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## Supervision of Facilitators in a Multisite Study: Goals, Process, and Outcomes

### NIMH HIV/STD Prevention Trial for African American Couples Group

#### Abstract

**Objective**—To describe the aims, implementation, and desired outcomes of facilitator supervision for both interventions (treatment and control) in Project Eban and to present the Eban Theoretical Framework for Supervision that guided the facilitators' supervision. The qualifications and training of supervisors and facilitators are also described.

**Design**—This article provides a detailed description of supervision in a multisite behavioral intervention trial. The Eban Theoretical Framework for Supervision is guided by 3 theories: cognitive behavior therapy, the Life-long Model of Supervision, and “Empowering supervisees to empower others: a culturally responsive supervision model.”

**Methods**—Supervision is based on the Eban Theoretical Framework for Supervision, which provides guidelines for implementing both interventions using goals, process, and outcomes.

**Results**—Because of effective supervision, the interventions were implemented with fidelity to the protocol and were standard across the multiple sites.

**Conclusions**—Supervision of facilitators is a crucial aspect of multisite intervention research quality assurance. It provides them with expert advice, optimizes the effectiveness of facilitators, and increases adherence to the protocol across multiple sites. Based on the experience in this trial, some of the challenges that arise when conducting a multisite randomized control trial and how they can be handled by implementing the Eban Theoretical Framework for Supervision are described.

#### INTRODUCTION

Project Eban is a multisite, randomized clinical trial designed to evaluate the efficacy of a culturally congruent behavioral intervention to reduce HIV and sexually transmitted disease (STD) risks for African American serodiscordant couples. Two conditions, Eban HIV/STD Risk Reduction Intervention (treatment) and Eban Health Promotion Intervention (control), were implemented at 4 sites across the United States. Both conditions involved 8 sessions: 4 group sessions and 4 couple sessions. The treatment intervention focused on couple-based skills steeped in African American culturally congruent Nguzo Saba principles, whereas the Eban Health Promotion Intervention involved increasing healthful behaviors and medication adherence. Rigorous quality control procedures were used to ensure adherence to trial protocols at all levels. Supervision of intervention facilitators was conceptualized as an avenue to optimize treatment fidelity and quality assurance.

Most supervision models focus on clinical supervision of practitioners providing therapy. However, supervision in the current study needs to balance the demands of the research

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protocol with the personal issues of the research participants. The guidelines developed by Johnson and Remien<sup>1</sup> address the tension between the demands of the research (to ensure internal validity) and the need for clinical flexibility (to ensure external validity). These guidelines address framing intervention relationships, training and supervision, and quality assurance, and were useful in fine-tuning supervision procedures of Project Eban. These considerations are reflected in the selection of Project Eban facilitators and in ongoing supervision. Training and supervision require a structured, focused protocol, and manuals and training procedures that are consistent across sites.<sup>2,3</sup> Some flexibility is required, however, to address barriers to behavior change and maintain rapport with participants. Facilitators who have extensive experience in helping people may lapse into a therapeutic mode, and supervisors must be vigilant to maintain balance.<sup>4</sup> Facilitators should be skilled at maintaining a focus on the intervention material while also addressing the needs of a particular individual or couple.

## THEORETICAL FRAMEWORK FOR SUPERVISION

Most behavioral intervention trials use supervision, and there have been many varied approaches to the format and structure of supervision in multisite trials.<sup>5</sup> Researchers have noted the dearth of clear supervision guidelines for clinical work, and there are even fewer supervision guidelines in the context of a behavioral intervention research study.<sup>3,6</sup> Baer et al<sup>5</sup> note that the procedures of supervision remain understudied. In detailing the aims and implementation of supervision in Project Eban, this article offers specific procedures for effective supervision in a behavioral intervention trial. A clear framework, derived from theoretical and methodological considerations, allows supervisors to address the challenges that may arise when implementing a behavioral intervention for a research study.<sup>1</sup> The importance of framing supervision within a theoretical model is also emphasized in Fehrenbach and Coffman's<sup>4</sup> analysis of supervision issues arising from the use of experienced private practitioners in clinical trials. Based on prior clinical experience, facilitators may have different expectations about what an intervention for couples should be. Supervisors must be attentive to the difference between a behavioral intervention for a research study and therapy. When supervisors train facilitators, issues related to behavioral intervention research, such as the importance of the eligibility criteria, need for structure, methodological rationale for the protocol, goals guiding the intervention, research ethics, and participant and facilitator roles, are made clear. Supervisors must train facilitators to handle any clinical issues that may arise in the session according to research protocols, such as addressing participants' needs and making appropriate clinical referrals for suicidal or violent research participants.

The Eban Theoretical Model for Supervision in Project Eban integrated 3 theories: (1) a cognitive behavior therapy (CBT) approach to supervision<sup>6</sup>; (2) elements of Barretta-Herman's<sup>7</sup> Model of Life-Long Supervision; and (3) "Empowering supervisees to empower others: a culturally responsive supervision model."<sup>8</sup> Project Eban adapted these client-focused models to set the goals, process, and outcomes for supervision that were useful for addressing the tension between the demands of research and the need for clinical flexibility.<sup>2</sup>

### Cognitive Behavior Therapy

**Supervisors Model Skills**—Rosenbaum and Ronen's<sup>6</sup> CBT model was developed to guide supervision of cognitive behavior therapists. Many of its goals and features, however, are applicable to supervision of Project Eban facilitators. First, the CBT supervision process uses modeling to demonstrate how the intervention sessions should be conducted, to teach the skills of setting up role-plays, and to use problem-solving techniques, which are an integral part of the interventions in Project Eban. Supervisors model these procedures in the group supervisory sessions with the facilitators.<sup>1,6</sup>

**Facilitators Practice Skills**—Second, the CBT model emphasizes the importance of practicing new behaviors as part of the change process.<sup>6,9,10</sup> In Project Eban, facilitators practice their facilitation skills through strategies such as role-playing, problem solving, and behavioral rehearsal. Behavioral rehearsal, for example, might involve facilitators practicing how to convey critical session content in a clear, well-paced manner or how to guide couples to more realistic weekly goals. This permits the facilitators to learn experientially in supervision rather than solely through self-report and discussion.

**Reinforce Skills as Change Agents**—Third, the CBT model emphasizes the skills and strengths needed for facilitators and participants to become their own agents of change.<sup>7</sup> Supervision helps facilitators improve and maintain their skills in implementing the interventions, which then promotes participants' behavior change. Supervisors highlight how facilitators' skills serve to effect change. In particular, facilitation skills help couples learn the skills necessary to make changes in their relationships and risk behaviors for the treatment intervention and in health screening and behaviors for the control intervention.

**Understand Context of Beliefs**—Fourth, supervision and the effective delivery of the intervention are opportunities where experiences can be understood in the context of one's belief system.<sup>6</sup> Eban facilitators need to be aware of the meaning that condom use and other health behaviors have for themselves, first, and then for participants, to understand how to help couples change maladaptive behaviors (eg, by framing condom use as communicating intimacy and love rather than solely reducing risky behaviors). Supervisors must attend to the impact of facilitators', and their own, meanings and beliefs on the intervention and supervision process. For example, if a facilitator had the belief that a man's sexual pleasure was more important than a woman's, the supervisor would identify this belief, examine its accuracy and usefulness, explore how it might impact the facilitator's implementation of the intervention, and collaborate with the facilitator to change it.

**Set Realistic Goals**—The model uses a goal-directed approach to the clinical process.<sup>6,9,10</sup> Because Eban facilitators must help participants set realistic goals for behavior change and problem-solve barriers to achieving goals, the supervision process must support this key element of the intervention. Supervisors discuss with facilitators the degree to which the goals of the intervention are being met for each couple in the treatment condition and each individual in the control condition. Supervisors and facilitators collaborate to use planning and problem solving to develop strategies to help the participants work toward their behavior change goals. For example, if a couple is having difficulty using condoms because they do not want to interrupt the buildup of their sexual experience, the supervisor and facilitator would plan when and how to explore solutions with the couple. The supervisor would work with the facilitator to develop some possible strategies, such as specific ways of incorporating condoms into the couple's sexual experience (eg, putting a condom on in a sexy way).

### Ongoing Supervision Model

The theoretical framework for supervision in Project Eban also uses elements of Barretta-Herman's<sup>7</sup> Model of Life-Long Supervision, which emphasizes the importance of ongoing supervision throughout the supervisees' careers. Ongoing supervision serves educational, supportive, and administrative purposes, and it contributes to the ongoing professional development of the supervisees.<sup>6,9,10</sup>

In this model, supervising and implementing the clinical goals are collaborative efforts between the therapist and the client, making no assumption of the supervisor's clinical superiority. In Project Eban, facilitators work with the research participants to help them change their behavior to achieve goals that they set for themselves as part of the intervention. The expertise of both

supervisors and facilitators is valued, and they decide together how best to help couples achieve their goals. This explorative, collaborative atmosphere establishes trust and openness between facilitators and supervisors.

### **Empowerment Model**

Porter's<sup>8</sup> "Empowering supervisees to empower others: A culturally responsive supervision model" describes a 4-stage, culturally responsive psychotherapy training process, moving from didactic to experiential, from cognitive and objective to personal and subjective. Each of the 4 stages of the model is incorporated into Project Eban facilitator training. The first stage (introducing a culturally responsive, cross-cultural perspective) involves teaching facilitators about the ecological framework guiding the intervention, factors influencing health behaviors, health issues specific to African Americans, and the Afro-centric perspective. In the second stage (introducing a sociocultural framework and analysis of oppression), the effects of oppression and racism on health behaviors are discussed. Recognition of the achievements of African American people despite these barriers is used to inspire participants to draw on their strengths and resources to battle HIV and other health behaviors by reducing their risk behaviors. Real-life issues and barriers to behavior change are problem-solved. In the third stage (exploring supervisees' biases and stereotypes), facilitators identify their assumptions, experiences, and biases; and how these can affect reactions to participants and implementation of the intervention. They also explore how to respond when participants' assumptions or biases affect the group process or their responses to facilitators. In the fourth stage (inclusion of a collective social action perspective in healing), facilitators are taught a conceptualization of behavior change, building from the individual and the couple and expanding to the broader community. Facilitators also learn how to help couples support each other's healthy behavior change.

## **QUALITY ASSURANCE PROCEDURES FOR SUPERVISORS AND FACILITATORS**

### **Qualifications**

**Qualifications of Supervisors**—Eban supervisors are required to have a master's or doctoral-level degree in psychology or a related field, and most are doctoral-level psychologists or social workers. Experience with cognitive behavioral strategies enhances the quality of the supervision for both interventions. Supervisors of the Eban HIV/STD Risk Reduction Intervention facilitators must have knowledge of HIV and STD risk reduction strategies. Supervisors for the Eban Health Promotion Intervention need expertise in health issues, such as nutrition, exercise, and/or cancer and heart disease prevention.

**Qualifications of Facilitators**—Qualified facilitators are critical for ensuring treatment efficacy and the success of a clinical trial.<sup>2</sup> The Project Eban protocol requires facilitators to "be African Americans with a master's degree in a social science or human services-related field, or a bachelor's degree with two years experience working with couples or conducting health-related interventions with urban populations." They must also have expertise in the area of HIV/STD or general health issues and 2 years of experience conducting groups.

### **Training**

**Training of Supervisors**—Given the high level of skills and experience possessed by Project Eban supervisors, their initial training was focused on learning study protocols and intervention content and on handling difficult situations, with less emphasis on cognitive behavioral strategies (see Table 1 for examples of difficult situations and ways to handle them). Supervisors received a general study orientation provided by project directors and principal

investigators (PIs) at each site, although project directors also served as supervisors at some sites. Supervisors were given readings about the theoretical framework of the study, HIV-serodiscordant couples, sociocultural issues, and behavior change principles. Supervisors for the HIV/STD Risk Reduction Intervention were also given articles on HIV risk reduction, whereas supervisors for the Eban Health Promotion Intervention read about general health issues such as disease prevention, detection, and control. To create a common approach and expectations among sites, supervisors attended training sessions, which included discussions of how to (1) identify elements of process to practice in supervision; (2) incorporate the intervention skills and frameworks into supervision; (3) respond to difficult client issues and troubleshoot in intervention delivery; and (4) use audio recordings in supervision. Supervisors also participated in 4 days of centralized training with the facilitators.

**Training of Facilitators**—Facilitators were oriented to the study by supervisors, project directors, and PIs at each site. Facilitators for the Eban HIV/STD Risk Reduction Intervention were given readings about the theoretical framework of the study, HIV-serodiscordant couples, sociocultural issues, and behavior change principles, whereas Eban Health Promotion Intervention facilitators read about more general health issues such as disease prevention, detection, and control. In addition to discussing these articles, supervisors conducted mock sessions with facilitators to practice delivering the intervention and handling difficult situations, such as a participant's refusal to practice putting a male or female condom on a realistic model or a participant revealing an occurrence of domestic violence.<sup>11</sup> Thus, facilitator training involved both didactic and experiential elements.<sup>1,12</sup> After the initial training at the sites, facilitators participated in a 4-day centralized training.

### **Initial Certification and Ongoing Quality Assurance**

Both supervisors and facilitators were certified on completion of the centralized training. Certification was based on performance during mock role-plays. Supervisors were certified as facilitators. There was no separate certification for supervisors.

Quality assurance was conducted at the site and centrally. Although supervision must be tailored to the needs of facilitators at each site, most elements of supervision should be consistent across sites. Project Eban developed a protocol that included supervision manuals, analogous to psychotherapy treatment manuals, which ensured a standard supervisory process.<sup>3,14</sup> A centralized quality assurance monitor evaluated the quality of on-site supervision over the course of the study. During intervention quality assurance site visits, supervisors were evaluated on adherence to supervision protocols and competency of their supervisory process. The content, process, and structure of supervision were examined. Project directors and PIs also provided on-site oversight of supervisors.

Weekly supervision ensured that the facilitators were implementing the interventions in a standardized way. Thus, supervision functioned as part of the quality assurance for facilitators and is described below as an outcome of supervision. In addition, a central quality assurance monitor visited sites to observe how the intervention was being implemented and to ensure that facilitators were delivering both interventions in a standardized way. A centralized quality assurance team also evaluated facilitators' adherence to the intervention from audio recordings of intervention sessions.

### **Corrective Action Procedures**

When supervisors were found to be either suboptimally adherent or competent, corrective action was taken on a case-by-case basis, depending on the nature of the problem. Some supervisors were removed from supervisory duties, whereas others received more training. Additional staff was also used in a supplementary fashion. For example, if a white supervisor

was found to be not competent in handling some issues related to race/ethnicity, other staff who were competent to manage those issues offered supplemental supervision.

Similarly, if a facilitator was found to be repeatedly suboptimally adherent or competent, action was taken by site supervisors or project directors. Corrective action might involve additional readings, training, or supervision. Once a facilitator was identified, mock role-plays were required to recertify the facilitator before he or she resumed intervention delivery. If the facilitator was unable to improve sufficiently, they were removed from facilitator duties. Over the course of the trial, a few facilitators were taken off the project and replaced.

### Staff Turnover

Multiyear research projects have personnel changes. Supervisors hired after the beginning of the trial were trained by site staff, such as prior supervisors and project directors. All supervisors continued to refine their skills through ongoing dialogues with project directors and PIs.

The Eban protocol outlines the required hours, topics, and modes of training for facilitators hired after the original centralized training. Supervisors ensure that new facilitators receive training comparable with that of the original facilitators and help to evaluate their performance to ensure competency. For example, supervisors evaluate skill delivery and coverage of content by observing facilitators conducting mock intervention sessions. Certification of these facilitators. was the same as the certification procedures for the original facilitators.

## SUPERVISION: GOALS, PROCESS, AND OUTCOMES

### Overview

Each intervention condition (treatment and control) received separate supervision to minimize the possibility of contamination between them. Supervisors met with facilitators at least once a week. Facilitators received 45–120 minutes of supervision per week, depending on the experience of the facilitators in delivering the intervention, whether they were conducting more than 1 group at a time, and how challenging that week's sessions were.

Supervisors had to be available to facilitators when difficult situations occurred, even if outside the structured supervision time.<sup>13</sup> If a referral was required, the supervisors helped facilitators identify appropriate referrals and plan the most effective way of offering the referral to a participant. Facilitators also completed the Participant Referral Form that described the precipitating events and disposition and was used to track referrals given to participants.

Supervisors reviewed audio recordings of sessions either before or during supervision.<sup>9,10,12</sup> Hearing a facilitator's style provided supervisors with valuable information, including a perspective on subtle issues like pacing and voice inflection.<sup>2</sup> Supervisors listened for opportunities to assist facilitators in enhancing their rapport with participants and monitored disruptions in their rapport. Facilitators could also request feedback on how to improve an element of the session.

There is limited research on the comparative efficacy of different ethnic and cultural pairings in supervision.<sup>3</sup> Although Project Eban matched the race/ethnicity and culture of the facilitators and the participants (all facilitators identified as black or African American and at least 1 member of each couple must be black or African American to meet study entrance criteria), supervisors came from a variety of racial and ethnic backgrounds. Given the prominence of culture and ethnicity in Project Eban, supervisor training included cultural competence and ethnic identity elements. Whenever there was a difference in the ethnicity or culture of the supervisor and the facilitator, additional senior African American staff were available to

consult on specific issues as needed. This was particularly important for the Eban HIV/STD Risk Reduction Intervention, which emphasized an Afro-centric paradigm.

### Goals for Supervision

**Supervisors Model Skills**—The way the supervisor conducted the supervisory group sessions modeled how the facilitators should conduct sessions. A wide range of specific skills, including reinforcement, modeling, role-playing, and problem solving, were reviewed and refined over the course of supervision. Supervisors helped facilitators identify additional opportunities for reinforcement or modeling. If facilitators struggled with a role-play in a session, the supervisor reviewed strategies for effectively setting up and managing role-plays or modeled how to coach participants during a role-play. Supervisors ensured that facilitators were implementing key elements of effective problem solving (eg, generating options) by modeling this skill in supervisory sessions.

**Facilitators Practice Skills**—In Project Eban, facilitators needed to be proficient in specific skills required to conduct the 8 sessions with fidelity. For example, participants in the Eban HIV/STD Risk Reduction Intervention are taught communication skills such as “Talk and Listen,” in which participants take turns speaking and listening. Similarly, participants in the Eban Health Promotion Intervention are taught how to create a medication schedule to aid medication adherence. Supervisors ensured that facilitators practiced the skills required to deliver all the elements in the sessions. Supervisors also helped facilitators brainstorm how to illustrate concepts when participants required examples beyond those provided in the intervention manual.

**Reinforce Skills as Change Agents**—The skills that are modeled and practiced in supervision were considered necessary skills to bring about change, but they were not sufficient. The facilitators needed to effectively model the skills required for behavior change in the intervention sessions. When participants practiced new skills in session, facilitators needed to reinforce small movements toward change. Supervisors monitored facilitators’ success in doing these. Supervisors also examined how clearly facilitators communicated session topics to participants and offered feedback about the pace of presentation or the language the facilitators use as change agents. For example, to make changes in their life, couples must be able to say “I” rather than “you” when practicing during sessions, and facilitators should reinforce them for speaking to each other in this new manner.

Facilitator: I’ve noticed Madeline says “you” when she’s talking about her feelings, such as, “You get frustrated you can’t just have sex spontaneously.”

Supervisor: I’m glad you noticed this pattern. Does it happen when she verbalizes commitments too?

Facilitator: Yes. I think it keeps her from personalizing some of her goals as much as she could.

Supervisor: So this is important to address. Could you gently point this out when it happens, and ask her to restate it using an “I”? Then, whenever she uses an “I” instead of “you,” be sure to recognize this in a positive manner.

Facilitator: How do I point it out without offending or embarrassing her? She seems sensitive.

Supervisor: Let’s do a role play. I’ll play you, and you play Madeline.

**Understand Contexts for Beliefs**—To assist couples to achieve their goals and make important behavioral changes in their lives, facilitators must understand the contexts of their

own beliefs and those of the couples. For example, if a facilitator believes that the female condom is too much trouble to actually use, this attitude is likely to manifest when teaching participants to use it. Supervisors must be vigilant to even subtle beliefs insofar as this might impact facilitators' delivery of the intervention. Supervision then provides an arena to address the facilitators' attitudes. The following vignette illustrates how these kinds of beliefs might be identified and how they could start to be explored.

Facilitator: We covered the female condom quickly so we could spend more time on how to use male condoms correctly.

Supervisor: What made you decide to devote less time to female condoms?

Facilitator: I just think people are more likely to really use male condoms.

Supervisor: How do you think you developed this belief? What do you think it is based upon?

Another crucial aspect of facilitation involves ensuring that participants understood the presented material and options for doing this, such as asking participants to paraphrase concepts, and were reviewed in supervision. Supervisors can help facilitators practice asking participants to reflect back what they understand.

**Develop Realistic Goals for Behavior Change**—A major component of successful behavior change is setting realistic goals. Thus, supervisions must ensure that facilitators are ever focused on realistic goals when they are implementing the intervention. Supervisors can support this process by reviewing the goals set for homework to ensure that they can be achieved by the couple at their skill level and within the timeframe. When facilitators have difficulty helping participants identify goals, supervisors can highlight the possibilities.

Supervisor: What goals did they set for this week?

Facilitator: They said they want to spend more time talking as a couple this week.

Supervisor: What do you think of that as a goal?

Facilitator: I think it's too broad, but they started with saying they wanted to spend more time together in general.

Supervisor: So one way you worked with them to improve the goal was to specify how they would spend their time. What about helping them be even more specific, such as setting a specific time of the day when they would talk and for how long?

Facilitator: OK. So something like, "Spend ½ hour each evening before dinner sharing what happened during the day?"

Supervisor: Exactly. That is a more achievable goal because it is more operationalized.

### Process for Supervision

**Ongoing Interactive Supervision**—In this trial, the protocol mandated weekly supervision to ensure that there was ongoing review of intervention implementation. Supervisors served as models for effective interactive collaboration that should be emulated by the facilitators in conducting the intervention sessions. Supervisors prompt cofacilitators to reflect on how they function together as cofacilitators by examining issues such as coordination and management of the session, differences in facilitation style, and balance of time spent talking or leading the session. Supervision provides a safe place to discuss these issues, and this kind of discussion is often done while practicing Project Eban skills, such as "Talk and Listen."



**Cross-Cultural Perspective**—The communities targeted by Project Eban are made up of individuals from varied ethnic and racial backgrounds (the Caribbean, Africa, and other countries of the world) and migrated within the United States. The process of supervision involves increasing the facilitator’s awareness of ethnic diversity and the ways in which ethnic and cultural experiences shape beliefs, behavior, and social structure. Couples have different values and different belief systems about familial and community roles and relationships that influence health behavior change. Different cultural groups have different beliefs about how and why people become sick and are cured. It is important to explore these cross-cultural issues to frame behavior change goals that can be achieved. The values rooted in the culture of African-descended people form the basis for behavior change. Culture is a salient aspect of a worldview that encompasses a group’s history; values; knowledge; and behavioral norms that are implicit in human social interactions, symbols, and societal values. Culture filters and shapes the reasons for certain behaviors but is often overlooked in interventions. In Project Eban, the treatment condition incorporates the 7 principles of Nguzo Saba—unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith—that guide the Afro-centric worldview and belief systems of African Americans.

**Sociocultural Factors and Analysis of Oppression**—The worldview of African Americans is linked to the history of racism and oppression experienced in the United States, which has had an impact on health behavior. Project Eban supervisors must be sensitive to sociocultural factors related to health behaviors and risks, and they need to be knowledgeable about research protocols and their implementation in both interventions. Facing racism daily causes significant strain on African American individuals, and this must be attended to in supervision.

**Explore Bias and Stereotypes**—Facilitators cannot conduct sessions in a vacuum because each person comes to the group with a set of biases and preconceived notions about how things should be done. Supervisors helped facilitators identify their personal assumptions, experiences, and biases; and then how these affect reactions to participants and implementation of the intervention. Supervisors also explored how to respond when participants’ assumptions or biases affected the group process or their responses to facilitators.

**Collective Social Action**—Collective social action is important in the African American community. The Nguzo Saba principles that guide the Eban HIV/STD Risk Reduction Intervention reinforce collective work and responsibility and cooperative economics. The treatment condition was designed to expand the perception of behavior change from simply being an individual activity to being viewed within the community context. There are exercises that refer to the group as a village. Supervisors worked with the facilitators of the treatment condition to expand delivery beyond the couple to include collective solutions to problems.

## Outcomes of Supervision

**Adherence to Protocol**—A major outcome of the supervisory process was adherence to the protocol. Content, delivery, and dose should be the same for all intervention participants, and supervisors are the first-line monitors of this critical element. Process measures are instruments that document implementation of the intervention, and they aided supervisors in monitoring facilitators’ adherence to the intervention’s session content and protocols. The process of monitoring promoted fidelity to the intervention and ensured that any difficulties are addressed quickly.

Project Eban used several process measures, including the Facilitator Session Implementation Form, Participant Referral Form, and Incident Report, which were reviewed during the course of supervision. The primary process measure used regularly in supervision was the Facilitator

Session Implementation Form, which each facilitator completed independently after each session. This form was tailored to the content of the session and asked facilitators to rate their delivery of each topic in the session on a 3-point scale. Facilitators also indicated the actual time spent on each topic for later control to the allotted time. In supervision, the Facilitator Session Implementation Form was reviewed by the supervisor as a quick check to determine whether each of the key topics of the session was delivered. The time spent on each topic, and the overall length of the session, could also be efficiently monitored through the use of this form.

Supervisors ensured that facilitators correctly provided the intervention material, such as how to use a female condom or how to perform a breast self-examination. Ongoing monitoring of content delivery was important to prevent drift from the protocol as the study progressed. When necessary, supervisors also helped facilitators budget the time designated for a session.

Supervisors inquired as to whether any material outside of the written protocol was discussed in a session. If so, they explored the seriousness of the deviation, particularly any mention of topics from the other intervention condition. Supervisors offered suggestions on how to tactfully redirect and bring participants back to the intervention material and used role-playing to have the facilitators practice. The Eban Health Promotion Intervention is monitored to ensure that there were no extended discussions of HIV/STD risk reduction, which would contaminate the control condition.

**Competent Delivery of Interventions**—Having determined that the sessions are being implemented correctly, the next outcome of supervision is to ensure that there was competent delivery of the intervention.<sup>6,10,12</sup> Facilitators were evaluated after their initial training and monitored weekly through process measures, audio recordings, and the facilitators' self-report.

Supervisors encouraged facilitators to identify ways in which they had effectively implemented the intervention, to note any changes in participants' beliefs or behaviors, and to explore ways to refine their skills. When facilitators wanted specific feedback about how to improve an element of the session, supervisors reviewed the audio recording of that segment. Barretta-Herman<sup>7</sup> defined the supervisor's role as critiquing and supporting the facilitator "in maintaining the highest level of competence possible through continual extension and refinement of his/her skills and knowledge" (p. 61). Recognizing successes, in addition to challenges, helped establish a sense of mastery and self-efficacy.<sup>1</sup> Balancing reinforcing strengths with correcting weaknesses was critical to effective supervision and intervention implementation.<sup>4,10</sup>

For group sessions, it was important that facilitators elicited active participation, managed potentially disruptive behaviors, and built an atmosphere of respect and support. Building support and community was an essential part of Project Eban's culturally congruent approach. Supervision explored how to do this and how to manage group dynamics, including ethnicity, which might impede the development of the group (called a "village" in the Eban HIV/STD Risk Reduction Intervention). Supervision also addressed couple management issues, including how to maintain an atmosphere of mutual respect and to stay focused on shared goals rather than on old disagreements.

**Couples Set Realistic Goals and Achieve Them**—In the Eban HIV/STD Risk Reduction Intervention, participants set goals together as a couple, whereas in the Eban Health Promotion Intervention participants set individual goals. During supervision, facilitators and supervisors monitored participants' progress on their goals and explored challenges. Setting realistic goals and achieving them were a critical outcome of effective supervision. Supervisors offered guidance on how to modify goals to be more achievable and how to reinforce the

positive steps participants made toward achieving their main goal to shape behavior change. This was vital because it directly influenced the primary outcomes and determined whether the behavior change in the treatment condition was significant.

## Vignettes

The following vignettes are presented to illustrate how supervision was used to address a range of issues.

Debra and Charles arrive a few minutes late to a group session, and the facilitators can smell alcohol on Debra's breath. Debra has a long history of drinking. The female facilitator pulls the couple aside and notes that Debra does not seem up for the session. She reminds them they can only participate in a session if both partners are clean and sober at the time of the session.

This kind of challenging situation arose numerous times over the course of the study. Facilitators had been advised that the trial protocol mandated that participants not be allowed to participate when altered by the influence of substances. Supervision provided a forum in which the specifics of how to implement this policy most effectively with this particular couple could be addressed. In supervision, management of the above first incident could be deconstructed. How to address future potential incidents with this couple was then planned. The supervisor helped the facilitators explore how they could maximize the opportunity if Debra were to arrive for a future couples session intoxicated. Additionally, the supervisor demonstrated how to try to garner a commitment from Debra not to drink before future sessions. Further exploration of how drinking can increase sexual risk-taking would be planned for a session when Debra arrived sober. The supervisor first modeled how to speak to the couple and then role-played the situation with the facilitators. Thus, supervisors offer an experienced perspective in how to balance setting limits without damaging rapport.

Ben and Arlene have been actively participating in sessions and have a good rapport with their facilitators. During the course of an exercise in identifying risky behaviors and triggers to unsafe sex, Ben reveals he has been engaging in sex outside of their relationship for money and drugs. Arlene is shocked, upset, and angry. She was aware he had been using for several years, but she had not known about his sex work. The facilitators are able to keep the discussion from escalating but are unsure how to most effectively address this revelation in the next session.

The supervisor first noted and reinforced the skill of the facilitators in creating a sufficiently safe space for Ben to reveal this information. Then, the supervisor highlighted how one of the core skills, Talk and Listen, could be used by the couple to further discuss this issue. Role-playing in supervision demonstrated how this skill could help slow down discussion of this kind of intense, hot topic to enable more effective problem solving and planning. In this example, Ben was unwilling to give up his outside sex work, but through Talk and Listen discussions with Arlene, he acknowledged that using condoms with Arlene, and with his other sexual partners, made sense. Arlene decided she would only have sex with Ben if they used a condom. Thus, although Ben did not choose to end a risky behavior, each member of the couple was able to identify steps to decrease transmission risk.

Dominique, who is HIV positive, and Robert, who is HIV negative, are reluctant to use condoms. Robert views not using condoms as an expression of his "true, higher love" and states he would not be upset if he became positive because then he would be "joining" Dominique. Dominique does not push for using condoms and wishes sex could be "normal" between them. The facilitators want to reframe the meaning of condom use for this couple but are unsure of the most effective means of doing so.

A variety of options were brainstormed in supervision. Talk and Listen was identified as an effective means for the couple to talk about this subject. The supervisor helped facilitators plan how to assist participants in expressing concerns that would then allow for a reframing of the meaning of condoms. Talk and Listen was used to allow Dominique to express anxiety about the guilt she would feel if transmission occurred and Robert to express concern about becoming infected. The supervisor modeled how to elicit these types of concerns from the couple. Highlighting the couple's value of family, particularly the desire for both of them to be as healthy as possible for their children, was also discussed. Dominique and Robert were eventually able to set a goal of using condoms when having sex. Dominique, in particular, was able to view this as a way of showing her love for Robert.

Devon is blind and Kim is severely visually impaired. Neither are fluent in Braille. The facilitators know they will be teaching male and female sexual anatomy and condom use in the next session but are unsure how best to teach these without visuals.

Although the specifics of this situation were not common, unusual situations and participant needs arose throughout the course of the trial, and supervision was the ideal venue to address them. In this example, the supervisor first recommended explaining to the couple that the intervention has yet to be adapted for the visually impaired and that teaching HIV/STD prevention skills requires modeling and practice of condom use. Second, the supervisor recommended the facilitators acknowledge that the couple are the experts on their relationship and emphasized the importance of collaborating with the couple in adapting this activity. The supervisor also recommended asking the couple how they currently handle condom use. Together, the supervisor and facilitators developed strategies for teaching the skills and verifying understanding, which could then be adapted in session as needed and in response to feedback from the couple. The facilitators encouraged the couple to feel the parts on the model as the facilitators described putting on a condom, thus matching the partners' touch to each detailed, verbal step. When the couple practiced the skills, the facilitators asked them to verbalize each step and guided their hands only when needed, as the couple expressed a preference for feeling on their own. In the next supervision session, the supervisor and facilitators discussed what did and did not work and developed recommendations for future sessions. These recommendations were then presented to the Steering Committee for possible addition to a Special Situations section of the training manual.

## CHALLENGES AND RECOMMENDATIONS

### Balancing Research Protocol With Clinical Issues

One of the challenges was adhering to the research requirements while working with research participants who have many clinical problems. Facilitators were encouraged to discuss challenging clinical issues in supervision. Supervision provided a context in which the management of these situations could be collaboratively discussed. Over time, a comprehensive list of potential problems and ways to handle them in the session was developed. Site staff shared their experiences with challenging situations with other sites to provide experienced knowledge and increase standardization of responses across sites. There was also a clinical professional on call at all times to handle emergent mental health problems. A plan for referral was also developed so that follow-up care could be implemented at an appropriate clinic as needed.

### Standard Delivery of Intervention Across Multiple Sites

Another challenge posed by a multisite study is standardized delivery of the treatment and control conditions across multiple sites with different staff. The Eban Theoretical Framework for Supervision was instrumental in achieving adherence to protocol, performing competently as facilitators, and having the couples achieve their behavior change goals. Consistent

supervision ensured standardization across groups, allowed facilitators to help each other cope with difficult issues, and promoted professional development.<sup>4,15</sup>

### Contamination Across Interventions

A critical challenge was how to avoid contamination between treatment and control conditions. This was achieved by having different teams of supervisors and facilitators for the 2 interventions and delivering the interventions in different days and places. The process measures also carefully monitored whether aspects of Eban HIV/STD Risk Reduction Intervention were introduced in the control condition.

### Certifying New Staff

Another challenge in an ongoing clinical trial is the turnover in staff. The success of a clinical trial depends on selection, certification, and training of facilitators.<sup>2</sup> The first generation of staff was centrally trained to maintain adherence to the protocol. The training and certifying of new facilitators were conducted in the same way with supervisors and other site staff to ensure that the new facilitators achieved the same level of certification.

## SUMMARY

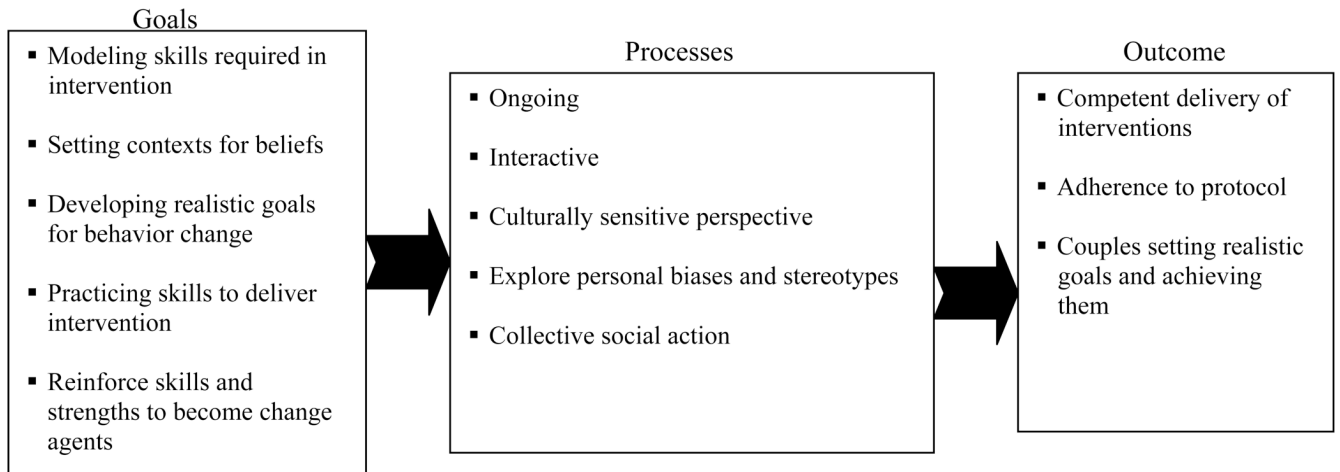
The Eban Theoretical Framework for Supervision was developed specifically for use in a research project and was designed to balance the need for research rigor with the reality of addressing the concerns of couples receiving health-related interventions. The model includes goals for the supervision and the process issues that need to be included. Supervisors were accepting and empathetic and “attentive and responsive” (p. 120).<sup>9</sup> Facilitators needed to feel comfortable sharing difficult experiences and expressing concerns. Ongoing supervision contributed to facilitators’ ability to address issues that arose with participants and ensured that they were able to adhere to the protocol across the sites. Facilitators were encouraged to identify and examine any difficult situations they encountered when implementing the intervention. In Project Eban, these have included potentially suicidal participants, skeptical and intoxicated participants, and couples experiencing relationship conflict. Supervisors gave facilitators support and guidance around these issues. In addition, ongoing supervision provided a forum to discuss how to handle boundary issues, such as contact outside of intervention sessions. Finally, ongoing group supervision helped reduce facilitators’ isolation and encouraged them to explore problems that participants raised as system-wide issues, influenced by the social and cultural context.

The training and supervision of facilitators were directed to achieving research outcomes: adherence to the protocol, competent delivery of the interventions, and the achievement of couples’ goals.

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**FIGURE 1.**  
Eban Theoretical Framework for Supervision

TABLE 1

## Handling Challenging Behaviors and Situations Within the Sessions General responses

*General responses*

- Ignore inappropriate behavior
- Redirect participant toward appropriate behavior
- Reward even the slightest movement toward appropriate behavior

*Challenging participant behaviors:* Disruptive, rambles, overly talkative, complaining frequently  
*Possible reasons for the behavior*

- Desire for attention
- Angry about something and does not know another way to express it
- Hides feelings of insecurity/avoidance of sensitive material
- Looking for partner or facilitator respect
- Is in a lot of pain
- Under the influence of alcohol or drugs
- Is bothered by disorganized thoughts

*Facilitator's responses*

- Keep temper in check
- Reinforce appropriate behavior: "You know, John, I think it is really great the way you are focusing on what Diane has to say right now."
- Summarize, reframe, and move on: "You make some interesting points, I wonder though, if we can go back to a point that was made earlier, \_\_\_\_\_." or "I am sorry that I interrupted you, unfortunately we only have a brief period of time and I really want to get to \_\_\_\_\_."
- Actively involve participant in constructive participation, for example, ask the person to role-play with their partner: "Wow, you are really full of energy today. Maybe we can harness that and have you act out a role play with [partner's name]."
- Ask the other participants for any comments that lead back to the topic: "That's great, you've really given the group a lot to think about, let's see if anyone else wants to respond."
- If participant is unable to participate constructively, take the person aside and suggest that he/she leave and come back later in the session (in extreme situations only). Check in with person at the end of the session: "Alex, it seems as if it is difficult for you to participate in the session in a way that feels calm and constructive. Are you okay? I'd like to take a minute to help you explore what might be bothering you. Let's step outside for a few minutes and we'll rejoin the session later."