EBP to adopt. This study is the first attempt at connecting workers' attitudes toward group supervision with barriers to implementing and adopting EBPs throughout community-based organizations. Each of the principal researchers involved in this study held expertise in the provision of both clinical supervision and post-secondary education. All supervisors were trained on clinical supervision principles and techniques using Dr. David Powell's (1993) text. There were two types of supervision provided to participants. Individual supervision was conducted with participant's direct supervisor and group supervision was conducted within a mixed group of clinicians and two manager-level supervisors. In order to best manage any bias surveys were anonymous

and all supervisors along with any upper-level managerial staff were not present during survey completion. Principal researchers were motivated to highlight observations gathered through supervisory practices in the interest of aiding agencies toward a smoother adoption of EBPs.

Method

This study looked at 2003 survey results from a community-based treatment agency serving a variety of individuals within several inner-city programs (e.g., alcohol and other drug treatment, HIV/AIDS services, probation and parole client services, homelessness programs, dually diagnosis services, and long-term treatment services). The research method chosen for this project was the qualitative, phenomenological research method. As described by Creswell (2007), qualitative research "begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem" (p. 37). The qualitative, phenomenological research method offered an efficient framework for exploring how clinicians experienced group supervision.

Participants provided confidential responses describing what they "liked best" about weekly group supervision and what they "liked least" about weekly group supervision. In addition, participants were invited to provide general comments about their experiences with weekly group supervision. On the conditions of confidentiality and informed consent, participants agreed to answer three questions in written feedback form. The principal researchers utilized Moustakas' (1994) adaptation of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological Data through acquiring a "*full description* of participants' experience with the phenomenon; considering *each statement with respect to significance for description of the experience* and recording *all relevant statements* (horizontalization); listing *nonrepetitive, nonoverlapping statements* (delimiting); listing (then synthesizing) textural and structural descriptions of the phenomenon into a *universal description of the experience representing the group as a whole*" (p. 122).

All staff providing any type of clinical services at different stages of professional development are required to engage in both individual and group supervision. Clinicians who participated in the study were professional social workers and counselors who were certified in alcoholism/drug counseling, or who were working in some stage of the certification process while being supervised by a certified counselor. Participants received group supervision on a weekly basis with an average of eight to 10 participants per group. They were providing various evidence-based practices such as Motivational Interviewing, Cognitive Behavioral Therapies, Solution Focused and HIV/AIDS related interventions such as condom negotiations and pre, post-test counseling.

Participants were expected to "real-play" or role play clinical activities and present their representations during both group and individual supervision sessions. Group supervision was lead by two senior managers and met each week during regular work hours. All groups were expected to comply with standard supervision procedures. There were opportunities to present educational related materials (e.g., research articles, other EBP techniques, discussion of difficult clients, self-care issues, professional relationships and development topics, etc.) during both forms of supervision sessions.

Clinical supervisors were extensively trained and were supervised following recommendations in Powell (1993). Because these programs were state and federally funded, evidence-based and other empirically-based practices were utilized and often mandated by funders. In order to best inform and direct individual and group supervision throughout the agency, both quantitative and qualitative data were collected annually from those receiving clinical supervision. It was determined by the organization's Director to make the surveys completely anonymous resulting in no reportable demographic data on sample. While this increased participant's response rates, it did hamper overall analysis and conclusions. A bi-annual meeting that was scheduled for all workers was used to distribute and collect the surveys. All workers who participated in supervision were invited to complete the survey. Fifty-one participants completed and handed in surveys. Directors and managers were not present during the time when surveys were completed. Participants' were asked to place their completed surveys in an envelope and they were returned to the department Director by a non-clinical support staff. The program director coded and reported the data. These data were used as internal program development and evaluation. IRB approval was granted as researching existing data.

This study reports the qualitative data utilizing procedures outlined by Creswell (2007), including "preparing and organizing the data for analysis (i.e., text data as in transcripts, or image data as in photographs), then reducing the data into themes through a process of coding and condensing the codes, and finally representing the data in figures, tables, or a discussion" (p. 148). The response section selected for this study was compiled from participants' open-ended feedback questions regarding features including "what do you like best and least" about weekly group supervision. Participants' responses were submitted anonymously and recorded confidentially.

Results

The results of this study were arranged according to themes which emerged through analysis of the interviews. There were both positive and negative aspects about group supervision indicated during this evaluation process and non-repetitive, non-overlapping responses emerged as meaning units or themes (Creswell, 2007). Attitudinal themes represented within the sample group were: (a) Skill level and competency of group facilitator; (b) Technology utilization; (c) Practice specialties and content; and (d) Effectively conveying the benefits of supervision.

Skill Level and Competency of Group Facilitator

Nine participants reported experiencing the clinical supervision group facilitators' skill levels as inadequate: Participants' expressed, non-overlapping concerns included the facilitators' failure to keep the group "on task"; failure to prevent participants from "talking over others"; failure to keep the group process "on schedule"; failure to create a "comfortable" milieu; and failure to provide a sufficient amount of constructive feedback on trainees' technique (instead, focusing on the client's audiotaped content). More research is needed to examine the differences between facilitating patient group therapy sessions and facilitating group supervision of therapists. The long understood view that

doctors make difficult patients is not lost on the therapist who assumes the role of supervisor to a group of colleagues. Dynamics beyond alliances – especially competency – may interplay crucially when transferable skills become scrutinized in a potentially defensive culture of clinical supervision (Falender & Shafranske, 2008). Participants in this study appeared to notice even the smallest perceived lapses in clinical judgment and deviations in style from one supervisor to the next. Events common to therapy groups (including "talking over" other participants permitted or committed by the facilitator) were not forgiven in the clinical supervision groups. An enhanced focus on the fundamental practices of supervising professional therapists, though often eschewed by many seasoned supervisors, appears germane to effective supervision (Bernard & Goodyear, 2004).

A Second Look at Technology

Nine participants characterized their experiences with the technological recording/feedback method used in clinical group supervision (audiotaped recordings) as inadequate. Non-overlapping comments included: the current (audiotape) "recorder just isn't able to pick up enough sound"; that the audiotape process was "boring"; that the repeated use of this method lacked "creativity" in the group supervision process. The importance of upgrading technological aids and using current materials to be effective in clinical supervision is well documented in the literature (Haynes, Corey, & Moulton, 2003). Participants in this study demonstrated small patience for any utilization of outdated technology in reviewing case studies and other features of clinical supervision. Though the highest quality video conferencing and recording equipment may be unrealistic for many agencies, pre-testing techniques and devices for ease of use and reproductive quality may negate numerous distractions and improve the overall quality of the supervision experience.

Practice Specialties and Content

Seven participants reported experiencing the group supervision feedback and process as lacking specificity. Non-overlapping participant feedback included: A "weak connection" to clinical supervision of trainees' client caseloads; inclusion of counselor trainees who did not view their day-to-day work activity as matching the content of group supervision (for example, viewed their role as didactic only) explaining, "I don't do therapy", or the content of group supervision "rarely applies to what I actually do", or "I don't see the need of me going since I have no client contact its strictly research/data entry that I am involved in"; and, "too much diversity" or "not enough diversity". Varying clinical settings and practice specialties complicate supervision (Holloway, 1995). Participants in this study voiced concern that the didactic content included in clinical supervision groups often failed to target their daily practice with clients. Multiple modules designed to address the needs of therapists practicing within various settings and through varying specialties may improve the overall experience of participants.

Effectively Conveying the Benefits of Supervision

Five participants expressed experiencing the group supervision process as "monotonous" and lacking sufficient "creativity". Therapists and others in the helping professions may often respond to the pressures of high caseloads with a conclusion that little time can be afforded for clinical supervision. A 2003 study by Boisvert and Faust (as cited in Corey, Corey, & Callahan, 2007) examining "leading international psychotherapy researchers' views on psychotherapy outcome research" found "strong agreement" that "most therapists learn more about effective therapy techniques from their experience than from research" (p. 425). These and other research findings, when effectively conveyed to supervisees prior to clinical supervisory sessions, may serve to alter negative attitudes toward supervisory practices.

Though an adequate number of participants provided data for this study, research findings carry the limitation of a single geographic area/city in which all participants worked. More research is needed across rural and varied geographic locations to strengthen the representative body of data in this area of study.

While the majority rated group supervision positively, there were common themes expressed which could result in less than useful supervision sessions. A majority stated that clinical supervision contributed to skill development, aided in professional growth, and provided more confidence at work. Some participants, however, reported feeling more qualified than their supervisor; that time in supervision takes away from time with clients; weak connections between individual and group supervision; and not feeling the need for clinical supervision. By focusing on problem areas described by participants, the authors seek to improve participants' overall attitudes and experiences with the group supervisory process, thereby better preparing workers to carry out EBP in their profession.

Some supervisory features were associated with increased resistance to the adoption of EBPs. The universal description of the group described a negative experience with clinical supervision when the skill level of the facilitator is viewed as inadequate; when the technology utilized is viewed as outdated; when the supervisory content is not sufficiently applicable to client population or therapy type; when supervisory methods lack sufficient creativity to interest participants; and when the practice of supervision is viewed as adding to the clinician's workload or depleting the clinician's time. Factors which the authors contend contribute to the credibility of this study's findings include the established importance of a focus on the participants' *experiences* with the process (Moustakas, 1994); the awareness of the potential for unique contributions to the body of scientific data resulting from directly extracting observances offered by those who have personally experience the specific phenomenon (Polkinghorne, 2005), and the participants' ability to submit feedback anonymously.

Conclusions

Because the internal structures within an agency can impede the implementation of EBPs (Hemmelgarn et al., 2006), understanding participants' attitudes regarding supervision and making the necessary adjustment to better position staff to utilize EBPs is vital within community-based services. The results of this study suggest the importance

of several key areas when agencies prepare for group supervision: (1) that the skill level of the facilitator in conducting group supervision may be scrutinized and a facilitator viewed by participants as possessing an inadequate skill level may contribute to the group's overall negative experience with group supervision, (2) that antiquated technology utilized in clinical supervisory practices may contribute to participants' perception that the process is not viewed as important by the agency or facilitator, (3) that didactic content viewed as inapplicable to participant's day-to-day practice may detract from a positive group supervision experience, and (4) that group supervision practices which fail to convey the time-benefit equation to participants may be interpreted as an inefficient use of the participants' time.

Though the strength of supervisory relationships appears to be a determinant in the level of satisfaction supervisees experience (Ramos-Sanchez et al., 2002), specific practices observed during group supervisory functions may improve participants' attitudes toward group supervision. Avoiding methods viewed as problematic (such as those identified by participants in this study) may decrease the amount of time and energy participants spend internally critiquing supervisory practices and increase the amount of time and energy used to assimilate the content delivered by the supervisor.

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