A Trainees Guide to Managing Clinical Placements

Estella Keary & Michael Byrne

This paper profiles how clinical psychology trainees can maximise their learning opportunities during their clinical placements. It details information on organisational and administrative issues, sets out how to contract and monitor learning goals during placement and suggests how trainees may engage with and contribute to supervision.

Introduction

Psychologists in clinical training (hereafter referred to as trainees) are required to develop an array of core competencies during their training. Along with psychological assessment, formulation and intervention, these include research, personal and professional skills, and communicating and teaching (British Psychological Society [BPS], 2010). Mastery of skills specific to these domains facilitates their working to at least a minimum standard with varied clinical populations, presentations and theoretical models. Each core competency consists of particular “knowledge, skills and (professional) attitudes or values” (O’Callaghan & Byrne, 2011, p.43).

Although inputs such as academic reading, assignments and clinical workshops will facilitate trainees learning and developing these core competencies, more than half of their learning may occur while on clinical placements (Falender & Shafranske, 2004). Hence, trainees need to maximise their placement learning. During placement, learning may occur in a variety of ways. Preparation before the placement begins, setting specific learning goals and monitoring progress towards these goals can help to enhance competency development during placement. Engagement in mutual observation, one-on-one and group interventions, and in meaningful supervision can facilitate learning technical competencies. Supervisory guidance can also facilitate trainees learning how to process their experiences and developing an awareness of their competency levels, and can be crucial in progressing towards contracted learning goals.
Select Placement

Given that it is primarily the responsibility of trainees to focus their learning on developing core competencies, they need to ensure in so far as is possible that their clinical placements, particularly elective ones, will facilitate their developing desired competencies. Hence, if given a selection of placement options, as often happens where trainee cohorts are asked to self-manage placement allocation, they need to reflect on what competencies are in need of most development and select placements accordingly. This selection process can be facilitated by researching the type of clinical experience on offer in specific placements, the quality of supervision therein and other factors such as the anticipated travel burden. Hence, trainees need to be encouraged to contact other trainees about their experiences of specific placements, the supervisors who provide these placements and academic staff such as placement monitors.

Manage Placement

Trainees need to manage their placements in a variety of ways including contacting their supervisor, preferably preplacement, and discussing their learning goals and how best these can be met while on placement (as delineated in a learning contract; Hughes & Byrne, 2011). More specifically, there needs to be agreement about arranging mutual observation and opportunities for group work, accessing secondary supervision, engineering an appropriate caseload and arranging access to needed resources. Ideally, trainees will also acknowledge the need to proactively manage potential placement challenges, give something back to the placement and engage in self-care.

Learning Contract

A learning contract is traditionally described as “a written agreement between teacher and student which makes explicit what a learner will do to achieve specified learning outcomes” (Richardson, 1987, p.201). In the context of clinical training, a supervisor takes the role of a teacher and a trainee the role of a student. Within the nursing literature there is a substantial evidence base suggesting the effectiveness of a learning contract. The benefits include increased student control and autonomy, improved student motivation during the learning process and increased learning focused on students’ individualised learning needs (Chan & Wai-tong, 2000). The process of negotiating a learning contract (see Table 1) necessitates both the supervisor and the trainee being upfront about their expectations of each other and what the placement might realistically offer.

Table 1. Sample Learning Contract Headings

<table>
<thead>
<tr>
<th>Heading</th>
<th>Key Questions</th>
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<tbody>
<tr>
<td>Objective</td>
<td>• What do you aim to learn and what competency do you hope to develop?</td>
</tr>
<tr>
<td>Strategies and resources</td>
<td>• How are you going to learn it?</td>
</tr>
<tr>
<td>Timescale</td>
<td>• How long will it take?</td>
</tr>
<tr>
<td>Evidence and validation</td>
<td>• How will you know you have learned it?</td>
</tr>
</tbody>
</table>

Most importantly, trainees need to delineate what core competencies they want to develop. One way of evaluating competency development and/or attainment is to employ the Knowledge, Skill, Ability and Other method (KSAO; Krishnamurthy et al., 2004; see Table 2). In this model skills refer to a person’s capability to do a clinically-related task well (e.g., formulation) while abilities refer to more general traits such as critical thinking and communication styles. Ideally, targeted skills will be broken down into more specific, practical skills. For example, a subgoal of developing formulation skills might be to fluidly apply theoretical models in clinical practice. A learning contract also needs to detail a mutually agreed strategy to develop each core competency along each KSAO dimension.

Table 2. KSAO Approach to Establishing Competencies

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Knowledge</td>
<td>• Theoretical knowledge acquired through coursework</td>
</tr>
<tr>
<td>3. Abilities</td>
<td>• Critical and integrative thinking, intelligent interpretation of a wide range of information, ability to transfer skills, support building</td>
</tr>
<tr>
<td>2. Skills</td>
<td>• A proficiency in clinical skills (e.g., scoring psychometric instruments, writing reports efficiently)</td>
</tr>
<tr>
<td>4. Other</td>
<td>• Sensitivity to cultural diversity, attention to detail, time management</td>
</tr>
</tbody>
</table>

Engineer Appropriate Caseload

To facilitate a good placement start, trainees need to negotiate, preferably preplacement, a caseload that is developmentally appropriate, both quantitatively and qualitatively (Hughes & Byrne, 2011). Too small a caseload may predispose to not being sufficiently challenged to manage a caseload and to a lack of exposure to the breadth of presentations that a clinical psychologist would be expected to work competently with. Too large a caseload, while possibly good for the service provider in terms of crunching numbers, may result in superficial engagement with service users (e.g., minimal time for preparatory reading, formulating and reflecting on and learning from cases), feeling overwhelmed and ultimately burned out (Hannigan, Edwards, & Burnard, 2004). Unless trainees communicate on an ongoing basis the developmental status of each of their competencies and their learning needs, supervisors may indiscriminately assign “next on the waiting list” cases. Hence, a trainee needs to continually request opportunities to work with desired specific presentations (e.g., diagnostic type, short- vs. long-term engagement). Cognisance also needs to be given to the fact that long-term work may best be engaged with at the earliest possible point in a placement, while more discrete pieces of work (e.g., administration of specific psychometric batteries) may be best left until the latter end of a placement.
Arrange Resources

Administrative or organisational issues that need to be discussed prior to training include access to resources such as clinical rooms, a desk, a filing cabinet, a telephone, a designated laptop (and internet access), a photocopier, a printer, the support of a clerical officer (e.g., timely typing of reports) and car parking (Hughes & Byrne, 2011). As it may influence access to specific diagnostic presentations, supervisors need to clarify preplacement the amount of travel expected of a trainee and what procedures are in place (if any) to reimburse travel expenses. If such expenses cannot be reimbursed, trainees need to decide if they are willing to undertake additional travel. If not, they need to communicate this to their supervisor preplacement.

Arrange Mutual Observation

Observing one’s supervisor engaging in clinical work and also having him/her observe one’s own clinical work are effective means of developing one’s clinical competencies. Indeed, social learning theory stresses the importance of observational learning and the process of modelling (Bandura, 1977). Although trainees may understandably be anxious about the prospect of being observed, it allows supervisors the opportunity to provide direct feedback on trainees’ ability and skill level as a developing clinician (Milne & James, 2002). Ideally, such mutual observation will occur in the first two weeks of placement (Hughes & Byrne, 2011).

Mid-placement Review

Using one’s learning contract as a guide, a mid-placement review not only provides an opportunity to acknowledge competency development but to also highlight competencies that need to be further developed during the remainder of a placement. It is critical to acknowledge that challenges will arise during the majority of placements and that these need to be both acknowledged and proactively managed. Trainees can use their mid-placement review to formulate a plan to address any issues that have been identified and then put this plan into action during the remainder of the placement.

Manage Potential Challenges

A placement may present a trainee with a variety of challenges (see Table 3).

Table 3. Issues that may Arise during Placement and Recommended Response

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
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</thead>
<tbody>
<tr>
<td>Time constraints</td>
<td>Create a timetable to schedule commitments and deadlines</td>
</tr>
<tr>
<td>Disclosure of sexual abuse or suicide intent</td>
<td>Become familiar with standardised protocol before meeting service users</td>
</tr>
<tr>
<td>Problems with a supervisor</td>
<td>The trainee should first attempt to discuss the issue with his/her supervisor. If the supervisor is non-responsive, the trainee needs to consult with the placement monitor and programme staff. If the situation is still untenable, the trainee needs to contact the Liaison Principal Psychology Manager for their training programme</td>
</tr>
</tbody>
</table>

Organise Group Interventions

Group therapy is a cost efficient mode of service delivery and is particularly effective for certain presentations (e.g., panic disorder; Otto, Pollack, & Maki, 2000). Brabender (2011) suggests that observation of a group therapy session, as well as the opportunity to cotherapy with a clinical supervisor can be beneficial in learning the skills associated with group therapy. In clinical group settings, counselling trainees...
have been shown to find feedback on their technical, task specific performance (e.g., use of language) more acceptable and useful than feedback on their personal qualities as therapists (e.g., ability to communicate) (Coleman, Kivlghan, & Roehlke, 2009). Therefore, it might be constructive for trainees to request this type of feedback from their supervisor. Elements such as openness and being receptive to feedback also contribute to developing group therapy competencies (Brabender, 2011). Hence, despite the unique challenges of running groups, trainees would be well served in proactively arranging groups for certain populations.

Source Secondary Supervision
A trainee’s clinical supervisor may not have the competency to provide supervision on specific psychometric instruments or with specific care populations (e.g., the elderly). In such circumstances, either the supervisor and/or trainee need to source supervisory input from another psychologist, such as a colleague of the supervisor.

Give Back
Progressive supervisors appreciate honest and constructive feedback from trainees as to how the placement they provide could be improved for future trainees. Additionally, trainees might organise psychoeducational talks or training to other staff or other stakeholders (e.g., service users) on topics that have been flagged as a training need. Along with other activities (e.g., representing psychology at a meeting), this process can be facilitated by trainees understanding the pressures their supervisor may be under and directing some of their capacity towards managing these. For example, if a supervisor had a large number of priority cases to see, a trainee might volunteer to input on some of these cases provided it was within their level of competence and progressed his/her placement learning objectives.

Practice Self-care
Along with many clinical psychologists (Hannigan et al., 2004), trainees find their work challenging and stressful (Scott, Pachana, & Sofronoff, 2011). This highlights the importance of trainees prioritising self-care while on placement. There are many benefits to self-care. For example, mindfulness-based stress reduction training has been shown to reduce levels of stress and enhance ability to regulate emotional states among trainees (Shapiro, Brown, & Biegel, 2007). While a mindfulness-based approach may not be the method by which every trainee practices self-care, all trainees need to have some strategy for implementing self-care. Norcross (2000) outlines some basic principles to self-care that can be adapted by many health care practitioners such as promoting self-awareness as well as avoiding wishful thinking and self-blame.

Supervision
Clinical supervision is “a relationship-based education and training” (Milne, 2007, p. 439) that is developed and maintained through collaboration between the trainee and the supervisor (Milne & Grace, 2001). It is fundamental to placements progressing well (O’Donovan, Halford, & Walters, 2011). Although supervisors have the more influential role when relating with trainees, trainees also need to significantly contribute to creating an effective and productive partnership.

Models of Supervision
Trainees need to become familiar with what models of supervision are used by their supervisor. Different models can prioritise different elements (e.g., reflective practice or use of theoretical models) and knowing this can help structure how one might prepare for and approach supervision. While the majority of psychologists do not favour a particular model (Fleming & Steen, 2004), models tend to fall into two broad categories: those embedded in psychotherapy (e.g., CBT, psychodynamic) and process models developed specifically for supervision (O’Callaghan & Byrne, 2011). There are some notable models such as Stoltenberg’s (2005) integrated developmental model and the competency-based approach (Falender & Shafranske, 2004), both of which can be classified as process models.

The integrated developmental model works on the assumption that becoming proficient in a professional capacity is a developmental process and the level of supervision provided to trainees should vary as their competencies improve. It is proposed that there are three broad development stages in training and when a trainee reaches a new stage of development, the amount if structured supervision given by the supervisor should decrease (Stoltenberg, 2005). The competence-based approach is a model that suggests that trainees should develop a range of skills, knowledge and attitudes consistent with the duties and responsibilities associated with their professional qualification (Falender & Shafranske, 2004). Competency-based supervision involves identifying the competencies that a trainee needs to develop and establishing learning strategies and evaluation procedures that aim to develop these competencies sufficiently.

Use Supervision Productively
Trainees need to agree a schedule of formal supervision meetings, preferably at the same time every week, for their entire placement. Before each meeting, they need to prepare thoroughly, possibly by using a supervision preparation sheet (see Table 4) and define what they want to learn from each supervision meeting. When kept on file, such preparation sheets can facilitate charting the progress of competency development and can feed into summative feedback at either mid- or end-of-placement meetings.

During supervision, trainees need to present clinical cases in a suitable and efficient manner. This may involve giving a brief overview of each case including information about age, gender, presenting problem, assessment findings, case formulation, any interventions to date, and how service users are engaging and progressing. Without adequate profiling of a case and of the issues arising therein, trainees are unlikely to learn what they need to learn from supervision.
Engage in Self-reflection

Self-reflection is a process whereby individuals engage in critical evaluation of their own affective, cognitive and behavioural experience, and through dialogue and generalisation, produce insights and fundamental shifts in their original assumptions and beliefs (Orchowski, Evangelista, & Probst, 2010, p.51). Such self-reflection is likely to help trainees work more effectively with services. Relative to those that did not engage in self-reflection, Skovholt and Rønnestad (1992) found that practitioners who continually did so reported having a more complete professional development. Orchowski et al (2010) suggested that clinicians who are more self-aware and reflective are more likely to recognise their own deficiencies and to try to improve upon these. Trainees can use self-supervision practices to deepen their own understanding of their own affective processes and help prepare for supervision meetings. Table 5 outlines examples of how trainees can engage in self-supervision.

Self-disclose During Supervision

There is evidence to suggest that many trainees fail to disclose information to their supervisors about a variety of issues including clinical mistakes, evaluation concerns and general service user observations (Ladany, Hill, Corbett, & Nutt, 1996). This can be due to trainees fearing negative feedback and wanting to portray a positive and competent image of themselves to their supervisors. Although trainees may be anxious about appearing incompetent, not providing relevant information can be detrimental to their learning (Costa, 1994). They need to be open with their supervisors about their fears and what they perceive to be their apparent shortcomings. Both can then create strategies and learning goals to combat and develop the areas in which the trainee needs to improve.

Table 4. Sample Headings for a Supervision Preparation Sheet

<table>
<thead>
<tr>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Time and date of weekly supervision meeting</td>
</tr>
<tr>
<td>- Joint work to date — List of service users</td>
</tr>
<tr>
<td>- Observations to date</td>
</tr>
<tr>
<td>- Independent work to date</td>
</tr>
<tr>
<td>- Assessment</td>
</tr>
<tr>
<td>- Intervention</td>
</tr>
<tr>
<td>- Outstanding reports</td>
</tr>
<tr>
<td>- Technical aspects of cases</td>
</tr>
<tr>
<td>- Self-awareness / personal issues</td>
</tr>
<tr>
<td>- Review of placement contract (e.g., consideration of new areas of work, presentations still sought)</td>
</tr>
<tr>
<td>- Administration / organisational issues / any other business</td>
</tr>
<tr>
<td>- Date of next supervision meeting</td>
</tr>
</tbody>
</table>

Table 5. Some Methods of Self-supervision

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Self-reflective questions</td>
<td>- After a puzzling or challenging session with a service user:&lt;br&gt;  - Describe the therapy events that precipitated your puzzlement&lt;br&gt;  - What was the feel, the emotional flavour, of the interaction between you?&lt;br&gt;  - Was it similar to or different from your usual experience with this service user?</td>
</tr>
<tr>
<td>- Journaling (Orchowski, Evangelista &amp; Probst, 2010)</td>
<td>- Trainees reflect about their clinical experiences in a journal and use the journal entries as a means of measuring progress and current level of competencies</td>
</tr>
<tr>
<td>- Self-supervision checklist</td>
<td>- A list of criteria compiled by the trainee and supervisor, that the trainee can use to evaluate and reflect upon his/her performance in sessions with service users</td>
</tr>
</tbody>
</table>

Contribute to Psychological Safety

Psychological safety refers to individuals’ attitudes and beliefs about the consequences of taking interpersonal risks in a working environment (Edmondson, 1999). Within the supervisory relationship, psychological safety refers to interpersonal trust, respect for the other person’s competence and consideration for them. It facilitates learning behaviour and creativity, and increases team performance (Edmondson, 1999; Kark & Carmeli, 2009). When robust psychological safety exists within a working relationship, task conflict can even improve task performance (Bradley, Postlethwaite, Klotz, Hamdani, & Brown, 2012). For the supervisory relationship, this suggests that disagreement can actually benefit the productivity of supervision if a psychologically stable relationship exists between the parties.

Both supervisors and trainees are responsible for creating a climate of psychological or participative safety. Research suggests that the most common means by which a trainee can create an atmosphere of conflict and distrust is by their remaining resistant to contributing to supervision and/or believing that they do not need supervision (Nelson, Barnes, Evans, & Triggiano, 2008). They need instead to be open to feedback (Hoffman, Hill, Holmes, & Freitas, 2005). Other trainee characteristics that facilitate effective supervision include: honest self-evaluation, the ability to ask for help when needed, a desire to learn and improve, and the willingness to give accurate and full information about service users and therapeutic sessions (Ladany et al., 1996; O’Donovan et al., 2011; Vespia, Heckman-Stone, & Delworth, 2002).
Conclusion

The importance of clinical placements in the training of clinical psychologists should not be underestimated. They offer trainees the opportunity to develop knowledge and skills through the application of theoretical knowledge. The purpose of this paper is to promote a proactive approach by trainees when managing their placements. This begins with both trainees and supervisors setting out, in a learning contract, a trainee’s specific goals and learning aims of a placement. These goals should incorporate the knowledge, skills and attitudes involved in developing the required clinical competencies (BPS, 2010). The learning contract needs to also detail the strategies for achieving desired learning aims, including how to access resources, specific populations and secondary supervision; engineering an appropriate caseload; arranging supervision times and opportunities for mutual observation; and guidelines for managing placement challenges.

Once a placement begins, the onus is on trainees to ensure that they engage in work that progresses their learning goals as detailed in their learning contract. This includes engaging in appropriate and proportionate clinical activity and maximising their learning from scheduled supervision (e.g., thorough preparation before each session). If they find they are not progressing their learning goals (e.g., at mid-placement), it is primarily their responsibility to address this with their supervisor, or if necessary, with their placement monitor or liaison principal psychology manager. Given that clinical placements can be stressful, trainees also need to prioritise engaging in self-care to prevent burnout or fatigue.

The ability to self-reflect is critical to the development of clinical skills. Through supervision, trainees are presented with individual feedback by their supervisor on progress during placement. To use supervision efficiently, trainees must be prepared to accept and act upon feedback. In addition, readily self-disclosing one’s clinical mistakes, evaluation concerns and general service user observations can facilitate developing process-related competencies during supervision.

References


ARTICLE
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THE DIVISION OF WORK AND ORGANISATIONAL PSYCHOLOGY (DWOP)

Is holding the following workshop on

“Facet 5 Conversion Course”

On Saturday 23 February 2013 from 10am – 1pm in PSI Grantham House
Presented by: John Guinan and Nigel Evans

The objectives of this seminar are to:

- To familiarise delegates with the structure and utility of the Facet 5 personality questionnaire,
- To develop skills in profile interpretation and feedback of Facet 5
- To familiarise delegates with the Facet 5 online interface and functionality
- To illustrate how the instrument can be utilised in a range of contexts (e.g. selection, individual development and coaching, team development, identification of potential) and illustrate its utility through exercises and case studies.
- Attendees will have the opportunity to complete a free Facet 5 in advance of the seminar
- Attendees will be also eligible for a free trial of the Facet 5 Assessment and will receive a User Certificate in Facet 5.

For those already qualified in the use of an accredited personality questionnaire, part of this complimentary seminar can be used to upgrade to TUP in an additional instrument (formerly Level B Plus) with the British Psychological Society. Further details are available for those who wish to apply for this qualification.

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