Journal of Psychotherapy Integration

1053-0479/20/$12.00

2020, Vol. 30, No. 1, 16–24
http://dx.doi.org/10.1037/int0000167

Supervision in Interprofessional Education: Benefits, Challenges, and Lessons Learned

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As interprofessional teamwork and collaboration in health care becomes a larger component of a psychologist's role, there is a growing need for training and supervision in this competency area. The interprofessional education (IPE) at Memorial University of Newfoundland provides psychology doctoral students with didactic and experiential training in collaborative practice supervised by a practitioner from another discipline. The cross-disciplinary supervision provided in IPE is associated with a unique supervisory experience, in which supervision of the interprofessional competency occurs in a group with students from other disciplines, and the supervisor-supervisee relationship is less clearly defined as compared with typical psychologist-trainee supervision. In this paper, three doctoral students involved in the Memorial IPE training will discuss their experiences with supervision in IPE, highlighting benefits and challenges of cross-disciplinary supervision, and applications of the IPE training in a clinical setting. While there are a number of differences and challenges associated with the supervision received by the three students in IPE, this training has been found to be useful preparation for working on interprofessional teams and gaining insight and appreciation into the roles of various professionals on health care teams.

Keywords: interprofessional supervision, supervisory relationship, cross-disciplinary supervision

In clinical training and in practice, supervision is not only a mandatory competency, but also an essential aspect of improving a clinician's skills, autonomy, and reducing burnout and job turnover (Knudsen, Ducharme, & Roman, 2008). As health care systems continue to evolve, interprofessional collaboration and the training of psychologists in interdisciplinary competencies has become more common (Johnson, Stewart, Brabeck, Huber, & Rubin, 2004). Interprofessional teamwork serves to utilize the multiplicity of professional expertise and skills of a variety of practitioners, to best care for patients with complex or multifaceted health care needs. As a response to the growing presence of interprofessional teams and as a means to ensure best practice, interprofessional education (IPE) has become integrated into many clinical training programs. The goal of IPE is to help students understand their own professional identity in the context of the interprofessional team while gaining an understanding of other professionals' roles to improve cohesion across disciplines. Different models of IPE have been implemented across various training programs, with best practice suggesting the inclusion of committed faculty across disciplines interested in both their own and student learning (Bridges, Davidson, Soule Odegard, Maki, & Tomkowiak, 2011).

Given the critical role of interprofessional collaboration both for psychologists in training and in practice, the role of clinical supervision in IPE for psychologists must be considered. In this paper, we (three doctoral students in clinical psychology) will discuss our experiences

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The authors would like to acknowledge Olga Heath for her mentorship and guidance on this article.

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with clinical supervision in the IPE program at Memorial University of Newfoundland (MUN), and will reflect on the ways in which supervision around interprofessional competency has impacted our clinical experiences.

IPE at MUN

The curriculum framework for MUN's IPE program is based upon the collaboration competencies identified by the Canadian Interprofessional Health Collaborative and is consistent with the fundamental principles related to IPE, collaborative practice, and adult education (Orchard et al., 2010). Horizontal integration of IPE across the professional curriculum of each participating academic unit ensures that core uniprofessional instructional outcomes remain intact while confirming that the collaborator competencies are addressed comprehensively for each profession.

MUN's IPE program consists of a series of 11, half-day sessions offered over six semesters, and utilizes reflections and interactive, case-based blended learning activities. Training is designed to enhance student skills in collaboration competencies including interprofessional communication and conflict management. Themes woven throughout interprofessional content include patient safety, cultural sensitivity, vulnerable patient populations, and stigmatization based on personal values and biases. Students are assigned to the same small interprofessional group over the first eight sessions (2 years), allowing students to create meaningful interprofessional relationships. Participating students include those from the specialties of medicine, nursing, pharmacy, social work, psychology, human kinetics and recreation, and police studies.

The program utilizes a blended learning approach for IPE including activities such as web-based resources (including videoconferencing by distance for students and professionals), online and face-to-face interprofessional discussion, reflection and self-awareness exercises, case-based learning, role plays and simulated patient interviews utilizing standardized patients, plenary sessions including panel presentations, and small/large group discussions.

Through completion of IPE modules, students are expected to be able to develop a number of skills. Early modules help students identify and describe the role of their profession and the role of other professions in collaborative patient care. As modules progress, students learn to explain the importance of interprofessional teamwork in the provision of health care, demonstrating respect for the roles of other health professionals, and describing the important characteristics of a patient-centered approach to health care. Building on these skills, students work collaboratively to develop an interprofessional plan of care for patients within various health care settings, and discuss possible barriers to teamwork and collaboration.

Interprofessional student teams are facilitated by faculty or clinicians. Faculty who facilitate are academic staff members who may also actively participate in curriculum development. Clinicians are volunteers from the Regional Health Authority who are currently working in interprofessional teams and have an interest in IPE as an avenue to produce "collaboration-ready" practitioners. Facilitators fill the role of supervisor during these IPE learning activities. The small proportion of clinical psychology students (approximately 18 psychology students in a total of about 200 across disciplines) is also reflected in the underrepresentation of facilitators from the field of psychology. Consequently, psychology students participating in IPE sessions are routinely supervised by non-psychologists, and also do not have other psychology students within their own interprofessional teams. The lack of a psychology supervisor or peer support from other psychology students in IPE results in a unique learning environment where students must explore their professional identity and role without the scaffolding of a more experienced psychology clinician or peer support. This paper is a description of the experiences of the authors within this model and when applying the training to subsequent clinical work. The experience of each author is denoted by her initials.

Cross-Disciplinary Supervision

Early Experiences

Interprofessional supervision, or cross-disciplinary supervision, occurs when there is a lack of trained supervisors in a given field, or when supervisors possess specific skills to train students in other disciplines (Beddoe & How-

ard, 2012). Within the context of MUN's IPE program, cross-disciplinary supervision is the primary way in which the interprofessional competency is taught. When the IPE training began, I (SB) initially found it challenging to advocate for the profession and translate the knowledge of my limited experiences to represent psychology in an interprofessional setting. As a first-year doctoral student, I was still formulating my professional identity and it was daunting to be responsible for asserting my profession's role in health care within a team of students from other disciplines. While it was challenging to not have a professional modeling the role of a psychologist in an interprofessional setting, this forced me to independently advocate for my profession and myself. In one of my first IPE modules, while discussing a case study, the supervisor[1] indicated to my student team that there would likely not be a need for all professions in the mock case and that a social work could perform counseling in place of a psychologist. Even with my foundational knowledge of the role of psychology on team, I felt it important to speak to the role of a psychologist beyond counseling, despite the team supervisor suggesting otherwise. Having to speak to a psychologist's skill set and oppose the supervisor so early in my professional development likely contributed to accelerated growth in the interprofessional collaboration competency.

Supervisor: We likely would only need a social worker or a psychologist. Given the strong family component influencing the child in this case, we could probably benefit more from having a social worker on the team, and a psychologist might not be necessary.

Supervisee: I agree a social worker would be important for the family therapy component, but given the child's academic difficulties and behavioral issues, I think it would be good to have a psychologist on the team. Psychologists can provide educational assessment and diagnose any relevant mental health or cognitive concerns, bringing something different to the table.

Supervisor: Interesting point, I didn't consider the role of assessment.

In this IPE module, I was certainly open to hearing about how different scopes of practice in health care influence team role functioning. However, having a facilitator/supervisor outside of my own profession who did not understand the role of psychology made this learning more accelerated and ingrained. There is literature that suggests cross-disciplinary supervision helps students better understand hierarchies and broaden understanding about role overlap and the skills of other professions (Crocket et al., 2009), and my experience in IPE was certainly enriched by the cross-disciplinary supervision provided. For example, when I had a module led by a supervisor who was a nurse, there was an emphasis on being succinct and avoiding jargon in the professional discussion. The supervisor worked in a position where she served as a hub for both health care professionals and patients, and much of her feedback focused on pointing out aspects of each student's discussion points that were unclear. Receiving feedback about unintentional jargon allowed me to develop my interprofessional communication, as well as simplify my communication for the benefits of patients. Had my supervisor been from the psychology profession, I may not have received the same quality of feedback regarding others' perception of my communication.

Unlike my colleague (SB), I (AR) had the opportunity to receive supervision in the first year of the IPE program from a facilitator clinician in the psychology field. Supervision by an individual in the psychology field allowed for additional support in the description of the psychologist's role, with the supervisor adding to my own explanation and providing examples to which I was unaware as I developed greater confidence and competence to do so. The opportunity to work with a supervisor in the psychology field allowed for immediate consolida-

[1] Supervisors' identities have been protected throughout this article in order to maintain anonymity.

tion of support by a more senior clinician through encouragement and agreement with my own viewpoint, thus quickly developing my emerging confidence in my own clinical perspective, consistent with the development of a connection within the supervisor-supervisee relationship (Watkins, 2017).

Supervisor: What would the role of the psychologist be in this case?

Supervisee: To complete an intake assessment, and provide any individual treatment necessary based on that assessment.

Supervisor: Exactly! We would also be responsible for providing psychoeducation to the family and team members around how symptoms could present in this patient.

This was helpful in my future experience in interprofessional meetings as I was better able to advocate for the position of psychology within the team when confronted with differing opinions by professionals in other fields. I have since had experiences in which I expressed a differing opinion from other team members regarding such issues as the findings of a cognitive assessment and readiness for change in multiple clients, which I attribute to the active encouragement and validation I received when presenting my clinical impressions to a more senior clinician during my training.

Later Experiences

I (LR) have had very similar experiences as my coauthors throughout my IPE training experiences. As a more senior student, I have had the opportunity to complete all IPE training activities at the time of writing. During one of the final modules, interprofessional teams were asked to conduct a brief interview with a standardized patient presenting with HIV, formulate a treatment plan, then provide the patient with feedback and relevant treatment information. After compiling a list of questions to pose, we were left to determine which team member would conduct the interview on behalf of everyone. Our supervisor, a doctoral level pharmacist, was happy to let the team choose for itself, and possessed a different perspective than most members of the team. At this point in my training, I was quite confident in my interviewing skills, and offered to speak to the standardized patient. Another team member, from the nursing profession, preferred to do the job, so I deferred to her. During the interview, our standardized patient took exception to the phrasing of some of our questions, later saying during the debriefing that she felt discriminated against. When it came time to bring the standardized patient back into the room to offer feedback, I felt more assertive in my request to conduct the session, and was supported by my supervisor, as well as other team members in so doing. This emerging sense of confidence in my own skill set subsequently translated into me taking on broader roles in my later practicum placements. For example, I provided a training workshop to the psychiatry department at one particular site, a task that, as a practicum student, undoubtedly requires a significant level of faith in one's own knowledge. I was happy to have had the opportunity to advocate for myself in IPE first with the support of my facilitator supervisor.

Utility of Feedback

One of the less favorable outcomes of cross-disciplinary supervision was the absence of a rapport between the students and supervisor. Unlike in traditional psychological supervision, where the relationship between supervisor and supervisee is frequently evaluated, discussed, and is continually progressing, the IPE training groups met only twice per semester (a total of 8 times in 2 years). The limited contact meant the professional feedback was generalized toward the group and focused primarily on the activities and expanding upon the ideas of interprofessional collaboration, rather than on an individual's performance on a task or within their role. However, despite the lack of targeted feedback, self-evaluation and reflection was a large part of these training sessions and supervision was provided on the student reflections. It is recognized within the literature that supervision should aim to promote effective supervised self-evaluation by stimulating reflection on practice (O'Donovan, Halford, & Walters, 2011), which is precisely what occurred during the IPE activities. Receiv-

ing feedback on personal reflections from a health care professional outside of psychology provided a unique perspective because of the differences in professional competencies and experiences.

However, not all feedback from these activities was helpful. While some facilitators' feedback provided specific examples of alternative perspectives and provided questions to help the student reflect on a deeper level, others spent apparently less time and effort on the activity. I (AR) have received vague feedback such as "well done" or "demonstrates shallow understanding of the material" with no further insight into how best to proceed. This deficiency of feedback helps to elucidate the importance of faculty committed to student learning regardless of discipline, as demonstrated by best practice in IPE (Bridges et al., 2011).

I too (LR) received relatively scant, albeit positive, feedback from my cross-disciplinary supervisors. In fact, the most valuable and pertinent evaluation I received over the course of my IPE training came from a clinical psychologist facilitator. My impression as to why this disparity occurred is due to the knowledge that IPE facilitators possess (or lack) on the roles of the professions that the students in their groups represent. During an exercise similar to the one I (SB) described earlier, again with a standardized patient, I participated in an IPE activity that first began with students from the same professional background (clinical psychology) collaborating on a case before transitioning to interdisciplinary groups. During this activity, my psychologist facilitator provided pointed and ongoing feedback throughout the interview.

Supervisor: Good job conducting the mental status exam. I think you'd better move on to some other important areas to cover given how little time you've got left with the patient.

Supervisee: Okay, perhaps I'll dive into his family structure in order to assess his supports available.

Supervisor: Alright, how might you go about that?

Supervisee: Well, the referral says that he has two adult children, but I know that the patient lives in a rural community. I think I'll ask if either of his children live nearby or if they've relocated.

Supervisor: Sounds like a good place to start. I'd also be sure to ask him about any younger siblings the patient might have—lots of folks in these rural communities stay quite close to their immediate family members as they age.

It is possible my facilitator was able to provide such rich feedback because she was familiar with the level of proficiency we possessed at that point in our training, and also knew what types of comments might best serve us in our practicum placements and future residencies. Her evaluation spoke to a level of familiarity with psychology that cross-disciplinary supervisors could perhaps have attained by simply asking student team members to provide a summary of the clinical activities they engage in on a typical day with patients. Although facilitators receive training on the roles of the various professions they will be supervising in IPE, this was not borne out in my experiences.

Consistency in Supervision

Over the course of the two years in which I (AR) have participated in the IPE program, my supervision differed greatly from Year 1 to Year 2. Year 1 consisted of supervision by a facilitator in the field of psychology for the duration of the year, which fell in stark contrast to the supervision in Year 2with different supervisors for each session, none of whom were in the psychology profession. The consistent supervision by an individual in the psychology profession over the course of the first year helped me to deepen my understanding of what it is a psychologist does, as well as to feel more confident over the course of the IPE program in contributing to discussions.

In the first year, the consistent supervisor was able to get to know the group, and develop supervisor-supervisee relationships in ways that supported and enhanced the group dynamic,

consistent with what would be expected with a positive supervisory experience (Watkins, 2017). As they came to know the group over the course of the year, the supervisor increasingly called on students who were more passive/quieter in an effort to ensure their perspective was heard and guarantee their learning; this also enhanced group cohesion as all members of the group were speaking during each session. Further, the supervisor's continued presence allowed them to recall and integrate examples provided across sessions to enhance learning throughout the year, and even allowed them to incorporate self-disclosure related to their own professional practice as the sessions progressed.

Supervisor: So it sounds like most of you did not find that you fell into one particular communication style.

Supervisee: No, I would say we have a tendency to use different communication styles depending on the context.

Supervisor: That's quite similar to what [medical student supervisee] said in one of our other sessions regarding the role you play on a team. Was there anybody who did fall into one particular communication style? [Quiet supervisee] you're nodding—what was our main communication style?

This supervisor was able to facilitate supervisee competence, capability, and identity through the development of a bond, expectation, and these specific actions taken, consistent with the contextual supervision relationship model (Watkins, 2017). This was a glaring difference between the first and second years of IPE training.

Inconsistency

With inconsistent supervision in Year 2, the further development of supervisee competence, capability, and identity through supervision became increasingly difficult. Our discussion sessions became increasingly quiet with fewer people speaking up each time, and as our supervisors did not have the time to develop a relationship with each supervisee, they were unable to successfully facilitate group cohesion and thus group discussion faltered. As compared with year one, the facilitators did not actively call on specific group members for their opinions, seemingly out of a lack of familiarity and comfort with group members. In the circumstance where the supervisor lacks the ability to develop a trusting bond with the supervisees, a necessary component of supervision is missing. Thus, the actions taken cannot be tailored to the group members, and are instead more generic and less successful in their implementation (Beddoe & Howard, 2012; Watkins, 2017). This appears to have impacted the ability for the facilitators to provide self-disclosure from their own professional practice, as none of the single-session facilitators did so, limiting the vulnerability within the sessions. The limited nature of such supervision has implications for the transferability of the IPE program to real-world clinical practice. Given the typical interprofessional team develops greater cohesion over time, and is rarely working together with a supervisor for only one session, the practicality of such an exercise remains limited. While there is some merit to such supervision should the facilitators be open to encouraging students and providing constructive feedback, this cannot be guaranteed. Further, the difficulties associated with single-session supervision may impede on the existing group dynamic and thus weaken the effectiveness of supervision and learning.

Putting IPE to Work

After completing more than half of the IPE training, I (SB) had the opportunity to work at a practicum site with an interprofessional team of nurses, physicians, psychiatrists, dieticians, physiotherapists, social workers, and psychologists. At this training site, I participated in team rounds where I was one of four individuals representing the profession of psychology. Being one of many in my field was a contrast to my time in IPE because I was able not only to look to my supervisor for guidance and consultation in the team context, but to other psychologists as well. What made this particularly interesting was observing not only the interprofessional differences within the team, but also the intraprofessional differences among psychologists. Observing multiple psychologists

discuss ethical considerations of a case allowed me to see how each psychologist brought their unique experiences and theoretical orientations to their clinical practice.

Engaging in the IPE training in advance, and alongside of, this practical experience allowed me to contrast this training both with and without a supervisor figure to aid me in understanding the team dynamics. On occasion, the practice team experienced role overlap in terms of whose responsibility it was to provide a specific service to a patient, and additionally there were some instances where the code of ethics for psychology differed from that of other professions, resulting in team members asking the psychologists to practice outside of their scope and/or ethical limits. As a trainee at this site, my supervisor discussed these ethical concerns in detail with me, asked me to propose solutions in line with the Canadian Psychological Association Code of Ethics, and invited me to draw on my experiences from IPE in discussing this situation. This experience was one in which I was thankful to have a supervisor in psychology to help navigate the dilemma, and it also allowed me to see how the competencies explored in IPE supervision closely mirror clinical practice.

Developing Core Competencies

Collaboration is one of the core competencies for psychologists in a health care setting, and the goals of supervision related to this competency include appreciating and understanding the contributions of health care professionals, developing collaborative relationships, and managing team dynamics (McDaniel et al., 2014). I (SB) had experience with interprofessional supervision in the IPE activities, which translated well into practice with patients and teams. For example, one of the IPE modules focused on leadership in teams and navigating the interprofessional stereotypes surrounding roles on teams. My supervisor for this module was a psychiatrist, and they facilitated an honest discussion about professional hierarchies and the intersection of profession and personality. The supervisor used appropriate self-disclosure to share their experience with health care hierarchies, as well as the equalizing changes they have observed throughout their career. During this IPE session, the other student professionals gave their opinions on hierarchies and provided information about their role, which allowed for the group to dismantle professional stigma and understand role overlap. I later worked on a mental health team of psychologists, social workers, and mental health nurses. On this team there was often significant role confusion between professionals because the team members had to collaboratively decide which service was most appropriate for each client. My experience in IPE prompted me to proactively engage in a conversation with my psychologist supervisor about psychology's role on the team and how to navigate the matching process at intake meetings. My supervisor gave me examples of the different diagnostic profiles that each professional on the team typically saw, and guidelines for how to maintain balance in each provider's caseload without exceeding their scope of practice. My IPE sessions on navigating team role confusion, paired with my supervisor's site-specific guidelines, allowed me to participate effectively in team intake meetings without generating any team conflict.

Supervisee: At the team meeting today I was thinking about referring a client with concerns related to their gender identity to the social worker on the team, however given the client's comorbid diagnosis of OCD I decided not to. I remember the social worker saying last week they didn't feel confident working with OCD.

Supervisor: That seems like good clinical judgment. What factors do you think would need to be in place for you to address it with the clinician?

Supervisee: I suppose it was going to impair the client treatment, such as if the client's concerns about OCD came up after the referral was made. Then we would have to address it as a team.

Supervisor: Exactly, an issue like that may cause a small rupture in the cohesion of the team if

> people felt their skills weren't being used appropriately, but ultimately we have to consider client care above all else.

Another aspect of IPE supervision that helped with interprofessional competencies was learning to recognize when, and how, to use other team members' expertise. In IPE training, the team supervisor would continuously remind us to consult with other members of the team before deciding on an action. Supervisors would facilitate conversations about each profession's scope of practice, within which professional's purview an aspect of treatment resides, and which combination of professional skill sets would best support a specific case or challenge. This supervised training in recognizing the role and experience of other team members helped me understand how patient care is a team responsibility, which is something I am grateful to have learned so early in my clinical training.

Takeaways

Despite the challenges that can arise from the cross-disciplinary supervision utilized in MUN's IPE program, including the pressure on junior students to quickly develop the confidence to assert themselves without support from classmates or psychology supervisors, the lack of depth in the student/supervisor relationship, and the variations in supervisory standards across disciplines, our collective experience has been that it provides a rich opportunity for clinical psychology students at our institution to grow into their professional identities. It also provides an opportunity to advocate for and educate about the role of psychology among fellow health care students. Even within our limited collective experience as clinicians, the real-world applicability of what we learn from both the curriculum and overall experience of IPE demonstrates the influence and importance of such a program. It is our hope that not only will we be better clinicians as a result of our experience, but also that the interactions we have with our team members will help to create physicians, pharmacists, nurses, social workers, physiotherapists, and recreational therapists that understand and appreciate the field of psychology on their own interprofessional teams in the future.

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Supervisión en la educación interprofesional: Beneficios, desafíos, y lecciones aprendidas

A medida que el trabajo en equipo interprofesional y la colaboración en el cuidado de la salud se hacen más grandes componentes del papel de un psicólogo, existe una creciente necesidad de capacitación y supervisión en esta área de competencia. La educación interprofesional (IPE) en la Universidad Memorial of Newfoundland ofrece a estudiantes de doctorado en psicología capacitación didáctica y experiencial en práctica colaborativa supervisada por un practicante de otra disciplina. La supervisión interdisciplinaria proporcionada en IPE está asociada con una experiencia de supervisión única, en la cual la supervisión de la competencia interprofesional ocurre en un grupo con estudiantes de otras disciplinas y la relación supervisor-supervisado está menos claramente definida en comparación con la supervisión típica de psicólogo-aprendiz. En esto documento, tres estudiantes de doctorado involucrados en la capacitación del Memorial IPE discutirán su experiencias con supervisión en IPE, destacando los beneficios y desafíos de la supervisión interdisciplinaria y aplicaciones de la capacitación IPE en un entorno clínico. Mientras hay una serie de diferencias y desafíos asociados con la supervisión recibido por los tres estudiantes en IPE, se ha encontrado que esta capacitación es útil preparación para trabajar en equipos interprofesionales y obtener conocimiento y apreciación en los roles de varios profesionales en equipos de atención médica.

supervisión interprofesional, relación de supervisión, interdisciplinaria supervisión

跨专业教育中的督导：益处，挑战和经验教训

医疗保健领域跨专业的团队合作已经成为心理学家很重要的一部分角色。在这一能力领域里，对培训和督导的需求越来越大。纽芬兰Memorial大学的跨专业教育（IPE）为心理学博士生提供了一个说教和体验式的培训。这一培训由另一个学科的从业者协同实践督导。IPE的跨学科督导提供独特的督导体验。与典型的心理学家——受训者督导模式相比，跨专业能力的督导是其他学科学生一起。相比较传统的督导模式，其定义不太明确。在这篇论文中，参与 Memorial大学的IPE培训的三名博士生将讨他们在IPE监督方面的经验，特别会谈到跨学科督导的好处和挑战，以及IPE培训在临床中的应用。虽然，参加IPE的三名学生在督导中也有很多不同和挑战，但这项培训在预备跨学科团队工作及医疗保健团队中获得洞见和益处也是十分有帮助的。

跨专业督导, 督导关系, 跨学科督导

Received September 14, 2018
Revision received February 5, 2019
Accepted February 9, 2019 ■