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The Role of Clinical Supervision in Supervisee Burnout: A Call to Action

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Professional burnout is a well-documented issue in professional psychology and has been associated with multiple negative personal, professional, and institutional consequences. Interestingly, burnout in the context of psychologists-in-training has received very little attention. This article defines burnout in the context of professional psychology, outlines the factors leading to burnout, discusses burnout in the context of psychologists-in-training, and examines how clinical supervisors can play a preventative and/or remedial role in supervisee burnout. The article concludes by highlighting the need to integrate education and wellness plans into supervisory relationships and settings.

Keywords: supervisees, burnout, burnout prevention, professional psychology, clinical supervision, clinical training

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Decades of research have strongly suggested that the same qualities that make professional psychologists effective–such as empathy and compassion–also place them at risk for adverse psychological outcomes such as professional burnout (Lim, Kim, Kim, Yang, & Lee, 2010). Psychologists-in-training (referred to herein as *supervisees*) are especially vulnerable to burnout given their pressures to manage the multiple demands associated with academia, clinical training, and their personal lives (Cieslak, 2016; Thompson, Frick, & Trice-Black, 2011). Importantly, the experience of burnout does not only negatively impact supervisee competence, morale, satisfaction, and self-concept (Pakenham & Stafford-Brown, 2012) but it may also compromise client welfare (Schwartz-Mette, 2009). While the literature in this area has focused extensively on the contributing factors and consequences of burnout among practicing psychologists and related professions such as licensed counsellors and psychotherapists (Thompson, Amatea, & Thompson, 2014), discussions regarding the impact of burnout on supervisee development are in their infancy (Pakenham & Stafford-Brown, 2012). Moreover, the role of clinical supervisors and, by extension, supervision models in preventing or remediating burnout has received only cursory mention in the literature (Cieslak, 2016). Hence, the purpose of this article is to explore the relationship between clinical supervision and supervisee burnout. This article begins with a brief review of the theory and research underpinning professional burnout and its consequences for clinical practice. Next, the potential of clinical supervision to serve a preventative and/or remedial role in supervisee burnout is examined. This article

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concludes with a discussion of the relative absence of research on supervision practices designed to address supervisee burnout, highlighting the need to integrate education and wellness plans into existing supervisory relationships and settings.

Conceptualization and Prevalence of Burnout

Burnout was first identified as a stress-related condition among counselling and psychotherapy professionals in the 1970s (Maslach & Leiter, 2016). Since this time, burnout has come to be defined as an extreme and enduring stress syndrome characterized by mental and emotional exhaustion, and in some cases, poor physical health (Volpe et al., 2014). A burgeoning body of literature has indicated that licensed psychologists, counsellors, and psychotherapists face a multitude of stressors that make them particularly vulnerable to burnout, such as the emotionally demanding nature of providing services, excessive administrative tasks and paperwork, and increasing organizational pressures to increase efficiency and persons served (Rupert, Miller, & Dorociak, 2015; Thompson et al., 2014).

While there is no consensus for defining the construct of burnout in professional psychology (Cieslak, 2016), a large proportion of the literature has conceptualized burnout more generally as an extreme stress syndrome (Volpe et al., 2014). Thompson et al. (2011) conceptualized this phenomenon specifically as it relates to graduate students in psychology, describing burnout as "a loss of enthusiasm and compassion, difficulty delineating and separating personal and professional boundaries" and "struggl[ing] to be assertive, set limits, maintain realistic expectations, and not assume personal responsibility for client outcomes" (p. 156). Given the complexity of burnout illustrated in supervisee descriptions, arriving at a unitary conceptualization of this phenomenon has been challenging. For the purpose of constructing a meaningful, comprehensive discussion of burnout among supervisees in the clinical realm, this article aligns with the current, predominant definition espoused in the literature, which defines burnout as a work-related, stress-induced condition characterized by emotional exhaustion, cynicism (or depersonalization), and a diminished sense of efficacy or personal accomplishment (Maslach, Schaufeli, & Leiter, 2001).

Although several conceptualizations of burnout have arisen in the literature (Maslach et al., 2001), Maslach's (1976) framework has been the most generative in terms of empirical research. According to this conceptualization, burnout is comprised of three elements: emotional exhaustion, depersonalization, and personal achievement (Maslach, 1976; Maslach et al., 2001). Emotional exhaustion refers to the feeling of being overwhelmed with emotions and void of energy (Maslach & Goldberg, 1998). Depersonalization refers to a negative, unsympathetic, or disinterested attitude toward one's clients (Maslach & Goldberg, 1998). Personal achievement involves negative self-evaluation and dissatisfaction regarding one's personal work and productivity (Maslach & Jackson, 1981). In addition, earlier research among healthcare professionals found a correlation between self-reported burnout and a range of mental and physical health symptoms, including depression, anxiety, sleep problems, memory impairments, neck and back pain, and alcohol consumption (Peterson et al., 2008). Beyond Maslach's (1976) conception of burnout, research has demonstrated that physical symptoms such exhaustion and pain are strongly associated with supervisee burnout (Kaeding et al., 2017). Collectively, and in

the context of professional psychology, these elements manifest in a diminished desire to engage in clinical work (Thompson et al., 2011). Moreover, the mental and physical symptoms associated with burnout may compromise supervisees' personal and professional development, the therapeutic alliance with clients, and ethical and professional judgment in clinical work (Cieslak, 2016; Kaeding et al., 2017; Schwartz-Mette, 2009).

Early research into the prevalence of burnout found that approximately 44% (n = 571) of practicing, licensed psychologists in the United States reported symptoms consistent with the emotional exhaustion element of burnout (Rupert & Morgan, 2005). In a later study that examined overall levels of burnout (i.e., composite levels of emotional exhaustion, depersonalization, and personal achievement), Kaeding et al. (2017) found that nearly half (49.2%) of a sample of 1,172 clinical and counselling psychology supervisees indicated severe levels of burnout, a rate slightly higher but comparable to their licensed counterparts. The prevalence of burnout in professional psychology, regardless of career stage, suggests that there may be factors inherent to clinical work that increase the risk of burnout. While more research is needed to establish the degree of burnout in professional psychology, these early studies suggest that licensed psychologists and supervisees may be at risk of burnout. In order to identify avenues for intervention, it is first necessary to have a fuller understanding of the factors contributing to burnout and their implications for supervisees and clinical practice.

Factors Contributing to Burnout

According to Hardiman and Simmonds (2013), professional burnout may result from a combination of individual and environmental factors. Individual factors refer to the influence of personality characteristics, beliefs, and attitudes, whereas environmental factors refer to the influence of the setting on an individual's work, its culture, and the inherent demands associated with one's role (Hardiman & Simmonds, 2013). Empirical research offers compelling evidence to suggest that both sources influence burnout within the field of professional psychology (Lim et al., 2010).

Individual Factors

Meta-analytic research has revealed that individual factors such as gender and age are associated with burnout among licensed psychologists (Lim et al., 2010). In an early study, age was negatively correlated with self-reported rates of burnout (Ackerley, Burnell, Holder, & Kurdek, 1988). More recently, Rupert and Kent (2007) found that those who identify as female were found to experience burnout at a higher rate than those who identify as male. While demographic factors such as gender and age are important considerations for understanding burnout in professional psychology, the majority of research on individual factors has focused on psychologists' coping orientations, perceptions of control, expectations of client change and outcomes, and personal schemas pertaining to clinical practice (Ben Zur & Michael, 2007; Kaeding et al., 2017; Lee, Lim, Yang, & Lee, 2011).

Ben Zur and Michael (2007) found that coping orientations play a role in the risk for burnout among counsellors and psychotherapists. Using the Burnout Scale (Maslach & Jackson, 1981) to measure elements of depersonalization, emotional exhaustion, and personal achievement, Ben Zur and Michael (2007) found that emotion-focused coping (e.g., denial,

"venting") orientations were positively correlated with depersonalization and negatively correlated with personal achievement. In contrast, coping orientations characterized by problem-solving strategies (e.g., planning, positive reframing, obtaining support) were negatively correlated with depersonalization and positively correlated with personal achievement (Ben Zur & Michael, 2007). While this research did not involve supervisees specifically, the findings suggest that coping orientations characterized by problem-solving may serve as a protective factor in the specific occupational contexts occupied by professional psychologists.

Research has also revealed that professional helpers' (e.g., psychologists, social workers, counsellors) level of involvement and perceptions of control with their clients is a strong predictor of burnout. According to Lee et al. (2011), *over-involvement* is a term used to describe professional helpers' tendency to feel responsible for clients, frequently think about clients outside of sessions, and/or work harder than the client toward making change. *Perceptions of control* refers to professional helpers' appraisal of the degree to which they control the activities that comprise their workday and when these activities take place (Lee et al., 2011). In a recent meta-analysis, Lee et al. (2011) found a strong positive relationship between over-involvement and the emotional exhaustion subtype of burnout. Furthermore, results revealed a strong negative correlation between perceptions of control and emotional exhaustion, in that low control correlated strongly with high emotional exhaustion (Lee et al., 2011).

An additional body of literature has examined the relationship between idealistic and/or unrealistic expectations about the psychotherapy process and supervisee burnout (Pakenham & Stafford-Brown, 2012). Specifically, supervisees may exhibit an unrealistic optimism about their capacity to generate client change (Skovholt & Rønnestad, 2003). Supervisees who are new to clinical practice may also grapple with the realization that the same skillset that yielded mastery in their academic coursework does not transfer directly to the complexities of clinical practice (Skovholt & Rønnestad, 2003). For instance, Thompson et al. (2011) pointed out that idealistic and unrealistic expectations about client progress (e.g., high levels of supervisee effort will translate to positive client change; client progress will occur quickly and in a linear fashion) may inadvertently reduce personal feelings of self-efficacy and professional competence among supervisees. These expectations, ideals, and the potential for subsequent disillusionment, are further exacerbated by supervisees' stress and uncertainty surrounding evaluation of their performance (Schwartz-Mette, 2009).

Several authors have explored the role of supervisees' schemas and belief patterns in increasing the risk for burnout. Kaeding et al. (2017) found that supervisees frequently self-reported two maladaptive schemas: self-sacrifice (SS) and unrelenting standards (US). SS refers to a heightened sensitivity to the suffering of others, coupled with an inclination toward taking responsibility for others at the expense of personal health (Kaeding et al., 2017). US refers to the internalization of unrealistically high standards in order to eschew criticism from others (Kaeding et al., 2017). Interestingly, research has revealed a statistically significant positive correlation between the endorsement of SS and US schemas and self-reported burnout among supervisees (Kaeding et al., 2017). These findings suggest that supervisees with these schemas may be challenged to strike a balance between meeting the needs of their clients and meeting their own needs, thereby increasing the risk for emotional exhaustion and limited self-care (Kaeding et al., 2017).

Collectively, this body of research highlights the importance of professional psychologists' coping orientations, perceptions of control, expectations of client change and outcomes, and personal schemas pertaining to clinical practice. While it is important to address these individual factors as they pertain to supervisee development, it is equally important to understand the intersection of these individual factors with the organizational climate within which professional psychology and supervisee clinical training is taking place (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012; Pakenham & Stafford-Brown, 2012). These organizational factors are discussed in greater detail in the following section.

Environmental Factors

There are numerous environmental factors associated with burnout that have been highlighted in the literature. In general, characteristics such as number of hours worked, volume of paperwork, workload, and time pressure are positively correlated with risk for burnout across various occupational contexts and settings (Rupert et al., 2015). In research specific to professional psychology, factors such as level of control and autonomy over occupational demands and activities, complexity and severity of client presentations, emotional demands of therapeutic work, and practicing in public sector settings have been associated with burnout (Craig & Sprang, 2010; Rupert et al., 2015; Skovholt & Rønnestad, 2003). While a discussion of all these factors is beyond the scope of this article, the current section focuses on those factors unique to professional psychology that also place supervisees at an increased risk for burnout.

One of the foremost features of professional psychology that has been linked to burnout is the emotionally demanding nature of clinical work (Skovholt & Rønnestad, 2003). The emotionally demanding nature of clinical work may take several forms and the impact on professional psychologists may be profound. Exposure to clients' painful, tragic, or traumatic narratives is a common dimension of professional psychology practice that can alter even seasoned psychologists' worldview and understanding of humanity (Cieslak, 2016). Working with clients at high risk of harming themselves or others places tremendous demands on psychologists, in that they may experience apprehension about their clients' safety as well as the threat of personal, professional, and legal implications associated with this level of risk (Webb, 2011). Because the inherent demands of clinical work require the supervisee to be open, compassionate, and empathic, exposure to emotionally-charged content has the potential to "drain a counsellor's reservoir of resilience" (Thompson et al., 2011, p. 152). The emotionally-demanding nature of these relationships with clients, coupled with the stage of professional development for supervisees, where insecurity, anxiety, and uncertainty about one's clinical skills and judgment is commonly experienced, may intensify conditions for burnout among supervisees (Testa & Sangganjanavanich, 2016; Thompson et al., 2011).

As noted earlier, supervisees may also be particularly vulnerable to burnout because they are often balancing the demands of academic, professional, and personal spheres of life because they are concurrently enrolled in graduate studies (Pakenham & Stafford-Brown, 2012). Ongoing demands/pressures to balance the expectations of the academic curriculum, accreditation bodies, the clinical training site, and their personal lives, can leave little time or space for self-care and reflection (Cieslak, 2016; Pakenham & Stafford-Brown, 2012). Graduate students in the field of professional psychology are expected to devote considerable time and effort to their work, which

may become the source of additional stress and pressure (El-Ghoroury et al., 2012). Research suggests that graduate students in clinical and counselling streams of psychology report numerous stressors, including academic coursework, finances and debt, poor work/school-life balance, family issues, marital/relationship problems, and time-consuming research obligations (El-Ghoroury et al., 2012). The continuous need to balance these complementary—and at times competing—demands, may exceed supervisees' coping resources and increase their susceptibility to burnout (Pakenham & Stafford-Brown, 2012).

Organizational climates and professional culture represent an additional factor that may contribute to supervisee burnout. Kaedling et al. (2017) maintained that supervisees may find themselves in settings that promote high or idealistic standards for client outcomes, which can lead to additional stress, evaluative pressure, and feelings of self-doubt. Thompson et al. (2011) interviewed supervisees about their experience of clinical supervision related to self-care and burnout. Interestingly, supervisees in this study reported that professional cultures that valued professional invulnerability and/or viewed being overwhelmed as both a rite of passage and a customary experience for entry into the psychology profession promoted supervisee burnout (Thompson et al., 2011). According to Kaeding et al. (2017), in these professional climates and cultures, supervisees may be reluctant to disclose overwhelming stress and/or distress out of fear of being labeled as incompetent or unfit for entry into the profession. In turn, the fear of disclosure in these settings limits opportunities for intervening with supervisee burnout.

An additional external factor, and of particular focus in this article, is the philosophical approach and characteristics of supervision. To date, there is a dearth of empirical literature on the role of clinical supervision practices in supervisee burnout. However, one qualitative study conducted by Thompson et al. (2011) revealed a considerable gap between faculty supervisors and field supervisors' tendency to discuss and address burnout with supervisees. Specifically, supervisees reported that faculty supervisors were more likely to directly address issues such as burnout, self-care, personal wellness, time management, and the need to self-assess for these issues (Thompson et al., 2011). In contrast, supervisees indicated that field supervisors did not directly discuss personal wellness, and in extreme cases, put forth the attitude that burnout, as well as sacrificing personal time and family obligations, were unavoidable and necessary costs of clinical work (Thompson et al., 2011). This relative gap in supervisor perspectives, and the perception of distress in supervisees as a rite of passage into the profession, suggests that integrating education and awareness of burnout into supervisory models is warranted.

Implications of Supervisee Burnout

It is evident that burnout exerts a significant toll on the health and well-being of supervisees (Kaeding et al., 2017). While this is concerning for psychologists who have only just entered their careers in professional psychology, what is equally concerning is the impact of supervisee burnout on clinical practice and client care (Pakenham & Stafford-Brown, 2012). Specifically, when burnout goes unacknowledged and unaddressed, the capacity to conduct clinical work competently and ethically is compromised (Pakenham & Stafford-Brown, 2012; Thompson et al., 2011). Hence, the following section of this article describes the implications of supervisee burnout with respect to client care, professional and ethical practice, and challenges

with terminology. While the majority of research on this topic was undertaken with licensed and practicing psychologists, it can be extrapolated that supervisee burnout would carry similar risks in terms of the therapeutic alliance. Notably, this is an area that clearly needs to be more explicitly addressed in the supervision literature.

Client Care Issues

In the absence of empirical research on supervisees, the current discussion borrows from literature on licensed professionals (e.g., psychologists, counsellors, psychotherapists) to provide an illustration of the potential effects of burnout on client care. In general, licensed professionals' self-reports have illustrated a relationship between burnout and poor morale (Maslach & Leiter, 2016). Interestingly, this body of literature has hypothesized that professional burnout also leads to diminished empathy, lower quality care, and poor communication with clients, despite the absence of research to support such assertions (Everall & Paulson, 2004; Hardiman & Simmonds, 2013; Maslach & Leiter, 2016; Smith & Moss, 2009). Smith and Moss (2009) pointed out that logistical and ethical issues with examining the experiences of clients in therapy have limited the extent to which the relationship between professional burnout and client care may be empirically studied. In the absence of actual data, the impact of professional burnout on clients and the therapeutic process appears to be more speculative and cautionary rather than evidence-based (Smith & Moss, 2009). However, the absence of data should not undermine or discredit the concerns espoused by professional Codes of Ethics and opinionated literature surrounding the potential hazards of burnout for clinical practice (CPA, 2017a; Schwartz-Mette, 2009). Furthermore, several authors have postulated that because supervisees are normally at an earlier stage in their development than seasoned professionals, the effects of burnout may carry even greater risks to clients because supervisees may not have developed competence in identifying and repairing ruptures in the therapeutic alliance (Cieslak, 2016). Given that responsible caring is central to ethical psychological practice (CPA, 2017a), the potential harms associated with supervisee burnout warrants greater attention from field supervisors and the discipline of clinical supervision at large. Specifically, more empirical research should be devoted to better understand the link between supervisee burnout, therapeutic process, and client outcomes.

Professional and Ethical Issues

Previously, authors have speculated that burnout among clinical psychology professionals may lead to a number of ethical concerns, including professional-client boundary violations, harmful multiple relationships, and using treatment to serve the needs of the professional (Everall & Paulson, 2004; Schwartz-Mette, 2009). Hence, the potential for burnout to lead to professional and ethical violations cannot be overlooked. Ethical violations committed by licensed psychologists involve significant consequences, including compulsory rehabilitation, treatment, dismissal from professional regulatory bodies, and even criminal charges (Canadian Psychological Association [CPA], 2015). However, no studies to date to our awareness have revealed a direct relationship between supervisee burnout and ethical violations. Interestingly, the majority of the literature on ethical violations stemming from supervisee burnout emanates from opinionated literature or speculations (Collins, Falender, & Shafrankse, 2011; Schwartz-

Mette, 2009). This is not to suggest that supervisees experiencing burnout do not commit ethical infractions with their clients, but, rather, that empirical evidence as to the nature, course, and outcomes of such infractions is largely understudied. Hence, the picture of how supervisee burnout contributes to ethical violations remains incomplete and should be the focus of future research. As will be discussed in the following section, clinical supervisors are responsible for the care delivered to clients by their supervisees and, as such, play a critical role in preventing burnout among supervisees.

Terminology

While the relationship between supervisee burnout and ethical violations has been described as a form of *professional impairment* (Schwartz-Mette, 2009), this lexis has sparked controversy over its ethical and legal implications (Collins et al., 2011). According to Collins et al. (2011), using the term *impairment* to describe a supervisee who is affected by burnout carries long-term implications for the supervisee. Firstly, the term impairment carries the legal connotation of disability, and hence may not be an accurate description of the supervisees' professional and occupational status (Collins et al., 2011). Secondly, the term impairment connotes potentially irreparable issues that reside within the supervisee as a person (Collins et al., 2011). This places supervisors and agencies in a legal and ethical position to provide accommodations to the supervisee, whilst simultaneously overlooking the interplay of systemic and individual sources of burnout (Collins et al., 2011). Hence, the term impairment may be viewed as an intrapsychic issue despite the fact that the plethora of empirical research suggests that burnout is largely a product of systemic issues (El-Ghoroury et al., 2012; Pakenham & Stafford-Brown, 2012; Rupert et al., 2015; Thompson et al., 2011). Importantly, the vast and complex interplay between externally imposed, contextually-based stressors and individual factors may be mediated and alleviated with awareness, adequate supervision, and skill development (El-Ghoroury et al., 2012; Pakenham & Stafford-Brown, 2012; Rupert et al., 2015; Thompson et al., 2011). The historical use of the term impairment reinforces and maintains a long-standing intrapsychic tradition in the field of psychology that has the potential to pathologize supervisees who are experiencing tremendous and compounding pressures from multiple sources that may be beyond their control (Collins et al., 2011). More recently, Collins et al. (2011) have recommended replacing the term *impairment* with *problems of professional competency* (PPC). According to Collins et al. (2011), the nascent term PPC is considered more useful than its predecessor because it conceptualizes performance in relation to a professional standard while focusing on building competence (as opposed to focusing on impairment). PPC suggests that supervisee burnout remains a contentious issue in professional psychology and one which warrants attention from future researchers. Despite this shift in language, supervisee burnout remains a contentious issue in professional psychology and one that warrants attention from future researchers.

The Role of Clinical Supervision

The potential implications of professional burnout on clinical practice provides compelling impetus to devise solutions to prevent and alleviate supervisee burnout. However, before one concludes that the solution is simply to cultivate supervisees' individual coping

strategies and personal resilience, research has emphasized the critical role of clinical supervision in preventing and alleviating supervisee burnout (Thompson et al., 2011). As stipulated in the *Ethical Guidelines for Supervision in Psychology* (CPA, 2017b), supervisors are not only influential in shaping the development of their supervisee, but they also hold an ethical and professional obligation to improve their supervisees' professional skills, assure the quality of services provided to clients, and function as a gatekeeper for entry into the psychology profession at large. Moreover, supervisors hold a position of power in the supervisory relationship (CPA, 2017b) and may use this privilege to foster resilience and sustainable wellness practices in their supervisees (Collins et al., 2011). Finally, supervisors have an ethical responsibility to take up "opportunities and resources to continuously improve their ability as supervisors" (CPA, 2017b, p. 4), including developing an understanding of the complexity of burnout in supervisees and how supervision may alleviate associated risk factors.

Although beyond the scope of this article, it is important to acknowledge that supervisors may also face pressure from systems (e.g., session limits, budget constraints) and administrative structures (e.g., policies, position) that counteract their own efforts to prevent burnout and maintain wellness. As such, the current section emphasizes the role of clinical supervision in preventing and remediating supervisee burnout, while acknowledging that supervision represents only a portion of the much larger systemic and cultural shift that is needed to address burnout in the broader context of professional psychology. Moreover, this section advances its focus on supervision with the understanding that the prevention and remediation of supervisee burnout is a responsibility shared by supervisees, supervisors, graduate training programs, and the broader profession of psychology (CPA, 2017b; Tyre, Griffin, & Simmons, 2016).

The Ethical Imperative for the Monitoring of Self and Others

The *Canadian Code of Ethics for Psychologists Fourth Edition* (referred to herein as *the Code)* conveys the principles and values underlying the standards for professional conduct of psychologists in Canada (CPA, 2017a). Stated within these guidelines is the ethical imperative for all psychologists, including clinical supervisors, to demonstrate a level of awareness and reflectivity that enables them to monitor self and others with respect to their ability to deliver psychological services competently (CPA, 2017a). Specifically, standard II.11 of the Code calls upon psychologists to "seek appropriate help and/or discontinue scientific, teaching, supervision, or practice activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others" (CPA, 2017a, p. 20). Furthermore, standard II.12 states that psychologists should "engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others" (CPA, 2017a, p. 20). Although supervisees are not licensed psychologists, supervisees are expected to enter clinical training with knowledge of and the capacity to practice in adherence with the ethics and principles laid out within the Code. Hence, the aforementioned standards II.11 and II.12 reflect ideals that supervisees are expected to enact in their clinical training. With respect to the role of clinical supervisors, standards II.43 and II.44 explicitly state that psychologists should "act to stop or offset the consequences of harmful activities carried out by another psychologist or member of another discipline" (CPA, 2017a, p.

23) even when the harm appears to result from diminished sensitivity, knowledge, or experience. In the context of supervisee burnout, these guidelines suggest that the prevention and remediation of supervisee burnout is a shared responsibility between supervisee and supervisor (CPA, 2017b). Supervisees have an educational and ethical obligation to develop the capacity to self-monitor, whereas supervisors have an ethical duty to self-monitor and to intervene in situations in which the health and well-being of their supervisee is compromised. However, because of higher status and power and the supervisors' ultimate responsibility for client welfare, the supervisor also has greater responsibility to maintain a level of awareness regarding supervisee limitations and their potential impact on clientele (CPA, 2017b). Importantly, the ethical imperative to intervene translates to a continuum of potential measures, including preventative responses in early stages, remedial actions, and gatekeeping (CPA, 2017b). While these ethical guidelines present ethical grounds for integrating awareness and remediation of burnout into clinical supervision models (CPA, 2017b), research is in its infancy as to precisely how clinical supervisors can effectively prevent and manage supervisee burnout. Nevertheless, the ethical standards of professional psychology imply that supervisee wellbeing should be a central concern addressed by supervisors (Thompson et al., 2011).

Clinical Supervision and Supervisee Burnout/Wellness

Several authors have proposed viable avenues by which burnout among supervisees may be prevented or alleviated, including peer support, self-care, and personal counselling or psychotherapy (Cieslak, 2016). However, because clinical supervision facilitates the multidimensional development of the supervisee, and because burnout is directly related to the professional context of the supervisee, clinical supervisors are uniquely positioned to directly address supervisee burnout and monitor changes in the professional context. Despite the unique position of supervisors, the extant literature on clinical supervision suggests that the topic of burnout and wellness is frequently neglected in the supervisory relationship (Blount & Mullen, 2015; Thompson et al., 2011).

As previously mentioned, earlier research suggests that professional burnout results from an overcommitment to client outcomes, elusive measures for success, and emotional exhaustion (Lee et al., 2011; Skovholt & Rønnestad, 2003). To our knowledge, one study has addressed supervisees' perceptions of supervision practices related to self-care and burnout (Thompson et al., 2011). This study revealed that the aforementioned risk factors for burnout were not directly addressed by supervisors over the course of supervisee clinical training (Thompson et al., 2011). Moreover, supervisees in this study indicated that they believed supervisors can help prevent and remediate supervisee burnout by explicitly assessing supervisee expectations and beliefs surrounding psychotherapy and client outcomes, promoting supervisees' development of a personal wellness plan, and being present and available for supervisees (Thompson et al., 2011). Additionally, supervisees expressed the need for supervisors to model behaviours and attitudes that engender self-care and appropriate personal and professional boundaries (Thompson et al., 2011). Hence, supervisees viewed their supervisors as having the ability to play a preventative and remedial role in the degree of burnout they experienced during their training (Thompson et al., 2011). However, it is important to acknowledge that these findings are based on only a single study and may not be representative of the perceptions of all supervisees. Hence, our current

understanding is limited as to clinical supervisors' efforts and methods for intervening with supervisee burnout and additional research is required to extend this body of knowledge.

To date, empirical research in support of the effectiveness of clinical supervision in preventing and remediating supervisee burnout is lacking (Cieslak, 2016; Lenz & Smith, 2010). However, the lack of research has not deterred several authors from advancing the critical need for supervision to integrate education and training pertaining to supervisee burnout (Lenz & Smith, 2010). According to Tyre et al. (2016), advocates in the area of preventing burnout in professional psychology recommend integrating the following four pillars into education and training programs: a) education around the importance of self-care as a protective factor against burnout; b) ongoing self-assessment and reflection to increase awareness of resilience and burnout; c) programs and initiatives to cultivate resilience; and d) clinical supervision that directly addresses the propensity for burnout through education, coaching, and modeling wellness and resiliency. These four pillars illustrate the shared responsibility among supervisees, supervisors, graduate training programs, and the psychology profession to prevent supervisee burnout and simultaneously promote supervisee professional fitness, wellness, and resilience (Tyre et al., 2016). Tyre et al. (2016) emphasized the critical importance of clinical supervision as a learning environment by which supervisee-supervisor authenticity, reflection, and self-awareness may be fostered. Furthermore, clinical supervision represents a climate in which unique skills and strength-building opportunities that foster professional fitness and wellness emerge for the supervisee (Tyre et al., 2016). Supervisors are in the position to approach the topic of burnout with intentionality and use their privileged status to help supervisees explore and cultivate a realistic, balanced, and culturally-relevant philosophy with respect to their beliefs, attitudes, boundaries, and roles as an emerging counsellor or psychotherapist (Thompson et al., 2011; Tyre et al., 2016). Importantly, incorporating these dimensions into clinical supervision models may foster a level of professional fitness and wellness in supervisees that may be carried forward throughout their career (Lenz & Smith, 2010; Tyre et al., 2016). To this end, empirical evaluation of the implementation and efficacy of these four pillars is sorely needed to truly understand the benefits of strategies for burnout prevention.

Implications, Conclusions and Recommendations

Although limited, the extant literature examined in this article indicates that clinical supervision has the potential to play a preventative and/or remedial role in supervisee burnout (Lenz & Smith, 2010; Thompson et al., 2011). According to advocates in this area, the primary mechanism by which clinical supervision may accomplish this aim is through directly addressing supervisees' beliefs, attitudes, and perspectives that are likely to increase the risk for burnout, while simultaneously modeling and fostering appropriate self-care and wellness practices (Thompson et al., 2011; Tyre et al., 2016). While these recommendations are both encouraging and provoking, the dearth of research on the effectiveness of these practices in the context of supervision represents a significant barrier to widespread acknowledgment and integration among clinical supervisors (Lenz & Smith, 2010). Research that examines the execution, processes, and outcomes of integrating these practices into clinical supervision models is sorely needed.

It is also important that the field of professional psychology, including graduate training programs, broadens the conceptualization of wellness beyond an individual and intrapsychic view of self-care. This widening stance on the meaning of wellness may include the cultivation of healthy and realistic measures of professional success, including beliefs and expectations about clinical work, client change, and therapeutic outcomes (Thompson et al., 2011; Tyre et al., 2016), as well as an understanding that self-care and wellness involves an interaction between an individual and their environment, community, culture, and nature (Lenz & Smith, 2010). Moreover, education and awareness are needed to bring to light the complex interplay of individual and environmental factors that give way to professional burnout, and to dismantle the view that burnout is both an issue of professional impairment and an indicator of a lack of fitness for entering the field. The alarming prevalence of burnout in the field of professional psychology alone should provide sufficient cause to implore academic and professional communities to take up sorely needed research, education, and training that address individual factors with compassion and ameliorates environmental factors with systemic interventions for change.

As prominent figures in professional development, training, and gatekeeping, clinical supervisors occupy a unique position of power to not only acknowledge the concerning prevalence of burnout in our field, but also to embolden a culture that upholds wellness as a domain of competency that deserves the same care, attention, and practice that has been traditionally afforded to other core competencies underpinning professional psychology. It is imperative that clinical supervisors and clinical training sites move beyond cursory awareness of the risks associated with supervisee burnout and move toward full recognition of the centrality of wellness in professional psychology, not only as a pillar of clinical supervision but also as an active stance against the traditions within the field of psychology that contribute to burnout among psychology professionals. This article calls upon the field to appreciate that, in order to accomplish the latter, wellness must be integrated into supervisory models as a domain of professional competence in and of itself (Lenz & Smith, 2010). To this end, future research may explore how professional wellness may be represented as a domain of clinical competence, and how this explicit emphasis may hold all relevant stakeholders in the field of professional psychology accountable to their collective responsibility to prevent burnout and promote wellness in those entering the field. It is the position of the authors that a sustainable future of ethical and effective psychologists depends on our advancing this critical and timely issue.

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