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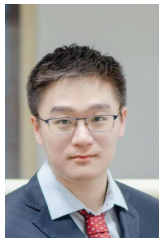

Lily Brown, Ph.D. Yiqin Zhu, M.S.

Spring is here, and the Clinical Psychologist editorial team would like to welcome you to a new issue with a new editorial board. I am thrilled to serve as the incoming Editor for the journal following the outstanding leadership of Dr. Shannon Sauer-Zavala, former Editor, and Dr. Stephanie Jarvi-Steele, former Associate Editor. Drs. Sauer-Zavala and Jarvi-Steele helped to make this transition seamless, and I sincerely thank them for their guidance and collaboration.

I am the Director of the Center for the Treatment and Study of Anxiety and an Assistant Professor in the Department of Psychiatry at the University of Pennsylvania. Since I began my training as a clinical psychologist, I looked to The Clinical Psychologist and The Society of Clinical Psychology to guide my decision-making as a clinical scientist. My vision for The Clinical Psychologist is to promote the important messages of The Society of Clinical Psychology, namely the need for continued emphasis on evidence-based practice in all aspects of clinical psychology, ranging from direct clinical practice to research and policy. I am motivated to highlight voices from historically excluded scholars and clinicians in an effort to enhance the dissemination of evidence-based practices to all communities. In addition, I want to highlight advances in our field, especially in areas where our field has stalled in progress. As an

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example from my own research area, we have made significant advances in assessing patients at high risk or suicide in real-time, but these assessment methods have not been disseminated into clinics. As another example in my own area, cognitive behavior therapy (CBT) has large effect sizes for a range of anxiety disorders, but many patients do not respond to this approach. I am interested in publishing thought-provoking pieces that highlight why research has remained stagnant in these domains and outline a path to move the field forward.

I am also thrilled to announce that Yiqin Zhu, M.S., will be serving as Editorial Assistant to the Clinical Psychologist. Mr. Yiqin Zhu is a Research Assistant at the Center for the Treatment and Study of Anxiety at the University of Pennsylvania. He is interested in personalized treatments for depression and anxiety disorders informed by a trans-diagnostic approach. He is also interested in applying trans-diagnostic approaches to address the mental health needs of individuals who identify as sexual and gender minorities. Mr. Zhu received his Master's degree in statistics from the University of Pennsylvania and a bachelor's degree in psychology from Peking University. He hopes to further pursue a clinical psychology Ph.D. degree and then obtain a faculty position in a Psychology department or in an academic medical setting.

As the editorial team, we hope to provide an inclusive and welcoming platform for mental health experts and trainees alike. We invite your submissions and ideas for themes or contributors in subsequent issues. We are grateful to serve in this role and thank you in advance for your support. ■

LEAD ARTICLE

Shifting from Treatments Developed Based on Averages to Treatments Based on the Individual: Eating Disorders Research Can Move the Field of Clinical Psychology Forward

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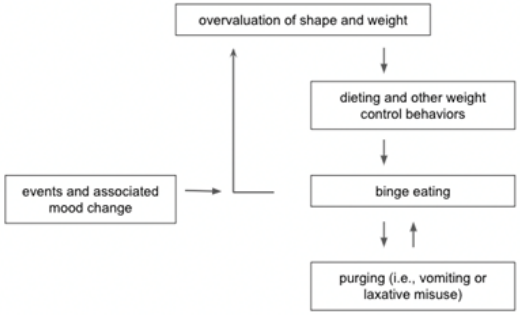
One of the primary goals of clinical psychology research is to develop new and better treatments for psychological disorders. Despite much progress in the past couple decades of research, response rates for existing and new treatments have remained rather steady (Castelnuovo, 2017). For most gold-standard treatments the response rates to evidence-based treatments generally range from 50% to 65% (Arcelus et al., 2011; Batelaan et al., 2017; Carter et al., 2004; Trivedi et al., 2009). This rate is comparable across mental disorders, including depression, anxiety, and eating disorders.

Eating Disorders. Our team at the Eating Anxiety Treatment (EAT) lab works specifically with eating disorders and our primary mission is to use cutting-edge research to develop new and better (i.e., more effective) treatments for eating disorders. Eating disorders are an area of clinical psychology in particular need of more effective treatments. Eating disorders are both extremely deadly and many subtypes of eating disorders have either no existing evidence-based treatments or treatments that work for only a small portion of people. Specifically, eating disorders carry one of the highest mortality rates of any psychological disorder, with only opioid use disorders causing more deaths (e.g., Arcelus et al., 2011; Chesney et al., 2014). In addition to the high mortality, there are no evidence-based treatments for adults with anorexia nervosa or other specified eating and feeding disorder (the most common eating disorder) and gold-standard treatments (Enhanced Cognitive Behavioral Therapy; CBT-E) only work for 50% of those with bulimia nervosa and binge eating disorder (Atwood & Friedman, 2020). Clearly given the high number of deaths (not accounting for additional associated morbidities and impairments) and low effectiveness of treatments, we need to do something to improve these outcomes.

Cheri A. Levinson, Ph.D.

How are treatments developed? First, we need to take a step back and think about how evidence-based treatments are developed. Usually, in ideal circumstances, treatments are based on a strong theory, which is then translated into specific interventions based on the theory (David & Montgomery, 2011; Michie & Abraham, 2004). For example, the primary evidence-based treatment for adults with eating disorders is CBT-E (Fairburn et al., 2003). CBT-E, based on the theory that overvaluation of weight and shape (i.e., a preoccupation with shape and weight and undue influence of shape and weight on one's self-esteem; Fairburn et al., 2003; Fairburn, 2008) is the primary maintaining mechanism of eating disorders. In Fairburn's CBT-E theory, overvaluation of weight and shape leads to additional problematic behaviors, such as restriction, which then leads to binge eating, and then purging, with these behaviors looping back to overvaluation of weight and shape. This ultimately creates a negative reinforcement cycle where overvaluation of weight and shape maintains problematic eating behaviors, which then further strengthens overvaluation of weight and shape (see Figure 1).

Rowan Hunt, M.S..



Claire Cusack, M.A.

Figure 1. Model adapted from Cognitive Behavior Therapy-Enhanced (Fairburn, 2003)

From Theory to Treatment. This theory was then used to develop a treatment (CBT-E) for eating disorders. Specifically, based on this theory, intervention was needed that could target overvaluation of weight and shape and related problematic behaviors (e.g., binge eating, purging), with the goal to disrupt this cycle. What is eventually created from this theory is what clinical psychologists call a manualized and standardized evidence-based treatment. In a manualized treatment, if delivered similarly as in randomized controlled trials, which tested the effectiveness of the treatment, patients are all given the same treatment, delivered in the same format, one intervention after the other in a similar order.

Targeting Problems on Average. Importantly, the entire premise of CBT-E is based on the idea that overvaluation of weight and shape is central (i.e., a primary mechanism) to eating disorder pathology. This premise is not wrong. There are decades of research showing that overvaluation of weight and shape is elevated in those with eating disorders compared to those without (Grilo et al., 2010; Lethbridge et al., 2011; Nikodijevic et al., 2018; Shafran & Robinson, 2004). Recent research from our team and others have used network analysis, which will be discussed more shortly, and shows that both fear of weight gain and overvaluation of weight and shape are central to the conceptualization of eating disorder pathology (Christian et al., 2021; Forbush et al., 2016; Forrest et al., 2018, 2019; Levinson et al., 2018). However, the problem with the premise underlying CBT-E is that it assumes that all eating disorders are maintained by overvaluation of weight in shape (Levinson et al., 2021). Unfortunately, this part of the premise does not seem to be the case.

Christina Ralph-Nearman, Ph.D.

Eating Disorders are Highly Heterogeneous. For anyone who has treated an eating disorder, or really any other type of clinical disorder, we know that what shows up in the therapy room is never very predictable and can vary widely, regardless of official diagnosis. For a concrete example, one person with anorexia nervosa may engage in restriction, excessive exercise, and be highly perfectionistic, whereas another individual with anorexia nervosa may restrict, purge, and be highly impulsive. Our recent work has demonstrated the high heterogeneity present in the eating disorders (Levinson et al., 2018; Levinson, Vanzhula, et al., 2020; Levinson et al., 2021, In press) and demonstrated that there are at least 21 different mechanisms, beyond overvaluation of weight and shape, that may possibly maintain eating disorders (Levinson et al., 2021). More specifically, in our recent work, we showed that about 50% of mechanisms fall into a more traditional' cognitive mechanism category, which consists of mechanisms such as overvaluation of weight and shape and body dissatisfaction. However, another 50% of individuals had mechanisms that are not traditionally addressed in standardized treatments, such as shame, guilt, and worry (Levinson et al., 2021). Despite this significant heterogeneity, clinicians are provided manualized treatments and the expectation is, that to deliver evidence-based treatment, they should use a manual, developed based on averages.

Moving to Personalized Treatments. For a clinician, what these standardized treatments mean is that they have the option to use a manual, whether or not it fits their patient, or to deviate from a tested and evidence-based supported treatment. Practically, this

may look like rearranging the order in which treatment is given or pulling in treatments from other evidence-based treatments for a mix and match approach. The problem with this approach is that there is a large body of literature suggesting that clinicians are not that great at knowing what they should target in treatment, how to do so, and that clinician judgment can be biased (Bowes et al., 2020; Featherston et al., 2020; Waller, 2016). Ideally, clinicians would have either a personalized treatment that works for everyone and/or a guidance system that could use data from their patient to inform what should be worked on in treatment and how.

Networkk Theoryy and Idiographic Networkk Analysis. The work in the EAT lab has taken a shift in recent years explicitly to develop such a personalized treatment and guidance system. To develop this type of personalized treatment we need a method that can quantify, for one person, which specific mechanism/s is/are maintaining an individual's illness. Our team has been using network theory and the associated analytic methodologies to identify for one person, which mechanisms maintain their eating disorder, and using that information to match existing and adapted evidence-based treatments to specific individual targets (Levinson et al., 2018, Levinson et al; Under Review). Network theory applied to psychopathology, proposes that clinical disorders are maintained by relationships between symptoms (Borsboom & Cramer, 2013). For example (see Figure 2), being afraid of weight gain leads to restriction, which then leads fatigue, increased cognitions focused on weight and shape, and avoidance of food, with this cycle maintaining an active eating disorder. Importantly, in network theory, central symptoms are theorized to be logical treatment targets because they impact the most other symptoms in the model. In other words, intervention on a central symptom should be like a deck of cards, where the entire deck starts to fall if you are able to move one card (Borsboom, 2017; Cramer et al. 2010). This type of theory likely sounds very similar to the CBT-E theory discussed above (Fairburn et al., 2003).

The advantage of network theory is that corresponding methods have been developed that can quantify the relationships among symptoms on the individual level (Epskamp et al., 2018). Specifically, methods combine use of ecological momentary assessment (EMA) data assessing symptoms/mechanisms collected from one person with idiographic network analysis, which models how one persons' pathology maintains itself and identifies the most central symptoms (i.e., mechanisms; see Figure 3 for an example).

Matching Central Symptoms to Treatment. In our recent paper (Levinson et al., 2021), we showed how to model idiographic networks of patients with eating disorders and use these data to match central symptoms to treatments. For example (see Table 1), if a patient's model identifies that shame and fear of weight gain are the most central symptoms, a clinician could use skills from the dialectical behavior therapy (Linehan, 2014) emotion regulation modules focused on shame and guilt and deliver imaginal exposure for fear of weight gain (Levinson, Christian, et al., 2020). Alternatively, if a patient's model shows that overvaluation of weight and perfectionism are the most central symptoms, a clinician could use CBT-E exercises for overvaluation of weight and shape, as well as CBT for perfectionism. Overall, these types of

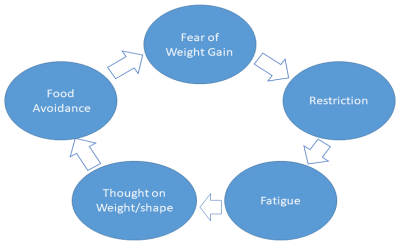


Figure 2. Example of maintained relationships among symptoms in a network of psychopathology

Table 1. Example of matching central symptoms to corresponding treatment intervention

Central Symptom (i.e., mechanisms_	Corresponding Intervention
shame	emotion regulation (DBT) shame and guilt modules
fear of weight gain	imaginal exposure for fear of weight gain
overvaluation of weight	identifying overvaluation and its consequences (CBT-E)
perfectionism	CBT for perfectionism

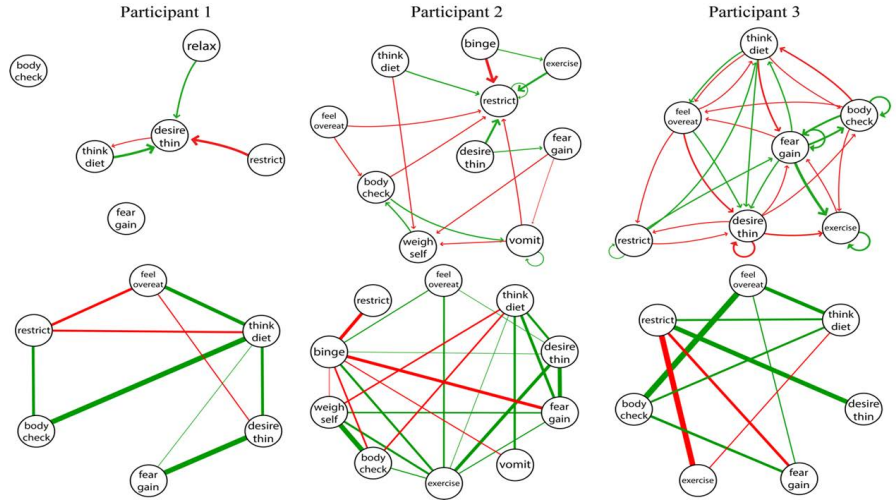


Figure 3. Figure from Levinson et al., 2018. The most central symptoms as measured by strength centrality are indicated by blue stars above the nodes. Green and red edges denote positive and negative symptom relations, respectively. Symptom abbreviations: feelovereat = feel like I have overeaten; thinkdiet = thinking about dieting; desirething = preoccupied with the desire to be thinner; feargain = terrified of gaining weight; exercise = excessive exercise; binge= binge eating; bodycheck = body checking; weighself = weighed myself; restrict = restriction; vomit = vomiting or other compensatory behaviors.

models can be used to (a) create new personalized treatments that target each mechanism that might maintain an eating disorder and (b) provide a new method to inform how and when to target which symptoms in treatment.

Moving This Type of Treatment into Clinical Practice. Of course, all these ideas are predicated on the very real fact that there must be a way to implement network-informed personalized treatment in clinical practice. In the eating disorder field, recent research has shown that network theory can be used as psycho-education with patients (Meier et al., 2022) and our team has demonstrated that Network-Informed Personalized Treatment for Eating Disorders is feasible, acceptable, and highly effective for the reduction of eating disorder symptoms and related comorbidities (Levinson et al., under review). However, other research with patients with anxiety and depression has shown that clinicians are more hesitant (than patients) about using idiographic network models to inform their practice (Frumkin et al., 2021). To be able to easily integrate these models into clinical practice, clinicians will need a system that is easy to work with, in which they do not have to run idiographic models, analyze data, or even fully understand network theory. To address this need, our team is developing a user-friendly clinician software guide. This guide pairs data collection on patients' phones with clinician-guidance on most central symptoms matched with treatment recommendations. Of course, more research is needed to pilot and test such a system, with clinician input, to truly develop a personalized treatment and guidance system that can assist clinicians to provide personalized and evidence-based treatment.

From Eating Disorders to Additional Clinical Disorders. Eating disorders are one of the most expensive to treat and most underfunded psychological disorders. For instance, although eating disorder treatments cost substantially more than schizophrenia treatments, eating disorder research received .14 less per affected individual of United States federal funding in 2015 (i.e., .73 vs. .87 per affected individual, respectively; e.g., Murray et al., 2017). At the same time, eating disorders are one of the most complex mental illnesses. For example, up to 95% of people with an eating disorder also have a diagnosis of at least one additional comorbid disorder, most frequently anxiety and depression (Hudson et al., 2007; Pallister & Waller, 2008). In other words, though the EAT lab focuses on eating disorders, we also study

every type of psychopathology.

The types of models we have discussed are not unique to eating disorders. Depression, substance use, and personality disorders are also highly heterogeneous (Levinson et al., 2018; Thompson et al., 1987) and also have low response rates for many treatments (Berends et al., 2018). Most treatments, with some caveats, regardless of psychological disorder, have been built based on averages, and not the individual. Even more convincingly to us, our recent data from our Network-Informed Personalized Treatment for Eating Disorders open series, showed not only huge drops in eating disorder symptoms across 10-weeks of treatment, but depression also dropped, from high-moderate levels of depression to minimal depression in ten weeks (Levinson et al., under review). Could those with a primary depression diagnosis benefit from network-informed treatment? We hope that researchers across many fields of clinical psychology will begin to answer that and related questions. Clearly, there is a need for personalized treatments across the spectrum of mental illnesses and our hope is that eating disorder research can help pave the way for a new movement in how we think about and provide treatment to those with clinical disorders.

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LEAD ARTICLE: From Averages to Individuals (continued)

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Improving Ethical Behaviors through the Supervisor-Supervisee Relationship

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Midwestern University
College of Health Sciences

As the final part of our two-part series on supervision ethics, this column will focus on supervisor-supervisee relationship dynamics and their relationship to ethical outcomes

Supervisors serve several roles and have significant influence over supervisees, including as teacher, role model and professional mentor. Supervisors are also responsible for the services delivered by supervisees. As Knapp and VandeCreek (2006) state, "Supervising psychologists retain authority over and responsibility for the services delivered. The supervisory relationship has an immediate impact on the patients of the supervisee because they are actually the patients of the supervising psychologist. The supervisor maintains responsibility of ensuring the quality of the services provided. The supervisees are the 'arms and legs' or service extenders of the supervisor…." (p. 217-218).

Ethical concerns can involve issues in the supervisor-supervisee relationship (e.g., unethical multiple relationships or coercion) and the supervision practices (e.g., lack of feedback or lack of knowledge of supervisee work), but are also related to the clients/ patients being served by supervisees. Examples of the latter include improper relationships between supervisees and clients/patients, client/patient risk that is not disclosed by supervisees, and/or ethical violations related to disclosure and reporting that may or may not be disclosed by supervisees. This column will discuss ways in which the supervisor-supervisee relationship may affect ethical outcomes.

Whyy Does the Supervisor-Supervisee Relationship Matter?

Much has been written on the importance of and ways to foster a positive supervisor-supervisee relationship. Similar to research that suggests a strong therapeutic alliance is tied to better clinical outcomes, a better supervisor-supervisee relationship may, in fact, promote better training and facilitate ethical decision-making. The supervisor-supervisee relationship is unique and differs in important ways from the psychologist-client/patient relationship. But in many ways, the responsibilities are similar. Similar to the therapeutic alliance, supervisee perceptions of the supervisor-supervisee relationship have been associated with a number of outcomes and behaviors, including the willingness of the supervisee to disclose information to a supervisor. In short, how a supervisee views their supervisor (including how they want their supervisor to see them) can make a big difference in terms of them seeking help and feedback. Supervisors often rely on the word of supervisees to know what's happening with cases but research suggests that supervisees frequently don't tell their supervisors everything. For example, a study by Mehr, Ladany, and Caskie (2010) found that 84.3% of their sample of 204 trainees withheld information from their supervisor. There are many factors that may affect willingness to disclose, including previous negative supervision experiences, concerns about evaluation, concerns about supervisor perception of supervisee, disagreement with the supervisor about how to view a case, perceived clinical mistakes, and personal life issues. In a follow-up study with 201 psychology doctoral students, Mehr, Ladany, and Caskie (2015) found that higher willingness to disclose was associated with stronger supervisor-supervisee relationships, lower supervisee anxiety, and higher counseling self-efficacy.

One area that also affects the supervisor-supervisee relationship among students is burnout. A study by Swords and Ellis (2017) of 203 health service doctoral students found that supervisee burnout was common and was significantly predicted by severe levels of workplace related stress and supervisory working alliance, including agreement on goals and tasks, perceived support, and emotional bond. The authors noted the importance of the supervisor-supervisee relationship, stating, "Nonetheless, considering that mental health supervisees have been found to spend less than an average of 2 hr per week in clinical supervision the association between supervisory alliance and participants' experience of burnout and vigor is remarkable. In short, these results provide further evidence for the importance of the supervisory alliance, and in particular, that both positive and negative experiences in clinical supervision can have a considerable impact on supervisees . (Sword & Ellis, 2017, pp. 1154-1155).

How Do Suervisor BBehaviors Affect the Relationship?

As several authors have noted, psychologists do not often receive training or education in supervision and the topic does not receive sufficient empirical examination, making it difficult for psychologists to gain competence in supervisory skills see Falender (2018) for an excellent discussion on promoting competency-based supervision training and reducation .

In addition to interpersonal factors that contribute to alliance, other supervisor behaviors can significantly affect the supervisor-supervisee relationship. Some research (e.g., Ellis, Berger, Hanus, Ayala, Swords, & Siembor, 2014) has highlighted issues of inadequate supervision and perceptions of harm through inappropriate supervisor actions, including physical, emotional, and psychologically aggressive or abusive behaviors. In addition, lack of supervisor availability can also negatively affect the relationship. Finally, inconsistent or lack of feedback about performance can lead to relationship difficulties, especially if the end-of-rotation feedback focuses on areas that were not addressed with the student during the experience (see Standard 7.06 Assessing Student and Supervisee Performance, APA, 2017).

How Do Supervisee Bbehaviors Affect the Relationship?

Supervisee factors can also affect the supervisor-supervisee relationship and the effectiveness of supervision. For example, supervisee anxiety (including forms of "imposter syndrome) and other personal problems can contribute to problems adequately and competently carrying out professional duties. Supervisee anxiety, which can include overall stress and uncertainty about performance or self-efficacy, may negatively affect their work and their engagement in the supervision experience (Mehr, Ladany, & Craskie, 2015). Not only do trainees rate certain outcomes and activities, such as situations when they perceive their client/patients are not making progress or they perceive themselves as unable to help their clients to feel better, as significantly more stressful than veterans (Rodolfa, Kraft, & Reilley, 1988), but they may not have an outlet to process experiences of stress and feelings of overwhelm or uncertainty about the quality of their professional work. Further, they may not feel comfortable sharing with supervisors or faculty who have grading or other evaluative authority.

Personal mental health problems can also impact the supervisee's work, especially when confronting difficult clinical situations, such as client/patient suicidality and self-harm, without the support of supervisors. Fears about how the supervisor may view them can also affect the relationship and extent to which supervisees disclose specific information (see above). In addition, supervisee behaviors that make supervision difficult can include lack of self-reflection or valuing of feedback, lack of respect for the role or expertise of the supervisor, and lack of accountability or valuing of professional behaviors, such consistently being late or not showing up to appointments or supervision, and late or incomplete documentation.

Relationship-Feedback Dynamics

Supervisors serve as gatekeepers of the profession in many ways (Fisher, 2021). Their evaluation of trainees provides critical knowledge about the abilities and skills of supervisees to provide services to others. Providing feedback to supervisees is often a challenging task for supervisors. Many authors have commented that supervisee awareness of the supervisor's evaluative authority affects many aspects of the supervisory experience, so it's important to discuss the process openly and early (Mehr, Ladany, & Caskie, 2015). Some have commented on student difficulties in receiving feedback that focuses on ways to improve that have made supervisors reluctant to provide honest feedback if they feel it may be received negatively.

Indeed, the responsibility to provide objective feedback (including recommendations to improve performance) in a timely and constructive manner is among the most important for supervisors. Nevertheless, it can be difficult to communicate to well-meaning students that they are failing to meet competencies or when a supervisee's personal issues are interfering with work. Similarly, more direct conversations about lack of supervisee engagement in work, refusal to follow supervisor directives or recommendations, or unprofessional behaviors that present risk to clients/ patients can also present special challenges for supervisors. Some tips for having difficult conversations are included in the last section.

Feedback should go both ways, though. That is, supervisors should invite supervisees to provide honest feedback about the experience, supervisory style, and environment. Demonstrating openness to feedback and conveying a willingness to listen to suggestions may communicate engagement with the process and respect for supervisees. It may, however, be difficult for supervisees to feel comfortable being honest when they know that the supervisor still has evaluative authority. Research by January et al. (2014) found that while almost one-third of their sample reported unethical faculty behaviors within their department, many did not report the violation. In Mehr and colleagues' study (2015), supervisees were least likely to talk about issues related to dissatisfaction with the supervision experience. Supervisors should critically evaluate whether the environment that they create is one where supervisees feel comfortable communicating honest feedback. Alternative methods of feedback might include anonymous methods or soliciting feedback from previous trainees about what they thought went well and what areas could be improved.

How to Make aBbetter Supervisor-Supervisee Relationship

Below are some general recommendations that may help to promote positive supervisor-supervisee relationships.

Setting Clear Expectations. In addition to clarifying the methods of assessment (e.g., observation, test reports, video sessions, etc.) and criteria for feedback, it may also be important to take time to discuss expectations and rules. For example, some

supervisees may have erroneous assumptions about the purpose and procedures of supervision, such as believing that confidentiality extends to what happens in supervision and that what is disclosed will not be used in evaluation.

Incorporating supervision contracts in which the expectations (including methods and frequency of feedback) for both supervisor and supervisee are clearly delineated and agreed upon can be very helpful in reducing confusion. Specifically, information about expected competencies and goals, and the extent to which the supervisee is meeting these goals, should be discussed and documented with the supervisee (Knapp & VandeCreek, 2006).

Tailoring the Experience. Supervisors have the responsibility of tailoring the clinical experience in terms of student's current competencies. APA Standard 2.05 Delegation of Work to Others states that psychologists should " authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided (APA, 2017). In other words, supervisors have a responsibility to assign only those tasks for which an individual is qualified and to monitor to ensure competent implementation (Fisher, 2023). When working with students, university training directors can provide valuable information about skills, experiences, classes completed, and previous experience of students.

Fostering Honest Conversations. Supervisors can be effective only if they are made aware of the issues that may be affecting the work of supervisees (both clinical and personal issues). What are supervisees telling us (and what are they not)? Communication can be particularly difficult when supervisees resist supervision or express that they don't "need help. Trying to be open and honest about the difficulties of the work of the supervisees, their role, and even about receiving supervision may open up new conversations. Feedback that simply isn't about correcting errors or pointing out shortcomings, but also emphasizes learning and self-reflection may be particularly valuable (Kaslow, Flaender, & Grus, 2012).

It may also be helpful to discuss issues related to supervisor and supervisee diversity as they affect the supervisee's work or the supervisor-supervisee relationship. As Fisher (2021) notes, "Expressions of racism, xenophobia, antisemitism, homophobia, and transphobia in the political arena and lived experiences of clients/patients and supervisees require the ability to engage in authentic dialogue about cultural, religious, and sexual and gender differences (Chung et al., 2018) (p. 338). Therefore, it's critical to discuss and understand how issues of power and privilege affect the supervisee's work and the supervisory relationship. It may be helpful to also discuss previous training experiences around diversity that may affect their understanding and approach to the supervisory experience.

Having Difficult Conversations. There are times when difficult conversations with supervisees are necessary and these can be stressful . Below are some tips that may be helpful in successfully navigating these situations:

- Be specific, constructive, and timely in providing feedback

- Self-assess and ensure you are in a place to deliver feedback that is not governed by feelings of frustration or anger

- In discussions, emphasize the importance of learning, growth, and feedback and, when appropriate, when behaviors may be developmentally appropriate. Limited self-disclosure, if appropriate, about personal training experiences may also help normalize trainee anxiety

- Be sure to highlight the positive things supervisees do

- Follow up to assess the supervisee's reaction to and reaction to the feedback.

Some of these recommendations may also be applicable for supervisees discussing supervision concerns with supervisors.

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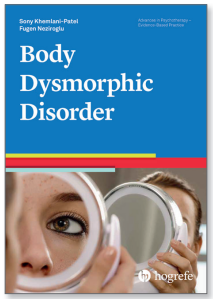

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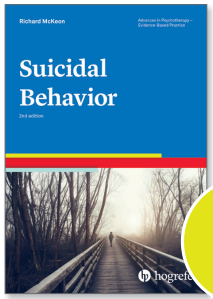

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