Clinical Supervision

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Chapter 1—Information the Clinical Supervisor Needs to Know

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Clinical Supervision and Professional Development of the Substance Abuse Counselor, *Treatment Improvement Protocol Series (TIP 52),*

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Definitions

This document builds on and makes frequent reference to CSAT's Technical Assistance Publication (TAP), *Competencies for Substance Abuse Treatment Clinical Supervisors* (TAP 21A; CSAT, 2007). The clinical supervision competencies identify those responsibilities and activities that define the work of the clinical supervisor. This TIP provides guidelines and tools for the effective delivery of clinical supervision in substance abuse treatment settings. TAP 21A is a companion volume to TAP 21, *Addiction Counseling Competencies* (CSAT, 2006), which is another useful tool in supervision.

The perspective of this TIP is informed by the following definitions of supervision:

- “Supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive” (Powell & Brodsky, 2004, p. 11). “Supervision is an intervention provided by a senior member of a profession to a more junior member or members. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper of those who are to enter the particular profession” (Bernard & Goodyear, 2004, p. 8).
- Supervision is “a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus and evidence-based practices” (CSAT, 2007, p. 3).

Rationale

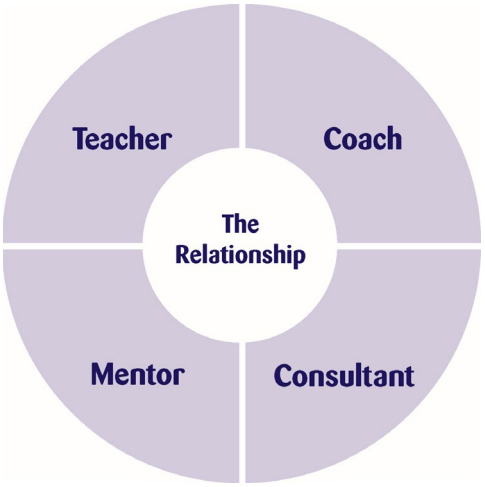
For hundreds of years, many professions have relied on more senior colleagues to guide less experienced professionals in their crafts. This is a new development in the substance abuse field, as clinical supervision was only recently acknowledged as a discrete process with its own concepts and approaches.

As a supervisor to the client, counselor, and organization, the significance of your position is apparent in the following statements:

- Organizations have an obligation to ensure quality care and quality improvement of all personnel. The first aim of clinical supervision is to ensure quality services and to protect the welfare of clients.
- Supervision is the right of all employees and has a direct impact on workforce development and staff and client retention.
- You oversee the clinical functions of staff and have a legal and ethical responsibility to ensure quality care to clients, the professional development of counselors, and maintenance of program policies and procedures.

- Clinical supervision is how counselors in the field learn. In concert with classroom education, clinical skills are acquired through practice, observation, feedback, and implementation of the recommendations derived from clinical supervision.

Functions of a Clinical Supervisor



You, the clinical supervisor, wear several important "hats." You facilitate the integration of counselor self-awareness, theoretical grounding, and development of clinical knowledge and skills; and you improve functional skills and professional practices. These roles often overlap and are fluid within the context of the supervisory relationship. Hence, the supervisor is in a unique position as an advocate for the agency, the counselor, and the client. You are the primary link between administration and frontline staff, interpreting and monitoring compliance with agency goals, policies, and procedures and communicating staff and client needs to administrators. Central to the supervisor's function is the alliance between the supervisor and supervisee (Rigazio DiGilio, 1997).

As shown in Figure 1, your roles as a clinical supervisor in the context of the supervisory relationship include:

- **Teacher:** Assist in the development of counseling knowledge and skills by identifying learning needs, determining counselor strengths, promoting self-awareness, and transmitting knowledge for practical use and professional growth. Supervisors are teachers, trainers, and professional role models.
- **Consultant: Bernard and Goodyear (2004) incorporate the supervisory consulting role of case consultation and review, monitoring performance, counseling the counselor regarding job performance, and assessing counselors.** In this role, supervisors also provide alternative case conceptualizations, oversight of counselor work to achieve mutually agreed upon goals, and professional gatekeeping for the organization and discipline (e.g., recognizing and addressing counselor impairment).

- **Coach:** In this supportive role, supervisors provide morale building, assess strengths and needs, suggest varying clinical approaches, model, cheerlead, and prevent burnout. For entry level counselors, the supportive function is critical.
- **Mentor/Role Model:** The experienced supervisor mentors and teaches the supervisee through role modeling, facilitates the counselor's overall professional development and sense of professional identity, and trains the next generation of supervisors.

Central Principles of Clinical Supervision

The Consensus Panel for this TIP has identified central principles of clinical supervision. Although the Panel recognizes that clinical supervision can initially be a costly undertaking for many financially strapped programs, the Panel believes that ultimately clinical supervision is a cost saving process. **Clinical supervision enhances the quality of client care; improves efficiency of counselors in direct and indirect services; increases workforce satisfaction, professionalization, and retention (see vignette 8 in chapter 2); and ensures that services provided to the public uphold legal mandates and ethical standards of the profession.**

The central principles identified by the Consensus Panel are:

1. **Clinical supervision is an essential part of all clinical programs.** Clinical supervision is a central organizing activity that integrates the program mission, goals, and treatment philosophy with clinical theory and evidence-based practices (EBPs). The primary reasons for clinical supervision are to ensure (1) quality client care, and (2) clinical staff continue professional development in a systematic and planned manner. In substance abuse treatment, clinical supervision is the primary means of determining the quality of care provided.
2. **Clinical supervision enhances staff retention and morale.** Staff turnover and workforce development are major concerns in the substance abuse treatment field. Clinical supervision is a primary means of improving workforce retention and job satisfaction (see, for example, Roche, Todd, & O'Connor, 2007).

3. **Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision.** Supervision needs to be tailored to the knowledge base, skills, experience, and assignment of each counselor. All staff need supervision, but the frequency and intensity of the oversight and training will depend on the role, skill level, and competence of the individual. The benefits that come with years of experience are enhanced by quality clinical supervision.
4. **Clinical supervision needs the full support of agency administrators.** Just as treatment programs want clients to be in an atmosphere of growth and openness to new ideas, counselors should be in an environment where learning and professional development and opportunities are valued and provided for all staff.
5. **The supervisory relationship is the crucible in which ethical practice is developed and reinforced.** The supervisor needs to model sound ethical and legal practice in the supervisory relationship. This is where issues of ethical practice arise and can be addressed. This is where ethical practice is translated from a concept to a set of behaviors. Through supervision, clinicians can develop a process of ethical decision making and use this process as they encounter new situations.
6. **Clinical supervision is a skill in and of itself that has to be developed.** Good counselors tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client goals and a knowledge base to complement a new set of skills. Programs need to increase their capacity to develop good supervisors.
7. **Clinical supervision in substance abuse treatment most often requires balancing administrative and clinical supervision tasks.** Sometimes these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the roles to promote the efficacy of the clinical supervisor. (See)
8. **Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence.** Supervisors require cultural competence at several levels. Cultural competence involves the counselor's response to clients, the supervisor's response to counselors, and the program's response to the cultural needs of the diverse community it serves. Since supervisors are in a position to serve as

catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.

9. **Successful implementation of EBPs requires ongoing supervision.** Supervisors have a role in determining which specific EBPs are relevant for an organization's clients (Lindbloom, Ten Eyck, & Gallon, 2005). Supervisors ensure that EBPs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring counselors. Excellence in clinical supervision should provide greater adherence to the EBP model. Because State funding agencies now often require substance abuse treatment organizations to provide EBPs, supervision becomes even more important.
10. **Supervisors have the responsibility to be gatekeepers for the profession.** Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of clients. More than anyone else in an agency, supervisors can observe counselor behavior and respond promptly to potential problems, including counseling some individuals out of the field because they are ill suited to the profession. This "gatekeeping" function is especially important for supervisors who act as field evaluators for practicum students prior to their entering the profession. Finally, supervisors also fulfill a gatekeeper role in performance evaluation and in providing formal recommendations to training institutions and credentialing bodies.
11. **Clinical supervision should involve direct observation methods.** Direct observation should be the standard in the field because it is one of the most effective ways of building skills, monitoring counselor performance, and ensuring quality care. Supervisors require training in methods of direct observation, and administrators need to provide resources for implementing direct observation. Although small substance abuse agencies might not have the resources for one-way mirrors or videotaping equipment, other direct observation methods can be employed (see the section on methods of observation, pp. 20–24).

Guidelines for New Supervisors

Congratulations on your appointment as a supervisor! By now you might be asking yourself a few questions: What have I done? Was this a good career decision?

There are many changes ahead. If you have been promoted from within, you'll encounter even more hurdles and issues. First, it is important to face that your life has changed. You might experience

the loss of friendship of peers. You might feel that you knew what to do as a counselor, but feel totally lost with your new responsibilities (see vignette 6 in chapter 2). You might feel less effective in your new role. Supervision can be an emotionally draining experience, as you now have to work with more staff related interpersonal and human resources issues.

Before your promotion to clinical supervisor, you might have felt confidence in your clinical skills. Now you might feel unprepared and wonder if you need a training course for your new role. If you feel this way, you're right. Although you are a good counselor, you do not necessarily possess all the skills needed to be a good supervisor. Your new role requires a new body of knowledge and different skills, along with the ability to use your clinical skills in a different way. Be confident that you will acquire these skills over time (see the Resources section, p. 34) and that you made the right decision to accept your new position.

Suggestions for new supervisors:

- Quickly learn the organization's policies and procedures and human resources procedures (e.g., hiring and firing, affirmative action requirements, format for conducting meetings, giving feedback, and making evaluations). Seek out this information as soon as possible through the human resources department or other resources within the organization.
- Ask for a period of 3 months to allow you to learn about your new role. During this period, do not make any changes in policies and procedures but use this time to find your managerial voice and decision-making style.
- Take time to learn about your supervisees, their career goals, interests, developmental objectives, and perceived strengths.
- Work to establish a contractual relationship with supervisees, with clear goals and methods of supervision.
- Learn methods to help staff reduce stress, address competing priorities, resolve staff conflict, and other interpersonal issues in the workplace.
- Obtain training in supervisory procedures and methods.
- Find a mentor, either internal or external to the organization.
- Shadow a supervisor you respect who can help you learn the ropes of your new job.
- Ask often and as many people as possible, "How am I doing?" and "How can I improve my performance as a clinical supervisor?"
- Ask for regular, weekly meetings with your administrator for training and instruction.

- Seek supervision of your supervision.

Problems and Resources

As a supervisor, you may encounter a broad array of issues and concerns, ranging from working within a system that does not fully support clinical supervision to working with resistant staff. A comment often heard in supervision training sessions is “My boss should be here to learn what is expected in supervision,” or “This will never work in my agency’s bureaucracy. They only support billable activities.” The work setting is where you apply the principles and practices of supervision and where organizations are driven by demands, such as financial solvency, profit, census, accreditation, and concerns over litigation. Therefore, you will need to be practical when beginning your new role as a supervisor: determine how you can make this work within your unique work environment.

Working with Staff Who Are Resistant to Supervision

Some of your supervisees may have been in the field longer than you have and see no need for supervision. Other counselors, having completed their graduate training, do not believe they need further supervision, especially not from a supervisor who might have less formal academic education than they have. Other resistance might come from ageism, sexism, racism, or classism. Particular to the field of substance abuse treatment may be the tension between those who believe that recovery from substance abuse is necessary for this counseling work and those who do not believe this to be true.

In addressing resistance, you must be clear regarding what your supervision program entails and must consistently communicate your goals and expectations to staff. To resolve defensiveness and engage your supervisees, you must also honor the resistance and acknowledge their concerns. Abandon trying to push the supervisee too far, too fast. Resistance is an expression of ambivalence about change and not a personality defect of the counselor. Instead of arguing with or exhorting staff, sympathize with their concerns, saying, “I understand this is difficult. How are we going to resolve these issues?”

When counselors respond defensively or reject directions from you, try to understand the origins of their defensiveness and to address their resistance. Self-disclosure by the supervisor about

experiences as a supervisee, when appropriately used, may be helpful in dealing with defensive, anxious, fearful, or resistant staff. Work to establish a healthy, positive supervisory alliance with staff. Because many substance abuse counselors have not been exposed to clinical supervision, you may need to train and orient the staff to the concept and why it is important for your agency.

Things a New Supervisor Should Know

Eight truths a beginning supervisor should commit to memory are listed below:

1. The reason for supervision is to ensure quality client care. As stated throughout this TIP, the primary goal of clinical supervision is to protect the welfare of the client and ensure the integrity of clinical services.
2. Supervision is all about the relationship. As in counseling, developing the alliance between the counselor and the supervisor is the key to good supervision.
3. Culture and ethics influence all supervisory interactions. Contextual factors, culture, race, and ethnicity all affect the nature of the supervisory relationship. Some models of supervision (e.g., Holloway, 1995) have been built primarily around the role of context and culture in shaping supervision.
4. Be human and have a sense of humor. As role models, you need to show that everyone makes mistakes and can admit to and learn from these mistakes.
5. Rely first on direct observation of your counselors and give specific feedback. The best way to determine a counselor's skills is to observe him or her and to receive input from the clients about their perceptions of the counseling relationship.
6. Have and practice a model of counseling and of supervision; have a sense of purpose. Before you can teach a supervisee knowledge and skills, you must first know the philosophical and theoretical foundations on which you, as a supervisor, stand. Counselors need to know what they are going to learn from you, based on your model of counseling and supervision.
7. Make time to take care of yourself spiritually, emotionally, mentally, and physically. Again, as role models, counselors are watching your behavior. Do you "walk the talk" of selfcare?
8. You have a unique position as an advocate for the agency, the counselor, and the client. As a supervisor, you have a wonderful opportunity to assist in the skill and professional

development of your staff, advocating for the best interests of the supervisee, the client, and your organization.

Models of Clinical Supervision

You may never have thought about your model of supervision. However, it is a fundamental premise of this TIP that you need to work from a defined model of supervision and have a sense of purpose in your oversight role. Four supervisory orientations seem particularly relevant. They include:

- **Competency based models.**
- **Treatment based models.**
- **Developmental approaches.**
- **Integrated models.**

Competency based models (e.g., micro training, the Discrimination Model [Bernard & Goodyear, 2004], and the Task Oriented Model [Mead, 1990], focus primarily on the skills and learning needs of the supervisee and on **setting goals that are specific, measurable, attainable, realistic, and timely (SMART).** They construct and implement strategies to accomplish these goals. The key strategies of competency-based models include applying social learning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using various supervisory functions (teaching, consulting, and counseling).

Treatment-based supervision models train to a particular theoretical approach to counseling, incorporating EBPs into supervision and seeking fidelity and adaptation to the theoretical model. Motivational interviewing, cognitive–behavioral therapy, and psychodynamic psychotherapy are three examples. These models emphasize the counselor's strengths, seek the supervisee's understanding of the theory and model taught, and incorporate the approaches and techniques of the model. The majority of these models begin with articulating their treatment approach and describing their supervision model, based upon that approach.

Developmental models, such as Stoltenberg and Delworth (1987), understand that each counselor goes through different stages of development and recognize that movement through these stages is not always linear and can be affected by changes in assignment, setting, and population served. (The developmental stages of counselors and supervisors are described in detail below).

Integrated models, including the Blended Model, begin with the style of leadership and articulate a model of treatment, incorporate descriptive dimensions of supervision (see below), and address contextual and developmental dimensions into supervision. They address both skill and competency development and affective issues, based on the unique needs of the supervisee and supervisor. Finally, integrated models seek to incorporate EBPs into counseling and supervision.

In all models of supervision, it is helpful to identify culturally or contextually centered models or approaches and find ways of tailoring the models to specific cultural and diversity factors. Issues to consider are:

- Explicitly addressing diversity of supervisees (e.g., race, ethnicity, gender, age, sexual orientation) and the specific factors associated with these types of diversity;
- Explicitly involving supervisees' concerns related to particular client diversity (e.g., those whose culture, gender, sexual orientation, and other attributes differ from those of the supervisee) and addressing specific factors associated with these types of diversity; and
- Explicitly addressing supervisees' issues related to effectively navigating services in intercultural communities and effectively networking with agencies and institutions.

It is important to identify your model of counseling and your beliefs about change, and to articulate a workable approach to supervision that fits the model of counseling you use. Theories are conceptual frameworks that enable you to make sense of and organize your counseling and supervision and to focus on the most salient aspects of a counselor's practice. You may find some of the questions below to be relevant to both supervision and counseling. The answers to these questions influence both how you supervise and how the counselors you supervise work:

- What are your beliefs about how people change in both treatment and clinical supervision?
- What factors are important in treatment and clinical supervision?
- What universal principles apply in supervision and counseling and which are unique to clinical supervision?
- What conceptual frameworks of counseling do you use (for instance, cognitive–behavioral therapy, 12 Step facilitation, psychodynamic, behavioral)?
- What are the key variables that affect outcomes? (Campbell, 2000)

According to Bernard and Goodyear (2004) and Powell and Brodsky (2004) the qualities of a good model of clinical supervision are:

- Rooted in the individual, beginning with the supervisor's self, style, and approach to leadership.
- Precise, clear, and consistent.
- Comprehensive, using current scientific and evidence-based practices.
- Operational and practical, providing specific concepts and practices in clear, useful, and measurable terms.
- Outcome oriented to improve counselor competence; make work manageable; create a sense of mastery and growth for the counselor; and address the needs of the organization, the supervisor, the supervisee, and the client.

Finally, it is imperative to recognize that, whatever model you adopt, it needs to be rooted in the learning and developmental needs of the supervisee, the specific needs of the clients they serve, the goals of the agency in which you work, and in the ethical and legal boundaries of practice. These four variables define the context in which effective supervision can take place.

Developmental Stages of Counselors

Counselors are at different stages of professional development. Thus, regardless of the model of supervision you choose, you must take into account the supervisee's level of training, experience, and proficiency. Different supervisory approaches are appropriate for counselors at different stages of development. An understanding of the supervisee's (and supervisor's) developmental needs is an essential ingredient for any model of supervision.

Various paradigms or classifications of developmental stages of clinicians have been developed (Ivey, 1997; Rigazio DiGilio, 1997; Skolvolt & Ronnestrand, 1992; Todd and Storn, 1997). **This TIP has adopted the Integrated Developmental Model (IDM) of Stoltenberg, McNeill, and Delworth**

(1998) (see figure 2, p. 10). This schema uses a three-stage approach. The three stages of development have different characteristics and appropriate supervisory methods. Further application of the IDM to the substance abuse field is needed. (For additional information, see Anderson, 2001.)

It is important to keep in mind several general cautions and principles about counselor development, including:

- There is a beginning but not an end point for learning clinical skills; be careful of counselors who think they "know it all."
- Take into account the individual learning styles and personalities of your supervisees and fit the supervisory approach to the developmental stage of each counselor.
- There is a logical sequence to development, although it is not always predictable or rigid; some counselors may have been in the field for years but remain at an early stage of professional development, whereas others may progress quickly through the stages.

Figure 2. Counselor Developmental Model

Developmental Level	Characteristics	Supervision Skills Development Needs	Techniques
Level 1	Focuses on self Anxious, uncertain Preoccupied with performing the right way Overconfident of skills Overgeneralizes Overuses a skill	Provide structure and minimize anxiety Supportive, address strengths first, then weaknesses Suggest approaches Start connecting	Observation Skills training Role playing Readings Group supervision Closely monitor clients

	Gap between conceptualization, goals, and interventions Ethics underdeveloped	theory to treatment	
Level 2	Focuses less on self and more on client Confused, frustrated with complexity of counseling Overidentifies with client Challenges authority Lacks integration with theoretical base Overburdened Ethics better understood	Less structure provided; more autonomy encouraged Supportive Periodic suggestion of approaches Confront discrepancies Introduce more alternative views Process comments, highlight countertransference Affective reactions to client and/or supervisor	Observation Role playing Interpret dynamics Group supervision Reading

Level 3	Focuses intently on client High degree of empathic skill Objective third person perspective Integrative thinking and approach Highly responsible and ethical counselor	Supervisee directed Focus on personal professional integration and career Supportive Change agent	

- Counselors at an advanced developmental level have different learning needs and require different supervisory approaches from those at Level 1; and
- The developmental level can be applied for different aspects of a counselor's overall competence (e.g., Level 2 mastery for individual counseling and Level 1 for couples counseling).

Developmental Stages of Supervisors

Just as counselors go through stages of development, so do supervisors. The developmental model presented in figure 3 provides a framework to explain why supervisors act as they do, depending on their developmental stage. It would be expected that someone new to supervision would be at a Level 1 as a supervisor. However, supervisors should be at least at the second or third stage of counselor development. If a newly appointed supervisor is still at Level 1 as a counselor, he or she will have little to offer to more seasoned supervisees.

Figure 3. Supervisor Developmental Model		
Developmental Level	**Characteristics**	**To Increase Supervision Competence**
Level 1	Is anxious regarding role Is naïve about assuming the role of supervisor Is focused on doing the "right" thing	Follow structure and formats Design systems to increase organization of supervision Assign Level I counselors

	May overly respond as an “expert” Is uncomfortable providing direct feedback	
Level 2	Shows confusion and conflict Sees supervision as complex and multidimensional Needs support to maintain motivation Overfocused on counselor’s deficits and perceived resistance May fall back to being a therapist with the counselor	Provide active supervision of the supervision Assign Level 1 counselors
Level 3	Is highly motivated Can provide an honest self-appraisal of strengths and weaknesses as supervisor Is comfortable with evaluation process Provides thorough, objective feedback	Comfortable with all levels

Cultural and Contextual Factors

Culture is one of the major contextual factors that influence supervisory interactions. Other contextual variables include race, ethnicity, age, gender, discipline, academic background, religious and spiritual practices, sexual orientation, disability, and recovery versus nonrecovery status. The relevant variables in the supervisory relationship occur in the context of the supervisor, supervisee, client, and the setting in which supervision occurs. More care should be taken to:

- Identify the competencies necessary for substance abuse counselors to work with diverse individuals and navigate intercultural communities.

- Identify methods for supervisors to assist counselors in developing these competencies.
- Provide evaluation criteria for supervisors to determine whether their supervisees have met minimal competency standards for effective and relevant practice.

Models of supervision have been strongly influenced by contextual variables and their influence on the supervisory relationship and process, such as Holloway's Systems Model (1995) and Constantine's Multicultural Model (2003).

The competencies listed in TAP 21-A reflect the importance of culture in supervision (CSAT, 2007). The Counselor Development domain encourages self-examination of attitudes toward culture and other contextual variables. The Supervisory Alliance domain promotes attention to these variables in the supervisory relationship. (See also the planned TIP, *Improving Cultural Competence in Substance Abuse Counseling* [CSAT, in development *b*].)

Cultural competence "refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p. 12). Culture shapes belief systems, particularly concerning issues related to mental health and substance abuse, as well as the manifestation of symptoms, relational styles, and coping patterns.

There are three levels of cultural consideration for the supervisory process: the issue of the culture of the client being served and the culture of the counselor in supervision. Holloway (1995) emphasizes the cultural issues of the agency, the geographic environment of the organization, and many other contextual factors. Specifically, **there are three important areas in which cultural and contextual factors play a key role in supervision: in building the supervisory relationship or working alliance, in addressing the specific needs of the client, and in building supervisee competence and ability.** It is your responsibility to address your supervisees' beliefs, attitudes, and biases about cultural and contextual variables to advance their professional development and promote quality client care.

Becoming culturally competent and able to integrate other contextual variables into supervision is a complex, long term process. Cross (1989) has identified several stages on a continuum of becoming culturally competent (see figure 4).

Although you may never have had specialized training in multicultural counseling, some of your supervisees may have (see Constantine, 2003). Regardless, it is your responsibility to help supervisees build on the cultural competence skills they possess as well as to focus on their cultural competence deficits. **It is important to initiate discussion of issues of culture, race, gender, sexual orientation, and the like in supervision to model the kinds of discussion you would like counselors to have with their clients.** If these issues are not addressed in supervision, counselors may come to believe that it is inappropriate to discuss them with clients and have no idea how such dialog might proceed. **These discussions prevent misunderstandings with supervisees based on cultural or other factors. Another benefit from these discussions is that counselors will eventually achieve some level of comfort in talking about culture, race, ethnicity, and diversity issues.**

If you haven't done it as a counselor, early in your tenure as a supervisor you will want to examine your culturally influenced values, attitudes, experiences, and practices and to consider what effects they have on your dealings with supervisees and clients. Counselors should undergo a similar review as preparation for when they have clients of a culture different from their own. Some questions to keep in mind are:

- What did you think when you saw the supervisee's last name?
- What did you think when the supervisee said his or her culture is X, when yours is Y?
- How did you feel about this difference?
- What did you do in response to this difference?

Constantine (2003) suggests that supervisors can use the following questions with supervisees:

- What demographic variables do you use to identify yourself?
- What worldviews (e.g., values, assumptions, and biases) do you bring to supervision based on your cultural identities?

- What struggles and challenges have you faced working with clients who were from different cultures than your own?

Beyond self-examination, supervisors will want continuing education classes, workshops, and conferences that address cultural competence and other contextual factors. Community resources, such as community leaders, elders, and healers can contribute to your understanding of the culture your organization serves. Finally, supervisors (and counselors) should participate in multicultural activities, such as community events, discussion groups, religious festivals, and other ceremonies.

The supervisory relationship includes an inherent power differential, and it is important to pay attention to this disparity, particularly when the supervisee and the supervisor are from different cultural groups. A potential for the misuse of that power exists at all times but especially when working with supervisees and clients within multicultural contexts. When the supervisee is from a minority population and the supervisor is from a majority population, the differential can be exaggerated. You will want to prevent institutional discrimination from affecting the quality of supervision. The same is true when the supervisee is gay and the supervisor is heterosexual, or the counselor is non-degreed and the supervisor has an advanced degree, or a female supervisee with a male supervisor, and so on. In the reverse situations, where the supervisor is from the minority group and the supervisee from the majority group, the difference should be discussed as well.

Ethical and Legal Issues

You are the organization's gatekeeper for ethical and legal issues. First, you are responsible for upholding the highest standards of ethical, legal, and moral practices and for serving as a model of practice to staff. Further, you should be aware of and respond to ethical concerns. Part of your job is to help integrate solutions to everyday legal and ethical issues into clinical practice.

Some of the underlying assumptions of incorporating ethical issues into clinical supervision include:

- Ethical decision making is a continuous, active process.
- Ethical standards are not a cookbook. They tell you what to do, not always how.

- Each situation is unique. Therefore, it is imperative that all personnel learn how to "think ethically" and how to make sound legal and ethical decisions.
- The most complex ethical issues arise in the context of two ethical behaviors that conflict; for instance, when a counselor wants to respect the privacy and confidentiality of a client, but it is in the client's best interest for the counselor to contact someone else about his or her care.
- Therapy is conducted by fallible beings; people make mistakes—hopefully, minor ones.
- Sometimes the answers to ethical and legal questions are elusive. Ask a dozen people, and you'll likely get twelve different points of view.

Helpful resources on legal and ethical issues for supervisors include Beauchamp and Childress (2001); Falvey (2002*b*); Gutheil and Brodsky (2008); Pope, Sonne, and Greene (2006); and Reamer (2006).

Legal and ethical issues that are critical to clinical supervisors include:

(1) vicarious liability (or respondeat superior), (2) dual relationships and boundary concerns, (4) informed consent, (5) confidentiality, and (6) supervisor ethics.

Direct Versus Vicarious Liability

An important distinction needs to be made between direct and vicarious liability. **Direct liability of the supervisor might include dereliction of supervisory responsibility, such as "not making a reasonable effort to supervise."** (defined below).

In vicarious liability, a supervisor can be held liable for damages incurred as a result of negligence in the supervision process. Examples of negligence include providing inappropriate advice to a counselor about a client (for instance, discouraging a counselor from conducting a suicide screen on a depressed client), failure to listen carefully to a supervisee's comments about a client, and the assignment of clinical tasks to inadequately trained counselors. The key legal question is: "Did the supervisor conduct him or herself in a way that would be reasonable for someone in his position?" or "Did the supervisor make a reasonable effort to supervise?" A generally accepted time standard for a "reasonable effort to supervise" in the behavioral health field is 1 hour of supervision for every 20–40 hours of clinical services. Of course, other variables (such as the

quality and content of clinical supervision sessions) also play a role in a reasonable effort to supervise.

Supervisory vulnerability increases when the counselor has been assigned too many clients, when there is no direct observation of a counselor's clinical work, when staff are inexperienced or poorly trained for assigned tasks, and when a supervisor is not involved or not available to aid the clinical staff. In legal texts, vicarious liability is referred to as "respondeat superior."

Dual Relationships and Boundary Issues

Dual relationships can occur at two levels: between supervisors and supervisees and between counselors and clients. You have a mandate to help your supervisees recognize and manage boundary issues. A dual relationship occurs in supervision when a supervisor has a primary professional role with a supervisee and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship. Examples of dual relationships in supervision include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an Alcoholics Anonymous sponsor for a former supervisee. Obviously, there are varying degrees of harm or potential harm that might occur as a result of dual relationships, and some negative effects of dual relationships might not be apparent until later.

Therefore, firm, always or never rules aren't applicable. You have the responsibility of weighing with the counselor the anticipated and unanticipated effects of dual relationships, helping the supervisee's self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship.

Exploring dual relationship issues with counselors in clinical supervision can raise its own professional dilemmas. For instance, clinical supervision involves unequal status, power, and expertise between a supervisor and supervisee. Being the evaluator of a counselor's performance and gatekeeper for training programs or credentialing bodies also might involve a dual relationship. Further, supervision can have therapylike qualities as you explore counter transferential issues with supervisees, and there is an expectation of professional growth and self-exploration. What makes a dual relationship unethical in supervision is the abusive use of power by either party, the likelihood that the relationship will impair or injure the supervisor's or supervisee's judgment, and the risk of exploitation (see vignette 3 in chapter 2).

The most common basis for legal action against counselors (20 percent of claims) and the most frequently heard complaint by certification boards against counselors (35 percent) is some form of boundary violation or sexual impropriety (Falvey, 2002*b*). (See the discussion of transference and countertransference on pp. 25–26.)

Codes of ethics for most professions clearly advise that dual relationships between counselors and clients should be avoided. Dual relationships between counselors and supervisors are also a concern and are addressed in the substance abuse counselor codes and those of other professions as well. Problematic dual relationships between supervisees and supervisors might include intimate relationships (sexual and nonsexual) and therapeutic relationships, wherein the supervisor becomes the counselor's therapist. Sexual involvement between the supervisor and supervisee can include sexual attraction, harassment, consensual (but hidden) sexual relationships, or intimate romantic relationships. Other common boundary issues include asking the supervisee to do favors, providing preferential treatment, socializing outside the work setting, and using emotional abuse to enforce power.

It is imperative that all parties understand what constitutes a dual relationship between supervisor and supervisee and avoid these dual relationships. Sexual relationships between supervisors and supervisees and counselors and clients occur far more frequently than one might realize (Falvey, 2002*b*). In many States, they constitute a legal transgression as well as an ethical violation.

The decision tree presented in figure 5 (p. 16) indicates how a supervisor might manage a situation where he or she is concerned about a possible ethical or legal violation by a counselor.

Informed Consent

Informed consent is key to protecting the counselor and/or supervisor from legal concerns, requiring the recipient of any service or intervention to be sufficiently aware of what is to happen, and of the potential risks and alternative approaches, so that the person can make an informed and intelligent decision about participating in that service. The supervisor must inform the supervisee about the process of supervision, the feedback and evaluation criteria, and other expectations of supervision. The supervision contract should clearly spell out these issues. Supervisors must ensure that the

supervisee has informed the client about the parameters of counseling and supervision (such as the use of live observation, video or audiotaping). A sample template for informed consent is provided in, chapter 2 (p. 106).

Confidentiality

In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor's vicarious liability. **Informed consent and concerns for confidentiality should occur at three levels: client consent to treatment, client consent to supervision of the case, and supervisee consent to supervision (Bernard & Goodyear, 2004).** In addition, there is an implied consent and commitment to confidentiality by supervisors to assume their supervisory responsibilities and institutional consent to comply with legal and ethical parameters of supervision. (See also the Code of Ethics of the Association for Counselor Education and Supervision [ACES], available online at http://www.acesonline.net/members/supervision/.

With informed consent and confidentiality comes a duty not to disclose certain relational communication. Limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies. Criteria for waiving client and supervisee privilege should be stated in institutional policies and discipline specific codes of ethics and clarified by advice of legal counsel and the courts. Because standards of confidentiality are determined by State legal and legislative systems, it is prudent for supervisors to consult with an attorney to determine the State codes of confidentiality and clinical privileging.

In the substance abuse treatment field, confidentiality for clients is clearly defined by Federal law: 42 CFR, and the Health Insurance Portability and Accountability Act (HIPAA). Key information is available at http://www.hhs.gov/ocr/privacy/. Supervisors need to train counselors in confidentiality regulations and to adequately document their supervision, including discussions and directives, especially relating to duty to warn situations. Supervisors need to ensure that counselors provide clients with appropriate duty to warn information early in the counseling process and inform clients of the limits of confidentiality as part of the agency's informed consent procedures.

Under duty to warn requirements (e.g., child abuse, suicidal or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may need to be waived. Organizations should have a policy stating how clinical crises will be handled (Falvey,

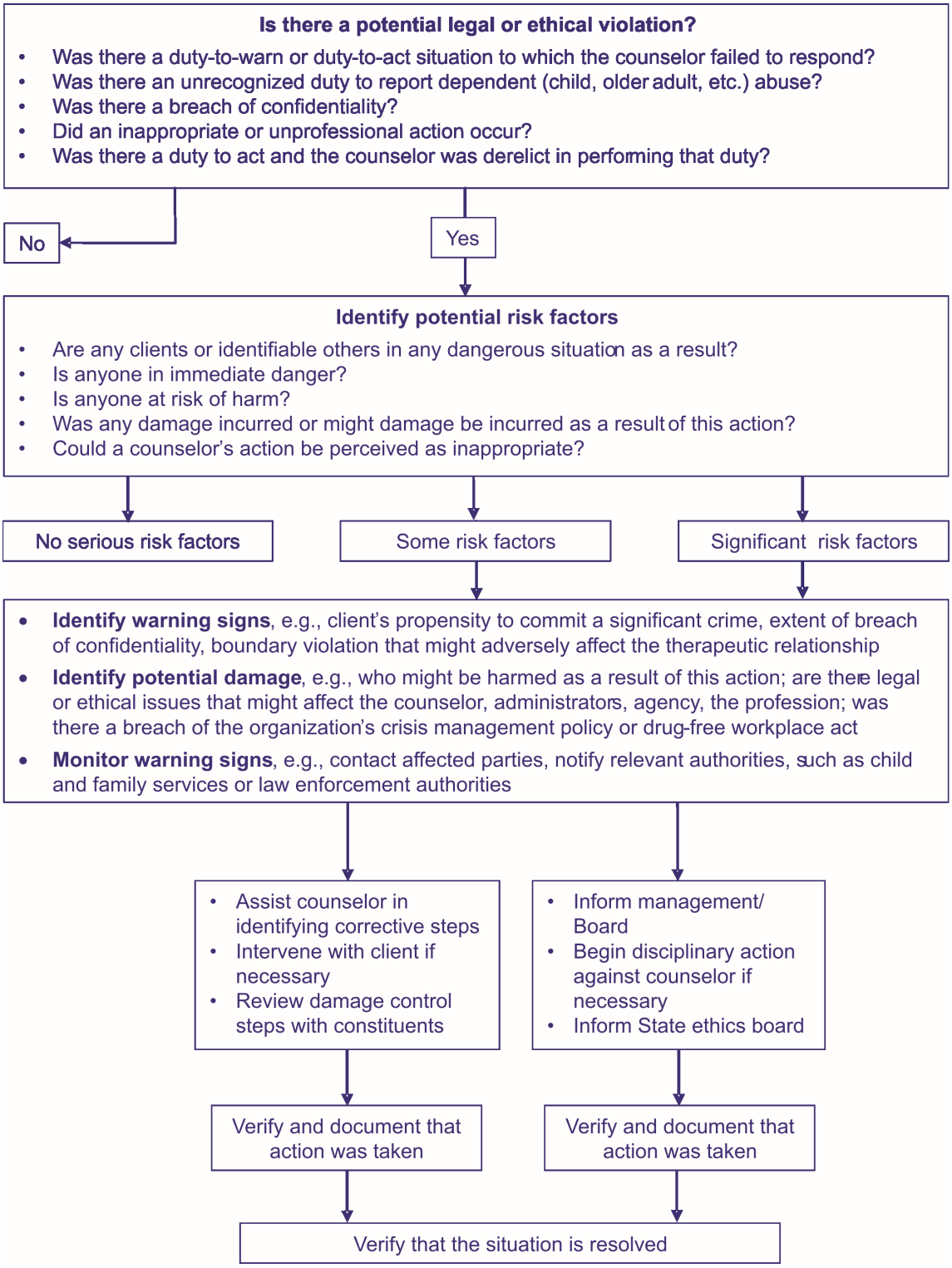
2002*b*). What mechanisms are in place for responding to crises? In what timeframe will a supervisor be notified of a crisis situation? Supervisors must document all discussions with counselors concerning duty to warn and crises. At the onset of supervision, supervisors should ask counselors if there are any duty to warn issues of which the supervisor should be informed. New technology brings new confidentiality concerns. Websites now dispense information about substance abuse treatment and provide counseling services. With the growth in online counseling and supervision, the following concerns emerge: (a) how to maintain confidentiality of information, counselors providing online services, and (c) how to establish reporting requirements and duty to warn when services are conducted across State and international boundaries. New standards will need to be written to address these issues. (The National Board for Certified Counselors has guidelines for counseling by Internet at http://www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf)

Supervisor Ethics

In general, supervisors adhere to the same standards and ethics as substance abuse counselors with regard to dual relationship and other boundary violations. Supervisors will:

- Uphold the highest professional standards of the field.
- Seek professional help (outside the work setting) when personal issues interfere with their clinical and/or supervisory functioning.
- Conduct themselves in a manner that models and sets an example for agency mission, vision, philosophy, wellness, recovery, and consumer satisfaction.
- Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate.
- Treat supervisees, colleagues, peers, and clients with dignity, respect, and honesty.
- Adhere to the standards and regulations of confidentiality as dictated by the field. This applies to the supervisory as well as the counseling relationship.

Figure 5: Deciding How To Address Potential Legal or Ethical Violations



Monitoring Performance

The goal of supervision is to ensure quality care for the client, which entails monitoring the clinical performance of staff. Your first step is to educate supervisees in what to expect from clinical

supervision. Once the functions of supervision are clear, you should regularly evaluate the counselor's progress in meeting organizational and clinical goals as set forth in an Individual Development Plan (IDP) (see the section on IDPs below). As clients have an individual treatment plan, counselors also need a plan to promote skill development.

Behavioral Contracting in Supervision

Among the first tasks in supervision is to establish a contract for supervision that outlines realistic accountability for both yourself and your supervisee. The contract should be in writing and should include the purpose, goals, and objectives of supervision; the context in which supervision is provided; ethical and institutional policies that guide supervision and clinical practices; the criteria and methods of evaluation and outcome measures; the duties and responsibilities of the supervisor and supervisee; procedural considerations (including the format for taping and opportunities for live observation); and the supervisee's scope of practice and competence. The contract for supervision should state the rewards for fulfillment of the contract (such as clinical privileges or increased compensation), the length of supervision sessions, and sanctions for noncompliance by either the supervisee or supervisor. The agreement should be compatible with the developmental needs of the supervisee and address the obstacles to progress (lack of time, performance anxiety, resource limitations). Once a behavioral contract has been established, the next step is to develop an IDP.

Individual Development Plan

The IDP is a detailed plan for supervision that includes the goals that you and the counselor wish to address over a certain time period (perhaps 3 months). Each of you should sign and keep a copy of the IDP for your records. The goals are normally stated in terms of skills the counselor wishes to build or professional resources the counselor wishes to develop. These skills and resources are generally oriented to the counselor's job in the program or activities that would help the counselor develop professionally. The IDP should specify the timelines for change, the observation methods that will be employed, expectations for the supervisee and the supervisor, the evaluation procedures

that will be employed, and the activities that will be expected to improve knowledge and skills. An example of an IDP is provided in, chapter 2 (p. 122).

As a supervisor, you should have your own IDP, based on the supervisory competencies listed in TAP 21A (CSAT, 2007), that addresses your training goals. This IDP can be developed in cooperation with your supervisor, or in external supervision, peer input, academic advisement, or mentorship.

Evaluation of Counselors

Supervision inherently involves evaluation, building on a collaborative relationship between you and the counselor. Evaluation may not be easy for some supervisors. Although everyone wants to know how they are doing, counselors are not always comfortable asking for feedback. And, as most supervisors prefer to be liked, you may have difficulty giving clear, concise, and accurate evaluations to staff.

The two types of evaluation are formative and summative. A formative evaluation is an ongoing status report of the counselor's skill development, exploring the questions "Are we addressing the skills or competencies you want to focus on?" and "How do we assess your current knowledge and skills and areas for growth and development?"

Summative evaluation is a more formal rating of the counselor's overall job performance, fitness for the job, and job rating. It answers the question, "How does the counselor measure up?" Typically, summative evaluations are done annually and focus on the counselor's overall strengths, limitations, and areas for future improvement.

It should be acknowledged that supervision is inherently an unequal relationship. In most cases, the supervisor has positional power over the counselor. Therefore, it is important to establish clarity of purpose and a positive context for evaluation. Procedures should be spelled out in advance, and the evaluation process should be mutual, flexible, and continuous. The evaluation process inevitably brings up supervisee anxiety and defensiveness that need to be addressed openly. It is also important to note that each individual counselor will react differently to feedback; some will be more open to the process than others.

There has been considerable research on supervisory evaluation, with these findings:

- The supervisee's confidence and efficacy are correlated with the quality and quantity of feedback the supervisor gives to the supervisee (Bernard & Goodyear, 2004).
- Ratings of skills are highly variable between supervisors, and often the supervisor's and supervisee's ratings differ or conflict (Eby, 2007).
- Good feedback is provided frequently, clearly, and consistently and is SMART (specific, measurable, attainable, realistic, and timely) (Powell & Brodsky, 2004).

Direct observation of the counselor's work is the desired form of input for the supervisor. Although direct observation has historically been the exception in substance abuse counseling, ethical and legal considerations and evidence support that direct observation as preferable. The least desirable feedback is unannounced observation by supervisors followed by vague, perfunctory, indirect, or hurtful delivery (Powell & Brodsky, 2004).

Clients are often the best assessors of the skills of the counselor. Supervisors should routinely seek input from the clients as to the outcome of treatment. The method of seeking input should be discussed in the initial supervisory sessions and be part of the supervision contract. In a residential substance abuse treatment program, you might regularly meet with clients after sessions to discuss how they are doing, how effective the counseling is, and the quality of the therapeutic alliance with the counselor. (For examples of client satisfaction or input forms, search for Client Directed Outcome Informed Treatment and Training Materials at http://www.goodtherapy.org/clientdirectedoutcomeinformedtherapy.html)

Before formative evaluations begin, methods of evaluating performance should be discussed, clarified in the initial sessions, and included in the initial contract so that there will be no surprises. Formative evaluations should focus on changeable behavior and, whenever possible, be separate from the overall annual performance appraisal process. To determine the counselor's skill development, you should use written competency tools, direct observation, counselor self-assessments, client evaluations, work samples (files and charts), and peer assessments. Examples of work samples and peer assessments can be found in Bernard and Goodyear (2004), Powell and Brodsky (2004), and Campbell (2000). It is important to acknowledge that counselor evaluation is essentially a subjective process involving supervisors' opinions of the counselors' competence.

Addressing Burnout and Compassion Fatigue

Did you ever hear a counselor say, “I came into counseling for the right reasons? At first, I loved seeing clients. But the longer I stay in the field, the harder it is to care. The joy seems to have gone out of my job. Should I get out of counseling as many of my colleagues are doing?” Most substance abuse counselors come into the field with a strong sense of calling and the desire to be of service to others, with a strong pull to use their gifts and make themselves instruments of service and healing. The substance abuse treatment field risks losing many skilled and compassionate healers when the life goes out of their work. Some counselors simply withdraw, care less, or get out of the field entirely. Most just complain or suffer in silence. Given the caring and dedication that brings counselors into the field, it is important for you to help them address their questions and doubts. (See Lambie, 2006, and Shoptaw, Stein, & Rawson, 2000.)

You can help counselors with selfcare; help them look within; become resilient again; and rediscover what gives them joy, meaning, and hope in their work. Counselors need time for reflection, to listen again deeply and authentically. You can help them redevelop their innate capacity for compassion, to be an openhearted presence for others.

You can help counselors develop a life that does not revolve around work. This has to be supported by the organization’s culture and policies that allow for appropriate use of time off and selfcare without punishment. Aid them by encouraging them to take earned leave and to take “mental health” days when they are feeling tired and burned out. Remind staff to spend time with family and friends, exercise, relax, read, or pursue other lifegiving interests.

It is important for the clinical supervisor to normalize the counselor’s reactions to stress and compassion fatigue in the workplace as a natural part of being an empathic and compassionate person and not an individual failing or pathology. (See Burke, Carruth, & Prichard, 2006.)

Rest is good; selfcare is important. Everyone needs times of relaxation and recreation. Often, a month after a refreshing vacation you lose whatever gain you made. Instead, longer term gain comes from finding what brings you peace and joy. It is not enough for you to help counselors understand “how” to counsel, you can also help them with the “why.” Why are they in this field?

What gives them meaning and purpose at work? When all is said and done, when counselors have seen their last client, how do they want to be remembered? What do they want said about them as counselors? Usually, counselors' responses to this question are fairly simple: "I want to be thought of as a caring, compassionate person, a skilled helper." These are important spiritual questions that you can discuss with your supervisees.

Other suggestions include:

- Help staff identify what is happening within the organization that might be contributing to their stress and learn how to address the situation in a way that is productive to the client, the counselor, and the organization.
- Get training in identifying the signs of primary stress reactions, secondary trauma, compassion fatigue, vicarious traumatization, and burnout. Help staff match up selfcare tools to specifically address each of these experiences.
- Support staff in advocating for organizational change when appropriate and feasible as part of your role as liaison between administration and clinical staff.
- Assist staff in adopting lifestyle changes to increase their emotional resilience by reconnecting to their world (family, friends, sponsors, mentors), spending time alone for self-reflection, and forming habits that reenergize them.
- Help them eliminate the "what ifs" and negative self-talk. Help them let go of their idealism that they can save the world.
- If possible, in the current work environment, set parameters on their work by helping them adhere to scheduled time off, keep lunch time personal, set reasonable deadlines for work completion, and keep work away from personal time.
- Teach and support generally positive work habits. Some counselors lack basic organizational, teamwork, phone, and time management skills (ending sessions on time and scheduling to allow for documentation). The development of these skills helps to reduce the daily wear that erodes wellbeing and contributes to burnout.
- Ask them "When was the last time you had fun?" "When was the last time you felt fully alive?" Suggest they write a list of things about their job about which they are grateful. List five people they care about and love. List five accomplishments in their professional life. Ask "Where do you want to be in your professional life in 5 years?"

You have a fiduciary responsibility given you by clients to ensure counselors are healthy and whole. It is your responsibility to aid counselors in addressing their fatigue and burnout.

Gatekeeping Functions

In monitoring counselor performance, an important and often difficult supervisory task is managing problem staff or those individuals who should not be counselors. This is the gatekeeping function. Part of the dilemma is that most likely you were first trained as a counselor, and your values lie within that domain. You were taught to acknowledge and work with individual limitations, always respecting the individual's goals and needs. However, you also carry a responsibility to maintain the quality of the profession and to protect the welfare of clients. Thus, you are charged with the task of assessing the counselor for fitness for duty and have an obligation to uphold the standards of the profession.

Experience, credentials, and academic performance are not the same as clinical competence. In addition to technical counseling skills, many important therapeutic qualities affect the outcome of counseling, including insight, respect, genuineness, concreteness, and empathy. Research consistently demonstrates that personal characteristics of counselors are highly predictive of client outcome (Herman, 1993, Hubble, Duncan & Miller, 1999). The essential questions are: Who should or should not be a counselor? What behaviors or attitudes are unacceptable? How would a clinical supervisor address these issues in supervision?

Unacceptable behavior might include actions hurtful to the client, boundary violations with clients or program standards, illegal behavior, significant psychiatric impairment, consistent lack of self-awareness, inability to adhere to professional codes of ethics, or consistent demonstration of attitudes that are not conducive to work with clients in substance abuse treatment. You will want to have a model and policies and procedures in place when disciplinary action is undertaken with an impaired counselor. For example, progressive disciplinary policies clearly state the procedures to follow when impairment is identified. Consultation with the organization's attorney and familiarity with State case law are important. It is advisable for the agency to be familiar with and have contact with your State impaired counselor organization, if it exists.

How impaired must a counselor be before disciplinary action is needed? Clear job descriptions and statements of scope of practice and competence are important when facing an impaired counselor. How tired or distressed can a counselor be before a supervisor takes the counselor offline for these

or similar reasons? You need administrative support with such interventions and to identify approaches to managing worn out counselors. The Consensus Panel recommends that your organization have an employee assistance program (EAP) in place so you can refer staff outside the agency. It is also important for you to learn the distinction between a supervisory referral and a self-referral. Self-referral may include a recommendation by the supervisor, whereas a supervisory referral usually occurs with a job performance problem.

You will need to provide verbal and written evaluations of the counselor's performance and actions to ensure that the staff member is aware of the behaviors that need to be addressed. Treat all supervisees the same, following agency procedures and timelines. Follow the organization's progressive disciplinary steps and document carefully what is said, how the person responds, and what actions are recommended. You can discuss organizational issues or barriers to action with the supervisee (such as personnel policies that might be exacerbating the employee's issues). Finally, it may be necessary for you to take the action that is in the best interest of the clients and the profession, which might involve counseling your supervisee out of the field.

Remember that the number one goal of a clinical supervisor is to protect the welfare of the client, which, at times, can mean enforcing the gatekeeping function of supervision.

Methods of Observation

It is important to observe counselors frequently over an extended period of time. Supervisors in the substance abuse treatment field have traditionally relied on indirect methods of supervision (process recordings, case notes, verbal reports by the supervisees, and verbatims). However, the Consensus Panel recommends that supervisors use direct observation of counselors through recording devices (such as video and audio taping) and live observation of counseling sessions, including one-way mirrors. Indirect methods have significant drawbacks, including:

- A counselor will recall a session as he or she experienced it. If a counselor experiences a session positively or negatively, the report to the supervisor will reflect that. The report is also affected by the counselor's level of skill and experience.
- The counselor's report is affected by his or her biases and distortions (both conscious and unconscious). The report does not provide a thorough sense of what really happened in the session because it relies too heavily on the counselor's recall.

- Indirect methods include a time delay in reporting.
- The supervisee may withhold clinical information due to evaluation anxiety or naiveté.

Your understanding of the session will be improved by direct observation of the counselor. Direct observation is much easier today, as a variety of technological tools are available, including audio and videotaping, remote audio devices, interactive videos, live feeds, and even supervision through web-based cameras.

Guidelines that apply to all methods of direct observation in supervision include:

- Simply by observing a counseling session, the dynamics will change. You may change how both the client and counselor act. You get a snapshot of the sessions. Counselors will say, “it was not a representative session.” Typically, if you observe the counselor frequently, you will get a fairly accurate picture of the counselor’s competencies.
- You and your supervisee must agree on procedures for observation to determine why, when, and how direct methods of observation will be used.
- The counselor should provide a context for the session.
- The client should give written consent for observation and/or taping at intake, before beginning counseling. Clients must know all the conditions of their treatment before they consent to counseling. Additionally, clients need to be notified of an upcoming observation by a supervisor before the observation occurs.
- Observations should be selected for review (including a variety of sessions and clients, challenges, and successes) because they provide teaching moments. You should ask the supervisee to select what cases he or she wishes you to observe and explain why those cases were chosen. Direct observation should not be a weapon for criticism but a constructive tool for learning: an opportunity for the counselor to do things right and well, so that positive feedback follows.
- When observing a session, you gain a wealth of information about the counselor. Use this information wisely, and provide gradual feedback, not a litany of judgments and directives. Ask the salient question, “What is the most important issue here for us to address in supervision?”
- A supervisee might claim client resistance to direct observation, saying, “It will make the client nervous. The client does not want to be taped.” However, “client resistance” is more likely to

be reported when the counselor is anxious about being taped. It is important for you to gently and respectfully address the supervisee's resistance while maintaining the position that direct observation is an integral component of his or her supervision.

- Given the nature of the issues in drug and alcohol counseling, you and your supervisee need to be sensitive to increased client anxiety about direct observation because of the client's fears about job or legal repercussions, legal actions, criminal behaviors, violence and abuse situations, and the like.
- Ideally, the supervisee should know at the outset of employment that observation and/or taping will be required as part of informed consent to supervision.

In instances where there is overwhelming anxiety regarding observation, you should pace the observation to reduce the anxiety, giving the counselor adequate time for preparation. Often enough, counselors will feel more comfortable with observation equipment (such as a video camera or recording device) rather than direct observation with the supervisor in the room.

The choice of observation methods in a particular situation will depend on the need for an accurate sense of counseling, the availability of equipment, the context in which the supervision is provided, and the counselor's and your skill levels. A key factor in the choice of methods might be the resistance of the counselor to being observed. For some supervisors, direct observation also puts the supervisor's skills on the line too, as they might be required to demonstrate or model their clinical competencies.

Recorded Observation

Audiotaped supervision has traditionally been a primary medium for supervisors and remains a vital resource for therapy models such as motivational interviewing. **On the other hand, videotape supervision (VTS) is the primary method of direct observation in both the marriage and family therapy and social work fields (Munson, 1993; Nichols, Nichols, & Hardy, 1990).** Video cameras are increasingly commonplace in professional settings. VTS is easy, accessible, and inexpensive. However, it is also a

complex, powerful and dynamic tool, and one that can be challenging, threatening, anxiety provoking, and humbling. Several issues related to VTS are unique to the substance abuse field:

- Many substance abuse counselors “grew up” in the field without taping and may be resistant to the medium;
- Many agencies operate on limited budgets and administrators may see the expensive equipment as prohibitive and unnecessary; and
- Many substance abuse supervisors have not been trained in the use of videotape equipment or in VTS.

Yet, VTS offers nearly unlimited potential for creative use in staff development. To that end, you need training in how to use VTS effectively. The following are guidelines for VTS:

- Clients must sign releases before taping. Most programs have a release form that the client signs on admission (see Tool 19 in chapter 2). The supervisee informs the client that videotaping will occur and reminds the client about the signed release form. The release should specify that the taping will be done exclusively for training purposes and will be reviewed only by the counselor, the supervisor, and other supervisees in group supervision. Permission will most likely be granted if the request is made in a sensitive and appropriate manner. It is critical to note that even if permission is initially given by the client, this permission can be withdrawn. You cannot force compliance.
- The use and rationale for taping needs to be clearly explained to clients. This will forestall a client’s questioning as to why a particular session is being taped.
- Risk management considerations in today’s litigious climate necessitate that tapes be erased after the supervision session. Tapes can be admissible as evidence in court as part of the clinical record. Since all tapes should be erased after supervision, this must be stated in agency policies. If there are exceptions, those need to be described.
- Too often, supervisors watch long, uninterrupted segments of tape with little direction or purpose. To avoid this, you may want to ask your supervisee to cue the tape to the segment he or she wishes to address in supervision, focusing on the goals established in the IDP. Having said this, listening only to segments selected by the counselor can create some of the same disadvantages as self-report: the counselor chooses selectively, even if not consciously. The supervisor may occasionally choose to watch entire sessions.

- You need to evaluate session flow, pacing, and how counselors begin and end sessions.

Some clients may not be comfortable being videotaped but may be more comfortable with audio taping. Videotaping is not permitted in most prison settings and EAP services. Videotaping may not be advisable when treating patients with some diagnoses, such as paranoia or some schizophrenic illnesses. In such cases, either live observation or less intrusive measures, such as audio taping, may be preferred.

Live Observation

With live observation you actually sit in on a counseling session with the supervisee and observe the session first hand. The client will need to provide informed consent before being observed. Although one-way mirrors are not readily available at most agencies, they are an alternative to actually sitting in on the session. A videotape may also be used either from behind the one-way mirror (with someone else operating the videotaping equipment) or physically located in the counseling room, with the supervisor sitting in the session. This combination of mirror, videotaping, and live observation may be the best of all worlds, allowing for unobtrusive observation of a session, immediate feedback to the supervisee, modeling by the supervisor (if appropriate), and a record of the session for subsequent review in supervision. Live supervision may involve some intervention by the supervisor during the session.

Live observation is effective for the following reasons:

- It allows you to get a true picture of the counselor in action.
- It gives you an opportunity to model techniques during an actual session, thus serving as a role model for both the counselor and the client.
- Should a session become countertherapeutic, you can intervene for the wellbeing of the client.
- Counselors often say they feel supported when a supervisor joins the session, and clients periodically say, “This is great! I got two for the price of one.”
- It allows for specific and focused feedback.
- It is more efficient for understanding the counseling process.
- It helps connect the IDP to supervision.

To maximize the effectiveness of live observation, supervisors must stay primarily in an observer role so as to not usurp the leadership or undercut the credibility and authority of the counselor.

Live observation has some disadvantages:

- It is time consuming.
- It can be intrusive and alter the dynamics of the counseling session.
- It can be anxiety-provoking for all involved.

Some mandated clients may be particularly sensitive to live observation. This becomes essentially a clinical issue to be addressed by the counselor with the client. Where is this anxiety coming from, how does it relate to other anxieties and concerns, and how can it best be addressed in counseling?

Supervisors differ on where they should sit in a live observation session. Some suggest that the supervisor sit so as to not interrupt or be involved in the session. Others suggest that the supervisor sit in a position that allows for inclusion in the counseling process.

Here are some guidelines for conducting live observation:

- The counselor should always begin with informed consent to remind the client about confidentiality. Periodically, the counselor should begin the session with a statement of confidentiality, reiterating the limits of confidentiality and the duty to warn, to ensure that the client is reminded of what is reportable by the supervisor and/or counselor.
- While sitting outside the group (or an individual session between counselor and client) may undermine the group process, it is a method selected by some. Position yourself in a way that doesn't interrupt the counseling process. Sitting outside the group undermines the human connection between you, the counselor, and the client(s) and makes it more awkward for you to make a comment, if you have not been part of the process until then. For individual or family sessions, it is also recommended that the supervisor sit beside the counselor to fully observe what is occurring in the counseling session.
- The client should be informed about the process of supervision and the supervisor's role and goals, essentially that the supervisor is there to observe the counselor's skills and not necessarily the client.

- As preparation, the supervisor and supervisee should briefly discuss the background of the session, the salient issues the supervisee wishes to focus on, and the plans for the session. The role of the supervisor should be clearly stated and agreed on before the session.
- You and the counselor may create criteria for observation, so that specific feedback is provided for specific areas of the session.
- Your comments during the session should be limited to lessen the risk of disrupting the flow or taking control of the session. Intervene only to protect the welfare of the client (should something adverse occur in the session) or if a moment critical to client welfare arises. In deciding to intervene or not, consider these questions: What are the consequences if I don't intervene? What is the probability that the supervisee will make the intervention on his or her own or that my comments will be successful? Will I create an undue dependence on the part of clients or supervisee?
- Provide feedback to the counselor as soon as possible after the session. Ideally, the supervisor and supervisee(s) should meet privately immediately afterward, outlining the key points for discussion and the agenda for the next supervision session, based on the observation. Specific feedback is essential; "You did a fine job" is not sufficient. Instead, the supervisor might respond by saying, "I particularly liked your comment about . . ." or "What I observed about your behavior was . . ." or "Keep doing more of . . . ."

Practical Issues in Clinical Supervision

Distinguishing Between Supervision and Therapy

In facilitating professional development, one of the critical issues is understanding and differentiating between counseling the counselor and providing supervision. In ensuring quality client care and facilitating professional counselor development, the process of clinical supervision sometimes encroaches on personal issues. The dividing line between therapy and supervision is how the supervisee's personal issues and problems affect their work. The goal of clinical supervision must always be to assist counselors in becoming better clinicians, not seeking to resolve their personal issues. Some of the major differences between supervision and counseling are summarized in figure 6.

Figure 6. Differences Between Supervision and Counseling			
	Clinical Supervision	**Administrative Supervision**	**Counseling**
Purpose	• Improved client care • Improved job performance	• Ensure compliance with agency and regulatory body's policies and procedures	• Personal growth • Behavior changes • Better self-understanding
Outcome	• Enhanced proficiency in knowledge, skills, and attitudes essential to effective job performance	• Consistent use of approved formats, policies, and procedures	• Open ended, based on client needs
Timeframe	• Short term and ongoing	• Short term and ongoing	• Based on client needs
Agenda	• Based on agency mission and counselor needs	• Based on agency needs	• Based on client needs

Basic Process	• Teaching/learning specific skills, evaluating job performance, negotiating learning objectives	• Clarifying agency expectations, policies and procedures, ensuring compliance	• Behavioral, cognitive, and affective process including listening, exploring, teaching

supervision may not always be clearly marked, for it is necessary, at times, to explore supervisees' limitations as they deliver services to their clients. Address counselors' personal issues only in so far as they create barriers or affect their performance. When personal issues emerge, the key question you should ask the supervisee is how does this affect the delivery of quality client care? What is the impact of this issue on the client? What resources are you using to resolve this issue outside of the counseling dyad? When personal issues emerge that might interfere with quality care, your role may be to transfer the case to a different counselor. Most important, you should make a strong case that the supervisee should seek outside counseling or therapy.

Problems related to countertransference (projecting unresolved personal issues onto a client or supervisee) often make for difficult therapeutic relationships. The following are signs of countertransference to look for:

- A feeling of loathing, anxiety, or dread at the prospect of seeing a specific client or supervisee.
- Unexplained anger or rage at a particular client.
- Distaste for a particular client.
- Mistakes in scheduling clients, missed appointments.
- Forgetting client's name, history.
- Drowsiness during a session or sessions ending abruptly.
- Billing mistakes.
- Excessive socializing.

When counter transferential issues between counselor and client arise, some of the important questions you, as a supervisor, might explore with the counselor include:

- How is this client affecting you? What feelings does this client bring out in you? What is your behavior toward the client in response to these feelings? What is it about the substance abuse behavior of this client that brings out a response in you?
- What is happening now in your life, but more particularly between you and the client that might be contributing to these feelings, and how does this affect your counseling?
- In what ways can you address these issues in your counseling?
- What strategies and coping skills can assist you in your work with this client?

Transference and countertransference also occur in the relationship between supervisee and supervisor. Examples of supervisee transference include:

- The supervisee's idealization of the supervisor.
- Distorted reactions to the supervisor based on the supervisee's reaction to the power dynamics of the relationship.
- The supervisee's need for acceptance by or approval from an authority figure.
- The supervisee's reaction to the supervisor's establishing professional and social boundaries with the supervisee.

Supervisor countertransference with supervisees is another issue that needs to be considered. Categories of supervisor countertransference include:

- The need for approval and acceptance as a knowledgeable and competent supervisor.
- Unresolved personal conflicts of the supervisor activated by the supervisory relationship.
- Reactions to individual supervisees, such as dislike or even disdain, whether the negative response is "legitimate" or not. In a similar vein, aggrandizing and idealizing some supervisees (again, whether or not warranted) in comparison to other supervisees.
- Sexual or romantic attraction to certain supervisees.
- Cultural countertransference, such as catering to or withdrawing from individuals of a specific cultural background in a way that hinders the professional development of the counselor.

To understand these countertransference reactions means recognizing clues (such as dislike of a supervisee or romantic attraction), doing careful self-examination, personal counseling, and receiving supervision of your supervision. In some cases, it may be necessary for you to request a transfer of supervisees with whom you are experiencing countertransference, if that countertransference hinders the counselor's professional development.

Finally, counselors will be more open to addressing difficulties such as countertransference and compassion fatigue with you if you communicate understanding and awareness that these experiences are a normal part of being a counselor. Counselors should be rewarded in performance evaluations for raising these issues in supervision and demonstrating a willingness to work on them as part of their professional development.

Balancing Clinical and Administrative Functions

In the typical substance abuse treatment agency, the clinical supervisor may also be the administrative supervisor, responsible for overseeing managerial functions of the organization. Many organizations cannot afford to hire two individuals for these tasks. Hence, it is essential that you are aware of what role you are playing and how to exercise the authority given you by the administration. Texts on supervision sometimes overlook the supervisor's administrative tasks, but supervisors structure staff work; evaluate personnel for pay and promotions; define the scope of clinical competence; perform tasks involving planning, organizing, coordinating, and delegating work; select, hire, and fire personnel; and manage the organization. Clinical supervisors are often responsible for overseeing the quality assurance and improvement aspects of the agency and may also carry a caseload. For most of you, juggling administrative and clinical functions is a significant balancing act. Tips for juggling these functions include:

- Try to be clear about the "hat you are wearing." Are you speaking from an administrative or clinical perspective?

- Be aware of your own biases and values that may be affecting your administrative opinions.
- Delegate the administrative functions that you need not necessarily perform, such as human resources, financial, or legal functions.
- Get input from others to be sure of your objectivity and your perspective.

There may be some inherent problems with performing both functions, such as dual relationships. Counselors may be cautious about acknowledging difficulties they face in counseling because these may affect their performance evaluation or salary raises. On the other hand, having separate clinical and administrative supervisors can lead to inconsistent messages about priorities, and the clinical supervisor is not in the chain of command for disciplinary purposes.

Finding the Time to Do Clinical Supervision

Having read this far, you may be wondering, “Where do I find the time to conduct clinical supervision as described here? How can I do direct observation of counselors within my limited time schedule?” Or, “I work in an underfunded program with substance abuse clients. I have way too many tasks to also observe staff in counseling.”

One suggestion is to begin an implementation process that involves adding components of a supervision model one at a time. For example, scheduling supervisory meetings with each counselor is a beginning step. It is important to meet with each counselor on a regular, scheduled basis to develop learning plans and review professional development. Observations of counselors in their work might be added next. Another component might involve group supervision. In group supervision, time can be maximized by teaching and training counselors who have common skill development needs.

As you develop a positive relationship with supervisees based on cooperation and collaboration, the anxiety associated with observation will decrease. Counselors frequently enjoy the feedback and support so much that they request observation of their work. Observation can be brief. Rather than sitting in on a full hour of group, spend 20 minutes in the observation and an additional 20 providing feedback to the counselor.

Your choice of modality (individual, group, peer, etc.) is influenced by several factors: supervisees’ learning goals, their experience and developmental levels, their learning styles, your goals for

supervisees, your theoretical orientation, and your own learning goals for the supervisory process. To select a modality of supervision (within your time constraints and those of your supervisee), first pinpoint the immediate function of supervision, as different modalities fit different functions. For example, a supervisor might wish to conduct group supervision when the team is intact and functioning well, and individual supervision when specific skill development or counter transferential issues need additional attention. Given the variety of treatment environments in substance abuse treatment (e.g., therapeutic communities, intensive outpatient services, transitional living settings, correctional facilities) and varying time constraints on supervisors, several alternatives to structure supervision are available.

Peer supervision **is not hierarchical and does not include a formal evaluation procedure, but offers a means of accountability for counselors that they might not have in other forms of supervision. Peer supervision may be particularly significant among well trained, highly educated, and competent counselors.** Peer supervision is a growing medium, given the clinical supervisors' duties. Although peer supervision has received limited attention in literature, the Consensus Panel believes it is a particularly effective method, especially for small group practices and agencies with limited funding for supervision. Peer supervision groups can evolve from supervisor-led groups or individual sessions to peer groups or can begin as peer supervision. For peer supervision groups offered within an agency, there may be some history to overcome among the group members, such as political entanglements, competitiveness, or personality concerns. (Bernard and Goodyear [2004] has an extensive review of the process and the advantages and disadvantages of peer supervision.)

Triadic supervision **is a tutorial and mentoring relationship among three counselors. This model of supervision involves three counselors who, on a rotating basis, assume the roles of the supervisee, the commentator, and the supervision session facilitator.** Spice and Spice (1976) describe peer supervision with three supervisees getting together. In current counseling literature, triadic supervision involves two counselors with one supervisor. There is very little empirical or conceptual literature on this arrangement.

Individual supervision**, where a supervisor works with the supervisee in a one-to-one relationship, is considered the cornerstone of professional skill development.** Individual supervision is the most labor intensive and time-consuming method for supervision. Credentialing requirements in a particular discipline or graduate studies may mandate individual supervision with a supervisor from the same discipline.

Intensive supervision **with selected counselors is helpful in working with a difficult client (such as one with a history of violence), a client using substances unfamiliar to the counselor, or a highly resistant client.** Because of a variety of factors (credentialing requirements, skill deficits of some counselors, the need for close clinical supervision), you may opt to focus, for concentrated periods of time, on the needs of one or two counselors as others participate in peer supervision. Although this is not necessarily a long-term solution to the time constraints of a supervisor, intensive supervision provides an opportunity to address specific staffing needs while still providing a "reasonable effort to supervise" all personnel.

Group clinical supervision **is a frequently used and efficient format for supervision, team building, and staff growth.** One supervisor assists counselor development in a group of supervisee peers. The recommended group size is four to six persons to allow for frequent case presentations by each group member. With this number of counselors, each person can present a case every other month—an ideal situation, especially when combined with individual and/or peer supervision. The benefits of group supervision are that it is cost effective, members can test their perceptions through peer validation, learning is enhanced by the diversity of the group, it creates a working alliance and improves teamwork, and it provides a microcosm of group process for participants. Group supervision gives counselors a sense of commonality with others in the same situation. Because the formats and goals differ, it is helpful to think through why you are using a particular format. (Examples of group formats with different goals can be found in Borders and Brown, 2005, and Bernard & Goodyear, 2004.)

Given the realities of the substance abuse treatment field (limited funding, priorities competing for time, counselors and supervisors without advanced academic training, and clients with pressing needs in a brief treatment environment), the plan described below may be a useful structure for supervision. It is based on a scenario where a supervisor oversees one to five counselors. This plan is based on several principles:

- All counselors, regardless of years of experience or academic training, will receive at least 1 hour of supervision for every 20 to 40 hours of clinical practice.
- Direct observation is the backbone of a solid clinical supervision model.
- Group supervision is a viable means of engaging all staff in dialog, sharing ideas, and promoting team cohesion.

With the formula diagramed below, each counselor receives a minimum of 1 hour of group clinical supervision per week. Each week you will have 1 hour of observation, 1 hour of individual supervision with one of your supervisees, and 1 hour of group supervision with five supervisees. Each week, one counselor will be observed in an actual counseling session, followed by an individual supervision session with you. If the session is videotaped, the supervisee can be asked to cue the tape to the segment of the session he or she wishes to discuss with you. Afterwards, the observed counselor presents this session in group clinical supervision.

When it is a counselor's week to be observed or taped and meet for individual supervision, he or she will receive 3 hours of supervision: 1 hour of direct observation, 1 hour of individual/one-on-one supervision, and 1 hour of group supervision when he or she presents a case to the group. Over the course of months, with vacation, holiday, and sick time, it should average out to approximately 1 hour of supervision per counselor per week. Figure 7 shows this schedule.

When you are working with a counselor who needs special attention or who is functioning under specific requirements for training or credentialing, 1 additional hour per week can be allocated for this counselor, increasing the total hours for clinical supervision to 4, still a manageable amount of time.

Figure 7. Sample Clinical Supervision Schedule

Counselor	Week 1	Week 2	Week 3	Week 4	Week 5
A	1 hour direct observation 1 hour individual supervision 1 hour group supervision of A's case (3 hours)	1 hour group	1 hour group	1 hour group	1 hour group
B	1 hour group	3 hour group	1 hour group	1 hour group	1 hour group
C	1 hour group	1 hour group	3 hour group	1 hour group	1 hour group

D	1 hour group	1 hour group	1 hour group	3 hour group	1 hour group
E	1 hour group	1 hour group	1 hour group	1 hour group	3 hour group

with clients, are kept separately and are intended for the supervisor's use in helping the counselor improve clinical skills and monitor client care. It is imperative to maintain accurate and complete notes on the supervision. However, as discussed above, documentation procedures for formative versus summative evaluation of staff may vary. Typically, HR accesses summative evaluations, and supervisory notes are maintained as formative evaluations.

An example of a formative note by a supervisor might be "The counselor responsibly discussed counter transferential issues occurring with a particular client and was willing to take supervisory direction," or "We worked out an action plan, and I will follow this closely." This wording avoids concerns by the supervisor and supervisee as to the confidentiality of supervisory notes. From a legal perspective, the supervisor needs to be specific about what was agreed on and a timeframe for following up.

Structuring the Initial Supervision Sessions

As discussed earlier, your first tasks in clinical supervision are to establish a behavioral contract, get to know your supervisees, and outline the requirements of supervision. Before the initial session, you should send a supportive letter to the supervisee expressing the agency's desire to provide him or her with a quality clinical supervision experience. You might request that the counselor give some thought to what he or she would like to accomplish in supervision, what skills to work on, and which core functions used in the addiction counselor certification process he or she feels most comfortable performing.

In the first few sessions, helpful practices include:

- Briefly describe your role as both administrative and clinical supervisor (if appropriate) and discuss these distinctions with the counselor.
- Briefly describe your model of counseling and learn about the counselor's frameworks and models for her or his counseling practice. For beginning counselors this may mean helping them define their model.
- Describe your model of supervision.
- State that disclosure of one's supervisory training, experience, and model is an ethical duty of clinical supervisors.
- Discuss methods of supervision, the techniques to be used, and the resources available to the supervisee (e.g., agency in service seminar, community workshops, professional association memberships, and professional development funds or training opportunities).
- Explore the counselor's goals for supervision and his or her particular interests (and perhaps some fears) in clinical supervision.
- Explain the differences between supervision and therapy, establishing clear boundaries in this relationship.
- Work to establish a climate of cooperation, collaboration, trust, and safety.
- Create an opportunity for rating the counselor's knowledge and skills based on the competencies in TAP 21 (CSAT, 2007).
- Explain the methods by which formative and summative evaluations will occur.
- Discuss the legal and ethical expectations and responsibilities of supervision.
- Take time to decrease the anxiety associated with being supervised and build a positive working relationship.

It is important to determine the knowledge and skills, learning style, and conceptual skills of your supervisees, along with their suitability for the work setting, motivation, self-awareness, and ability to function autonomously. A basic IDP for each supervisee should emerge from the initial supervision sessions. You and your supervisee need to assess the learning environment of supervision by determining:

- Is there sufficient challenge to keep the supervisee motivated?
- Are the theoretical differences between you and the supervisee manageable?
- Are there limitations in the supervisee's knowledge and skills, personal development, self-efficacy, self-esteem, and investment in the job that would limit the gains from supervision?

- Does the supervisee possess the affective qualities (empathy, respect, genuineness, concreteness, warmth) needed for the counseling profession?
- Are the goals, means of supervision, evaluation criteria, and feedback process clearly understood by the supervisee?
- Does the supervisory environment encourage and allow risk taking?

Methods and Techniques of Clinical Supervision

A number of methods and techniques are available for clinical supervision, regardless of the modality used. Methods include (as discussed previously) case consultation, written activities such as verbatims and process recordings, audio and videotaping, and live observation. Techniques include modeling, skill demonstrations, and role playing. (See descriptions of these and other methods and techniques in Bernard & Goodyear, 2004; Borders & Brown, 2005; Campbell, 2000; and Powell & Brodsky, 2004.) Figure 8 outlines some of the methods and techniques of supervision, as well as the advantages and disadvantages of each method.

The context in which supervision is provided affects how it is carried out. A critical issue is how to manage your supervisory workload and make a reasonable effort to supervise. The contextual issues that shape the techniques and methods of supervision include:

- The allocation of time for supervision. If the 20:1 rule of client hours to supervision time is followed, you will want to allocate sufficient time for supervision each week so that it is a high priority, regularly scheduled activity.
- The unique conditions, limitations, and requirements of the agency. Some organizations may lack the physical facilities or hardware to use videotaping or to observe sessions. Some organizations may be limited by confidentiality requirements, such as working within a criminal justice system where taping may be prohibited.
- The number of supervisees reporting to a supervisor. It is difficult to provide the scope of supervision discussed in this TIP if a supervisor has more than ten supervisees. In such a case, another supervisor could be named or peer supervision could be used for advanced staff.
- Clinical and management responsibilities of a supervisor. Supervisors have varied responsibilities, including administrative tasks, limiting the amount of time available for clinical supervision.

Figure 8. Methods and Techniques in Clinical Supervision			
	Description	**Advantages**	**Disadvantages**
Verbal Reports	Verbal reports of clinical situations Group discussion of clinical situations	Informal Time efficient Often spontaneous in response to clinical situation Can hear counselor's report, what he or she includes, thus learn of the counselor's awareness and perspective, what he or she wishes to report, contrasted with supervisory observations	Sessions seen through eyes of beholder Nonverbal cues missed Can drift into case management, hence it is important to focus on the clinical nature of chart reviews, reports, etc., linking to the treatment plan and EBPs
Verbatim Reports	Process recordings Verbatim written record of a session or part of session Declining method in the behavioral health field	Helps track coordination and use of treatment plan with ongoing session Enhances conceptualization and writing skills Enhances recall and reflection skills Provides written documentation of sessions	Nonverbal cues missed Self-report bias Can be very tedious to write and to read
Written/File Review	Review of the progress notes,	An important task of a supervisor to ensure	Time consuming

	charts, documentation	compliance with accreditation standards for documentation Provides a method of quality control Ensures consistency of records and files	Notes often miss the overall quality and essence of the session Can drift into case management rather than clinical skills development

Figure 8. Methods and Techniques in Clinical Supervision (continued)

	Description	Advantages	Disadvantages
Case Consultation/ Case Management	Discussion of cases Brief case reviews	Helps organize information, conceptualize problems, and decide on clinical interventions Examines issues (e.g., cross cultural issues), integrates theory and technique, and promotes greater self-awareness An essential component of treatment planning	The validity of self-report is dependent on counselor developmental level and the supervisor's insightfulness Does not reflect broad range of clinical skills of the counselor
Direct Observation	The supervisor watches the session and may provide periodic but limited comments and/or	Allows teaching of basic skills while protecting quality of care Counselor can see and experience positive change	May create anxiety Requires supervisor caution in intervening so as to not take over the session or to create

	suggestions to the clinician	in session direction in the moment Allows supervisor to intervene when needed to protect the welfare of the client, if the session is not effective or is destructive to the client	undue dependence for the counselor or client Can be seen as intrusive to the clinical process Time consuming
Audiotaping	Audiotaping and review of a counseling session	Technically easy and inexpensive Can explore general rapport, pace, and interventions Examines important relationship issues Unobtrusive medium Can be listened to in clinical or team meetings	Counselor may feel anxious Misses nonverbal cues Poor sound quality often occurs due to limits of technology
Videotaping	Videotaping and review of a counseling session	A rich medium to review verbal and nonverbal information Provides documentation of clinical skills Can be viewed by the treatment team during group clinical supervision session Uses time efficiently	Can be seen as intrusive to the clinical process Counselor may feel anxious and self-conscious, although this subsides with experience Technically more complicated Requires training before using

		Can be used in conjunction with direct observation Can be used to suggest different interventions Allows for review of content, affective and cognitive aspects, process relationship issues in the present	Can become part of the clinical record and can be subpoenaed (should be destroyed after review)

Figure 8. Methods and Techniques in Clinical Supervision (continued)			
	Description	**Advantages**	**Disadvantages**
Webcam	Internet supervision, synchronistic and asynchronistic Teleconferencing	Can be accessed from any computer Especially useful for remote and satellite facilities and locations Uses time efficiently Modest installation and operation costs Can be stored or downloaded on a variety of media, watched in any office, then erased	Concerns about anonymity and confidentiality Can be viewed as invasive to the clinical process May increase client or counselor anxiety or self-consciousness Technically more complicated Requires assurance that downloads will be erased and unavailable to unauthorized staff

Cofacilitation and Modeling	Supervisor and counselor jointly run a counseling session Supervisor demonstrates a specific technique while the counselor observes This may be followed by roleplay with the counselor practicing the skill with time to process learning and application	Allows the supervisor to model techniques while observing the counselor Can be useful to the client ("two counselors for the price of one") Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning Counselor sees how the supervisor might respond Supervisor incrementally shapes the counselor's skill acquisition and monitors skill mastery Allows supervisor to aid counselor with difficult clients	Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning The client may perceive counselor as less skilled than the supervisor Time consuming
Role Playing	Role play a clinical situation	Enlivens the learning process Provides the supervisor with direct observation of skills Helps counselor gain a different perspective	Counselor can be anxious Supervisor must be mindful of not overwhelming the counselor with information

		Creates a safe environment for the counselor to try new skills	

Administrative Supervision

As noted above, clinical and administrative supervision overlap in the real world. Most clinical supervisors also have administrative responsibilities, including team building, time management, addressing agency policies and procedures, recordkeeping, human resources management (hiring, firing, disciplining), performance appraisal, meeting management, oversight of accreditation, maintenance of legal and ethical standards, compliance with State and Federal regulations, communications, overseeing staff cultural competence issues, quality control and improvement, budgetary and financial issues, problem solving, and documentation. Keeping up with these duties is not an easy task!

This TIP addresses two of the most frequently voiced concerns of supervisors: documentation and time management. Supervisors say, "We are drowning in paperwork. I don't have the time to adequately document my supervision as well," and "How do I manage my time so I can provide quality clinical supervision?"

Documentation for Administrative Purposes

One of the most important administrative tasks of a supervisor is that of documentation and recordkeeping, especially of clinical supervision sessions. Unquestionably, **documentation is a crucial risk management tool. Supervisory documentation can help promote the growth and professional development of the counselor (Munson, 1993).** However, adequate documentation is not a high priority in some organizations. For example, when disciplinary action is needed with an employee, your organization's attorney or human resources department will ask for the paper trail,

or documentation of prior performance issues. If appropriate documentation to justify disciplinary action is missing from the employee's record, it may prove more difficult to conduct the appropriate disciplinary action (See Falvey, 2002; Powell & Brodsky, 2004.)

Documentation is no longer an option for supervisors. It is a critical link between work performance and service delivery. You have a legal and ethical requirement to evaluate and document counselor performance. A complete record is a useful and necessary part of supervision. Records of supervision sessions should include:

- The supervisor–supervisee contract, signed by both parties.
- A brief summary of the supervisee's experience, training, and learning needs.
- The current IDP.
- A summary of all performance evaluations.
- Notations of all supervision sessions, including cases discussed and significant decisions made.
- Notation of cancelled or missed supervision sessions.
- Progressive discipline steps taken.
- Significant problems encountered in supervision and how they were resolved.
- Supervisor's clinical recommendations provided to supervisees.
- Relevant case notes and impressions.

The following should not be included in a supervision record:

- Disparaging remarks about staff or clients.
- Extraneous or sensitive supervisee information.
- Alterations in the record after the fact or premature destruction of supervision records.
- Illegible information and nonstandard abbreviations.

Several authors have proposed a standardized format for documentation of supervision, including Falvey (2002*b*), Glenn and Serovich (1994), and Williams (1994).

Time Management

By some estimates, people waste about two hours every day doing tasks that are not of high priority. In your busy job, you may find yourself at the end of the week with unfinished tasks or matters that have not been tended to. Your choices? Stop performing some tasks (often training or supervision) or take work home and work longer days. In the long run, neither of these choices is healthy or effective for your organization. Yet, being successful does not make you manage your time well. Managing your time well makes you successful. Ask yourself these questions about your priorities:

- Why am I doing this? What is the goal of this activity?
- How can I best accomplish this task in the least amount of time?
- What will happen if I choose not to do this?

It is wise to develop systems for managing timewasters such as endless meetings held without notes or minutes, playing telephone or email tag, junk mail, and so on. Effective supervisors find their times in the day when they are most productive. Time management is essential if you are to set time aside and dedicate it to supervisory tasks.

Resources

The following are resources for supervision:

- Code of Ethics from the Association of Addictions Professionals (NAADAC; http://naadac.org).
- International Certification & Reciprocity Consortium's Code of Ethics (http://internationalcredentialing.org/).
- Codes of ethics from professional groups such as the American Association for Marriage and Family Therapy (http://www.aamft.org), the American Counseling Association (http://www.counseling.org), the Association for Counselor Education and Supervision (http://www.acesonline.net), the American Psychological Association (http://www.apa.org), the National Association of Social Workers (http://www.socialworkers.org), and the National Board for Certified Counselors (NBCC; http://www.nbcc.org).

- ACES Standards for Counseling Supervisors; ACES Ethical Guidelines for Counseling Supervisors (http://www.acesonline.net/members/supervision/); and NBCC Standards for the Ethical Practice of Clinical Supervision.

End of Chapter 1

We will continue with the remaining Chapters from the Treatment Improvement Protocol further along in the course. The next two chapters will be covering some statutes and regulations, and some further researched principles on Clinical Supervision.

Chapter 2. State Statutes Regulations for Clinical Supervision

Each jurisdiction will have different regulations regarding Clinical Supervision. In this section we will review the regulations for Clinical Supervisors in California. Whether a Social Worker, A Marriage and Family Therapist, or a Licensed Professional Counselor, you may be placed in a position to supervise an intern from a different profession, which may carry with its different regulations. It is important for the Clinical Supervisor to look up the regulations pertaining to their State and the profession of the person they are supervising.

While it is not in the purview of this course to provide regulations for each State, those from California are included here, it being the most populous State, and provides an idea of what regulations may pertain to a Clinical Supervisor in other States.

The following was retrieved from the California Board of Behavioral Sciences Statues and Regulations: https://www.bbs.ca.gov/pdf/publications/lawsregs.pdf

BBS Supervision Statutes and Regulations

LMFT's

§ 4980.397. REQUIRED EXAMINATIONS

(a) A registrant or an applicant for licensure as a marriage and family therapist shall pass the following two examinations as prescribed by the board:

(1) A California law and ethics examination.

(2) A clinical examination.

(b) Upon registration with the board, an associate marriage and family therapist shall, within the first year of registration, take an examination on California law and ethics.

(c) A registrant or an applicant for licensure may take the clinical examination only upon meeting all of the following requirements:

(1) Completion of all required supervised work experience.

(2) Completion of all education requirements.

(3) Passage of the California law and ethics examination.

§ 4980.398. EXAMINATION RESTRUCTURE TRANSITION SCENARIOS

(a) Each applicant who had previously taken and passed the standard written examination but had not passed the clinical vignette examination shall also obtain a passing score on the clinical examination in order to be eligible for licensure.

(b) An applicant who had previously failed to obtain a passing score on the standard written examination shall obtain a passing score on the California law and ethics examination and the clinical examination.

(c) An applicant who had obtained eligibility for the standard written examination shall take the California law and ethics examination and the clinical examination.

(d) This section shall become operative on January 1, 2016.

§ 4980.399. CALIFORNIA LAW AND ETHICS EXAMINATION

(a) Except as provided in subdivision

(a) of Section 4980.398, each applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application except as provided in subdivision

(d). If a registrant fails to obtain a passing score on the California law and ethics examination within his or her renewal period on or after the operative date of this section, he or she shall complete, at a minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a continuing education provider as specified by the board by regulation, a county, state or governmental entity, or a college or university. 31

(e) The board shall not issue a subsequent registration number unless the applicant has passed the California law and ethics examination.

§ 4980.42. TRAINEES' SERVICES

(a) Trainees performing services in any work setting specified in Section 4980.43.3 may perform those activities and services as a trainee, provided that the activities and services constitute part of the trainee's supervised course of study and that the person is designated by the title "trainee."
(b) Trainees subject to Section 4980.37 may gain hours of experience and counsel clients outside of the required practicum. This subdivision shall apply to hours of experience gained and client counseling provided on and after January 1, 2012.

(c) Trainees subject to Section 4980.36 may gain hours of experience outside of the required practicum but must be enrolled in a practicum course to counsel clients. Trainees subject to

Section 4980.36 may counsel clients while not enrolled in a practicum course if the period of lapsed enrollment is less than 90 calendar days, and if that period is immediately preceded by enrollment in a practicum course and immediately followed by enrollment in a practicum course or completion of the degree program.

(d) All hours of experience gained pursuant to subdivisions (b) and (c) shall be subject to the other requirements of this chapter.

(e) All hours of experience gained as a trainee shall be coordinated between the school and the site where the hours are being accrued. The school shall approve each site and shall have a written agreement with each site that details each party's responsibilities, including the methods by which supervision shall be provided. The agreement shall provide for regular progress reports and evaluations of the student's performance at the site. If an applicant has gained hours of experience while enrolled in an institution other than the one that confers the qualifying degree, it shall be the applicant's responsibility to provide to the board satisfactory evidence that those hours of trainee experience were gained in compliance with this section.

§ 4980.43. SUPERVISED EXPERIENCE: ASSOCIATES OR TRAINEES

(a) Except as provided in subdivision

(b), all applicants shall have an active associate registration with the board in order to gain post degree hours of supervised experience.

(1) Preregistered post degree hours of experience shall be credited toward licensure if all of the following apply:

(A) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master's degree or doctoral degree.

(B) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed State of California "Request for Live Scan Service" form with the application for licensure.

(C) The board subsequently grants the associate registration.

(2) The applicant shall not be employed or volunteer in a private practice until the applicant has been issued an associate registration by the board. (c) Supervised experience that is obtained for purposes of qualifying for licensure shall be related to the practice of marriage and family therapy and comply with the following:

(1) A minimum of 3,000 hours completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.

(6) Hours of experience shall not be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) Hours of experience shall not have been gained more than six years prior to the date the application for licensure was received by the board, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(8) A minimum of 1,750 hours of direct clinical counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

(9) A maximum of 1,200 hours gained under the supervision of a licensed educational psychologist providing educationally related mental health services that are consistent with the scope of practice of an educational psychologist, as specified in Section 4989.14. 35

(10) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant's supervisor.

(11) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights. This subdivision shall only apply to hours gained on and after January 1, 2010. (d) An individual who submits an application for licensure between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements of this section that were in place on January 1, 2015.

§ 4980.43.1. SUPERVISOR RESPONSIBILITIES

(a) All trainees, associates, and applicants for licensure shall be under the supervision of a supervisor at all times.

(b) As used in this chapter, the term "supervision" means responsibility for, and control of, the quality of mental health and related services provided by the supervisee. Consultation or peer discussion shall not be considered supervision and shall not qualify as supervised experience. Supervision includes, but is not limited to, all of the following:

(1) Ensuring the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the supervisee.

(2) Monitoring and evaluating the supervisee's assessment, diagnosis, and treatment decisions and providing regular feedback.

(3) Monitoring and evaluating the supervisee's ability to provide services at the site or sites where he or she is practicing and to the particular clientele being served.

(4) Monitoring and addressing clinical dynamics, including, but not limited to, countertransference, intrapsychic-, interpersonal-, or trauma-related issues that may affect the supervisory or practitioner-patient relationship.

(5) Ensuring the supervisee's compliance with laws and regulations governing the practice of marriage and family therapy.

(6) Reviewing the supervisee's progress notes, process notes, and other patient treatment records, as deemed appropriate by the supervisor.

(7) With the client's written consent, providing direct observation or review of audio or video recordings of the supervisee's counseling or therapy, as deemed appropriate by the supervisor. 36 §

4980.43.2. DIRECT SUPERVISOR CONTACT

(a) Except for experience gained by attending workshops, seminars, training sessions, or conferences, as described in paragraph (9) of subdivision (a) of Section 4980.43, direct supervisor contact shall occur as follows:

(1) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting.

(2) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of direct clinical counseling performed each week in each setting. For experience gained on or after January 1, 2009, no more than six hours of supervision, whether individual, triadic, or group, shall be credited during any single week.

(3) An associate gaining experience who performs more than 10 hours of direct clinical counseling in a week in any setting shall receive at least one additional hour of direct supervisor contact for that setting. For experience gained on or after January 1, 2009, no more than six hours of supervision, whether individual, triadic, or group, shall be credited during any single week.

(4) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, triadic supervision, or a combination of both. (b) For purposes of this chapter, "one hour of direct supervisor contact" means any of the following: (1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee. (2) Triadic supervision, which means one hour of face-to-face contact between one supervisor and two supervisees. (3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more

than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. A supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee. (c) Direct supervisor contact shall occur within the same week as the hours claimed. (d) Notwithstanding subdivision (b), an associate working in a governmental entity, school, college, university, or an institution that is nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring compliance with federal and state laws relating to confidentiality of patient health information. (e) Notwithstanding any other law, once the required number of experience hours are gained, associates and applicants for licensure shall receive a minimum of one hour of direct supervisor contact per week for each practice setting in which direct clinical counseling is performed. Once the required number of experience hours are gained, further supervision for nonclinical practice, 37 as defined in paragraph (9) of subdivision (a) of Section 4980.43, shall be at the supervisor's discretion. §

4980.43.3. SUPERVISED EXPERIENCE: ACCEPTABLE SETTINGS; ACCEPTABLE SUPERVISION PRACTICES (a) A trainee, associate, or applicant for licensure shall only perform mental health and related services as an employee or volunteer, and not as an independent contractor. The requirements of this chapter regarding hours of experience and supervision shall apply equally to employees and volunteers. A trainee, associate, or applicant for licensure shall not perform any services or gain any experience within the scope of practice of the profession, as defined in Section 4980.02, as an independent contractor. While an associate may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration.

(1) If employed, an associate shall provide the board, upon application for licensure, with copies of the W-2 tax forms for each year of experience claimed.

(2) If volunteering, an associate shall provide the board, upon application for licensure, with a letter from his or her employer verifying the associate's status as a volunteer during the dates the experience was gained. (b) (1) A trainee shall not perform services in a private practice. A trainee may be credited with supervised experience completed in a setting that meets all of the following: (A) Is not a private practice. (B) Lawfully and regularly provides mental health counseling or psychotherapy. (C) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice for the

profession, as defined in Section 4980.02. (2) Only experience gained in the position for which the trainee volunteers or is employed shall qualify as supervised experience. (c) An associate may be credited with supervised experience completed in any setting that meets both of the following: (1) Lawfully and regularly provides mental health counseling or psychotherapy. (2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice for the profession, as defined in Section 4980.02. (3) Only experience gained in the position for which the associate volunteers or is employed shall qualify as supervised experience. (4) An applicant for registration as an associate shall not be employed or volunteer in a private practice until he or she has been issued an associate registration by the board. 38 (d) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience. (e) A trainee, associate, or applicant for licensure shall not receive any remuneration from patients or clients and shall only be paid by his or her employer, if an employee. (f) A trainee, associate, or applicant for licensure shall have no proprietary interest in his or her employer's business and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer. (g) A trainee, associate, or applicant for licensure who provides voluntary services in any lawful work setting other than a private practice and who only receives reimbursement for expenses actually incurred shall be considered an employee. The board may audit an applicant for licensure who receives reimbursement for expenses and the applicant for licensure shall have the burden of demonstrating that the payment received was for reimbursement of expenses actually incurred. (h) A trainee, associate, or applicant for licensure who receives a stipend or educational loan repayment from a program designed to encourage demographically underrepresented groups to enter the profession or to improve recruitment and retention in underserved regions or settings shall be considered an employee. The board may audit an applicant who receives a stipend or educational loan repayment and the applicant shall have the burden of demonstrating that the payment received was for the specified purposes. (i) An associate or a trainee may provide services via telehealth that are in the scope of practice outlined in this chapter. (j) Each educational institution preparing applicants pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital, conjoint,

family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her associates and trainees regarding the advisability of undertaking individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, educational institutions and supervisors are encouraged to assist the applicant to locate counseling or psychotherapy at a reasonable cost.

§ 4980.43.4. SUPERVISEES: LOCATION OF SERVICES; MAXIMUM NUMBER OF SUPERVISEES; OVERSIGHT AGREEMENT

(a) A trainee, associate, or applicant for licensure shall only perform mental health and related services at the places where their employer permits business to be conducted.

(b) An associate who is employed or volunteering in a private practice shall be supervised by an individual who is employed by, and shall practice at the same site as, the associate's employer. Alternatively, the supervisor may be an owner of the private practice. However, if the site is incorporated, the supervisor must be employed full-time at the site and be actively engaged in performing professional services at the site.

(c) A supervisor at a private practice or a corporation shall not supervise more than a total of three supervisees at any one time. Supervisees may be registered as an associate marriage and family therapist, an associate professional clinical counselor, or an associate clinical social worker.

(d) In a setting that is not a private practice:

(1) A written oversight agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

(2) A supervisor shall evaluate the site or sites where a trainee or associate will be gaining experience to determine that the site or sites comply with the requirements set forth in this chapter.

(e) Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements in this chapter and regulation. §

4980.43.5. AUDITS OF SUPERVISORS The board may audit the records of any supervisor to verify the completion of the supervisor qualifications specified by this chapter and by regulation. A supervisor shall maintain records of completion of the required supervisor qualifications for seven years after termination of the supervision and shall make these records available to the board for auditing purposes upon request.

§ 4980.44. ASSOCIATE NOTICE TO CLIENT OR PATIENT; ADVERTISEMENTS

An associate marriage and family therapist employed under this chapter shall comply with the following requirements: (a) Inform each client or patient prior to performing any mental health and related services that the person is an unlicensed registered associate marriage and family therapist, provide the person's registration number and the name of the person's employer, and indicate whether the person is under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900), licensed educational psychologist, or a licensed physician and surgeon certified in psychiatry by the American Board of Psychiatry and Neurology. (b) (1) Any advertisement by or on behalf of a registered associate marriage and family therapist shall include, at a minimum, all of the following information: (A) That the person is a registered associate marriage and family therapist. (B) The associate's registration number. 40 (C) The name of the person's employer. (D) That the person is supervised by a licensed person. (2) The abbreviation "AMFT" shall not be used in an advertisement unless the title "registered associate marriage and family therapist" appears in the advertisement.

§ 4980.46. FICTITIOUS BUSINESS NAMES Any licensed marriage and family therapist who conducts a private practice under a fictitious business name shall not use any name which is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice.

§ 4980.48. TRAINEES; NOTICE TO CLIENTS OF UNLICENSED STATUS; ADVERTISEMENTS

(a) A trainee shall, prior to performing any professional services, inform each client or patient that the trainee is an unlicensed marriage and family therapist trainee, provide the name of the trainee's employer, and indicate whether the trainee is under the supervision of a licensed marriage and family therapist, a licensed clinical social worker, a licensed professional clinical counselor, a licensed psychologist, a licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology, or a licensed educational psychologist.

(b) Any person that advertises services performed by a trainee shall include the trainee's name, the supervisor's license designation or abbreviation, and the supervisor's license number.

(c) Any advertisement by or on behalf of a marriage and family therapist trainee shall include, at a minimum, all of the following information:

(1) That the trainee is a marriage and family therapist trainee.

(2) The name of the trainee's employer.

(3) That the trainee is supervised by a licensed person.

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§ 4996.19. LICENSED CLINICAL SOCIAL WORKERS' CORPORATION; APPLICATION OF ARTICLE

Nothing in this article shall prohibit the acts or practices of a licensed clinical social workers' corporation duly certificated pursuant to the Moscone-Knox Professional Corporation Act, as contained in Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code and Article 5 (commencing with Section 4998), when the corporation is in compliance with

(a) the Moscone-Knox Professional Corporation Act;

(b) Article 5 (commencing with Section 4998); and

(c) all other statutes and all rules and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

§ 4996.20. ASSOCIATE CLINICAL SOCIAL WORKER: ACCEPTABLE SUPERVISORS AND SUPERVISION DEFINITION (a) “Supervisor,” as used in this chapter, means an individual who meets all of the following requirements:

(1) Has held an active license for at least two years within the five-year period immediately preceding any supervision as either: (A) A licensed professional clinical counselor, licensed marriage and family therapist, psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900), licensed clinical social worker, licensed educational psychologist, or equivalent out of-state license. A licensed educational psychologist may only supervise the provision of educationally related mental health services that are consistent with the scope of practice of an educational psychologist, as specified in Section 4989.14. (B) A physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology or an out-of-state licensed physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology.

(2) For at least two years within the five-year period immediately preceding any supervision, has practiced psychotherapy, provided psychological counseling pursuant to subdivision (e) of Section 4989.14, or provided direct clinical supervision of psychotherapy performed by associate clinical social workers, associate marriage and family therapists or trainees, or associate professional clinical counselors. Supervision of psychotherapy performed by a social work intern or a professional clinical counselor trainee shall be accepted if the supervision provided is substantially equivalent to the supervision required for registrants.

(3) Has received training in supervision as specified in this chapter and by regulation.

(4) Has not provided therapeutic services to the supervisee.

(5) Has and maintains a current and active license that is not under suspension or probation as one of the following: 106 (A) A marriage and family therapist, professional clinical counselor, clinical social worker, or licensed educational psychologist issued by the board. (B) A psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900). (C) A physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology.

(6) Is not a spouse, domestic partner, or relative of the supervisee.

(7) Does not currently have or previously had a personal, professional, or business relationship with the supervisee that undermines the authority or effectiveness of the supervision. (b) As used in this chapter, the term “supervision” means responsibility for, and control of, the quality of mental health and related services provided by the supervisee. Consultation or peer discussion shall not be considered supervision and shall not qualify as supervised experience. “Supervision” includes, but is not limited to, all of the following: (1) Ensuring the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the supervisee. (2) Monitoring and evaluating the supervisee’s assessment, diagnosis, and treatment decisions and providing regular feedback. (3) Monitoring and evaluating the supervisee’s ability to provide services at the site or sites where the supervisee is practicing and to the particular clientele being served. (4) Monitoring and addressing clinical dynamics, including, but not limited to, countertransference-, intrapsychic-, interpersonal-, or trauma-related issues that may affect the supervisory or the practitioner-patient relationship. (5) Ensuring the supervisee’s compliance with laws and regulations governing the practice of clinical social work. (6) Reviewing the supervisee’s progress notes, process notes, and other patient treatment records, as deemed appropriate by the supervisor. (7) With the client’s written consent, providing direct observation or review of audio or video recordings of the supervisee’s counseling or therapy, as deemed appropriate by the supervisor.

§ 4996.21. AUDITS OF SUPERVISORS

The board may audit the records of any supervisor to verify the completion of the supervisor qualifications specified by this chapter and by regulation. A supervisor shall maintain records of completion of the required supervisor qualifications for seven years after termination of supervision and shall make these records available to the board for auditing purposes upon request.

§ 4996.23. SUPERVISED POST-MASTER'S EXPERIENCE (a) To qualify for licensure, each applicant shall complete 3,000 hours of post-master's degree supervised experience related to the practice of clinical social work. Except as provided in subdivision (b), experience shall not be gained until the applicant is registered as an associate clinical social worker. (b) Preregistered post degree hours of experience shall be credited toward licensure if all of the following apply: (1) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master's or doctoral degree. (2) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed "State of California Request for Live Scan Service" form with the application for licensure. (3) The board subsequently grants the associate registration. (c) The applicant shall not be employed or volunteer in a private practice until the applicant has been issued an associate registration by the board. (d) The experience shall be as follows: (1) (A) At least 1,700 hours shall be gained under the supervision of a licensed clinical social worker. The remaining required supervised experience may be gained under the supervision of a physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology, licensed professional clinical counselor, licensed 109 marriage and family therapist, psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900), licensed educational psychologist, or licensed clinical social worker. (B) A maximum of 1,200 hours gained under the supervision of a licensed educational psychologist providing educationally related mental health services that are consistent with the scope of practice of an educational psychologist, as specified in Section 4989.14. (2) A minimum of 2,000 hours in clinical psychosocial diagnosis, assessment, and treatment, including psychotherapy or counseling; however, at least 750 hours shall be face-to-face individual or group psychotherapy provided in the context of clinical social work services. (3) A maximum of 1,000 hours in client centered advocacy, consultation, evaluation, research, direct supervisor contact, and workshops, seminars, training sessions, or conferences directly related to clinical social work that have been approved by the applicant's supervisor. (4) A minimum of two years of supervised experience is required to be obtained over a period of not less than 104 weeks and shall have been gained within the six years immediately preceding the date on which the application for licensure was received by the board. (5) No more than 40 hours of experience may be credited in any seven consecutive days. (6) For hours gained on or after January 1, 2010, no more than six hours of supervision, whether individual, triadic, or group supervision, shall be credited during any

single week. (e) An individual who submits an application for licensure between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements of this section that were in place on January 1, 2015.

§ 4996.23.1 DIRECT SUPERVISOR CONTACT (a) Except for experience gained by attending workshops, seminars, training sessions, or conferences, as described in paragraph (3) of subdivision (d) of Section 4996.23, direct supervisor contact shall occur as follows: (1) Supervision shall include at least one hour of direct supervisor contact each week for which experience is credited in each work setting. (2) An associate gaining experience who performs more than 10 hours of direct clinical counseling in a week in any setting shall receive at least one additional hour of direct supervisor contact for that setting. (b) For purposes of this chapter, “one hour of direct supervisor contact” means any of the following: (1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee. 110 (2) Triadic supervision, which means one hour of face-to-face contact between one supervisor and two supervisees. (3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. A supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee. (c) Direct supervisor contact shall occur within the same week as the hours claimed. (d) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, triadic supervision, or a combination of both. (e) Of the 52 weeks of required individual or triadic supervision, no less than 13 weeks shall be supervised by a licensed clinical social worker. (f) Notwithstanding subdivision (b), an associate clinical social worker working in a governmental entity, school, college, university, or an institution that is nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring compliance with state and federal laws relating to confidentiality of patient health information. (g) Notwithstanding any other law, once the required number of experience hours are gained, an associate clinical social worker or applicant for licensure shall receive a minimum of one hour of direct supervisor contact per week for each practice setting in which direct clinical counseling is performed. Once the required number of experience hours are gained, further supervision for nonclinical practice, as described in paragraph (3) of subdivision (d) of Section 4996.23, shall be at the supervisor’s discretion.

§ 4996.23.2. SUPERVISED EXPERIENCE: ACCEPTABLE SETTINGS; ACCEPTABLE SUPERVISION PRACTICES (a) An associate clinical social worker or applicant for licensure shall only perform mental health and related services as an employee or as a volunteer, not as an independent contractor. The requirements of this chapter regarding hours of experience and supervision shall apply equally to employees and volunteers. An associate or applicant for licensure shall not perform any services or gain any experience within the scope of practice of the profession, as defined in Section 4996.9, as an independent contractor. While an associate may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration. (1) If employed, an associate shall provide the board, upon application for licensure, with copies of the corresponding W-2 tax forms for each year of experience claimed. (2) If volunteering, an associate shall provide the board, upon application for licensure, with a letter from his or her employer verifying the associate's status as a volunteer during the dates the experience was gained. (b) "Private practice," for purposes of this chapter, is defined as a setting owned by a licensed clinical social worker, a licensed marriage and family therapist, a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900), a licensed professional clinical counselor, a 111 licensed physician and surgeon, or a professional corporation of any of those licensed professions. (c) Employment in a private practice shall not commence until the applicant has been registered as an associate clinical social worker. (d) Experience shall only be gained in a setting that meets both of the following: (1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy. (2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4996.9. (e) Only experience gained in the position for which the associate clinical social worker volunteers or is employed shall qualify as supervised experience. (f) Any experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience. (g) An associate clinical social worker or applicant for licensure who provides voluntary services in any lawful work setting other than a private practice and who only receives reimbursement for expenses actually incurred shall be considered an employee. The board may audit an applicant for licensure who receives reimbursement for expenses and the applicant shall have the burden of demonstrating that the

payments received were for reimbursement of expenses actually incurred. (h) An associate clinical social worker or applicant for licensure who receives a stipend or educational loan repayment from a program designed to encourage demographically underrepresented groups to enter the profession or to improve recruitment and retention in underserved regions or settings shall be considered an employee. The board may audit an applicant who receives a stipend or educational loan repayment and the applicant shall have the burden of demonstrating that the payments received were for the specified purposes. (i) An associate or applicant for licensure shall not receive any remuneration from patients or clients and shall only be paid by his or her employer, if an employee. (j) An associate or applicant for licensure shall have no proprietary interest in his or her employer's business and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer. (k) Each educational institution preparing applicants pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her supervisees regarding the advisability of undertaking individual, marital, 112 conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, educational institutions and supervisors are encouraged to assist the applicant to locate counseling or psychotherapy at a reasonable cost. § 4996.23.3.

SUPERVISEES: LOCATION OF SERVICES; MAXIMUM NUMBER OF REGISTRANTS; OVERSIGHT AGREEMENT

(a) An associate clinical social worker or an applicant for licensure shall only perform mental health and related services at the places where their employer permits business to be conducted.

(b) An associate who is employed or volunteering in a private practice shall be supervised by an individual who is employed by, and shall practice at the same site as, the associate's employer. Alternatively, the supervisor may be an owner of the private practice. However, if the site is incorporated, the supervisor must be employed full-time at the site and be actively engaged in performing professional services at the site.

(c) A supervisor at a private practice or a corporation shall not supervise more than a total of three supervisees at any one time. A supervisee may be registered as an associate marriage and family therapist, an associate professional clinical counselor, or an associate clinical social worker.

(d) In a setting that is not a private practice:

(1) A written oversight agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer

(2) A supervisor shall evaluate the site or sites where an associate clinical social worker will be gaining experience to determine that the site or sites are in compliance with the requirements set forth in this chapter and regulations.

(e) Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements in this chapter and by regulation.

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§ 4999.46. SUPERVISED POST-MASTER'S EXPERIENCE

(a) Except as provided in subdivision

(b), all applicants shall have an active associate registration with the board in order to gain post degree hours of supervised experience. (b) (1) Preregistered post degree hours of experience shall be credited toward licensure if all of the following apply: (A) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master's degree or doctoral degree. (B) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed State of California "Request for Live Scan Service" form with their application for licensure. (C) The board subsequently grants the associate registration. (2) The applicant shall not be employed or volunteer in a private practice until they have been issued an associate registration by the board. (c) Supervised experience that

is obtained for the purposes of qualifying for licensure shall be related to the practice of professional clinical counseling and comply with the following: (1) A minimum of 3,000 post degree hours performed over a period of not less than two years (104 weeks). (2) Not more than 40 hours in any seven consecutive days. (3) Not less than 1,750 hours of direct clinical counseling with individuals, groups, couples, or families using a variety of psychotherapeutic techniques and recognized counseling interventions. (4) Not less than 150 hours of clinical experience in a hospital or community mental health setting, as defined in Section 4999.12. (5) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to professional clinical counseling that have been approved by the applicant's supervisor. (6) A maximum of 1,200 hours gained under the supervision of a licensed educational psychologist providing educationally related mental health services that are consistent with the scope of practice of an educational psychologist, as specified in Section 4989.14. 135 (d) An individual who submits an application for licensure between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements of this section that were in place on January 1, 2015. (e) Experience hours shall not have been gained more than six years prior to the date the application for licensure was received by the board.

§ 4999.46.1. RESPONSIBILITIES OF SUPERVISORS AND ASSOCIATES

(a) An associate or applicant for licensure shall be under the supervision of a supervisor at all times. (b) As used in this chapter, the term "supervision" means responsibility for, and control of, the quality of mental health and related services provided by the supervisee. Consultation or peer discussion shall not be considered supervision and shall not qualify as supervised experience. Supervision includes, but is not limited to, all of the following: (1) Ensuring the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the supervisee. (2) Monitoring and evaluating the supervisee's assessment, diagnosis, and treatment decisions and providing regular feedback. (3) Monitoring and evaluating the supervisee's ability to provide services at the site or sites where he or she is practicing and to the particular clientele being served. (4) Monitoring and addressing clinical dynamics, including, but not limited to, countertransference-, intrapsychic-, interpersonal-, or trauma-related issues that may affect the supervisory or practitioner-patient relationship. (5) Ensuring the supervisee's compliance with laws

and regulations governing the practice of licensed professional clinical counseling. (6) Reviewing the supervisee's progress notes, process notes, and other patient treatment records, as deemed appropriate by the supervisor. (7) With the client's written consent, providing direct observation or review of audio or video recordings of the supervisee's counseling or therapy, as deemed appropriate by the supervisor. (c) An associate shall do both of the following: (1) Inform each client, prior to performing any professional services, that he or she is unlicensed and under supervision. (2) Renew the registration a maximum of five times. No registration shall be renewed or reinstated beyond six years from the last day of the month during which it was issued, regardless of whether it has been revoked. (d) When no further renewals are possible, an applicant may apply for and obtain a subsequent associate registration number if the applicant meets the educational requirements for a 136 subsequent associate registration number and has passed the California law and ethics examination. An applicant issued a subsequent associate registration number shall not be employed or volunteer in a private practice. §

4999.46.2. DIRECT SUPERVISOR CONTACT

(a) Except for experience gained by attending workshops, seminars, training sessions, or conferences, as described in paragraph (5) of subdivision (c) of Section 4999.46, direct supervisor contact shall occur as follows: (1) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting. (2) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of direct clinical counseling performed each week in each setting. For experience gained after January 1, 2009, no more than six hours of supervision, whether individual, triadic, or group, shall be credited during any single week. (3) An associate gaining experience who performs more than 10 hours of direct clinical counseling in a week in any setting shall receive at least one additional hour of direct supervisor contact for that setting. For experience gained after January 1, 2009, no more than six hours of supervision, whether individual supervision, triadic supervision, or group supervision, shall be credited during any single week. (4) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, triadic supervision, or a combination of both. (b) For purposes of this chapter, "one hour of direct supervisor contact" means any of the following: (1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee. (2) Triadic supervision, which

means one hour of face-to-face contact between one supervisor and two supervisees. (3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. The supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee. (c) Direct supervisor contact shall occur within the same week as the hours claimed. (d) Notwithstanding subdivision (b), an associate working in a governmental entity, school, college, university, or institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible 137 for ensuring compliance with federal and state laws relating to confidentiality of patient health information. (e) Notwithstanding any other law, once the required number of experience hours are gained, associates and applicants for licensure shall receive a minimum of one hour of direct supervisor contact per week for each practice setting in which direct clinical counseling is performed. Once the required number of experience hours are gained, further supervision for nonclinical practice, as defined in paragraph (5) of subdivision (c) of Section 4999.46, shall be at the supervisor's discretion.

§ 4999.46.3. SUPERVISED EXPERIENCE: ACCEPTABLE SETTINGS; ACCEPTABLE SUPERVISION PRACTICES (a) A clinical counselor trainee, associate, or applicant for licensure shall only perform mental health and related services as an employee or volunteer, and not as an independent contractor. The requirements of this chapter regarding hours of experience and supervision shall apply equally to employees and volunteers. A clinical counselor trainee, associate, or applicant for licensure shall not perform any services or gain any experience within the scope of practice of the profession, as defined in Section 4999.20, as an independent contractor. While an associate may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration. (1) If employed, an associate shall provide the board, upon application for licensure, with copies of the corresponding W-2 tax forms for each year of experience claimed. (2) If volunteering, an associate shall provide the board, upon application for licensure, with a letter from his or her employer verifying the associate's status as a volunteer during the dates the experience was gained. (b) A clinical counselor trainee shall not perform services in a private practice. (c) A trainee shall complete the required pre-degree supervised practicum or field study experience in a setting that meets all of the following requirements: (1) Is not a private practice. (2) Lawfully and regularly provides mental health counseling or

psychotherapy. (3) Provides oversight to ensure that the clinical counselor trainee's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice of the profession, as defined in Section 4999.20. (4) Only experience gained in the position for which the clinical counselor trainee volunteers or is employed shall qualify as supervised practicum or field study experience. (d) (1) An associate may be credited with supervised experience completed in any setting that meets both of the following: (A) Lawfully and regularly provides mental health counseling or psychotherapy. 138 (B) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice for the profession, as defined in Section 4999.20. (2) Only experience gained in the position for which the associate volunteers or is employed shall qualify as supervised experience. (3) An applicant for registration as an associate shall not be employed or volunteer in a private practice until he or she has been issued an associate registration by the board. (e) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience. (f) A clinical counselor trainee, associate, or applicant for licensure shall not receive any remuneration from patients or clients and shall only be paid by his or her employer, if an employee. (g) A clinical counselor trainee, associate, or applicant for licensure shall have no proprietary interest in his or her employer's business and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer. (h) A clinical counselor trainee, associate, or applicant for licensure who provides voluntary services in any lawful work setting other than a private practice and who only receives reimbursement for expenses actually incurred shall be considered an employee. The board may audit an applicant for licensure who receives reimbursement for expenses and the applicant for licensure shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred. (i) A clinical counselor trainee, associate, or applicant for licensure who receives a stipend or educational loan repayment from a program designed to encourage demographically underrepresented groups to enter the profession or to improve recruitment and retention in underserved regions or settings shall be considered an employee. The board may audit an applicant who receives a stipend or educational loan repayment and the applicant shall have the burden of demonstrating that the payments were for

the specified purposes. (j) Each educational institution preparing applicants pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her associates and trainees regarding the advisability of undertaking individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, educational institutions and supervisors are encouraged to assist the applicant to locate that counseling or psychotherapy at a reasonable cost.

139 § 4999.46.4. SUPERVISEES: LOCATION OF SERVICES; MAXIMUM NUMBER OF REGISTRANTS; OVERSIGHT AGREEMENT

(a) A clinical counselor trainee, associate, or applicant for licensure shall only perform mental health and related services at the places where their employer permits business to be conducted. (b) An associate who is employed or volunteering in a private practice shall be supervised by an individual who is employed by, and shall practice at the same site as, the associate's employer. Alternatively, the supervisor may be an owner of the private practice. However, if the site is incorporated, the supervisor must be employed full-time at the site and be actively engaged in performing professional services at the site.

(c) A supervisor at a private practice or a corporation shall not supervise more than a total of three supervisees at any one time. A supervisee may be registered as an associate marriage and family therapist, an associate professional clinical counselor, or an associate clinical social worker.

(d) In a setting that is not a private practice:

(1) A written oversight agreement, as specified in regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

(2) A supervisor shall evaluate the site or sites where an associate will be gaining experience to determine that the site or sites provide experience that is in compliance with the requirements set forth in this chapter.

(e) Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements in this chapter and regulation. §

4999.46.5. AUDITS OF SUPERVISORS The board may audit the records of any supervisor to verify the completion of the supervisor qualifications specified by this chapter and by regulation. A supervisor shall maintain records of completion of the required supervisor qualifications for seven years after termination of supervision and shall make these records available to the board for auditing purposes upon request. §

4999.48. RULES AND REGULATIONS The board shall adopt regulations regarding the supervision of associates that may include, but not be limited to, the following: (a) Supervisor qualifications. (b) Continuing education requirements of supervisors. (c) Registration or licensing of supervisors, or both. 140 (d) General responsibilities of supervisors. (e) The board's authority in cases of noncompliance or gross or repeated negligence by supervisors.

Chapter 3. Further Principles in Clinical Supervision

INTRODUCTION

Supervision could well be the highest calling in social work, counseling and related professions. It requires passing on knowledge and skill, mentoring, monitoring, overseeing and evaluating. It includes developing a partnership that functions as the basis for the process. It's the way these professions are shared and carried from one generation of practitioners to another.

We currently understand the need for an established process because the mental health field has progressed, and supervision has developed into a core skill that requires evaluating and appraisal of the stages of supervisee readiness, proficiency, and influence, and for the supervisor to consider these also in himself. A supervisor must blend ideas, feelings, and experience into effective professional intervention.

Until the 21st century, astonishingly little focus was given to the concept of supervision. It was an art form handed from one generation to another. When the Association of State and Provincial Psychology Boards (ASPPB) organized a task force to study supervision, they were amazed that they found no requirements for graduate-level supervisor training had been established (ASPPB, 2003), especially as they recognized the vital role play by supervision in guarding the public from harm and in the training of clinicians (Kavanagh, Spence, Strong, Wilson, Sturk, & Crow, 2003).

For example, a specific structure and method for beginning, expanding, putting into use, as well as assessing the procedures and results has been developed for those with a competency-based view of therapy (Falender & Shafranske, 2004). The supervisee's evaluation is based on a standard, not on the performance of other practitioners. Because of this, supervision is more methodic in relationship to specific areas of expertise, knowledge and values than ever before, with both the supervisor and the supervisee being aware these areas of their own experience, as well as their attitudes and values.

This continuing education course is to review the background and methods for practicing distinctive supervision. Because of the prominence given to already-present assets and development of less-strong areas through encouragement, many problems common to supervisees can be avoided through competency-based supervision founded on a solid relationship between supervisor and supervisee. You will notice that some facts and topic are referred to many times. There are two reasons for this: 1) they have a slightly different emphasis in different contexts, and 2) repetition is a good learning tool.

DEFINITIONS

CLINICAL SUPERVISION

Powell and Brodsky (2004) define supervision as "a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive." A similar definition from Haynes, Cory, and Moulton (2003) states that “A primary aim of supervision is to create a context in which the supervisee can acquire the experience

needed to become an independent professional.” Fitting in with these definitions is one by Haynes, et al. (2003) which asserts supervision is “artful, but it's an emerging formal arrangement with specific expectations, roles, responsibilities, and skills.”

In its full context, supervision is made up of relationships, or connections, between:

- Supervisor
- Supervisee
- Clients
- Clinical setting or client's home
- Cultural influences, including age, gender, race, religion, gender identity, educational level, income, etc.
- Discipline being practiced (clinical social work, counseling, marriage and family therapy, etc.)

These relationships make up a complex whole. To fully understand the whole, the broad span of each part needs to be considered first, and then the interplay between them. On a practical level, none of these can be fully understood, but should at least be given as much thought as is reasonable and necessary.

Looking at the clients, they're "in the system," or in therapy for a reason. Often there is hesitation--or even resistance--to therapy. The therapy may have been brought on by trauma or other hurtful event which has caused anger, fear, or anxiety. These may be focused on the therapist or social worker, the paperwork or one of myriads of other entities that may be only superficially relevant. Even hopes for the future may play a dissonant role at times.

Looking at the supervisee, there are also hesitations and uncertainty. Lack of confidence in her role, feelings of both optimism and inadequacy, desire to please both the client and the supervisor, and fear of failure are only a few of them. Her own personal baggage and strengths--past or current dysfunctional homes, cultural background, prejudices, worldview, and values--have potential impact on her success.

Looking at the supervisor--you--you'll be challenged by multiple functions and roles, the need to combine affective and supportive elements for your supervisee, optimistic and uncertain feelings about the role of supervisor and the process of therapy or intervention, and worries--large or small--about whether the supervisee is competent to work with a difficult family or client. You also have your own baggage and strengths that will influence your proficiency as a supervisor.

Other elements in the context also influence the supervisory process. The local community and its attitudes and values as they relate to cultural, social, and economic circumstances influence how your supervisee (and you, in a less prominent way) can most effectively air or hinder the process.

Another way to look at supervision from the supervisor's viewpoint is that you're looking with experienced eyes at the work of the supervisee, being professionally discriminating but also a sensitive instructor. As supervisor, you can not only voice heart and significance of the therapeutic and social processes, but you can also model them.

Although there are technical aspects to be considered in overseeing the supervisee's work, if he's to grow in competency you'll also need to be somewhat artful. It's your responsibility to direct your supervisees into able professionals, either as a therapist or as a social worker (Bernard and Goodyear, 2004).

Supervision is not dominance of a professional over a student. Rather, it's a participation of the professional with the student in the student's clinical work to ensure the quality of that work. If you're to be effective you will:

- Observe
- Mentor
- Coach
- Evaluate
- Inspire
- Build teams
- Create cohesion
- Resolve conflicts
- Ensure ethical practices

While doing all of these things, you'll try to create an aura between you and your supervisee that will foster learning, self-motivation, and professional development. Doing these is essential for not only improvement in quality, but for effectual applications of both evidence- and consensus-based practice (Center for Substance Abuse Treatment, 2007).

Although clinical supervision is really a separate professional proficiency, standards and proper training seem to have been considerably neglected because many clinicians have never had official training in clinical supervision (Scott, Ingram, Vitanza, & Smith, 2000). Delivering skillful and valuable clinical supervision goes beyond the set of skills needed for providing therapeutic assistance to behavioral health clients. Quite simply, being a good clinician will not automatically lead to being a good clinical supervisor.

Clinical Supervision can also be a procedure that creates an opportunity for the assessment of the supervisee's interactions with a client, ensuring that the highest quality of care is given. This is a powerful, collaborative procedure that includes the ingredients of good training and mentorship and aims to make it possible for the supervisee to cultivate, attain, and maintain a top-notch practice.

The procedure gives an opportunity for consistent secured time for assisted, in-depth thought on clinical practice and professional issues. The reflective process can result in positive changes in the supervisee's work. In this way, clinical supervision both empowers and sustains individuals in practice and will likely continue on during the clinician's entire career. (Division of Behavioral Health Services, 2008)

COMPETENCY-BASED SUPERVISION

Sullivan and Glanz (2000) identified five approaches to supervision that were both practice- and theory-based. These are mentoring, peer assessment, peer coaching, action research and differentiated supervision. Smith (2011) described the managerial and consultative (or professional) approaches. Others have mentioned humanistic (Starak, 2001), integrative (Waskett, (2009), and the objective (Gonsalvez, et al., 2011) approaches. Because the

competency-based approach is the one generally referred to in this course, these other approaches will not be defined here.

The competency-based supervision is one of the most cited approaches (Falender and Shafranske (2004). It includes concepts that are also part of other approaches. If you practice competency-based supervision, you will:

1. Identify which competencies are both profession- and setting-specific.
2. Perform a beginning assessment of the values, knowledge and skills of the supervisee.
3. Lay the foundations for a satisfactory supervisory relationship.
4. Build a supervision contract that includes continual evaluation and feedback.

THE SUPERVISOR

ROLE OF THE CLINICAL SUPERVISOR

Clinical supervision has become the means by which practitioners obtain practical knowledge and proficiency for counseling and social work professions, creating a bridge from the classroom to the job. Over the last few years, clinical supervision has been considered the foundation of excellent care and treatment. It is NOT "pulling the strings" as the illustration suggests! Supervision is critical to effectively strengthen client care, increase the professionalism and reliability of clinical staff, and provide and sustain ethical standards within the profession.

Supervision has a distinctive role in aiding supervisees to progress from basic types of counseling skills to a more seasoned and perceptive type of counseling proficiency. The experience of the supervisee should be positive and enabling rather than demanding and negative. Supervision gives a dependable background to aid supervisees in adapting their learning experiences and developing professionalism (Rawson, 2003).

Excellent clinical supervision is established on a solid supervisor-supervisee partnership which advances client wellbeing as well as professional growth and development of the supervisee. You

might be a teacher, trainer, advisor, mentor, evaluator, and manager; you give encouragement, support, and training to supervisees who are dealing with a range of physical, interpersonal, emotional, and perhaps even spiritual issues of clients.

Essentially, successful clinical supervision helps to ensure that clients are suitably served; supervision also helps to ensure that counselors and other social workers continuously grow their skills, which then improves effectiveness of treatment, keeps clients, and satisfies staff. The clinical supervisor also may also function as a link between clinical and administrative staff (Center for Substance Abuse Treatment, 2009).

To sum it up so far, a supervisor:

- Realizes that people don't wish or need to be bossed, but they need to be guided.
- Displays integrity, honesty, wisdom, and strength of character (Malone).
- Keeps track of client welfare while keeping focused on the work of and the growth of the supervisee.
- Oversees her own relationship with the supervisee, along with the supervisee's relationships with clients.
- Aids in enhancing the professional growth and functioning of the supervisee, promoting transition from one stage to another.
- Monitors and evaluates the quality of service given by the supervisee

(Cole, 2001, and Padel, 1985)

Legally, you'll find there are two kinds of supervisees--trainee and intern. An intern is usually getting college credit for his work with you and will likely pay the agency rather than be paid by the agency. A trainee is an employee.

In California, supervisees are monitored through the Board of Behavioral Sciences (BBS). Be aware that typically you, being the supervisor, are required to follow the rules and regulations pertinent to the professional status of your supervisee. For instance, a social worker supervising a marriage and family therapist (MFT) trainee is required to follow the regulations associated with the supervision of MFT trainees. An MFT who is an assigned supervisor for a social worker intern is required to follow the regulations associated with social work interns (Sultanoff, 2008).

The Importance of Clinical Supervision

Although the important of clinical supervision has already been mentioned, it's worth stressing further. The Task Force that developed the guidelines for clinical supervisors in the area of substance abuse expressed the belief that further study is needed for clinical supervision in general and for the framework of supervisor competency. They believed that the implementation of experience-based and supported treatment interventions, the connection between the quantity and quality of supervision to clinical outcomes are dependent on better understanding of the relationship between effective delivery of clinical services and supervision.

The Task Force believed that research specific to the competence of supervision should focus on:

- Validating the relationship between improved quality of service and this competence;
- Developing more tools for assessing the proficiency of supervisors in the competencies;
- Determining the best ways to train supervisors and teach the competencies
- Pinning down the best ways to prepare future clinical supervisors (Center for Substance Abuse Treatment, 2007).

You, as clinical supervisor, wear several important and vital “hats.” You assist the process of integrating counselor self-insight, theoretical foundations, and continuing growth and development of clinical knowledge and skills. At the same time, you aid in improvement of functional skills and professional procedures. Your roles include:

- Teacher: You must identify the learning needs of the supervisee, determine her strengths as a counselor, promote self-awareness, and pass on practical knowledge and professional expertise. You'll teach, train, and model.
- Consultant: You'll play the role of case consultant and reviewer, as well as monitor performance, counsel, assess the therapist concerning job performance, and counsel how performance may be improved. Additionally, you'll present alternative conceptions of

management of specific cases, aid the counselor in achieving goals you have mutually agreed upon, and do whatever else seems necessary to aid the supervisee in crossing the bridge from student to professional (Bernard and Goodyear, 2004).

- Coach: You've probably seen movies of sports coaches that harass their players to make certain improvements. That may be acceptable (although questionably) in sports, but seldom works with therapists and social workers. You'll need to find supportive ways to build morale, suggest a variety of clinical approaches, and prevent burnout. You'll model good professional techniques and behaviors and be a cheerleader for your supervisees. This supportive approach is critical for most entry-level professionals.
- Mentor: One of the overlapping areas of coaching and mentoring is being a role model. As mentor you'll also do whatever you can to facilitate the supervisee's sense of professional identity and his general professional development. The manner in which you train and mentor your supervisees, is the manner in which many of the next generation of supervisors may be trained.

These roles often overlap and are fluid in the framework of the supervisory partnership. For this reason, the supervisor is in an exceptional placement as an advocate for the agency and the counselor, as well as the client. You're the main connection between management and front-line staff, interpreting and overseeing compliance with agency goals and objectives, regulations and procedures, in addition to presenting staff and client needs to administrators. Key to your supervisor’s performance is the alliance between the supervisor and supervisee (Rigazio-DiGilio, 1997).

Until somewhere in the first years of the 21st century, there were many who advocated for the importance of clinical supervision, but there was little written about it, especially in the U.S. Journal articles often show how trainees believe in the importance of clinical supervision, but less often how experienced professionals believe in it. Although it's changing, in the past, interest in supervision has quickly declined once "basic training" has been completed (McLean, Duncan, 1996).

"New" forces that have enforced a change in this attitude are:

1. Third-party insurance reimbursements usually require clinical social workers to be receiving formal supervision.
2. Professional organizations for social workers require a specific number of minimum hours of supervision for membership and or professional certificates.
3. Most state boards of social work, including California, require a minimal number of clinical supervision hours in order to obtain different levels of licenses in clinical social work.
4. Because of the above requirements, many agencies have additional external accreditation or internal administrative requirements for supervisors (Berman, n.d.)

Distinction between Supervision and Consultation

Supervision and consultation are not the same. Consultation is considered a distinct area of practice that is separate from supervision (Munson, 2002). A consultant is a professional clinician who offers advice to another professional and who has no authority over the services that professional provides (Cole, 2001). If a supervisee directly hires a supervisor, the relationship becomes one of consultation and not supervision (American Board of Examiners in Clinical Social Work, 2004). It's important that you function as a supervisor, not a consultant.

Clinical supervision concentrates on four domains:

1. Direct practice
2. Treatment-team collaboration
3. Continued learning
4. Job management

Within each of these domains, supervisors' practice either in the employment setting or under contract to an agency, never under contract to the supervisee.

According to the American Board of Examiners in Clinical Social Work (2004) the definitions of the four domains are:

1. Clinical Supervision of Direct Practices: Activities in which the supervisor educates and guides the supervisee in assessment, treatment/intervention, evaluation of interventions done with the client, and identification ad resolutions of ethical issues.
2. Clinical Supervision of Treatment-Team Collaboration: Client-oriented activities in which the supervisor educates and guides the supervisee in interacting with other professionals in the service environment, influencing policies and procedures in the professional environment, and affecting political systems whose policies have an impact on client treatment/ interventions.
3. Clinical Supervision of Continued Learning: Activities in which the supervisor educates and guides the supervisee in developing skills necessary for life-long continued professional learning.
4. Clinical Supervision of Job Management: Activities in which the supervisor educated and guides the supervisee in work-related issues that are adjuncts to the clinical work: record-keeping, report-writing, handling of phone calls and missed sessions, fees, caseload management, timeliness, and resolution of ethical issues.

Competencies of a Clinical Supervisor

There have been numerous attempts and articles to define the competencies of a good clinical supervisor. Martin and Cannon (2010) have given perhaps the largest list of these competencies, based on their experience as supervisors "in the field" and in a university. Because of its wide range, it's quoted here for your thought. Then you'll find a checklist of competencies for you to use to help you understand what your competencies are and where you need further work.

Martin and Canon state that, "Good clinical supervisors:

- Understand and practice good therapy.
- Understand and affirm the power differential between themselves and their supervisees.

- Unambiguously support their supervisees in forming clear goals for their supervision so that they gain self-awareness and skill in progress toward being effective practitioners.
- Should be willing and able to demonstrate their clinical skill for their supervisees.
- Know that their supervision exists in the real world where human lives are seriously impacted by their supervision, instead of only as an academic or intellectual exercise.
- Ask good questions of those whom they supervise and help the supervisee to experience the worth of the struggle to serve clients in a positive fashion, and to discover that therapy is more a way of being than a way of doing.
- Empower supervisees to confidently conduct clinical work, by confronting supervisee's inadequacies, but, moreover, by affirming their struggle to succeed and their consequent successes. They stay alert to opportunities for helping supervisees to improve their clinical judgment.
- Respect the boundary between clinical supervision and the supervisee's possible need for personal therapy.
- Understand that their way of responding to clinical situations is one among many clinically appropriate ways of responding.
- Seek to nurture counseling identity in their supervisees.
- Know that clients' needs take precedence over supervisors' and supervisees' needs.
- Remain cognizant of advancing the profession of counseling, along with nurturing supervisees' development.
- Understand that supervision is a process, not an event or a technique. The process involves a perpetual quest for meaning, satisfaction, and personal fulfillment as a supervisor, ever dependent on the need of supervisors and supervisees to improve the delivery of clinical services.
- Commit to spontaneity, experimentation, inventiveness, and other existential necessities, knowing that their self-discipline is indeed disciplined and well-informed. This means they're accountable for the process of growth for themselves and their supervisees and, paradoxically, subordinate to it.
- Know that their conjoint and occasional incapacity to help clients provides opportunities for growth. Further, a great deal may be learned from the experience failure.
- Understand that a professional working alliance with supervisees is necessary and mutual.

- Increase supervisees' awareness of transference and counter-transference issues in therapy, but also in supervision.
- Establish plans for their own professional development.
- Remain cognizant of the potential threats that sometime attend growth towards healthy and effective therapeutic functioning by their supervisees. This is to say that good therapy sometimes upsets individuals and the institutional political systems in which they function.
- Know that confrontation—along with its consequent stress—is necessary in the conduct of clinical supervision, but that tenderness and support are necessary, too.
- Appreciate empirical research in counseling and psychotherapy and self-consciously integrate findings into the process of supervision.

In 2002, Epstein and Hundert gave the following basic definition of competency: "Habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." The definition is applicable to any area, but has become foundational to competency-based supervision.

A Competencies Conference was held in 2002 by the Association of Psychology Postdoctoral and Internship Centers. An outline was made for psychology supervisor competencies, with the four basic areas being:

1. Knowledge
2. Skills
3. Values associated with supervision
4. Social context

These are also apropos to supervision of social work and clinical therapy. Using the following self-assessment given by Falender (2010) and based on Falender, et al. (2004), your competencies as a supervisor. This assessment adds several other areas to consider:

1. Training of Supervision Competencies
2. Assessment of Supervision Competencies
3. Other to be defined by supervisor/setting

Check List: For both your present practice and the practice you hope to attain, mark the range from 1 (which indicates you have no knowledge, values or skills in that area) to 7 (which indicates that you have superior knowledge, values or skills) --you'll have two marks for each competency (present and hopeful) You can then use the results to plan the steps you need and want to take to improve.

KNOWLEDGE

Of area being supervised
Of models, theories, modalities, and research on supervision
Of professional/supervisee development
Of evaluation, process/ outcome
Awareness of diversity in all forms

SKILLS

Supervision modalities
Relationship skills
Sensitivity to multiple roles: Perform and balance
Provide effective formative and summative feedback
Promote growth and self-assessment in trainee
Conduct own self-assessment
Assess learning needs and developmental level of supervisee
Encourage and use evaluative feedback from trainee
Teaching and didactic skills
Set appropriate boundaries and seek consultation when supervisory issues are outside domain of supervisor competence
Flexibility
Scientific thinking and translation of scientific finding to practice throughout professional development

VALUES

Responsibility for client and supervisee
Respectful

Responsibility for sensitivity to diversity in all forms

Balance between support and challenging

Empowering

Commitment to lifelong learning and professional growth

Balance between clinical and training needs

Value ethical principles

Commitment to knowing and utilizing available psychological science related to supervision

Commitment to knowing one's own limitations

SOCIAL CONTEXT OVERARCHING ISSUES

Diversity

Ethical and legal issues

Developmental process

Knowledge of immediate system and expectations within which the supervision is conducted

Creation of climate in which honest feedback is the norm (supportive and challenging)

TRAINING OF SUPERVISION COMPETENCIES

Coursework in supervision including knowledge and skill areas listed

Has received supervision of supervision including some form of observation (video or audiotape) with critical feedback

ASSESSMENT OF SUPERVISION COMPETENCIES

Successful completion of course on supervision

Verification of previous supervision of supervision document readiness to supervise independently

Evidence of direct observation (e.g., audio or videotape)

Documentation of supervisory experience reflecting diversity

Documented supervisee feedback

Self-assessment and awareness of need for consultation when necessary

Assessment of supervision outcomes – both individual and group

OTHER TO BE DEFINED BY SUPERVISOR/SETTING

Best Practices of Supervision

Falender and Shafranske (2007) characterized supervision best practices and detailed the steps to be taken to become successful and competent as a supervisor. The supervisor must:

- Examine her own competence and expertise as a clinician and as a supervisor.
- Describe expectations as a supervisor, including general practice, rules and standards.
- Recognize competencies that are setting-specific that the supervisee must achieve for a successful close to the supervision experience.
- Work with the supervisee to develop a supervisory contract or agreement (to be covered in detail later in the course).
- Model self-assessment and development of self-awareness of competencies throughout supervision, and engage the supervisee in doing the same.

Fouad, et al., (2009) reported that more and more evidence is appearing to show that reflection and self-assessment make it easier for supervisees to accept and integrate supervisory feedback--positive, corrective or negative--which is an essential part of supervision. This finding stresses the need for both supervisee and supervisor to do the reflection and self-assessments that are part of supervision best practices.

"Side Effects" of Being a Clinical Supervisor

Although there are many benefits of being a supervisor, there are "side effects" that may deter some folks from taking such a position. These are not mentioned here for that reason, but that you would be prepared to handle them successfully.

Increased Liability

Once you become a supervisor, you're not only legally liable for yourself, but also for your supervisee(s). You take responsibility for supervisee work; the agency for which you work shares that responsibility and liability. But the legal issues are largely on your shoulders.

Areas of risk assessment and risk management for which you need to give continual attentiveness are civil-law issues such as:

- Domestic violence
- Duty-to-report
- Duty-to-warn
- Perceived threat to your supervisee

Other areas under state mandates relate to malpractice and related topics. For instance:

- Fraudulent practice
- Abusive practice
- HIPPA rules
- Record keeping
- Relationship between supervisor and supervisee

(Munson, 2002)

Because of this need for exceptional alertness, and because of a supervisor's accountability for the safety and well-being of the client--based on the governing control you've been given, some state licensing boards have gone to great measures to oversee clinical licensure. They have made guidelines for requirements of clinical supervision, and have issued the names of social workers qualified to supervise licensure candidates. They do this to protect the public from illegal and unethical treatment. Some states even require supervisor hopefuls to demonstrate a defined competence level in their practice and awareness of what the legal and ethical issues are before they can become supervisors (ABECSW, 2004).

Legal and ethical issues and practices will be discussed in more detail throughout this course.

Liability Insurance

The fact that you assume these legal and ethical responsibilities requires you to have professional liability insurance. There are several facts you should be aware of regarding malpractice insurance:

- ✓ ALWAYS assume you could easily be sued in the current suit-happy culture. If a client perceives, imagines or perhaps even finds it convenient to lie that your services or lack thereof caused him harm, you could be sued. Any gaps in the plan your employer provides--a not uncommon occurrence--may cause you to rejoice that you have your own insurance.
- ✓ Even if your employer provides malpractice insurance for you, you should purchase your own individual policy. This policy protects only you, not also your employer. The policy the employer provides for you will focus more on its own interests should there be a lawsuit.
- ✓ Having your own policy will not increase the likelihood of you being sued. No one needs to know you have such a policy unless you're sued. Then it would be revealed and your insurance stands ready to help you.
- ✓ Having your own policy will not affect whether or not the plaintiff's attorney(s) will keep your name on a lawsuit's defendant list. If those attorneys believe or imagine that you're even remotely involved with the case in a way that could help its strength, they will keep you on the list whether or not you have an individual policy.

Gerson (2003) recommends listing all supervisees--interns, assistants, trainees--on your liability policy. This is an absolute must if you employ the supervisee. Even if the supervisee is not in your employ, it's extra assurance for you if you list them as co-insured or "addition insured." The supervisee should also have his own liability policy for self-protection supposing there could be litigation. Cole (2001) suggests having back-up supervision coverage for your supervisee if you're on an extended vacation or illness or are unavailable for some other reason.

Due Process

If you hear someone talk about "due process," they generally are taking about "their due," or something they feel entitled to (Stevens, 2003). Due process includes written policies and

procedures to be adhered to if a complaint or grievance has been made about the counselor, the supervisor or the administration. It makes certain that all sides are given opportunity to voice their point of view and that both the statement of disagreement and the response to it are given the consideration due to them. When all parties are appraised of the process for making a complaint, they're considered to have informed consent (Center for Substance Abuse Treatment, 2009a). It's your responsibility to ensure that both your supervisees and their clients know their rights and the procedures of due process (North Carolina Center for Credentialing and Education, 2008).

The policies and procedures also generally outline what to do for conflict resolution and for any decisions to be made concerning corrections to be made, as well as probation, suspension or termination of the individuals involved (Comish, 2011). The Ethics Committee of the American Association for Marriage and Family Therapy (AAMFT) considers as "innocent until proven guilty" those who have been accused (AAMFT, 2001).

If an individual is found guilty of charges or even a lesser problem, the agency usually has several possible ways to deal with that, depending on the severity of the issue. These generally include verbal warning, developmental/remedial plan, probation, extended or second period of training, suspension, temporary reduction or removal of case privileges, or termination.

Verbal Warning

The first level of dealing with a grievance that has been made is only for low level problems of inappropriate behavior and is a verbal warning to change the behavior. Of an educative nature, this consequence is usually handled in supervision times. The nature of the problem will dictate whether or not there is a need to increase supervision time, focus or format, or whether a change in case responsibilities is called for. (Comish, 2011)

Developmental/Remedial Plan

The developmental plan is to remediate a problem more serious nature than that which receives only a verbal warning. Competencies that are being looked at are listed with the date or dates they were discussed with the supervisee and by whom. Also listed are steps that have been taken to correct the problems--by the supervisee, supervisor or other staff. Required expectations are listed, as are the supervisee's responsibilities, the supervisor's or other staff's responsibilities, the time frame in which satisfactory performance is expected, assessment methods used, and evaluation dates. If remediation has been unsuccessful, the consequences of that are listed (Comish, 2011).

Probation Plan

If the grievance is too serious for the previous plans, or if the developmental plan didn't bring about the desired results, a probation plan will be written (Comish, 2011). In some places there are four possible reasons to place a supervisee on probation:

1. Inadequate response to supervision
2. The nature of a specific incident or incidents
3. Unacceptably low formal evaluations
4. Noncompliance with paperwork requirements

Probation is also designed for remediation and gives the supervisee a chance to improve or change her behavior or performance. Probation is time limited; during the time of probation the supervisee is carefully monitored by the supervisor, or even a site clinical supervisor, who will regularly consult with other training staff. The supervisee is also given timely and regular feedback about her improvement or lack therefore, and is also given a date for the next written, formal review (Internship Consortium, 2011).

Extension of the Supervision Time

When the supervisee's skills or behavior need improved, and when he has made some improvement but not sufficient improvement by the end of the period of required intense supervision, the supervisee may be required to extend the time. Sometimes this may include

remaining longer at a clinical site in order to finish the requirements. If the supervisee does not show a willingness and aptitude for complete remediation, he may be suspended or dismissed (Comish, 2011 and Internship Consortium, 2011).

Suspension

Suspension is a means of putting the supervisee's job "on hold" while the related problem is worked out or while a training committee reviews the problem. Examples of situations that could cause suspension are:

- A client or staff person is viewed as being endangered.
- Probation has not resulted in the problem being solved.
- The supervisee has not kept a required level of malpractice insurance

Supervisees are notified immediately of an impending suspension. They're given a copy of any related documentation and reminded of the procedures for grievance and appeal (Comish, 2011).

The nature of the problem and its resolution determine the length of the suspension. However, everyone involved is expected to do all in their power to hasten the resolution of the problem in such a way that all who are involved will have their best interested served. Supervisees who are suspended will need to make up the hours lost by extending the time of required supervision (Internship Consortium, 2011).

Termination

Termination is obviously the most severe consequence of problematic behavior of a supervisee. Because of the need to protect the rights of the supervisee and to secure the rights and standards of the agency and the profession, guidelines and policies for termination are set forth.

Generally, you, the supervisor, and the site clinical supervisor if your agency has one, would recommend termination in extreme instances in which the supervisee's performance has put a client at risk. Other reasons for termination may include the fact that the supervisee:

- Has a problem with appropriate and effective interaction with clients.
- Is unable to distinguish between social and professional relationships.
- Does not maintain a sufficient caseload.
- Does not properly respond to supervision.
- Does not follow policies of the agency.
- Shows unprofessional and inappropriate appearance and overall behavior.
- Does not adhere consistently and adequately to remediation plans in lesser stages of correction.
- Demonstrates little awareness of his improper or negative impact on clients, supervisors, colleagues and other staff.
- Does not take care of herself, such as not getting help for medical or emotional problems.
- Shows disregard for ethical and legal guidelines for the profession.
- Does not follow evaluative and other principles of the agency.

The supervisee is given notice in advance of a hearing, usually five days. If she does not attend the hearing, it's common for it to still take place. Also, the supervisee is generally notified in person and in writing of termination.

If, as sometimes happens, termination occurs because of something such as agency downsizing and no fault of the supervisee, many agencies will do their best to suggest alternative work places and will give recommendations (Internship Consortium, 2011).

Temporary Reduction or Removal of Case Privileges

If, at any time during this process, it's concluded that the supervisee's or client's welfare has been put at risk, the supervisee's case privileges may be either considerably reduced or taken away for a designated period of time. When the time is up, the supervisor will consult with other training

staff to evaluate the supervisee's ability to function effectively, and to decide whether or not to return the case privileges (Comish, 2011; Internship Consortium, 2011).

Appeal Procedure

Although most conflicts will be concluded jointly between the supervisee and the supervisor, there are times when the supervisee will wish to appeal a decision. Each agency has its own procedure for this. An example of this procedure is:

- The supervisee appeals in writing to whoever the supervisor is responsible to, perhaps the site administrator.
- A committee comprised of the supervisor, her superior and other staff that may be involved in supervising will meet as soon as possible after the appeal is received. Sometimes the supervisee making the appeal is invited to attend.
- This committee reviews the appeal and makes a decision concerning the supervisee's appeal and notifies the supervisee in writing.

During this process, primary importance must be given to the safety of the supervisee's clients. Consequently, the supervisee is expected to abide by the conditions of his case privileges set forth by the agency while the appeal is being deliberated (Internship Consortium, 2011).

Extra Work Load

Clinical supervision might be a much easier undertaking if the only task the clinical supervisor was required to do was to provide supervision. The requirements agencies and providers are under usually demand that the clinical supervisor wear many hats in addition to being the clinical supervisor. According to Malone (2009), additional positions the clinical supervisor might also need to perform are:

Therapist--All too often clinical supervisors must maintain their own caseloads; that includes giving clinical services to clients. However, having their own clients provides the clinical supervisors a chance to continually develop their own skills, and stay mindful of the daily challenges of clinical practice. Additionally, it's through this position that the clinical supervisor is able to demonstrate effectual procedures that the clinical supervisee can watch and emulate. Nevertheless, this isn't the spot in which the clinical supervisor can say, "do what I say, not what I actually do." That would be an invitation for failure that would end up in distrust and lack of believability.

Administrator--Sometimes clinical supervisors are also given administrative tasks that may include financial demands for the agency, hiring (and dismissing) staff, implementing and overseeing the goals of the agency, and/or being involved in legal and ethical issues of the agency. The clinical supervisor must balance the tasks of these two demanding areas. Should the supervisor spend too much time being an administrator, rather than the necessary time for being a clinical supervisor, the supervisees may believe they're on their own and act accordingly. The wise clinical supervisors will keep in mind that their main responsibility is to the supervisee. The business needs are second.

Employee--Being the clinical supervisor ought not afford the supervisor exceptional status. The supervisor is required to follow the agency's procedures and polices just like any other person in the agency. The supervisor is simply not exempt from sticking to the basics of the agency's procedures and practices--in fact, they should likely be even more particular about following them. Moreover, the supervisor needs to ensure that supervisees are well informed of all the policies and procedures that regulate the agency and the profession.

Overseer of professional advancement--The clinical supervisor might be a resource for professional growth for the people in the agency, regardless of their job. This can be successfully done by developing and maintaining a learning atmosphere that is both secure and encouraging. To phrase it differently, the clinical supervisor is a team player who's happy to share his know-how and experience with any staff member who asks. Professional advancement can be provided by the clinical supervisor participating in exercises that improve understanding, knowledge, proficiency, attitudes, and principles. Identifying the objectives and plan for the supervisor/supervisee alliance is an area the supervisor should practice. However, your role and

set of skills as a clinical supervisor are distinctive from those of other professionals and employees in the agency.

GOALS OF A SUPERVISOR

Probably every supervisor has her own set of goals. And there are most likely a lot of similarities between these lists. Five primary goals might be to help the supervisee:

1. Integrate the parts of the therapeutic process: professional and personal boundaries; limitations and potentials in counseling; thoughts, feelings and beliefs of both counselor and client; and use of intuition.
2. Develop their own principles of good professional practice, based on a healthy perception of ethical principles. This leads to refining their conscious considerations of the process and their decision making while moderating therapeutic change.
3. Develop belief in himself as a professional and a heightened ability to act independently in their work, while also knowing when and where to consult on matters they want to analyze with another professional (Hawkins & Shohet, 1989).
4. Recognize, explore and develop their own particular therapeutic style, including the context of their own experiences--past and present. The "art of therapy" includes counseling style as much as therapeutic interventions. Style and interventions have differing emphasis, but they're inseparably linked.
5. Explore different ways of understanding and aiding with specific client issues--developing deeper understanding of the clients and assisting in setting appropriate goals. In general, forming goals requires aid in education, motivation and evaluation (Cormier & Hackney, 1999); counselors who set goals appear to work more efficiently and effectively (Rawson, 2003).

A crucial first step, and therefore first goal, in the supervisory process is to establish an alliance between the supervisor and supervisee in which shared goals and methods for achieving them are jointly developed, hopefully with a resultant emotional bond (Bordin, 1983). The more clearly the expectations of this supervisory alliance are set forth, the more successful the alliance will be.

Through the following interactions, the set of goals that are developed are appropriate for the supervisee's developmental level and specific to the context in which the supervision takes place.

Once the goals are established, distinct methods are planned for reaching the goals. The emotional bond is developed and strengthened through the process of forming the goals and methods. Examples of the kinds of goals this planning might define are (Fallender, 2010):

- For therapeutic interventions with children and young people, improve skills in setting limits
- Focusing on process, cultivate group therapy skills
- Increase confidence in leading groups of young people (or adults) with (problem name)
- Develop skills in a (less familiar) intervention such as evidence-based treatment
- Strengthen knowledge and skills in assessing child abuse
- Acquire a fuller sense of his contribution to and role in the therapy process

Examples of possible tasks for meeting those goes are:

- Observe other groups of the same population in the same or similar setting
- Be co-therapist in another process-oriented group
- Videotape a group for individuals with (problem name) and analyze it in supervision
- Think about different theoretical perspectives and how process may be brought into play
- Carry out co-therapy with supervisor to develop skills in group or family therapy
- Have supervision specifically targeted to group therapy skills

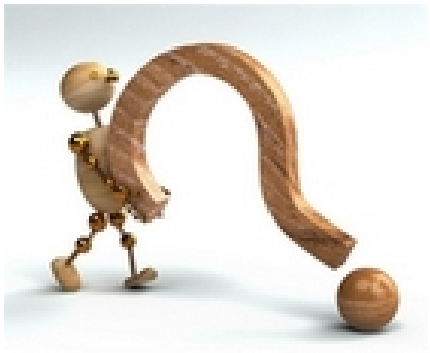
Another very concrete goal is to develop a supervisory agreement or contract between yourself and your supervisee. This agreement is a very important part of the relationship between the two of you. It defines the roles, expectations, responsibilities and requirements of both the supervisor and the supervisee during the training period and may be translated into an example for assessment. Each supervisor-supervisee relationship and the pertinent will have its own unique competencies, evaluations and other criteria, and thus each supervisory agreement must be tailored to meet those individual needs. The contract may include (Falender, 2010):

1. Time and length of supervision

2. Scope of practice, i.e., permitted actions, procedures, and processes
3. Requirements, rules, laws, and regulations of the agency
4. Supervisor's role
    - Frequency, time and length of supervision sessions
    - Policy for cancelling a supervision session by either party
    - Procedures for emergencies or crisis situations
        - Definition of what constitutes an emergency or crisis
        - State reporting laws and duty to warn
        - Procedures to contact a supervisor or an on-call therapies
        - Steps to take once an emergency or crisis has been identified
    - Who to contact when supervisor is on vacation, etc.
    - Limits of confidentiality in supervisory information exchange
    - Variety of roles of the supervisor (e.g., supervisor, training director, program director) and the supervisee (e.g., supervisee, therapist or social worker) and potential role conflicts
    - Theoretical models of supervision and therapy that will be used
    - Supervisor training and experience
    - Supervisor's areas of expertise
    - Supervisor's methodology
        - Specific techniques commonly used
        - Expectation
        - Type of supervision used, such as live or with video/audio
5. Mutual role
    - Mutually determined training goals and task for the supervisory experience
6. Supervisee's role
    - Responsibilities
    - Attendance
    - Record keeping/documentation
    - Productivity
    - Clinical caseload
        - Number of hours
        - Variety
        - Diversity variables between supervisor, supervisee and clients

    - Required limits
- Seminars, required and optional
- Theoretical orientation and how it may relate to the supervisor's theoretical orientation
- Expected forming of diagnoses, including diversity or multicultural conceptions
- Specific expectations of performance
    - Competence
    - Interpersonal and relationship skills
    - Teamwork
    - Emotional awareness
    - Limits of independence
    - Competence with diversity issues
    - Technical skills

Questions to Ask Yourself



At the beginning of your "supervisorship" and at intervals from thereon, it's a good idea to make a workbook to accomplish several things:

1. To develop and update your clinical supervision philosophy. To help in this, some of the scores of questions you can ask yourself might be (Martin and Cannon, 2010):
    - What is my definition of good clinical supervision?
    - What role do I prefer to play as a supervisor?
    - What resources (mentors, books, articles, records of my supervision) do I have access to, to help me define my concept of clinical supervision?
    - How should I express my supervision approach to my supervisees?
    - How can I best see where my clinical supervision is most effective, and where it's least effective?
    - Am I vulnerable to any professional ethical issues in my supervision approach? If so, which one(s)?

- Which problems of clients draw me? Does this aid or inhibit good clinical supervision? To what degree?
- Which populations of clients draw me? Does this aid or inhibit good clinical supervision? To what degree?
- How do I take care of my supervisees' clinical weaknesses?
- How do I take care of my supervisees' clinical strengths?
- How do I recognize my supervisees' progress?
- How do I keep track of my supervisees' progress?
- How do I articulate evaluations of my supervisees clearly and thoroughly?
- How can I make sure that my supervision reasonably matches the needs of my supervisee?

2. To help focus your supervision concerns primarily on the supervisee and secondarily on the client(s) there are other kinds of questions to ask (Cole, 2001):

- What is my logistics for supervisory meetings?
- What are my goals for each supervisee?
- How do I balance a commitment to train and supervise therapists, the need for my supervisees to do their jobs, and a need to be of service to my community?
- What are some of my general training issues that are central to my supervision?
- How do I respond to differing degrees of supervisee enthusiasm?
- Am I committed to improving my own skills?
- What do I need to do to further develop my supervisor methods?
- Do I know and practice the difference between supervision and training
- Should a case the supervisee can't cope with be transferred to me?
- Are differences in sex or age of the supervisee and me likely to be a problem in supervision?
- Do I use a variety of methods in supervision (live, audio/video, etc.)? or do I use several of the modes that are available in our agency?
- Are my supervisee and myself having any relationship issues, especially any that may be on the edge of ethical or legal guidelines?

More on Developing Your Supervisory Philosophy and Acumen

What clinical supervision is has already been discussed in detail? The definition may be summarized as "the process of training another clinician to function effectively" (Martin and Cannon, 2010).

It's often assumed that if an individual is a good counselor, he will be a good clinical supervisor. Regrettably, this is probably not the case. Although an essential prerequisite for being a supervisor is experience in clinical work, it's not enough.

Bernard and Goodyear (2004), in their classic clinical supervision text, differentiate between models of supervision that are based on a theory or theories of psychotherapy and those based on a developmental model of supervision.

Even though breaking down the components of concepts may be a needed and commendable practice, it does not comply with a clinical supervisor's responsibility. A clinical supervision philosophy might start with analyzing concepts, but that should be only a small part of it.

A primary obligation of a clinical supervisor is to discuss her personal and professional approach to clinical supervision with the supervisee. This is necessary, in part, as exemplified in the case of a supervisor who is oriented to psychodynamic therapy but is supervising an individual who is oriented to cognitive therapy. The supervisor may be closely connected with a particular theory of therapy, but must still be able to aid a supervisee who is following a very different theory. As a supervisor, you must have a sound understanding of and experience in therapy, but in the supervisory role you must be more effective in your relationship with your supervisees than in carrying out the responsibilities of a therapist.

To move yourself into this role, you might ask yourself the following questions:

- What do I believe about conducting therapy?
- What do I believe about clinical supervision?
- What is my model of clinical supervision?
- What do I hope to accomplish through clinical supervision?

- What is the role of the supervisor?
- What is the role of the supervisee?
- What kind of relationship do I want to develop with supervisees?
- How do I define the good clinical supervisor?
- What attributes--personal and profession --do I have that will aid in effective clinical supervision?
- What are the ethically sensitive issues that I am likely to encounter in conducting clinical supervision? (Martin and Canon, 2010)

When you're clear about the answers to questions like these, you'll be in a position to define a clinical supervision philosophy that encases your beliefs about supervision. These beliefs will arise from your thoughts, and from your experiences as a therapist, as one who has received clinical supervision, and an understanding of clinical supervision based on careful study. These beliefs will include--among other things--what you believe about people, about how they change and develop, and how therapy works.

Although years of carrying out clinical services is generally required before an individual is deemed capable of becoming a supervisor, McMahon and Simons (2004) believe there is a satisfactory substitute. That is clinical supervision training that includes a doctoral program in counselor supervision and education. They report that this has been shown to prepare able clinical supervisors.

Models of Supervision

The Center for Substance Abuse Treatment (2009a) states that it's vital for supervisors to work from a supervision model that is clearly defined and that provides a meaning and purpose for your role as supervisor. Different writers divide the models in different ways. For obvious reasons, none of them includes all of the possible models of supervision; examples of divisions include:

K. L. Smith (2009) gives the following groupings:

- Psycho-therapy based models of supervision
    - Psychodynamic approach to supervision
        - Patient-centered
        - Supervisee-centered

        - Supervisory-matrix-centered
    - Feminist model of supervision
    - Person-centered supervision
- Developmental models of supervision
    - Integrated development model
    - Developmental phase model
- Integrative models of supervision
    - Discrimination model
    - Systems approach

The Center for Substance Abuse Treatment (2009a) divides the models into four basic kinds:

- Competency-based models
    - Micro counseling
    - Discrimination
    - Task-oriented
- Treatment-based models
    - Motivational interviewing
    - Cognitive behavior
    - Psychodynamic psychotherapy
- Developmental approaches
    - Supervisee development
    - Supervisor development
- Integrated models

According to M. K. Smith (1996, 2005), Kadushin offers three models:

- Administrative or authoritative model
- Educational model
- Supportive or facilitative model

Others add other models to this list:

- Bureaucratic model

- Laissez-faire model

A grouping given by Fallender (2010) overlaps these at several points:

- Theory-based models
  - Psychodynamic
  - Cognitive-behavioral
  - Narrative/intersubjective Systemic models
- Developmental models
  - Supervisee development
  - Supervisor development
- Process-oriented and other models
  - Micro counseling
  - Dialectical behavioral
  - Interpersonal process recall
  - Seven-eyed supervisor model

For the purpose of combining these into one discussion, these approaches will be regrouped and integrated in perhaps unorthodox and certainly in unofficial ways in the following sections.

Functional Approaches to Supervision

When defining supervision and discussing the role of a supervisor, we were basically looking at the functions and focus of supervision. Among the different questions that arise when we do this is, "Whose interest is focused on in supervision?"

Four focuses are each addressed at different times in supervision, according to Rodenhauser, et al. (1985). These four focuses are: 1) organization and professional, 2) planning and assessment, 3) implementation, and 4) personal elements. Smith (1996, 2005) refers to three models of or

approaches to supervision developed by Kadushin (1992) that, between them, address these and other issues (Smith, 1996, 2005). Several of the approaches are to be used in tandem, not alone.

Administrative or Authoritative Model

The focus of the administrative model of supervision is the proper employment of policies and procedures of the agency. "Proper" employment includes accurate, productive and suitable implementation of them. Some feel that the goal of this model is to make sure that the supervisee exactly follows the procedures and policies, thus allowing her to work at their best level (Brown and Bourne, 1995).

Grasha (2002) states that the "expert and formal authority" style's main goal is to ensure that the supervisee is thoroughly prepared through having sufficient information. He believes that supervisees who find it more difficult to work independently, take initiative, and accept responsibility would most benefit from this approach. However, he also believes that this is not the best way to build a good relationship. Malone (2009) believe this approach does not allow much independent thought and can cause a passive-aggressive response as an attempt to equalize the power structure. However, this approach may be dictated in emergencies and situations that put unforeseen demands on the supervisee.

Bureaucratic Model

Closely related to the authoritarian model is the bureaucratic model. In this style or model, the supervisor is basically only looking after him- or her-self and may not back up the supervisee. This can lead to uncertainty and distrust. Supervisees will likely take no risks and will squelch their creativity, fearing that if they make a mistake, they may be "thrown under the bus." This approach also violates supervisory ethical codes which state that the responsibilities of the supervisor include watching out for the supervisees' wellbeing (Malone, 2009).

Laissez-Faire Model

At the other extreme of supervisory models is the laissez-faire model, which is just as unethical as the bureaucratic model. In this model, the supervisor exudes a "whatever," passive attitude and generates no confidence in the supervisee. The model lacks direction, objectives, and goals. The supervisee can never be sure what the "right thing" to do is (Malone, 2009).

Educational Model

Because on many levels' supervisees may lack in necessary knowledge, skills or attitude to do their work well, the educational model of supervision is to correct these lacks. Through encouraging exploration of and reflection on their job, the goal is to aid the supervisee to:

- Better understand the client
- Become conscious of their responses and reactions to the client
- Make sense of the dynamics of the interactions between them and the client
- Analyze what their interventions were and the consequences of them
- Investigate different ways they can work with specific client situations (Hawkins and Shohet, 1989)

Supportive or Facilitative Model

The primary goal of the supportive approach is to boost the supervisee's job satisfaction and morale. In this approach, the supervisor is aware that supervisees must cope with different stresses that are job-related and could severely influence how they work with their clients, resulting in unsatisfactory service to the clients. Additionally, the supervisee could become "burned out."

Therefore, the supervisor does whatever she can to prevent or reduce possibly stressful situations, remove the supervisee from stress, and aid him to adapt to stress. In the process, the supervisor is to be approachable and available, express confidence in the supervisee--even excusing failure if it's fitting, authorize and share responsibility for various decisions, give perspective and opportunities for the supervisee to function independently in situations that will likely be successful for him (Kadushin, 1992).

This approach to supervision uses teaching, counseling, coaching, and discipline as needed during the period of supervision. A non-judgmental and safe environment is given, and an effective relationship between the supervisor and supervisee is built. Supervisees are at liberty to explore and develop both the science aspect and the art aspect of clinical work (Malone, 2009).

Competency-Based Approaches to Supervision

Competency-based approaches to supervision primarily target the supervisee's skills and learning needs. This results in setting goals that are SMART (specific, measurable, attainable, realistic, timely). Strategies are planned and implemented to accomplish the goals. The basic strategies are role playing, modeling role reversal, demonstrations, teaching, counseling, and consulting (Center for Substance Abuse Treatment, 2009a).

Discrimination Model

The Discrimination Model, defined by Bernard (1997), offers three focuses for supervision (intervention, conceptualization, personalization) to be used in three supervisor roles (teacher, counselor, consultant). This means that a supervisor, in any given situation, would have nine potential ways to respond (three focuses times three roles). As an example, if the supervisor and supervisee are discussing an intervention the supervisee did, the supervisor could:

- Be a teacher while focusing on the intervention
- Be a counselor while focusing on the supervisee's conceptualization of the intervention
- Etc.

The response given is to be chosen according to the supervisee's specific needs, so it will be different at different times. The supervisor must first evaluate the ability of the supervisee in the focus area, and then choose the best role to use in his response. The trick for the supervisor is to not respond from the same role or focus because of personal preference, habit, or comfort, but to meet the most prominent needs of the supervisee at that moment (Bernard and Goodyear, 2009).

Task-Oriented Model

Meade and Crane (1978) explain that task-oriented supervision is taken from two areas: behavioral models and computer sciences. Categories of essential tasks were derived from computer science, especially expert systems, that are not specific to any theory. Behavioral variables are maneuvered to affect the outcome of supervision; this, in turn, determines the behaviors of both the supervisee and supervisor. In order to develop more effective counselors, the task-oriented supervisor will reinforce the variables of the counselor's behavior.

Meade described the supervisory process as "an experienced therapist safeguarding the welfare of clients by monitoring a less experienced therapist's performance with the clients in a clinical setting with the intent to change the therapist's behavior to resemble that of an experienced expert therapist" (Mead, 1990). In this model, the basic knowledge and skills necessary to carry out clinical tasks are inspected and assessed during supervision on the counselor level. The supervisor observes the counselor's abilities as demonstrated on the job and intervenes as needed to support and correct what the counselor does. The supervisor puts herself in a position to give helpful interventions by identifying tasks that are giving rise to difficulties (Mead, 1990).

Micro counseling Model

Another method for teaching skills is micro counseling (Daniels, Rigazio-Digilio, & Ivey, 1997). It's especially deemed useful for beginning therapists. Specific skills are sequentially organized, and each is taught--one at a time, using tools such as shaping, modeling and social reinforcement. The framework has been increased to include steps for effectively interview cross-culturally, called

a *Micro skills Hierarchy*. At the base of this hierarchy is "attending behavior," or being aware of and responsive to verbal, visual and other cues. Next is a listening sequence to aid in drawing the client out and establishing rapport:

- Open and closed questions
- Observation
- Encouraging
- Paraphrasing
- Summarizing

Other skills follow that are designed for various states of therapy:

- Reflection of feelings
- Influencing
- Integrating skills
- Personalizing skills
- Culture
- Specific theory

Theory- and Treatment-Based Approaches to Supervision

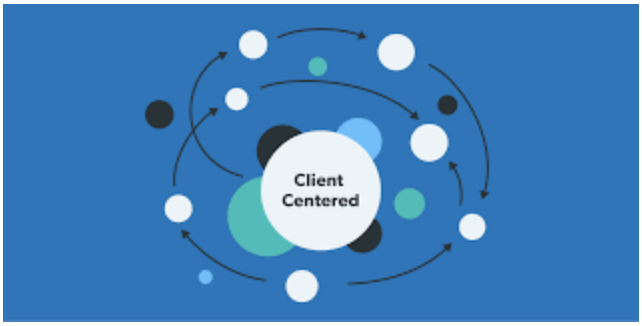
A perusal of a number of articles and sites that discuss different approaches to supervision finds that none of those looked at list both theory-based and treatment-based approaches. There is quite a bit of overlap of the content of the discussion of these two approaches, so--for the purposes of this course--we will look at them as being one and the same.

Psychodynamic Models

There are a number of models that demonstrate a psychodynamic orientation. They generally have two major areas of commonality:

2. Specifics of the theory, including transference and counter-transference, parallel processes, defense mechanisms, affective reactions and working alliance. Many of these are discussed separately in this course.
3. Three categories of psychodynamic supervision: client-centered, supervisee- or therapist-centered and supervisory-matrix-centered (Frawley-O'Dea and Sarnat, 2001; Falender, 2010).

Client-Centered Model



Freud began client-centered therapy and supervision, and--as suggested by the name--supervision sessions focus on the client's presentation and behavior. The supervisor acts as a teacher, aiding the supervisee in understanding and treating the client's problems. In essence, the supervisor is the expert who is largely uninvolved, but who has skills and knowledge to aid the supervisor. This approach assigns a great deal of authority to the supervisor. However, as long as both the supervisor and the supervisee understand the theoretical orientation in the same manner, there is little conflict between them because of the focus on the client. This often results in less anxiety in the supervisee, making it easier for her to learn. On the other hand, if conflict should develop, this model does not offer a way to directly deal with it (Frawley-O'Dea and Sarnat, 2001).

Supervisee-Centered Model

Psychodynamic supervisee-centered supervision focuses on the process and content of the experience of the supervisee as a counselor--anxieties, resistances, and learning problems. As in the client-centered approach, the supervisee is the uninvolved, authoritative expert. Since the psychological processes of the supervisee are the center of attention, this approach is less didactic and more experiential (Falender and Shafranske, 2004). The advantage of this approach is also a limitation of it: the supervisee gains understanding of her own psychological processes,

but is therefore very subject to stress because of the close examination (Frawley-O'Dea and Sarnat, 2001).

Supervisory-Matrix-Centered Model

This approach to supervision also watches over client and supervisee material; however, it also brings in an analysis of the supervisor-supervisee relationship. The supervisor is no longer uninvolved, with his role being to "participate in, reflect upon, and process enactments, and to interpret relational themes that arise within either the therapeutic or supervisory dyads" (Frawley-O'Dea and Sarnat, 2001). Included in this is an analysis of parallel process, which Haynes, Corey, and Moulton (2003) define as "the supervisee's interaction with the supervisor that parallels the client's behavior with the
supervisee as the therapist."

Feminist Model

Many people's initial response to the word "feminist" is "misandry" (Academic, 2011). However, the feminist approach to supervision is much more benign. Sometimes referred to as "developmental feminism," it's devoted to the ideas of acceptance, equality, integration, inclusion, and growth (Holman and Douglass, 2004). The feminist supervision model asserts that the experiences of an individual reflect standardized values and attitudes of the society (Smith, K. L., 2009). Thus, therapists using the feminist theory tend to put the client's, as well as their own experiences in the context of the society in which they live. Mental illness is often defined as an outcome of oppressive perceptions and behaviors (Haynes, Corey, and Moulton, 2003).

Although the Feminist Therapy Institute is now defunct, they were a leader in the feminist therapy model in 1999, and stressed the therapists' need to recognize differences of power in the client-counselor relationship, and to model productive use of power--personal, structural, and institutional (Smith, K. L., 2009). Though the supervisor-supervisee relationship was not directly addressed, it's assumed that the relationship would be equitable as much as possible, while focusing on empowering the supervisee (*ibid*).

Person-Centered Model

Carl Rogers' person-centered therapy was developed from the belief that a client is able to resolve problems and issues with no direction or interpretation from the counselor (Haynes, Corey, and Moulton, 2003). The counselor simply enables the client to solve them through a specialized collaboration. This is true also in person-centered supervision. The role of the supervisor is to give an environment in which productive learning and growth can take place (Lambers, 2000), utilizing the supervisor-supervisee relationship and their personal characteristics and attitudes to determine the results. Rogers' six conditions that are required in the counselor-client relationship are also important in the supervisor-supervisee relationship:

- Psychological contact between the two
- Incongruence, or an inconsistency causing some anxiety in the supervisee
- Congruence within the relationship, in which the supervisor can share if it's helpful or therapeutic
- Unconditional positive regard
- Empathy
- The empathy and unconditional positive regard are experienced

Cognitive-Behavioral Model

Just as in other theory-based models to supervision, a primary job for a cognitive-behavioral supervisor is to explain and demonstrate cognitive-behavioral techniques. More than in many other approaches to supervision, the cognitive-behavioral supervisor is recognized as a consultant who concentrates on skills and strategies (Falender, 2010). This sort of supervisor uses observable behaviors and understandings, especially the supervisee's reactions to the client and her identity as a therapist (Hayes, Corey, & Moulton, 2003). Techniques most often used by the supervisor include planning an agenda for each supervision session, connecting with the agenda of previous sessions, giving homework to the supervisee, and summarizing processes, gains, behaviors and all else that is faced along the way (Liese and Beck, 1997).

Narrative Systemic Model

Falender (2010) identifies narrative, intersubjective and postmodern models as being three names of the same model. There is overlap between the three, but they're distinct. Most simplistically:

Postmodern theory may be the father of narrative and intersubjective theories. Postmodern theory has been applied to a variety of disciplines, including counseling. It's a philosophical framework that believes that knowledge is constructed socially and is language based. It's in opposition to more common modernist beliefs that embrace objectivist approaches. In the midst of a growing understanding that no one clinical theory can possibly give reason for every type of problem and client. This gave rise to the strategic eclecticism model which permits a systematic selecting of different techniques and theories that focus on the process of change instead of the content to be changed (Rudes and Guterman, 2005). One common postmodern view is that what a person knows is based on his interpretation of the world around him; reality only exists in one's interpretations (Eppler and Carolan, 2005).

Intersubjective theory is a framework that emphasizes context and perspective, and can be used by people with a variety of theoretical outlooks. It has been depicted as a procedure in which two people, such as the therapist and client or the supervisor and supervisee, focus on the experiences of one of them (client or supervisee) and on how their relationship affects that person (Jacobs, 1992).

Narrative theory is based on the view of reality from the postmodern theories. It focuses on language and depends on narrative metaphors. When clients (and supervisees) tell their experiences, it's as a story for which the society they live in has "template narratives" for how these stories should unfurl. When the client's or supervisee's story unfurls differently from the social narrative "templates," the therapist or supervisor collaborates with the client or supervisee to discover their untold events and plots that may be used to address the experience or problem and conceive new story endings to pursue (Mick, 2011).

Each of these theories may be used as a model for supervision. And this is where the overlap of these theories comes to play. With each theory, the supervisor basically aids the supervisee in working with clients, developing the supervisee's experience in some type of context, and assembling the necessary reality around that (Falender, 2010).

Developmental Approaches to Supervision

For many years, developmental supervision theories have been a major focus for research and theory. In fact, there have been so many developmental models that some have encouraged researchers and theorists to work at consolidating those that already exist (Falender, 2010).

For the most part, developmental approaches to supervision describe advancing levels, from beginner to proficient, through which a supervisee progresses. Each level is made of distinct attributes and skills. Supervisees just beginning would only be expected to have few skills and little belief in themselves as counselors. Supervisees at a middle level of development would have more confidence and skill along with contradictory perceptions about their independence as a counselor and dependence on the supervisor. A supervisee who has reached the proficient level will probably have good problem-solving skills and give a great deal of thought about the process of counseling and supervision (Haynes, Corey, & Moulton, 2003).

Developmental-approach supervisors find that the essential element is correctly determining the current level of the supervisee and offering support and feedback that is suitable to that developmental level. At the same time, they must assist the supervisee's progress to the next level. To do this, the supervisor often uses a two-way process, called "scaffolding" (Zimmerman & Schunk, 2003). This process helps the supervisee to use preexisting knowledge and skills to bring about further learning.

As the supervisee begins to reach expertise at each level, the supervisor slowly moves the scaffold to include knowledge and skills from the next level up. All during this process, the supervisee is not only given additional information and counseling skills, but is able to develop better critical thinking skills through the interactions with the supervisor. This is not a linear

process; the levels can be influenced by changes in setting, assignment, and client population (Center for Substance Abuse Treatment, 2009a).

The supervisee may be in different levels at once. She may be at a middle development level in general, but still feel a high level of anxiety when a new client situation presents itself (Smith, 2009). Or the supervisee may be at a very high level in cognitive-behavioral intervention for children with ADHD, but only at a beginning level in strategic family therapy (Falender, 2010).

Levels are also subjective as related to the supervisee. A supervisee who has finished a master's program may be less clinically sophisticated than a particular practicum supervisee.

Falender (2010) sums up the premises of developmental approaches of supervision as:

- Supervisees grow and develop unless they're exposed to hurtful training/supervision atmospheres
- Development moves through levels or stages
- Supervisees wrestle with developmental concerns and issues such as identity and competency
- Supervisors need to be aware of their supervisees' developmental stages and plan supervision to match

Many developmental theories don't include a skill set, or set of competencies for the supervisee to work to attain. Hess and Hess (1983) labeled supervisee behaviors that supervisors find critical:

- Boundary management
- Clinical skills and interpersonal skills
- Decision-making abilities
- Disclosure
- Expertise
- Interest in the client and client welfare
- Openness to suggestions
- Preparation for supervision

- Self-esteem and self-awareness
- Self-exploration
- Theoretical knowledge

Integrated Developmental Model

From 1981 to 2004, the Integrated Developmental Model (IDM) was perhaps the most researched supervision developmental model. Three counselor-developmental levels are described in the theory:

- Level 1--Supervisees are usually still students; they're high in motivation, but also in anxiety. They may also be nervous about being evaluated.
- Level 2--These supervisees are at a middle level; they have vacillating motivation and confidence. They may connect client success with their own mood.
- Level 3--At this stage, supervisees are generally secure, motivation is stable, and empathy is accurately moderated by objectivity. They're able to use their "therapeutic self" in interventions.

As in other developmental theories, supervisors need to use approaches and skills that match the supervisees' level. Thus, when working with a supervisee who is at level 1, you need to be both supportive and authoritative to balance the high levels of anxiety and dependence. When working with a supervisee at level 3, you would need to give priority to supervisor autonomy and use collaborative challenging.

Should a supervisor habitually badly match her reactions with the supervisee's level of development, it would make it very difficult for the supervisee to gain mastery of any developmental stage. As an example, a supervisor who expects a level-1 supervisee to exhibit autonomous behavior will most likely increase the supervisee's anxiety.

Although the IDM presents a flexible but clear theoretical model of developmental supervision, there are several weaknesses to note (Haynes, Corey, & Moulton, 2003):

- It primarily focuses on developing graduate students who are in training, but gives little focus to post-graduate supervision.
- It offers minimal ideas for clear-cut methods of supervision that should be used at each supervisee level.

Integrative supervision models tend to rely on more than one technique and theory. Haynes, Corey, & Moulton (2003) tried to reduce the potential combination variations by focusing on discussions of two approaches: theoretical integration and technical eclecticism.

Theoretical integration includes more than a simple blending of techniques. The goal is to make a theoretic framework that combines two or more of the best theories, resulting in a richer effect than any single theory.

Technical eclecticism, on the other hand, focuses on differences. It chooses from a variety of approaches and is a collection of techniques. One may use techniques from any theory without necessarily subscribing to that theory.

Developmental Phase Model

The Developmental Phase Model from Ronnestad and Skovholt (1993) addresses the first weakness listed above for the IDM. One hundred counselors and therapists with experience ranging from graduate students to professionals having 25 years of experience on average were interviewed by Ronnestad and Skovholt. The acquired data was analyzed three ways, resulting in stage model, a model of professional development and stagnation, and the formulation of a theme (Ronnestad and Skovholt, 1993).

The 2003 revision of the model consists of six developmental phases. The first three phases are approximate matches of the IDM levels:

- The Lay Helper
- The Beginning Student Phase
- The Advanced Student Phase

The final three phases are related to a counselor's career development:

- The Novice Professional Phase
- The Experienced Professional Phase
- The Senior Professional Phase

In addition to their phase model, Ronnestad and Skovholt found 14 themes in the development of counselors (Smith, 2009):

1. Professional development involves an increasing higher-order integration of the professional self and the personal self.
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.
4. An intense commitment to learn propels the developmental process.
5. The cognitive map changes--beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise.
6. Professional development is a long, slow, continuous process that can also be erratic.
7. Professional development is a life-long process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.
9. Clients serve as a major source of influence and serve as primary teachers.
10. Personal life influences professional functioning and development throughout the professional lifespan.
11. Interpersonal sources of influence propel professional development more than ‘impersonal’ sources of influence.
12. New members of the field view professional elders and graduate training with strong affective reactions.

13. Extensive experience with suffering contributes to heightened recognition, acceptance and appreciation of human variability.
14. For the practitioner there is a realignment from self as hero to client as hero.

In summary, this theory notes that process of developing a therapist or counselor is complex and needs constant reflection. Ronnestad and Skovholt (2003) also report that just like the strong influence the client-counselor relationship has on treatment outcome, the way therapists handle problems and challenges in the client relationship influences the therapist's professional growth or stagnation.

Summary of Developmental Models

The IDM model of Stoltenberg, Delworth, and McNeil (1998) offers a concise summary of stages of development for both the supervisee and the supervisor. These make a good, overall summary of the focal points of developmental models.

Supervisee Development Model

Developmental Level	Characteristics	Supervision Skills Development Needs	Techniques
Level 1	Focuses on self Anxious, uncertain Preoccupied with per-forming the right way Overconfident of skills Over-generalizes Overuses a skill	Provide structure and minimize anxiety Supportive, address strengths first, then weaknesses Suggest approaches Start connecting theory to treatment	Observation Skills training Role playing Readings Group supervision Closely monitor clients

	Gap between conceptualization, goals, and interventions Ethics underdeveloped		
Level 2	Focuses less on self and more on client Confused, frustrated with complexity of counseling Over-identifies with client Challenges authority Lacks integration with theoretical base Overburdened Ethics better understood	Less structure provided; more autonomy encouraged Supportive Periodic suggestion of approaches Confront discrepancies Introduce more alterna-tive views Process comments, high-light counter-transference Affective reactions to client and/or supervisor	Observation Role playing Interpret dynamics Group supervision Reading
Level 3	Focuses intently on client High degree of empathic skill Objective third person perspective Integrative thinking and approach	Supervisee directed Focus on personal-pro-fessional integration and career Supportive Change agent	Peer supervision Group supervision Reading

	Highly responsible and ethical counselor

Supervisor Development Model

Developmental Level	Characteristics	To Increase Supervision Competence
Level 1	Is anxious regarding role Is naïve about assuming the role of supervisor Is focused on doing the “right” thing May overly respond as an “expert” Is uncomfortable providing direct feedback	Follow structure and formats Design systems to increase organization of supervision Assign Level I counselors
Level 2	Shows confusion and conflict Sees supervision as complex and multidimensional Needs support to maintain motivation Overfocused on counselor’s deficits and perceived resistance May fall back to being a therapist with the counselor	Provide active supervision of the supervision Assign Level 1 counselors
Level 3	Is highly motivated Can provide an honest self-appraisal of strengths and weaknesses as supervisor Is comfortable with evaluation process	Comfortable with all levels

	Provides thorough, objective feedback

Process-Oriented and Other Approaches to Supervision

Process-oriented approaches to supervision are those in which basic roles and tasks are defined (Bernard, 1997). In that sense, the tables above could be called process-oriented. In 1980, Hess defined several roles, calling them "models":

- Lecturer
- Teacher
- Case reviewer
- Colleague-peer
- Monitor
- Therapist

Other models are discussed below. Each of the models can be helpful in talking with supervisees in order to decide what roles the supervisor may play during supervisory sessions, whether or not the roles are balanced, and if the supervisee would be more comfortable with less of some of them. It also helps to find out if the supervisee believes that the descriptions are sufficient to cover the complete supervisory process, and if they aren't, what could you add (Falender, 2010).

Discrimination Model

The Discrimination Model, first published in 1979 by Janine Bernard, has been mention as a competency-based approach. It's also one of the most used and researched of the integrative supervision models. In review, this model is made up of three possible roles for a supervisor (teacher, counselor, consultant) and three different focuses (intervention, conceptualization, personalization). The resulting nine possible ways a supervisor can respond at any given time form the basis for supervision. Bernard and Goodyear (2004) mention other models that offer extended ideas of supervisor roles that include administrator, evaluator, facilitator, and monitor.

Systems Model

The center of supervision in a systems approach is the supervisor-supervisee relationship. This relationship involved both parties mutually and aims to give power to both (Holloway, 1995). This central relationship connects the seven supervision dimensions:

1. Supervision functions
2. Supervision tasks
3. The client
4. The supervisee
5. The supervisor
6. The institution

The supervision function and tasks are at the forefront of interactions, while the other four dimensions relate to factors in the context that are hidden influences in the process of supervision. Any specific instance of supervision is reflective of a singular mixture of the seven dimensions (Smith, 2009).

Holloway (1995) provides a grid to represent the functions and tasks of the systems approach model:

Functions	Tasks				
	Counseling Skill	Case Conceptualization	Professional Role	Emotional Awareness	Self-Evaluation
Monitoring/Evaluating					
Advising/Instruction					
Modeling					

Consulting					
Supporting/Sharing					

To use the grid in a practical way in supervision, it can be looked at this way:

A. The supervisee is over-identified with a client, but is similar to the client demographically.
B. The supervisor is from a different ethnic group and culture.

They could be used to determine potential interventions of sharing and supporting in a context of self-assessment, or advising and instructing case conceptualization, while at the same time aiding the supervisee to pull out personal elements that could be intersecting with the professional role (Falender, 2010).

Dialectical Behavioral Model

The focus of dialectical behavioral therapy (DBT) supervision is a kind of parallel process in which the therapist treats the client and the supervisor "treats" the supervisee (Fruzzetti, Waltz, & Linehan, 1997). The approach leads to eloquent clinical supervision, but needs intricate and involved training in the model in order to be able to be used in supervision.

It's assumed that the logical agreement is arbitrated so that there is no absolute truth, the therapist is fallible and not necessarily consistent; the therapist also consults with the client about effective interaction with professionals. A balance must be found between finding, valuing, and nurturing the innate ability of the supervisee to skillfully help others, all the while determining which skills the supervisee does not have and helping him to develop them.

According to Falender (2010), some aspects of DBT supervision are:

- Supporting development and autonomy while directing supervisee progress, confronting inadequacies, and influencing supervisee’s clinical work
- Weaving together problem-solving and skills training with validation of existent supervisee responses

- Ongoing supervision is an essential part of therapy
- Cognitive System

Specific Knowledge

- Theory
- Principles of learning, cognition, etc.
- Ethical and legal issues
- Theory and research literature

Conceptual capabilities

- Ability to organize and integrate information, apply basic knowledge, conceptualize cases, identify clinically relevant problems, plan effective treatment, make good clinical judgments, awareness of impact of own beliefs and values and those of immediate and larger environment

Overt motor

- Therapy-specific assessment and treatment techniques
- Interpersonal clinical skills
- Behavioral-clinical (teach)
- Professional (reports)
- Self-development (outside therapy, reading)

Physiological-affective

- Control of problematic emotional responses
    - Monitor and manage reactions to client *and* to supervisor (evaluation anxiety)
- Attend to and manage arousal that is not emotion-linked
    - Self-monitor personal limits to avoid burnout

Interpersonal Process Recall Model

Based on the hypothesis that people behave diplomatically, Interpersonal Process Recall (IPR) states that a supervisee automatically disregards much of what he thinks, feels, or intuits during therapy because it would challenge the fundamental inclination to be diplomatic if they were allowed to surface. IPR purposes to give the supervisee a protected place for internal responses. The supervisor acts as a facilitator, provoking greater awareness of what took place during the therapy session.

The actual IPE process requires the supervisor and supervisee to view a video made of the counseling session. While looking at it, at any time when either notices a valuable moment that was not addressed, the video is stopped and the supervisee reflects. She may attest to impatience, anger, frustration or other emotional reactions. The supervisor lets the supervisee explore internal resolution processes. The supervisor doesn't teach, but may ask question such as:

- “What do you wish you had said to her?”
- “How do you think she would have reacted had you said those things?”
- “What kept you from saying what you wanted to say?”
- “If you had the opportunity now, how might you tell her what you're thinking and feeling?”

They continue the process with the tape once again turned on. It's a very slow process and it puts these interpersonal dynamics in a spot that so magnifies them that they may be distorted. The supervisor's role is to decide which interactions are truly important. This technique should not be used until a meaningful supervisory alliance has been established (Falender, 2010).

Seven-Eyed Supervisor Model

In this uniquely named supervision model, Hawkins and Shohet (2000) proposed exploring a variety of influences on supervisory activity. The basis is understanding the ways things connect, interrelate, and arouse activity. It also joins together aspects and insights of psychotherapy and the internal life of the people involved (Hawkins, 2008).

1. The supervisor and supervisee look at therapy sessions with seven different focuses.
2. Look at a therapy session from the client's perspective: what he saw, heard, and felt; try to separate this data from their preconceptions, interpretations and assumptions.
3. Look at the supervisee's interventions and strategies, determine effectiveness and alternatives.
4. Aid the supervisee to step outside the relationship with the client and look at it from a new angle, paying attention to boundaries, behaviors, and variables such as metaphors, hunches and images that were presented.
5. Aid the supervisees to look at themselves, what is being re-stimulated in them by the client's material--counter-transferences.
6. What the supervisor has unconsciously picked up from the client system and how it may be affecting the dynamics of the supervisee-supervisor relationship--parallel or mirroring processes.
7. Look at the supervisor's "here and now" experience (counter-transference) with the supervisee and what can be learned from this about their relationship.
8. The supervisory context--the impact of the organization within which the supervision takes place, the code of ethics and contractual context, economic restrictions, social context, and the expectations of each one involved.

In moving through these modes, the supervisor needs to be sure that she doesn't get stuck in using just one of them. It is recommended to begin with #1 by talking about specific counseling sessions. Move to #3 and #4 to explore what is happening in the supervisee/client relationship as well as in the supervisor/supervisee relationship. Then move to #5 and #6, exploring the here and now supervisor/supervisee relationship, and include #7 to bring in a wider context. Finally, using new insights and a shift in the supervisory pattern, go to #2 to investigate other interventions that might be used in the next session. According to Hawkins (2008), a live rehearsal of using that

intervention while in the supervision session makes it much more likely to happen in the therapy session.

ETHICAL ISSUES AND OTHER POTENTIAL PROBLEMS OF A SUPERVISOR

In many ways, you're the gatekeeper of your organization for legal and ethical issues. As supervisor, you must model proper ethical and legal practices in your supervisory relationships--the place where ethical procedures are developed and strengthened.

You're first accountable for maintaining the highest legal, ethical, and moral standards and for being a model of practice to other staff members. You need to be alert to ethical concerns and respond to them properly. Part of your job is to aid in merging solutions for daily ethical and legal issues into clinical practice.

Some of the basic assumptions for combining ethical issues into clinical supervision are:

- Ethical standards tell you *what* to do, but not always *how*.
- Because every situation is unique, each person needs to know how to make solid ethical and legal decisions.
- The most difficult ethical issues are those in which two ethical behaviors are at odds, such as adhering to confidentiality of a client, but it is in the client's best interest to talk to someone else about the client's care.
- Even therapists and supervisors make mistakes; it's hoped they will only be minor mistakes.
- Sometimes it's difficult to find the answer to a legal or ethical question; if you ask ten people you might get ten different answers.

Ethical and legal issues most important to clinical supervisors include:

- Boundary concerns and dual relationship
- Confidentiality
- Informed consent
- Vicarious liability, aka “*respondeat superior”*
- Supervisor ethics

Communication

If you google "communication skills" in regards to a clinical supervisor, you'll see a multitude of job listings for supervisors "with good communication skills." So, just what are communication skills?

According to most management gurus, a person who has good communicator skills has already won half the battle. Whether on the personal front or the frontlines at work, a person needs the sharpened tools of effective communication. If you listen and speak well, there is not much opportunity for misunderstanding. Keep that in mind: the basic reasons for misunderstandings are lack of ability to listen effectually or to speak ably.

The dictionary definitions of communication skills include:

- For use in interpersonal connections, communication skills can include sign language, finger-spelling, and lip reading.
- The skill set that allows a person to give information in such a way that it's accepted and understood.
- The consistent ability of an individual to efficiently give and exchange ideas and information with colleagues, supervisors, subordinates, and clients professionally and personally.
- The technique or art of persuasions via oral and written language. To best understand the fundamentals of communication skills, you need to realize that "communication" is a very hyped word in modern culture. It involves a wide range of experiences, events, and actions; a variety of technologies, meanings, and happenings.

Taking all of this into consideration, one realizes that every opportunity to present ideas, thoughts, aims, or principles is a communication event. This includes formal situations--meetings,

workshops, seminars, trade fairs, etc.--as well as informal conversations. It includes communication media (newspaper, TV, radio, etc.), and communication technologies (phones, pagers, Internet, and more). Communication professionals include camera crews, journalists, advertisers--and clinical supervisors (*Definition of Communication Skills*, 2011).

Lack of Timely Supervisory Feedback

The lack of timely supervisory feedback is the cause of many ethical complaints (Cole, 2001). What is meant by "timely" feedback? To have the most compelling impact, feedback should take place as close to the event to be discussed as possible. However, McConnell (1993) states, "It is important to know that supervisors don't always have to respond instantaneously. However, they do have to respond in a timely manner. The difference lies in the nature of the problem." He goes on to describe a situation where the supervisee is abusing equipment, which requires immediate feedback, vs. the supervisee needing to know the number of hours to be worked to qualify for a particular benefit, which does not require immediate feedback.

Wilson (1980) stated that "the time and effort expended on process recording become virtually meaningless without appropriate and timely supervisory feedback" (pg. 33). As process recording is very important within the work of several different theories, this must be carefully noted.

Other Communication Issues

Poor communication is one of the causes for conflict, including personality clashes, in the workplace. Skills that can facilitate good communication include (Mistry and Latoo, 2009):

- Active listening
- Being open
- Building areas of agreement
- Demonstrating understanding
- Using open questions

A good communicator should avoid:

- Stating unreasonable expectations, opinions or views
- Offering incentives
- Revealing feelings
- Warning of consequences

A key role of the supervisor is feedback, which--to be successful--must be:

- Honest
- Relevant
- Objective
- Specific
- Timely
- Planned

In addition, it needs to be:

- Built on accurate information, not hearsay
- Focused on things the supervisee can change--performance and behavior, not things he cannot change such as personality
- Constructive, not critical, blaming or personalizing
- Descriptive, not evaluative
- Private, not public

If your supervisee is offended by feedback, check to be sure you don't have a hidden agenda and that you're not acting bullyish. Giving feedback should be an ongoing process that boosts motivation and moral and leads to greater job satisfaction and effectiveness. If you're doing your job of feedback properly, the final report will never be a surprise to the supervisee because it will have been constant and always about his performance.

Competence

In this day and age, supervisors are required to have a large group of skills and knowledge of procedures. The list of skills includes the ability to (Malone, 2009):

- Introduce and keep up a positive supervisory relationship
- Be competent and to display competence
- Assess the supervisees needs as well as all the clients they will help
- Practice numerous kinds of direct observation of the supervisee's work

The goal is that the supervisee will become competent, too.

Counselor Competence

It's interesting that a search for the areas in which a counselor needs to develop competence turns up many thousands of results regarding the need for competence, but it seems that few of them actually discuss in which areas competence is needed. However, there are at least eight areas in which the supervisor will want to assess and foster competence in the supervisee:

1. Factual knowledge
2. Generic clinical skills
3. Model-specific clinical skills
4. Ability to implement interventions and move from theory to practice
5. Capacity to accurately reflect on progress
6. Interpersonal skills
7. Ability to work effectively with professional colleagues
8. Ability to apply professional and ethical standards in practice

Of all of these competencies, it has been found, however, that supervisees who become effective counselors are not necessarily those who can use any specific techniques (Wampold, 2001), but rather those who show tolerance, empathy, social intelligence, a sense of well-being and self-

esteem (Eriksen and McAuliffe, 2006). Therefore, as a supervisor, you may want to focus on helping your supervisees to develop these personal characteristics.

A four-level or stage development theory of counselor competence has been given by Smith (2006). It's a simple, but useful tool for helping determine where a counselor is at in her development:

Stage one is "The Unaware" counselor, one who has unconscious incompetence. A counselor in this stage will typically make statements such as:

"Well, let me tell you of an even worse situation than yours…")
"What you ought to do about this situation is ___."
"When this happened to me, I ___."

Stage two is "The Novice" counselor, one who has conscious incompetence. This counselor has at the very least realized how incompetent she is. A counselor in this stage will commonly make statements like:

"Golly, can you tell me a little more how he/she feels?"
"I don't know how I can be of help to you."
"What can I do to make you feel better about your situation?"

Stage three is called "The Technician," a counselor who has developed a level of competence of which he's aware--conscious competence. This level of counselor often makes statements such as:

"You feel ___ because ___."
"I hear anger/fear/joy in your voice. Can you tell me some more about those feelings?"
"…and that makes you feel___."
"What I hear you saying is ___."

Stage four in this model is "The Artist," one who has reached a level of unconscious competence. Characteristic comments at this level may be:

"I hear the hurt/anger/joy that you're experiencing now. Let's you and me focus on these present feelings."

"Be aware of your eyes. I can see the tears in your eyes as you express this hurt."

"I, too, have felt such hurt--yes, it is a painful feeling. Let's stay with that hurt feeling for a while."

"The pressure to look 'OK' is great, and I sense that pressure right now, with me."

Supervisor Competence

The Substance Abuse and Mental Health Services Administration, a section in the U.S. Department of Health and Human Services, has put out a number of publications for those working with clients who are substance abusers. Their *Technical Assistance Publication (TAP) Series 21-A* is for clinical supervisors in the field of substance abuse treatment. However, because it's 100% applicable and very important for any sort of clinical supervisor and because of its thoroughness, the areas of competencies for clinical supervisors are largely included here (Center for Substance Abuse Treatment, 2007).

Foundation Areas

Theories, Modalities and Roles of Clinical Supervision

Counseling and supervising are two very different things, even though there are similarities. There is a unique knowledge base for clinical supervision, and a supervisor needs to know various theoretical views. A supervisor must also be aware of the variety of roles she must fill, as well as many different approaches to put them into effect. Competencies include:

1. Understanding the clinical supervisor's role as the primary means for overseeing clinical services and ensuring their quality
2. Realizing that the clinical supervisor is a fundamental link between direct services and management.

3. Being aware of the different roles the clinical supervisor must play, such as administrator, consultant, evaluator, mentor, teacher, and team member.
4. Being familiar with many theoretical models of clinical supervision, including (but not limited to) those mentioned in this course.
5. Having defined and able to explain one's own supervision model.
6. Knowing at least the individual, direct observation, group, and consultation modalities of clinical supervision.
7. Be up-to-date in knowledge of current research literature related to practices that are recommended for both clinical supervision and mental health therapy.
8. Knowing a variety of learning strategies, such as instructions, role plays, demonstration and critiques.
9. Understanding the importance of building a fruitful, healthy learning relationship with the supervisee that is aimed at improving job performance and client services.
10. Strengthening the complementary roles of members of a team with a variety of disciplines.
11. Knowing how to assess needs, carefully plan, and systematically implement individual and group supervisory activities that improve clinical services and programs.

Leadership

Obviously, an essential feature of clinical supervision, leadership has many definitions, such as (Leadership, 2011), "organizing a group of people to achieve a common goal," "ultimately about creating a way for people to contribute to making something extraordinary happen," and "the process of social influence in which the supervisor can enlist the aid and support of supervisees accomplishing a task" such as achieving organizational goals.

Leaders coach, inspire, mentor and motivate. They build teams, create cohesion, provide structure, and resolve conflict. Additionally, leaders build the culture of an organization, assist

growth and change for both individuals and the organization, and advocate for service delivery that is culturally sensitive and of high quality. Competencies include:

1. Having a leadership style that fosters teamwork, mutual respect and trust.
2. Taking responsibility of one's decisions and supervisory practices, as well as personal wellness.
3. Seeking feedback on job performance from managers, peers, and supervisees in order to improve supervisory procedures.
4. Creating, continually assessing, and revising one's own leadership plan to give direction for ongoing professional development.
5. Clarifying and interpreting for the supervisee the agency's vision, objectives, service goals and mission.
6. Understanding, overseeing, and ensuring compliance with state, federal, and--if applicable--accrediting body regulations.
7. Recognizing, enforcing, and enhancing organizational safety and security issues.
8. Being aware of and accepting power differentials inherent in the supervisor-supervisee relationship, and fairly using power and avoiding its abuse.
9. Proactively scheduling and structuring clinical supervision activities.
10. Giving honest feedback that is constructive, positive, and corrective.
11. Guiding with motivation rather than control. Using coaching, support, team building, and training to do this.
12. Organizing and planning orderly workflow, keeping details in control but not being overbearing.
13. Encouraging supervisees to share observations, ideas, and suggestions with agency management.

Supervisory Alliance

The context of clinical supervision is the relationship between the supervisor and supervisee. To have a positive relationship, there must be a mutual understanding of goals and tasks, and a healthy professional bond between the two. An effective supervisor needs a thorough understanding of the dynamics and nature of this relationship. Competencies in this alliance include:

1. Being up-to-date with literature about supervisory alliance, including basic factors that can either build or compromise the alliance, supervisory contracting, and relational issues such as transference and counter-transference.
2. Understanding the intricate nature of the client/counselor/supervisor triad, and maintaining awareness of potential boundary violations and dual relationships within that triad.
3. Recognizing that the supervisor-supervisee relationship is one that develops over time and that the stage of development affects the roles, rules, and expectations of the alliance.
4. Creating an unambiguous supervisory contract, one that clarifies goals and expectations, the structure of the supervisor-supervisee relationship, and criteria for evaluation, as well as the limits of confidentiality between them.
5. Modeling ethical behavior and boundaries and reinforcing ethical standards between the supervisor and the supervisee, as well as between the supervisee and his clients.
6. Continually being alert to the effects on one's own interpersonal style on the supervisee.
7. Paying attention to diversity issues (racial, cultural, age, gender, etc.) vital to a fruitful supervisor-supervisee relationship.
8. Recognizing and knowing how to improve results of personal counter-transference that may be elicited by the supervisee's interpersonal style, developmental issues, or unresolved personal issues.
9. Identifying supervisory impasses and interpersonal conflicts, accepting appropriate responsibility, and actively participating in resolution of difficulties.

Critical Thinking

Processes referred in critical thinking include analyzing, applying information, conceptualizing, evaluating, and synthesizing. In addition to using these processes to solve problems and make sound decisions, supervisors also must help supervisees to develop these skills. Competencies in critical thinking include:

1. Understanding the entire context in which supervision takes place--organizational, cultural, societal, and political.
2. Evaluating agency policies and issues to better clarify, understand, and participate in continual improvement of staff and agency performance, and service outcomes.

3. Choosing, adapting, implementing, and judging suitable techniques for solving problems, making decisions, and resolving conflicts.
4. Applying critical thinking to information gathering through content evaluation and source credibility.
5. Asking relevant and clarifying questions of supervisees and listening critically for underlying issues and content in their self-disclosure.
6. Aiding supervisees to develop skills in conceptualizing cases and analyzing client-counselor interactions.
7. Negotiating and documenting processes and outcomes for resolution of conflicts and performance problems.
8. Developing and helping supervisees to develop sound bases for self-evaluation and clarification of personal beliefs and values.

Performance Areas

Counselor Development

Key to delivering high-quality client care is the constant development of staff clinical skills. This is an intricate process involving collaborating, facilitating, supporting and teaching counselor capabilities. In the context of the supervisor-supervisee relationship and within professional, legal, and ethical guidelines, supervisors need to facilitate this process. A consistent maintenance of a multicultural perspective is also a supervisor's responsibility. Supervisor competencies for counselor development include:

1. Teaching supervisees the intentions of clinical supervision and how to get the most out of it.
2. Making sure that new employees get thorough orientation, including the agency's client population, vision, mission, procedures and policies.
3. Building individualized and supportive supervisory alliances that respect professional boundaries.
4. Maintaining a helpful supervisory learning environment that encourages awareness of self and others, motivation, enthusiasm, efficiency and mutual feedback.

5. Planning individual and groups supervision activities, using supervisees' learning styles, genders, cultures, ages and other appropriate variables.
6. Encouraging supervisees to appraise their possible biases regarding race, culture, religion, values, sexual orientation and gender.
7. Aiding supervisees develop empathy and acceptance skills for working with culturally diverse clients.
8. Providing specific and timely feedback on their concepts of client needs, attitudes towards clients, counseling skills, and overall performance in given responsibilities.
9. Using a variety of direct supervisory activities such as role play, live observation, review of video-taped sessions, presentation and discussion of case studies as means to reach the stated goals.
10. Aiding supervisees to recognize, comprehend, and cope with specific transference and counter-transference problems when working with clients.
11. Giving frequent recognition of supervisee's development and accomplishments.
12. Encouraging and aiding supervisees to develop a personal wellness plan to cope with their stress and prevent compassion fatigue and burnout.

Professional and Ethical Standards

In an environment of regulatory, statutory, and professional guidelines, supervisors must identify competencies that relate to protecting the public, staff members and clients. They also develop their own professional integrity and identity in the context of supervisory practice. In this context, competencies include:

1. Being familiar with relevant codes of ethics, client's rights documents, and laws and regulations governing both clinical supervision and counseling practices.
2. Being sure that supervisees know the professional codes of ethics, state and federal statutes regarding duty to warn (e.g., threat of physical violence against a reasonably identifiable victim), duty to report (e.g., child abuse), confidentiality regulations (e.g., HIPPA laws) and other legal restrictions on counseling relationships.
3. Following due process guidelines when responding to grievances and making sure that all involved understand the agencies grievance procedures.
4. Being sure that supervisees know what the clients' rights are.

5. Making sure that supervisees tell clients about limits of confidentiality (e.g., reporting specific threats of violence or child abuse).
6. Being sure that supervisees inform clients about supervision practices such as session transcripts or direct observation, and that they acquire appropriate informed consent documents (e.g., releases for recording of sessions).
7. Learning about factors that may influence a supervisee's job performance, such as culture, lifestyle or beliefs.
8. Modeling and teaching ethical decision making.
9. Understanding potential conflicts of interest and risks of dual relationship in the supervisor-supervisee relationship and constantly maintaining a proper relationship.
10. Helping supervisees cultivate awareness of potential dual relationships in the counselor-client relationship.
11. Monitoring supervisee's clinical work to improve their competence and ensure ethical treatment of their clients.
12. Giving timely guidance and consultation to supervisees in circumstances that present legal, moral and/or ethical dilemmas.
13. Being sure that supervisees always keep necessary, accurate and complete documentation, including detailed descriptions of processes followed in critical situations.
14. Intervening immediately and taking necessary actions when a supervisee's job performance seems to present problems.
15. Seeking consultation and supervision to evaluate one's own needs for further education and training, to get feedback on supervisory job performance, and to make a professional development plan.
16. Practicing only in one's areas of supervisory and clinical competence.

Performance Evaluation

Evaluation of counselors is pivotal in the assurance of high-quality client care. Clinical supervisors have a professional and ethical responsibility to regularly monitor the quality of performance of supervisees, to assist in improving their clinical competence, and to

evaluate their readiness to assume more autonomy in practice. This area is very closely related to Counselor Development; the competencies for each are very interactive and complementary, but still are distinct. Performance evaluation competencies include:

1. Communicating expectations of the agency concerning job duties and competencies, performance indicators, and standards for job performance evaluation.
2. Understanding supervision is a two-way evaluative process with supervisor and supervisee giving feedback to one another, including positive sharing and resolving of disagreements.
3. Assessing professional development, counseling proficiency, and cultural competency of supervisees.
4. Knowing when an issue is simply one of counselor development and when it's one that requires corrective action (e.g., incompetence, ethical violation).
5. Ensuring evaluations are accurate and backed up by using a variety of data (qualitative and quantitative), observations (direct and indirect), and assessment methods (formal and informal).
6. Identifying supervisees' training needs via ongoing proactive, formalized process; actively involving supervisees in reviewing objectives and goals, and giving positive feedback to reinforce performance improvement.
7. Clearly communicating feedback, both orally and in writing, regarding performance shortages, competency weaknesses, or detrimental activities.
8. Working with relational issues that are common to evaluations: anxiety, disagreements, and complete discussion of performance difficulties.
9. Guiding, encouraging, and evaluating ability of supervisees to use a range of effective evaluation tools such as memory work, process recordings, direct observation, and audio- or videotapes.
10. Self-assessing for conflicts with other supervisory roles and for evaluator bias such as lenience, favoritism, stereotyping, or overemphasizing one area of performance.
11. Adhering to professional standards of supervisory documentation, such as ongoing records, supervision session notes, written individual development plans, written recognition of good performance, and written documentation of corrective actions.

Transference and Counter-Transference

Transference

Sigmund Freud noted that patients sometimes had fantasies about him and strong feelings that were not founded in reality. He invented the word "transference" to describe this process. He believed that these patients were transferring feelings from important people in their childhood to the therapist. Many folks believe that transference happens in everyday life, not just psychotherapy (Connor, 2006), although Freud designed psychoanalysis to encourage this transference (Reidbord, 2010).

In this context, it's assumed the client will assume things about what the therapist is fond of and what he dislikes, what her life out in the world is like, what her attitude is toward the client, and so on. These assumptions are derived from the client's experiences with and assumptions about other major relationships, such as relations with the client's parents as a child.

Another way to describe transference is as taking your past psychological and emotional needs and placing them in the present--reacting to a person (client to therapist, supervisee to supervisor, and vice versa in both of these relationships) in terms of your fears, what you need to see, or what you see when you know almost nothing about that person. This occurs without you understanding why you react and feel the way you do. Causes of transference reactions are unmet emotional needs, neglect, and abuses that occurred when one was a child.

The therapist may encourage transference through deliberate opacity and non-disclosure. This is to try to re-create dynamics of the client's formative years in a way that both the therapist and client may observe them. The goal is that clients will discover that they have assumptions about others and themselves that are not based on fact or are obsolete and are not helpful to them. This is an insight that can lead to long-lasting psychological change.

Once a transference pattern is discovered, the client has a choice to respond in terms of what is truly going on instead of what happened years ago. If the client can't recognize the difference between the present and the past, it's likely that she will continue to repeat the same screwed up relationships over and over or have the same problem over and over.

Sometimes transference is referred to as a "projection." This focuses on the person projecting his own motivations, emotions or feelings onto another person, not being aware that the response is more about him than about the other person. The therapist may remind the client of things his father did when he was growing up. This can cause the client to "fall in love" or "fall in hate" with the therapist.

These very intense forms of transference can also occur when clients assume someone is a terrible person simply because that person's hairdo or favorite TV program reminds them of a mother that sexually abused them or an emotionally abusive father. That sort of transference is negative. At the other extreme, a warm, kind and supportive therapist may remind clients of what is absent in their life that they're wanting. This might then cause the client to idealize the therapist and put her on a pedestal that is totally beyond reason. They may then become excessively attached to the therapist.

These intense forms of transference can become full-blown obsessions if not dealt with. These "meltdowns" can end in nightmares, dangerous choices, fantasies, accidents, stalking someone, and even violence.

Signs to make one suspicious that a transference reaction is happening:

- A strong reaction that is not reasonable
- Strong sexual reaction of client to therapist, supervisee to supervisor or vice versa
- Anger towards therapist/supervisor as if he was a parent
- Premature termination of therapy

Counter-Transference

Several times in the discussion of transference, the words "vice versa" have been used, indicating that the transference is not necessarily always client towards therapist or supervisee towards supervisor; it may also go the other direction. In these cases, it's called "counter-transference." The therapist or supervisor is reacting, or counter-reacting, to the client's transference. This is the

reason a therapist may feel like they're falling in love with a client, or a supervisor with a supervisee.

Originally, counter-transferences were considered to always be hindrances to therapy. However, since the 1950s, they have been considered as potentially important information for the therapist to employ to aid the client (Reidbord, 2010). They can act as discriminating interpersonal indicators--finely adjusted instruments in the realm of social interactions. For instance, if a therapist is irritated by a client for no apparent reason, she may ultimately discover unconscious, difficult to perceive provocations by the supervisee that aggravate and repulse others, thus keeping the client isolated and lonely.

Counter-transference reactions that are based on the therapist’s reactions to immaterial attributes of the client (such as physical resemblances to a relative), experience with a prior client, or by circumstances unrelated to therapy (such as an argument at home, a traffic jam in coming to work, an anticipated vacation) are not useful for helping the client. They may, however, indicate that the therapist should also pursue therapy.

Unrecognized or unexamined counter-transference is not only not helpful, it can be detrimental to treatment. It can happen even if the counter-transference is positive, such as enjoying the client's humor to the point that underlying bitterness or anger is either ignored or not recognized. However, counter-transference is more often a problem if it's negative. The therapist may be irked, contemptuous, bored or paralyzed when seeing a particular client. The therapist must identify these feelings and handle them. Once in a while, if the counter-transference is not manageable, the therapist may need to refer the client to a colleague. However, most of the time the therapist can recognize and understand these feelings and constructively use them in the treatment.

In the above discussion, you could also substitute the word "supervisor" for "therapist," and "supervisee" for "client."

Another approach to counter-transference is broader and less Freudian in its approach. It includes anything in a therapeutic alliance that distorts or hides the reality of it. This is often called a "parallel process," still based on the therapist having issues similar to those of the client, and

trying to take care of her own unresolved problems (pain, anxiety, etc.) by "fixing" the client. This ignores the client's needs.

Masterson (1989) stated that often clients like this approach because they don't need to do any of the work. Instead, the therapist transfers their own hurting self to the client and therefore treats the client in the way they want others to treat them. Freud called this "acting out"--what is forgotten is reborn through enactment. Even though parts of the personality may be dissociated or repressed, the feelings are close to consciousness; the consequences are both feeling and fighting anxiety. The anxiety and associated defensiveness then become apparent in therapy (or supervision).

The therapist/supervisee may be attempting to express something that is happening with the client, but the supervisee may be unable to consciously describe it in supervision because of his own anxiety. Gediman and Wolkenfeld (1980) stated that the core of resistance to learning is the need to expose oneself in order to learn. Supervisees (and supervisors) often have a narcissistic need to retain his image, which causes them to both want and resist learning.

For you, as the supervisor, it's important to be aware of possible counter-transference or parallel process, and be sure it's not your own. A way to do this is to ask yourself some questions, and perhaps look at a checklist.

Important questions you must ask yourself any time you become aware of possible counter-transference are (Reidbord, 2010):

- Is this feeling characteristic for you (or the therapist), i.e., do you have it a lot of the time? If so, it may say more about you than the client.
- Is this feeling triggered by something not related to the supervisee or client? For example, if it's caused by your personal life, bureaucracy in the agency, or hunger, etc. it's not useful for helping the supervisee.
- Is this feeling obviously related to the supervisee or client? For instance, if the client is yelling obscenities and savagely tearing up the office, your feelings might be called counter-transference in a way, but it's not very enlightening.
- Is the feeling uncharacteristic for you (or the therapist), a reaction to one specific supervisee (or client), but the precise trigger is not obvious at once? These are the feelings

that it will be helpful to notice in yourself, as they may often point to important but subtle dynamics in the supervisee or client.

The comparable checklist approach is to check off which of the following are accurate statements you as a supervisor could make (Cole, 2001).

As the supervisor,

- ✓ I am experiencing a very strong emotional response to the supervisee.
- ✓ I feel like my supervisee is engaging me in his/her own tension.
- ✓ The supervision is starting to feel more like a therapeutic client-therapist relationship than supervision.
- ✓ I am able to identify commonalities between the dynamics enacted within the supervisory session and the dynamics of the intern's therapeutic relationships. (Williams, 1997).
- ✓ I am aware of and considering the potential anxieties my intern might have that are contributing to the enactment of the parallel process.
- ✓ I am able to invite my intern to explore their own involvement in the replication. Acknowledge the supervisee's efforts in the discovery process.
- ✓ I am working with my supervisee to establish mutually accepted efforts to address these issues as they arise in future supervision sessions.
- ✓ I will work with my intern to develop strategies for working with their clients, despite the parallel process.

Sexual Issues between You and Your Supervisee

Upfront, any sexual relationships between supervisors and supervisees are unethical. That, however, does not mean that sexual transference and counter-transference issues will not come up. Brodsky (1977) states that there are four potential causes of these issues:

1. Power--To the supervisee, the supervisor is a respected authority on life in general. The supervisee often has a strong degree of dependence and will usually not risk challenging or angering the mentor.
2. Nurturance--It's hard to know how much to nurture in regard to fostering dependence, comforting, or giving a clear message that the supervisee is out of control--especially when the supervisee is tearful.
3. Empathy--The supervisor must be clear on the limitations of the supervisees' life experiences and backgrounds which may hinder their ability to understand their client. There is the danger of over-identification or too many assumptions if the supervisor and supervisee have similar life experience--for instance, if they're both parents.
4. Transference/Counter-transference--Supervisees are constantly concerned with who would bring it up if there was unfinished business between you, the supervisor, and the supervisee.

Any or all of these may be going on at the same time, complicating the analysis of the problem(s) and what is happening.

Seduction

Seduction is more than seduction for sexual behavior. It can include instances of a client trying to "seduce" the therapist into liking her. Or it can be a way to try to gain power. Even these goals, however, are often demonstrated by acting seductively with the opposite sex or telling sexual jokes with one's own gender (White, 1992).

This can also be true of a therapist trying to "seduce" the client for those same reasons. Identical situations can take place between supervisors and supervisees. In all cases, the trick for the supervisor or therapist is to constantly not be themselves seduced by thoughts of power, but still be available for the supervisee or client.

There are special problems when dealing with a suicidal client, especially one with a borderline personality disorder. If the client either seduces or idealizes the therapist, it can easily lead to violations of boundaries. If the client demonstrates demeaning or provocative behavior, the

therapist could be rejecting of the behavior, or even cruel. The client might easily take this as personal rejection and actually commit suicide. Another possible scenario, is that this kind of a client might try to give the therapist the responsibility of keeping them alive (Slipp, 2000).

The sooner it's realized what kind(s) of counter-transference are occurring, the more likely it is that these extreme situations may be avoided. Constant asking of the questions and looking at the check-lists that were given earlier are good steps to take in this direction.

Family Issues

From the previous discussion, it can easily be seen that issues from the family of origin can be a common cause of transference issues. Because transference happens "all the time" and in all kinds of relationships, there are likely to be many transference issues with a family and based on the family.

Hayes, et al. (1998) examined data from 127 interviews with eight psychologists using brief family therapy; the therapy of eight clients was involved. This brought to light three realms relevant to counter-transference in family therapy--and likely in any kind of therapy. These realms were:

1. Origins
    - Issues specific to therapy
    - Cultural issues
    - Family issues, needs, and values

2. Triggers
    - Content of client material
    - Therapist comparing client with others
    - Change in therapy procedures or structures
    - Therapist aiding progress of therapy

- Therapist's perception of client
- Emotions

3. Manifestations
    - Approach
    - Avoidance
    - Negative feelings
    - Treatment planning

These give a framework for where to look for possible transference and counter-transference issues.

Social Network and Other Technology Issues

Social networks are a common part of an individual's life, and will affect his psychological issues. These can be a source of some transference and counter-transference issues. However, these issues will be much like those already discussed.

Nowadays, a different tack regarding social networks involves those that have arisen because of modern technology: social networks and social networking--Facebook, Twitter, Blogster, Flickr, LinkedIn, Skype--the list goes on and on. These groups can be the cause of many psychological problems, many of which involve transference and counter-transference, and many of which do not.

The availability of technology and the Internet has had a huge impact on both attitude and practices concerning issues such as privacy, crossing boundaries, and self-disclosure--even the delivery of clinical supervision. Often associated legal, ethical, and practice *standards* for the use of technology lags behind the *use* of technology. As a supervisor, you have a responsibility to oversee the proper use of technology by your supervisees, and that you properly educate them. You'll likely also need to ensure that your agency offers enough safeguards and training in this area.

As an example, here are a couple of situations that bring up multiple issues to be resolved (Gilbert and Maxwell, 2011).

Scenario 1: Joanne was a Facebook friend of her supervisor, Moira. Moira hosted a wedding shower for another staff member, and there were Facebook postings from the shower. Joanne was astounded to see pictures of Moira obviously intoxicated and wearing a coconut bra, even though it was worn over her other clothing. After that, whenever Joanne met with Moira for supervision, she was unable to get that picture out of her mind.

Issues:

- Should supervisors have a life of their own outside of work?
- Should supervisors be social friends of supervisees as long as personal issues are kept outside of the workplace?
- How would supervision dynamics be affected by knowledge of the other person's personal actions?

Beverly's job is stressful, and she often uses Facebook to get emotional support from her friends about frustrations related to her job. One day, believing she had masked client identifications, Beverly entered a message about problems of patients and families and her reactions. A friend of one of Beverly's friends realized that Beverly had spoken about one of her relatives; she filed a complaint with the federal Office for Civil Rights. Beverly, her supervisor, and her agency faced a huge fine for breach of confidentiality, an unannounced survey by The Joint Commission, and possible employment termination for both Beverly and her supervisor.

Issues:

- Did Beverly's agency give adequate education about patient privacy, including warnings against the use of social networking sites to debrief and vent regarding professional activities?
- Did the supervisor talk about these potential hazards with Beverly?

Be sure you go over these issues with your supervisees. Otherwise, your job may be at risk.

Contextual Issues

Other potential sources for transference and counter-transference issues are contextual issues. These issues include:

- Academic background
- Age
- Culture
- Disability
- Discipline
- Ethnicity
- Gender
- Race
- Recovery vs. non-recovery status
- Religious and spiritual practices
- Sexual orientation

The factor that receives the most attention is culture. The U.S. Department of Health and Human Services (2009) believes that more care should be given to:

- Identifying the necessary competencies for counselors to work with a variety of individuals and to navigate intercultural communities.
- Identifying methods for supervisors to aid counselors in cultivating these competencies.
- Providing evaluation criteria to aid supervisors in establishing whether or not their supervisees have met minimal competency standards for productive and appropriate practice.

Supervisor competencies in general have been discussed twice in great detail earlier in the course. Cultural competence is the capability to respect and honor the language, convictions, behaviors, and interpersonal styles of individuals and families that are being given services, as well as staff providing those services. Cultural competence is an ongoing, active developmental

process demanding commitment. Belief systems are fabricated by culture, especially regarding mental health issues. Culture also forms symptoms, coping patterns, and relational styles.

The supervisory process must consider three levels of culture:

1. The culture of the client being served
2. The culture of the therapist being supervised
3. The cultural issues of the agency, its geographic environment, and other contextual factors.

There are also three important areas in supervision in which cultural and contextual factors are key:

1. Building the supervisory relationship or working alliance
2. Addressing specific needs of the client
3. Building competence and ability of the supervisee

As a supervisor, it's your responsibility to address the attitudes, beliefs, and biases of your supervisee regarding contextual and cultural variables in order to move their professional development forward and further quality client care. Becoming culturally competent and able to incorporate other contextual variables into supervision is an intricate, long-term procedure.

Cross, et al. (1989) recognized six stages of a continuum of cultural proficiency:

1. Cultural Destructiveness--Superiority of dominant culture and inferiority of other cultures; active discrimination
2. Cultural Incapacity--Separate but equal treatment; passive discrimination
3. Cultural Blindness--Sees all cultures and people as alike and equal; discrimination by ignoring culture. This viewpoint is sometimes called "universalist." Of concern here is that families are seen as typical, and their cultural and individual nuances are not explored (Cole, 2001).
4. Cultural Openness (Sensitivity)--Basic understanding and appreciation of importance of socio-cultural factors in work with minority populations
5. Cultural Competence--Capacity to work with more complex issues and cultural nuances
6. Cultural Proficiency--Highest capacity for work with minority populations; a commitment to excellence and proactive effort

One view that didn't find a place in Cross' stages is the "particularist." In this view, families are more different than alike; each family is entirely unique and there are no generalizations. This view allows culture to be spread to include each family's internal beliefs. The primary worry here is that environmental factors will be completely ignored and all issues seen only for an internal exclusive perspective (Cole, 2001).

Another view stresses family differences only based on ethnicity, involving cultural generalizations. The result is a danger of stereotyping and over-systematizing shared meanings (Cole, 2001).

The multidimensional perspective looks at the large number of factors that impact the clinical picture. This approach includes a large variety of sub groups and proceeds beyond generalizations. In fact, this view has so many facets that it can be overwhelming and confusing to supervisees (Cole, 2001).

Regardless of the level of training you or your supervisees may or may not have had in multicultural counseling, it's your responsibility to aid them in building on the skills they have and be aware of where they fall short in cultural competence. If you've not already done it, you'll need to examine cultural influences on your own attitudes, experiences, practices, and values and assess what their effects are on your relations with supervisees and clients. Some questions to ask yourself during this examination are (U.S. Department of Health and Human Services, 2009):

- What did you think when you saw the supervisee’s last name?
- What did you think when the supervisee said her culture is X, when yours is Y?
- How did you feel about this difference?
- What did you do in response to this difference?

Constantine (2003) offers the following questions that can also be used with supervisees:

- What demographic variables do you use to identify yourself?
- What worldviews (e.g., values, assumptions, and biases) do you bring to supervision based on your cultural identities?

- What struggles and challenges have you faced working with clients who were from different cultures than your own?

Because of the nature of cultural differences, you and your supervisee will want to attend workshops and conferences and take continuing education classes that focus on cultural competence and other contextual factors. You should also participate in multicultural activities, such as discussion groups, community events, religious festivals and other ceremonies.

In any instance, the supervisory relationship involves a basic difference in power. It's important to heed this difference, especially if the supervisor and supervisee come from different cultural backgrounds. The misuse of power is always a risk, but even more so when working together with clients and supervisees from differing cultural contexts.

When the supervisee is from a minority group and the supervisor from a majority group, this difference can be exaggerated. You'll need to guard against supervision quality being a threat from institutional discrimination.

This is also true if the supervisee is gay and the supervisor is heterosexual, or the supervisee has only a bachelor's degree and the supervisor have a master's degree or higher. Other alliances that need careful watching are a female supervisee and a male supervisor, a supervisee who is older than the supervisor, and so on. You'll also need to watch and discuss those supervision relationships that go the other direction.

Power

Power has been mentioned as a potential cause for transference and counter-transference. Brodsky's (1977) statement included the idea that the supervisor is considered an authority, and the supervisee is often quite dependent and will generally not risk angering or challenging the supervisor.

At the risk of furthering an untruth and in order to help round out the discussion of power with transference and counter-transference, a theory of Abusive Multiple Transference (AMT) has been supposedly posited by David W. Bernstein. We could find no scholarly reference to it, but there are scores, if not hundreds of sites, including Wikipedia (Wikipedia, n.d.), that give this piece of wisdom as fact. Because it's so widespread, and because it seems plausible, it has been included here.

In this assumed theory, it's stated that abusers not only transfer negative feelings they hold towards their abusers to their own victims, but also transfer the dominance and power of the former abusers to themselves.

The case of the serial killer Carroll Cole is given as an example of this kind of power transference. Cole's mother took part in several illicit sexual relationships when his father was gone during World War II. She forced Cole to watch these affairs, and later beat him to be sure that he would not tell his father. In school, classmates tease him because he "had a girl's name." Whether it was related to this or not, at age 10 he drowned a classmate of his own age. When he was 42, he was arrested for killing a woman and confessed to killing 14 or more women, apparently those he felt were "loose" and who reminded him of his mother.

Carl Jung gave a more positive view of power and counter-transference. He speaks of counter-transference as being all of the feelings that the therapist has towards the client. He pictured the importance of those feelings by the image of the "wounded physician," stating that "it is his own hurt that gives the measure of his power to heal." Jung also said that "only what he [the therapist] can put right in himself can he hope to put right in the patient" (Stevens, 2011).

Nurturance

As mentioned earlier, the question of nurturing is how much to nurture, in relation to promoting dependence, offering comfort, or giving a clear message that the supervisee is out of control--especially if the supervisee is tearful (Brodsky, 1977).

According to Adams (2010), under the appearance of kindness, too much nurturance can undermine the goal. Although the statements he makes are focused on clients, there is some application of them to supervisees also:

- Anyone in a client role can become mildly to moderately manipulative
- Clients can quite quickly learn to be "entitled" and demanding
- The ultimate goal of a relationship with a client is to have the client become self-sufficient
- Meeting a client's dependency needs often does not empower the client to recover
- Clients can have financial, drug--even criminal--issues that they don't mention, but can use their issue to their own interest
- It's easier to look for drugs when you have a person whom you have convinced that you cannot function with narcotics
- Counter-transference is always a potential in which the therapist becomes excessively identified with the client's difficulty and loses objectivity, even though he may not have all the data

Adams (2010) uses a situation of pain and a pain clinic to illustrate these points. A pain clinic was giving one client high amounts of OxyContin, advocating for his pain disability. However, the pain clinic had no clue about the client's past--addictive, criminal, economic and social. This past included a dishonorable discharge from the military, alcoholism, drug convictions, prison terms, an estimated eight divorces and other instances suggesting he had little or no impulse control and likely no ability to learn from his own experiences.

Although it's appropriate to be supportive of a client, it's also necessary to understand what is truly motivating and/or controlling the client. If supervisees appear too much involved with a client, they must be directed as to whether they have a complete and accurate understanding of the client (Adams, 2010).

In the mid-1960s, research was done to compare counselor experience, the degree to which they "liked" clients. They related these to the type of approach the counselors made to client hostility and dependency. It was found that only in the more inexperienced counselors was there a link between "liking" and nurturance. Counselor approach to client hostility correlated with counselor needs for nurturance and affiliation; the approach to dependence didn't correlate with either

nurturance or affiliation (Mills and Abeles, 1965). This research gives you clues as to which of your supervisees might be inclined to give inappropriate nurture.

Empathy

Just as with nurturance, there is healthy and unhealthy empathy. The supervisee's background and life experiences may enhance or hinder their ability to understand a client. Between you and the supervisee, there is the possibility of over-identification or assumption if, for example, you have similar life experiences such as parenthood (Brodsky, 1977).

Empathy may be defined as the natural human ability to be aware of the emotions and feelings of others and to try and help them. The word "empathy" comes from the German *Einfühlung*, literally "to feel inside something" (Wispé, 1986). *Einfühlung* is the result of a process when an observer would project himself inside the perceived object.

Kohut (1984) believes that the therapist can only rely on two things to promote analytic cure: empathy and interpretation. He defines empathy as the "capacity to penetrate with thought and sentiment into the life of another person."

Even the neurosciences have aided in explaining the phenomena that are at the root of empathy. Decety and Jackson (2004) use two perspectives: 1) a psychodynamic perspective (empathy as the art of communication), and 2) a humanistic perspective (empathy as an innate ability). They suggest that empathy in humans has three basic constituents:

1. Affective Sharing between yourself and another, based on the **perception-action** relation which causes the shared representations.
2. **Conscience of the ego and of the other**. Even if there is some temporary identification, the self and the other are never confused.
3. **Mental flexibility** is needed in order to subjectively adopt another's perspective and the regulatory process.

These three constituents interweave. They should act together to produce empathy.

The relief in all of this is that these constituents are generally unconscious and occur naturally. As a supervisor, you only need to be certain that your supervisee is displaying empathy appropriately and is not over-identifying with the client.

Therapeutic Relationships

The therapeutic relationship has several other names, also:

- The helping alliance
- The therapeutic alliance
- The working alliance

No matter the name, it may be defined as the relationship between a healthcare professional and a client. It's the means, or instrument, by which the professional hopes to connect with and influence change in a client (Therapeutic Relationship, n.d.).

Ford (1978) evaluated the Client's Perception of the Therapeutic Relationship (CPTR), and learned that individual therapists had a considerable effect on CPTR ratings, while the client's significant others were correlated negatively with the outcome. Ford made several other conclusions:

- The therapeutic relationship is not enough for change, but is important.
- The therapeutic relationship is an elusive construction that is not solely dependent on the therapist's behavior.

Studying Ford's research alongside several others, Niolon (1999) concluded that, as everyone knows, the therapeutic relationship interacts with specific therapy strategies to either hinder or enhance reaching client goals. Perhaps more valuable, the relationship is at least as important to productive therapy as the techniques used.

Although given in a context of nursing, the Registered Nurses' Association of Ontario (2006) listed two areas required to establish a therapeutic relationship that are also apropos for therapists:

1. Knowledge
    - Background knowledge
    - Knowledge of interpersonal, caring and development theory
    - Knowledge of culture, diversity, influences and determinants of health
    - Knowledge of person
    - Knowledge of health/illness
    - Knowledge of the broad influences on health care and health care policy
    - Knowledge of systems.

2. Capacities
    - Self-awareness
    - Self-knowledge
    - Empathy
    - Awareness of ethics, boundaries, and limits of professional role.

Many of the aspects of a therapeutic relationship have already been discussed, from theory to supervision approaches, from communication and competencies to transference and counter-transference issues. Two more need some attention.

Dual Relationships

Dual or multiple relationships in psychotherapy are situations where multiple roles exist between a therapist and a client. For example, there is a dual relationship when the client is also a business associate, employee, family member, friend or student of the therapist (Zur, 2011a).

In 1990, Kenneth Pope made a claim that became an authoritarian standard of therapeutic ethics: ". . . non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships." The following year, Simon (1991) voiced his agreement, stating that "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual

sexual involvement itself." It's no wonder that social workers and therapists came to believe that if we avoid any appearance of dual relationships, we also avoid all forms of harm and exploitation" (Zur, 2011b).

However, Zur (2011b) argues that, "To assert that self-disclosure, a hug, a home visit, or accepting a gift is likely to lead to sex is like saying doctors' visits cause death because most people see a doctor before they die." Dr. Arnold Lazarus (1994) labels Pope's kind of thinking as "an extreme form of syllogistic reasoning." Sequential statistical relationships cannot simply be translated to causal ones (Zur, 2011b).

Zur goes on to state that this attempt to protect the public from therapists who might exploit them, is not only a simplistic solution to a complex problem, but it imposes isolation on the therapeutic sessions that could increase the likelihood of exploitation and decrease treatment effectiveness. He states that it allows incompetent therapist to express their power with neither witnesses nor accountability, and to go along with the isolation and disconnection so prevalent currently in our culture. He believes that, "If we dare to cultivate multiple, non-sexual and non- exploitive relationships with our clients when appropriate, we can be better, more effective therapists" (Zur, 2011b).

Even though many still believe that there should be no dual relationships between therapist and client, this is not always practical. For example, in a small town there was one middle-aged therapist who had likely treated most of the adults at one time or another over the years. She was attempting to build a small addition to her home, pretty much on her own. However, she needed to hire someone to do some of the heavier jobs for her. The only person who seemed to be available was a young man who was currently a client. Her agency approved her hiring him to do the job.

By this, one might assume along with Zur (2011b) that some dual and multiple relationships between therapist and client, as well as between supervisor and supervisee are ethical and some are not. Obviously, sexual relationships in these relationships are always unethical and often illegal (U.S. Department of Health and Human Services, 2009). However, other dual relationship issues may be more subtle and complex, as in the example given. In a dual or multiple relationship, the challenge is to avoid potential harm to or risk of exploitation of the individual in the subordinate position (Reamer, 2009).

Another challenge is to maintain proper boundaries, which can blur. If the two individuals are working together on a community event, sitting on the same committee, or partaking in a work-sponsored activity can open doors for crossing boundaries. Some safeguards for managing dual or multiple relationships include (Malone, 2009):

- ✓ As they move from one function to another, the supervisor or therapists must be clear in their boundaries.
- ✓ The supervisor or therapist must be clear about appropriate use of his power. A covert agenda should never be employed, because they focus on the needs and objectives of the supervisor or therapist. Using an overt agenda--putting the supervisee's or client's needs first, and following ethical guidelines will protect the trust and safety in the working relationship.
- ✓ An all-inclusive discussion with the supervisee or client about times when boundary crossing occurs will also aid in keeping the proper relationship.

Of course, the simplest way to deal with dual or multiple relationships is to avoid them. If this is impossible, solutions can be found (Reamer, 2009) for even complex ethical issues if:

- ➢ There is a diligent wiliness for social workers and their colleagues to work together.
- ➢ There is an intentional effort to take into account and be directed by social work/therapist ethical standards.
- ➢ There is mindful, imaginative problem solving.

As a supervisor, it's your responsibility to see that solutions are found when dual and multiple relationships become an issue.

Self-Disclosure

As with dual relationships, self-disclosure on the part of a therapist or supervisor has generally been

frowned upon in the past. Again, as with dual relationship, this has been changing since the end of the twentieth century.

Self-disclosure is an example of boundary crossing, but not a violation of boundaries or dual relationships. Zur (2011c) states that self-disclosure can be a therapeutic technique that is both ethical and highly effective when used skillfully and appropriately. In fact, he believes that non-disclosure by a therapist can be damaging to therapy when working with a population that is stigmatized, such as gays and lesbians.

Referring specifically to the supervisor-supervisee relationship, Brown and Bourne (1996) believe that the supervisor must attract the supervisee's interest by modeling and offering practice in engagement skills by using metacommunication, feedback, and self-disclosure. They believe that this improves both supervisor-supervisee relationships, and those of therapist-client.

The way a supervisor may use self-disclosure in clinical supervision differs with different supervision styles (Ladany and Lehrman-Waterman, 1999). The Supervisory Styles Inventory identified three kinds of supervisory styles (Friedlander and Ward, 1984):

1. Attractive Style -- Based on being warm, friendly, open, and supportive
2. Interpersonally Sensitive Style -- Supervisor helps supervisees identify how clients affect them
3. Task-Oriented Style -- Goal oriented and pragmatic

They discovered that those using the Attractive Style were more likely to use self-disclosure both in general and when specifically relating neutral counseling experiences. Those who followed the Interpersonal Sensitive Style used fewer disclosures of neutral counseling experiences.

Marketplace Issues

A primary marketplace issue for clinical social workers and other therapists is being paid by insurance companies, i.e., can you independently bill insurance companies and Medicare. Until 2002, only physicians were generally allowed direct payment by these companies. A mental

health practitioner had to be under the supervision of a physician, who would bill the insurance company and pay the therapist. Community mental health centers would hire a physician to sign-off on therapist case notes so the agency could bill the insurance companies for the services rendered.

In 2002, Medicare listed some non-physician practitioners who could independently bill for psychiatric diagnostic evaluations and psychotherapy (Medicare Payment Advisory Commission, 2002). The same rules generally apply to federal CHAMPUS/TRICARE programs and the Indian Health Service. General rules require that the practitioner must have at least a master's degree from appropriate programs.

The specific categories include:

Marriage and Family Therapists: MFTs are trained in family systems and psychotherapy; they diagnose and treat emotional and mental disorder within the framework of couples' relationship, marriage, and family systems. They usually have at least a master's degree, and often a doctor's degree in marriage and family therapy, plus two or more years of supervised clinical experience. They can be licensed in 44 states, including California.

In California, requirements for supervision and experience had a number of changes in regards to supervision hours after January 1, 1010 (California Board of Behavior Sciences, 2010). You will want to annually check for the most up-to-date requirements in your state.

Licensed Mental Health Counselor and Licensed Professional Clinical Counselors: These licensed professionals have at least a master's degree and sometimes a doctoral degree in counseling, and have at least 3,000 hours of supervised clinical counseling. Historically these counselors have received their degrees via a university's education department and have worked in a number of settings, such as colleges and schools, community and government agencies, private practices and businesses. The Department of Health and Human Services reports that their counseling is differentiated by a preventive and developmental orientation, plus its focus on the environmental context of the individual (Medicare Payment Advisory Commission, 2002).

A significant marketplace issue is the signing of insurance forms for reimbursement:

The form required the signature of the professional who provided the service.
A trainee provided the service.
A supervisor signed the form.

This constitutes fraud. It also constitutes a dilemma for the service-providing agency. A good solution, which has usually been accepted by the insurance company, is to have the trainee sign as the one providing the service, and the supervisor co-sign as "Supervisor."

Licensed Clinical Social Workers: Although the *Report to Congress: Medicare Coverage of Nonphysician Practitioners* (Medicare Payment Advisory Commission, 2002) does not have a separate section for licensed clinical social workers as it does for the other categories just listed, there are references in it that show that an LCSW may also directly bill for Medicare payment. However, it stipulates that the LCSW must be legally authorized to make diagnosis and treat mental illness by the state in which they're licensed. California LCSW licenses do allow for this (California Board of Behavior Sciences, 2011a).

Medicare Part B currently allows psychiatrists and certain nonphysician practitioners such as psychologists and social workers with the equivalent of a master's degree in psychotherapy to bill independently for mental health services, and Medicare will make direct payment to them. Psychologists are paid at 100% of the physician fee schedule, but social workers only receive 75%.

Liability

As a supervisor, you must be realistic about the fact that the minute you took on the responsibilities of a supervisor, you also took on a bigger risk for liability and potential ethical violations. The moment you became a supervisor, you amplified the risk that you could sit in a chair in the California Board of Behavior Sciences--or worse--answering questions.

By becoming a supervisor, you amplified the risk that you might need to defend the actions of yourself and/or your supervisee in a circuit court hearing. Because of the heightened statistical risks, you need to understand some fundamental legal principles and the impact they have on your practice of supervision (Haarman, 2011).

Clinical supervision is administered within the structure of a legal, contractual relationship and under a few ethical and legal constraints (Munson, 2002). You, as supervisor, take official responsibility for the supervisee's work, and you therefore appropriate its legal liability; the agency that gave you authority to supervise also assumes that liability.

You must constantly be vigilant in risk-assessment and risk management of matters relating to domestic violence, duty-to-report, duty-to-warn, perceived threats to the supervisee, and so on. In addition to civil law, most states regulate the practice of clinical social work to prevent abusive and fraudulent practice. In many jurisdictions, the clinical supervisor is legally accountable to the state licensing board (Munson, 2002).

There are five general legal principles you must understand so you can direct your practice and so you can practice effective risk management (Falvey, 2001):

1. **Standard of Care** - The normative or expected practice performed in a given situation by a given group of professionals.
2. **Statutory Liability** - Specific written standards with penalties imposed, written directly into the Law
3. **Negligence** - When one fails to observe the proper standard of care.
4. **Direct Liability** - Being responsible for your own actions or authority and control over others.
5. **Vicarious Liability** - Being responsible for the actions of others based on being in a position of authority and control.

From this you may surmise that there are many causes for alleged malpractice--from breach of confidentiality to financial improprieties to failure to exercise due care. Although many legal issues are specifically associated with the supervisory relationship, there are other areas of concern

related to job-management activities, such as styles of record-keeping and the impact of HIPAA rules. Because these legal concerns are so complex, there needs to be a formal, written agreement between the supervisor, supervisee, and agency carefully defining the essential features and limits of the supervisor-supervisee relationship (Munson, 2002).

Robb (2004) pointed out that a supervisor's legal liability includes more than her direct supervisees. It includes partners, paraprofessionals, unlicensed assistants, volunteers, other professional coworkers, and student interns. Managing risk is an open-ended undertaking.

Standard of Care

Even when clients consent to allow a trainee to treat them, they're not by that consenting to substandard care (Harrar, Vande Creek, and Knapp, 1990). The standard of care is a continually changing, to some degree loosely defined, and slowly emerging principle concerning the practice of a profession that the people in a society should be able to have confidence in.

Haarmon (2011) uses the dentist as a concrete example to define standard of care. If a person seeks dental services, he has a right expect certain practices. Those expectations are not the same as they were in the 1870s, and have developed over time.

The public has a right to be given dental care that is consistent with current technology, current standards and current knowledge of dentistry. A person gets services from a licensed dentist, and several months later discovers that the dentist had a crazy idea that he was only going to sterilize his instruments every four or five months in order to conserve energy and water. If that person later develops a disease that is blood-borne, he will probably be able to hold the dentist liable, because he without a doubt violated the standard care of the dental profession.

There is a standard of care for the mental health professions. A standard of care for supervision is emerging (Haarman, 2011).

The center of the standard of care includes an essential feature of competency. Those who look for services from professionals, especially licensed professionals, have a right to expect that the professional is able to provide what they say they can provide. If someone is providing services without suitable credentials or under falsified credentials, she's violating the standard of care, and if damages occur, you could have a claim against them.

Those seeking service expect confidentiality, which--with certain limitations--is part of the standard of care. If that confidentiality is violated by a professional and damages occur, a client may have a valid liability claim and an expectation of compensation for damages.

Implications for some dual relationships are part of the standard of care. If you seek services from a mental health professional, it doesn't mean I am agreeing to subject yourself to a sales presentation about vitamins or real estate investments (Haarman, 2011).

Saccuzzo (1997) found five major principles of standard of care that were found over and over again in case law, statutes, professional literature, and codes of ethics:

- Competence
- Confidentiality
- Dual Relationship
- Welfare of the Consumer
- Informed Consent

Standards of Care for Supervision were brought out of statutes, ethics, case law, and clinical practice by Falender and Shafranske (2004). Included were:

- Supervising only within your area of competence
- Providing appropriate feedback and evaluation
- Consistently monitoring and controlling supervisee’s activities
- Accurately documenting supervisory activities

- Providing consistent and timely supervision

Statutory Liability

There are definite requirements for practicing your profession that are stated and explained in statutes or administrative rules. These are called the principle of statutory liability. If you overlook, ignore, or violate the requirements that are spelled out in the statutes, you'll probably be found civilly or criminally liable. For example, all states and U.S. territories have mandatory reporting laws for child abuse. If you fail to report such abuse, or choose not to, you would likely be blamed for wrongdoing and fined or possibly even imprisoned (Haarman, 2011).

California law demands that all supervisees keep weekly written logs of all supervised experience. The law also demands that the supervisee gets the supervisor's signature on each of those logs. Logs must include notation of the precise work setting in which the work took place, dates, the kind of interaction (e.g., face-to-face, phone, individual, group), and the professional services given or work performed. The supervisor's license may be revoked for inadequate supervision (California Board of Behavior Sciences, 2011).

Violation of a statute in California only results in a rebuttable presumption of negligence. Therefore, if a violation of the licensing statute occurs in California, the burden is transferred to the supervisor to prove that, in fact, he was not negligent (Saccuzzo, n.d.).

These statutes are just a few among many. You'll want to get the whole list from the website of the California Board of Behavior Sciences and familiarize yourself with them.

Negligence/Malpractice

It's important that you, as a supervisor, understand the legal concept of negligence when a professional does not observe the standard of care. As a supervisor, you can be negligent by not observing--whether intentionally or unintentionally--the applicable standard of care as it pertains to supervision.

There are appropriate assumptions about supervision, the chief of which is that supervision truly takes place. In a board complaint or a court setting, a supervisee might show documentation that the supervisor canceled supervision 25 times in 52 weeks of supervision. This is obvious evidence that the supervisor failed to meet the responsibilities and duties of supervision, and is potential negligence. This lack of timely and consistent supervision may have brought about injury to a client, or at the least may not have given enough quality control or allowed for the supervisee's development and growth (Haarman, 2011).

Malpractice is professional negligence and is thus a tort--a wrong involving an infraction of a civil duty that is owed to another person. A person who has received a tortuous injury has the right to receive "damages," usually monetary compensation, from the person or people who are responsible--liable--for those injuries. If the person who is injured can prove that the one(s) who cause the injury acted without taking reasonable care to prevent hurting others--that is, negligently--tort law allows compensation. For a successful malpractice suit, there must be substantial evidence and must show "the four Ds"--Dereliction of a Duty Directly causing Damages (Behnke, et al., 1998).

Four tests of malpractice were described by Bennett, et al. (1990) and expanded by Guest and Dooley (1999) in the framework of supervision:

1. There was a professional relationship between the supervisor and supervisee.
2. There is a demonstrable standard of care, and the supervisor breached that standard.
3. The supervisee suffered demonstrable injury or harm.
4. The supervisor's breach of duty to practice within the standard of care was the proximate cause (reasonably foreseeable) of the supervisee’s or client’s injury.

Supervisory malpractice includes lawsuits filed by a supervisee or a client against a supervisor who has allegedly breached the practice standards of professional supervision. Because of the nature of the supervisory relationship, supervisors are at high risk of undergoing licensing board complaints (Harris, 2003). According to Reaves (1998), state psychology licensing boards reported that the fifth most common violation reported as improper or inadequate supervision. You need to take care that you're not part of that statistic.

Direct Liability

If you do something resulting in damages to a person or thing, you can be held directly liable for the damages. Some common examples are causing automobile accidents because of what you're doing while you drive--texting, putting on makeup, reading a map, etc.

Direct liability for supervisors is founded on incorrect, improper, or unethical omissions or actions on the part of the supervisor. Direct liability takes place if a person takes some sort of action, or fails to act, causing some sort of damage to another person. Harrar, VandeCreek, and Knapp (1990) gave examples of supervisory direct liability that might be summarized as involving any action or lack of action that is a dereliction in carrying out the responsibility to adequately supervise a supervisee's work.

A list of supervisor behaviors that represent potential direct liability charges might include:

- Not providing clear expectation of the supervisee
- Not having a supervisory contract
- Failure to assess the supervisee's abilities and skills
- Assigning tasks to the supervisee that the supervisor should have known the supervisee was not adequately trained to handle
- The supervisee has been assigned too many clients
- Allowing the supervisee to practice outside his scope of practice
- Not consistently supervising
- Not supervising in a timely basis
- Not adequately monitoring a supervisee's caseload
- Lack of consistent feedback prior to evaluation
- A biased or unfair evaluation
- Violating professional boundaries
- Failure to provide emergency coverage
- Failure to provide crisis procedures
- Giving a supervisee inappropriate treatment recommendation
- Failure to understand a client's needs because of not carefully listening to a supervisee's comments

Vicarious Liability

Not only do you have direct liability for your actions as a supervisor, you may also be liable for the actions of your supervisees. Vicarious liability is founded on three concepts (Falvey, 2001):

1. Respondeat Superior--The supervisor is in a position of authority and responsibility. To whatever extent the supervisor has the responsibility and ability to control a supervisee's activities, the supervisor has liability and responsibility for the supervisee's actions.
2. Borrowed Servant--The supervisee is under the direct control of the supervisor. Necessary for deciding supervisory liability is if a person is subject to the control of another person in regard to both the work to be done and the manner in which that work is performed (Sacuzzo, 1994).
3. Enterprise Liability--The supervisor or the supervisor's agency may profit from the actions of their supervisees (Behnke et al., 1998). The potential for gain from a supervisory relationship changes the nature of the relationship and creates additional liability (Haarman, 2011).

Even though you did nothing wrong as a supervisor, if your supervisee caused damages, you may hold some responsibility for her actions. Saccusso (1997) asserted that "supervisors can be liable not only for their own negligence in failing to supervise adequately, but also for the actions of their supervisees."

Factors that could determine a supervisor's vicarious liability include:

- The supervisor's power to control the supervisee
- The supervisee's duty to perform the act in question
- The supervisee's motivation for engaging in the act
- The time, place, and purpose of the act

In our society where folks are inclined to litigate, a supervisor must comply with accepted professional practices, as well as with regulations of state and licensing agencies.

Risk Management Strategies

It's obvious that you'll want to do all you can to minimize the likelihood of being sued because of your role of supervisor. There are steps you can take to accomplish this.

The first step may occur when you or your agency hires a new employee. It might be wise to require a formal application process with appropriate documentation. Make sure the supervisee is selected according to approved evaluation procedures concerning minimal standards for a trainee position. "Reasonable care" in hiring supervisees might involve asking the following questions about an applicant (Cole, 2001):

- Has the applicant completed the needed course work for performing the specified clinical work?
- Is the applicant recommended by faculty members or former employers in the field, or others familiar with his work?
- Is the applicant able to define concepts so they can be expressed or measured through practical applications with clients?
- Are the applicant's personal people skills appropriate and sufficient for the work setting?
- Are there currently or have there ever been any malpractice concerns of allegations of misconduct filed against the applicant?

Other steps to take include:

- Investigate employment gaps or discontinuity in training.
- Conduct a thorough background check, including a criminal record search.
- Ask for references from prior employers or supervisors to see if the applicant has the ability to adapt to rules and get along with others.

Taking these steps may prevent you from agreeing to supervise "walking lawsuits," or "loose cannons." For your use once you have accepted a supervisee, Falvey (2001) set forth a list of the "Top 10 Risk Management Strategies for Supervision":

1. Maintain Written Policies
2. Monitor Supervisees Competence through Work Samples
3. Supervision Contract
4. Be Accessible, Dependable, and Available
5. Informed Consent for Supervision
6. DOCUMENT, DOCUMENT, DOCUMENT
7. Consult with Others Appropriately
8. Know the Law and Administrative Regulations
9. Discuss Ethical Codes
10. Liability Insurance

In a similar vein, Recupero & Rainey (2007) exposited a practical list of actions a supervisor could and should do to cut down the possibility of liability:

1. Develop supervision guidelines or a supervision contract.
2. Develop an informed consent form for supervisees to sign, indicating they understand what is expected of them.
3. Establish and maintain appropriate supervision boundaries.
4. When assigned a new supervisee, make inquiries to determine if there are any special concerns about a particular supervisee.
5. Establish regular hours for supervision and adhere to them.
6. Review charts of clients in treatment with supervisees. Develop a regular schedule for chart review.
7. Follow up on complaints or concerns about a supervisee promptly and thoroughly. Documenting steps taken to resolve the problem may further reduce risk.
8. Establish routine guidelines for supervisees related to the management of suicidal or violent clients.

9. When the supervisee is providing therapy associated with increased risk, more intensive supervision may be appropriate.
10. Review charts of clients in treatment with supervisees. Develop a regular schedule for chart review.
11. Document all supervision sessions. Take notes, and encourage supervisees to take notes as well. Ask supervisees to develop reports or to keep a supervision journal.

Therapy Records

Therapy records involve a number of demands and constraints. Some of the demands are considering ethical standards, legal requirements, situational contexts and more. As a supervisor, one of your jobs is to aid your supervisees to keep proper records. You may also have some input into agency policies.

Some of the record keeping is required by state and/or federal laws. These will be addressed as you continue through this program. You'll need to combine your training and education, as well as a multitude of skills to recognize pertinent issues and to resolve problems that you run into.

Ten Sixteen Recovery Network (n.d.) gives a good overall picture when it tells its clients that the clinical file serves as a:

1. Basis for planning the client's care and treatment
2. Means of communicating among clinical staff who contribute to your care
3. Legal document describing the care the client received
4. Means by which the client or a third-party payer can verify that she actually received the services billed for.
5. Tool for education (i.e., interns)
6. Source of information for the public health officials charged with improving the health of the regions they serve
7. Tool to assess the appropriateness and quality of care given
8. Basis for accrediting organizations, licensing, and third-party audits to evaluate the treatment.

Because of the nature of the clinical file, also called the therapy records, it's very important to be sure they're used only for proper purposes and in proper situations. It's part of your job as supervisor to aid in this protection of the records.

The American Psychological Association publishes guidelines for keeping records. Thirteen guidelines are given (American Psychological Association, 2007). Although they relate specifically to psychologists, they're applicable to any mental health practitioner and supervisor. The records are not necessarily the sole responsibility of these folks, but a collective responsibility of them and their agency. However, to bring home the importance for you, as a supervisor, to be aware of these guidelines, the original APA wording of "psychologist" has been changed to "supervisor" and some adaptations have been made to fit your role:

1. **Responsibility for Records**: Supervisors generally have responsibility for overseeing the maintenance and retention of their supervisees' records.
2. **Content of Records**: A supervisor strives to be sure the supervisees maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the supervisor’s jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services, and related fees.
3. **Confidentiality of Records**: The supervisor takes reasonable steps to establish and maintain the confidentiality of information arising from service delivery.
4. **Disclosure of Record Keeping Procedures**: When appropriate, supervisors either inform clients or guide their supervisees to inform them of the nature and extent of record keeping procedures (including a statement on the limitations of confidentiality of the records).
5. **Maintenance of Records**: The supervisor strives to be sure the records are properly organized and maintained to ensure their accuracy and to facilitate their use by the supervisor, the supervisee and others with legitimate access to them.
6. **Security**: The supervisor takes appropriate steps to protect records from unauthorized access, damage, and destruction.
7. **Retention of Records**: The supervisor strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional, and ethical requirements and to keep the supervisees apprised of them.

8. **Preserving the Context of Records**: The supervisor strives to aid the supervisees to be attentive to the situational context in which records are created and how that context may influence the content of those records.
9. **Electronic Records**: Electronic records, like paper records, should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access, as well as their compliance with applicable legal and ethical requirements.
10. **Record Keeping in Organizational Settings**: Supervisors working in organizational settings (e.g., hospitals, schools, community agencies, prisons) strive to follow and help supervisees to follow the record keeping policies and procedures of the organization as well as the Ethics Code of their discipline.
11. **Multiple Client Records**: The supervisor trains the supervisees to carefully consider documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.
12. **Financial Records**: The supervisor strives to ensure accuracy of financial records. Even if this is not the normal domain of the supervisor, he will want to keep tabs on it.
13. **Disposition of Records**: The supervisor plans for transfer of records to ensure continuity of treatment and appropriate access to records when the supervisee and/or the supervisor is no longer in direct control, and in planning for record disposal, the supervisor endeavors to employ methods that preserve confidentiality and prevent recovery.

There are a number of ways the information and requirements regarding records could be presented. It was decided to use these 13 guidelines as the framework for the more details discussions of significant points.

Responsibility for Records

Both the supervisor and the supervisee are responsible both ethically and professionally to build and keep up the clinical records. To sound redundant, the records record and, in some way copy or reflect the supervisee's professional work. Often the records are the only way for you, the supervisee, and necessary others to know what the supervisee did and why. Consequently, the

supervisee will want to keep high-quality records to reflect high-quality work. If any of it is called into question in the future, accurate records will make explanations and accountability easier.

Some keys to good records are legibility and accuracy, made as soon as possible after therapy or another contact is completed. Logical organization that is replicated in every record is also essential. If there is ever a conflict between agency policies and procedure of the applicable code of ethics, you'll need to address the conflict in the manner delineated in the code of ethics. You must clarify the nature of the conflict, state your commitment both to the agency and the code of ethics, and--as much as possible--resolve the conflict in a way that follows the code of ethics (American Psychological Association, 2007).

Content of Records

Some states have a list of requirements for what is included in the mental health record of any child or young adult that is in foster care. California has no such requirement.

As a matter of course, the client's record is often quite full before much therapy has taken place. Under the guidelines of your agency, you'll need to make some decisions about the record content. You should consider the:

- Nature of the service(s) given to the client
- Source of recorded information
- Intended use of the records
- Professional obligations of each profession contributing to or otherwise using the file

Some agencies have a mandated record format, a list of specific information to be collected and recorded, and a given time frame within which to create the records. Your supervisees will try to include only information pertinent to the purposes of the service given. They--and you--will need to be cognizant of the possible impact on the client of language used in the record (e.g., representing symptoms as a disease, using derogatory terms).

Ethical and legal requirements must be met and risks considered. Information given in broad or vague terms may not be enough for continuity of care or building a satisfactory defense against malpractice, criminal, or state licensing board complaints. On the other hand, some clients may want you to keep a minimal record to give them maximum privacy and protection.

As you struggle with some of these issues, there are several specifics that may offer some guidance (American Psychological Association, 2007):

The Client's Request. For whatever reasons, a client may ask that only limited records of treatment be kept. Sometimes the client may even make that the deal breaker as to whether or not she will accept treatment. You and the supervisee may decide that treatment cannot be given under this circumstance and that serving such a client is not in the best interest of either the client or the supervisee.

Emergency or Disaster Relief Settings. An emergency or disaster relief situation may not allow or require substantial records. A disaster relief agency may only want short identifying information, the date and quick summary of services rendered, and the name of the provider. Or opportunity to keep detailed records may be lacking, especially in an immediate or short-term crisis. In some settings, such as disaster relief following a hurricane, there is not likely to be intervention beyond what may occur on-site; the brevity and small number of services provided may not allow detailed records to be constructed even after the crisis.

Alteration of Destruction of Records. Many regulations, statutes and rules of evidence forbid alteration or removal of information once a record has been made. In a litigation, adding or removing information from a record that has been subpoenaed could create liability for your supervisee and yourself. It's best that anything added later be documented as: "When reviewing the file on (date), I realized I had forgotten to mention…."

Legal/Regulatory: Some regulations and statutes order that certain information must, or must NOT be included in the record. For example, a statute may forbid you referring the results of an HIV test or giving information about chemical dependency treatment. You and your supervisee will need to follow all such mandates.

Agency/Setting: The agency for which you work may have policies and procedures about the level of detail permitted in the record. This will be discussed further in the section on *Record Keeping in Organizational Settings*.

Third-Party Contracts: You'll need to think about whether the amount of detail in a record meets the agreements in contracts with the agency and third-party payers. A number of third-party payers' contracts call for specific information to be included in a record. Not meeting the terms of the contract could precipitate non-payment, required reimbursement of funds that were already received, or legal actions.

Three kinds of information may be included in the record of psychological services (American Psychological Association, 2007):

1. Basic information
    - Identifying data (e.g., name, client id number)
    - Contact information (e.g., phone number, address, next of kin)
    - Fees and billing information
    - Where appropriate, guardianship or conservatorship status
    - Documentation of informed consent or assent for treatment
    - Documentation of waivers of confidentiality and authorization or consent for release of information
    - Documentation of any mandated disclosure of confidential information (e.g., report of child abuse, release secondary to a court order)
    - Presenting complaint, diagnosis, or basis for request for services
    - Plan for services, updated as appropriate (e.g., treatment plan, supervision plan, intervention schedule, community interventions, consultation contracts)
    - Health and developmental history

2. For each contact of substance with a client
    - Date of service and duration of session
    - Types of services (e.g., consultation, assessment, treatment, training)

- Nature of professional intervention or contact (e.g., treatment modalities, referral, letters, e-mail, phone contacts)
- Formal or informal assessment of client status

3. Other information, dependent upon the circumstances
    - Client responses or reactions to professional intervention
    - Current risk factors in relation to dangerousness to self or others
    - Other treatment modalities employed, such as medication or biofeedback treatment
    - Emergency interventions (e.g., especially scheduled sessions, hospitalizations)
    - Plans for future interventions
    - Information describing the qualitative aspects of the professional-client interaction
    - Prognosis
    - Assessment or summary data (e.g., psychological testing, structured interviews, behavioral ratings, client behavior logs)
    - Consultations with or referrals to other professionals
    - Case-related telephone, mail, and e-mail contacts
    - Relevant cultural and sociopolitical factors

Medical and Psychiatric History

When discussing the presenting complaint, diagnosis, or basis for request for services the therapist will attempt to get a routine, but sound medical and psychiatric assessment. The client may or may not be willing and/or able to give this history. If not, then the therapist must try to get information from family and caregivers. It's possible that much will have already been given to the agency before the client ever appears, such as previous psychiatric assessments and treatments, and the extent the client conformed to past treatment. Review this information as soon as possible.

The therapist may not request information without the consent of the client. However, if that information is giving without a request from the therapist, patient confidentiality is not violated (Routine Psychiatric Assessment, 2009).

The interview should first investigate--through the use of open-ended questions--why the client has come. Then exploration for broad view of the client's personal history is pursued. The therapist will review significant past and present life events and the client's responses to them. Using both overt and covert means, a mental status exam (MSE) will be given to determine the cognitive functions of:

- Orientation to person, time and place
- Spatial orientation
- Short- and long-term memory
- Concentration
- Abstract reasoning
- Judgment
- Following commands
- Simple math
- Word finding
- Naming objects
- Writing

Also, to be noted in this initial assessment are:

- Appearance
- Attitude
- Behavior
- Mood and affect
- Speech
- Thought content
- Thought process
- Perceptions

- Cognition
- Insight

Related to the psychiatric history are social history, family health history, responses to normal variations of life, developmental history, daily conduct, and the potential of the client harming himself or someone or another person. *The Merck Manual* sums up the most basic things to explore in each of these areas:

Areas to Cover in the Initial Psychiatric Assessment	
Area	**Some Elements**
Psychiatric history	Known diagnoses Previous treatments, including drugs and hospitalizations
Medical history	Known disorders Current drugs and treatments
Social history	Education level Marital history, including quality and stability of marriage Employment history, including stability and effectiveness at work Legal history, including arrests and incarcerations Living arrangements (e.g., alone, with family, in group home or shelter, on street) Pattern of social life (e.g., quality and frequency of interaction with friends and family)
Family health history	Known diagnoses, including mental disorders

Response to the usual vicissitudes of life	Divorce, job loss, death of friends and family, illness, other failures, setbacks, and losses
Developmental history	Family composition and atmosphere during childhood Behavior during schooling Handling of different family and social roles Sexual adaptation and experiences
Daily conduct	Use or abuse of alcohol, drugs, and tobacco Behavior while driving
Potential for harm to self or others	Suicidal thoughts and plans Intent to harm others

(Routine Psychiatric Assessment, 2009)

The most important psychological diagnostic tools are the history and the mental status examination (MSE). These tools have been standardized, but they're still primarily subjective measure. They begin the instant the client comes into the office. The therapist pays close attention to the client's presentation--personal appearance, interactions with the office staff and others in the area, and the patient is accompanied by someone (to help determine if the client has social support). Important information about the client can be obtained through these observations that might not be disclosed through an interview or a one-on-one conversation (Brannon and Bienenfeld, 2011).

From this information the therapist will determine a working diagnosis, another permanent part of the record. Depending on agency guidelines, this will probably be based on the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. (The fifth edition is/was due in May, 2013.) As a rule, the initial diagnosis remains attached to the client, although other diagnoses may be added if necessary. It's therefore important to be thorough in determining the diagnosis, for it will not only be used as a therapeutic guideline, but also as a determination for payment.

Required Client Forms

There are a few forms that are required in most mental health records. In some cases, the client only needs to be notified verbally or in writing only. Often these notifications are part of the intake paperwork. This is good, because it will not be easily overlooked. However, often the client will not carefully read what he's signing, so it's recommended that each of the following consents and acknowledgments be given both in writing and verbally. A copy of the signed, written form should be included in the record; in this way there will never be a doubt as to whether the client received the information or not.

Consents and Acknowledgements

In these instances, the client is either giving consent for something, such as treatment, or is acknowledging that she has received information, such as privacy rules.

Informed Consent

Informed consent, which must be in the client file, requires anyone who receives any service or intervention to be adequately aware of what will be happening, what the potential risks are, as well as alternative approaches so that the person can make an informed and intelligent decision to accept and participate in that service. This form is essential for protecting the supervisee and/or supervisor from legal concerns. As supervisor, you must inform the supervisee about what the process of supervision includes, including evaluation criteria and feedback, as well as other supervision expectations. You must be certain that the supervisee has informed the client regarding counseling and supervision parameters, such as live observation, and audio- or videotaping.

The consent should include:

- The purpose of supervision: The structure and mutual understanding of supervision
  - Goals of supervision
  - How goals will be evaluated and the specific timeframes
  - Specific expectations of the supervisor and the supervisee
  - Integration of theoretical models

- Professional disclosure: Information about the supervisor that includes credentials, qualifications and approach to supervision
  - Educational background
  - Training experiences
  - Theoretical orientation
  - Clinical competence with various issues, models, techniques, populations
  - Sense of mission or purpose in the field
  - Educational plans and professional goals

- Supervision process: Methods and format of supervision
  - Individual, group, peer, dyadic
  - Method of direct observation
  - Permission to record sessions on audio- or videotape

- Due Process: Includes written procedures to be followed when a grievance or complaint has been made against the administration, the supervisor, or the counselor. It ensures that all sides are heard and that the complaint and response to the complaint receive due consideration. In this case, informed consent means that all parties are aware of the process for lodging a complaint.
- Ethical and legal issues: Policies, regulations, and laws regarding supervisory and therapeutic relationships
  - Number of supervisees for which the supervisor will be responsible
  - Emergency and back-up procedures (e.g., supervisor accessibility)
  - Ethical codes of conduct
  - Process for discussing ethical dilemmas

    - Confidentiality regarding information discussed in supervision
    - Confidentiality issues when more than one supervisee is involved
    - Dual roles and relationships
    - Process for addressing supervisee issues (e.g., burnout, counter-transference)

- Statement of agreement
- Signed acknowledgement by all parties that they understand and agree to comply with the contract

Source: (Center for Substance Abuse Treatment, 2009b--Adapted from Falvey, 2002)

Although it often is treated as such, informed consent is not a single event. Rather, it's a process that changes over time. During the course of treatment, it's necessary for the therapist to periodically review the risks and benefits of the current approach to therapy, and those of alternative treatment methods, especially when the client's health seems to have changed considerably. These subsequent consent to treatment discussions should be documented just as the first one was (Weiner and Wettstein, 1993).

Consent to Be Treated by a Trainee

Consent to be treated by a trainee is generally included as part of the Informed Consent. Supervisees should tell the client her:

Professional discipline (i.e., social work, counseling, psychology, nursing)
Specialty (i.e., counseling, clinical, school)
Treatment philosophy or orientation

If the client wants to know about the therapist's background working with a particular problem, the therapist should be straightforward in his answer. However, there is no need to answer questions that are more personal. It's very important not to mislead the client in any area, whether it's the proposed treatment or the qualifications of the therapist.

When the therapist is a trainee, you--as the supervisor--have the legal responsibility for the treatment provided. As a part of the informed consent procedure(s), the client should be apprised that the therapist is in supervised training, and your name should be given as the supervisor.

Notice of Privacy Practices

The Notice of Privacy Practices is about how the client's mental health information is used and disclosed. The client should get a written notice either with the intake paperwork or on the first visit with the therapist. The notice must tell the client how to exercise her rights under the Health Insurance Portability and Accountability Act (HIPAA). It must also explain how the client can file a complaint with the mental health care provider and, in California, with the Health and Human Services Office of Civil Rights (Privacy Rights Clearing House, 2011).

Except in an emergency situation, the client should sign a copy of the "Notice of Privacy Practices" acknowledging its receipt. That signed copy should be a part of the client's record (University of California, 2003).

Financial Arrangements

There are a couple of potential ways for a client to pay for mental health services:

1. Personal Health Insurance: Insurance policies vary widely in the amount and type of mental health care they will cover. The client will need to know about their particular policy. There are a number of questions they should ask their insurance company. Before they make an appointment they should ask:

- Will the policy pay for mental health services in the city and state the agency is located in?
- Which mental health services are covered by my policy?
- Can I see the provider of my choice or must I choose from a "preferred list of providers"
- What happens if I want to see someone not on that list?
- Is there an annual limit on the number of counseling sessions covered?

- Does my plan exclude certain diagnoses or pre-existing conditions?

If the answers to those questions are satisfactory, then the client should ask the company representative:

- Will the company pay for the services I need? If so, will they pay the entire cost?
    - If not, what costs are not covered?
    - Is there a co-pay?
    - Is there a deductible?
    - What is the amount of my plan's "usual, customary, and reasonable (UCR)" coverage?
    - Does fee of the therapist at the agency I want to go to ($___) meet the UCR coverage?
- Do I need a pre-certification, prior authorization, or referral from my primary care provider?

2. Sliding Scale Fee. Community mental health services (and sometimes other services) often offer a sliding scale option. Clients who must pay from their own funds because they have no insurance or because their insurance does not cover the treatment, they need may be able to work out a sliding fee scale from your agency. The agency will then charge the client according to what he can afford based on the financial condition and household income.

No matter which forms of payment is agreed upon, the exact agreement must be in writing and signed. A signed copy of this agreement is part of the client's record.

HIPAA and Limits of Confidentiality

It has already been mentioned that a HIPPA "Notice of Privacy Practices" must be signed by the client, indicating their receipt of that notice. The notice likely will give a list of patients' rights under that law. As with any law, changes may be made over time, but in 2011 these rights included:

- The right to receive the Required Notice of Privacy Practices--Discussed earlier.
- The right to request restriction on the uses and disclosures of protected health information (PHI)--The agency must give the client an opportunity to ask for restrictions of uses and

disclosures of the PHI for treatment, payment, and operations, and to family, friends, and other involved in their care. However, the agency is not required to agree to the request, but will abide by it if they do agree, except in an emergency. If the restricted PHI is given to a provider for treatment in an emergency, that provider will be requested to not use further or discover the information.

- The right to request confidential communications--The client may ask the mental health agency to give them the communications from their protected health information with no explanation of the reason for the request. The agency will accommodate any reasonable request, although they may ask for payment of costs of mailing if they apply.
- The right to access and copy the designated record set--Unless HIPAA rules allow an exception (such as therapy notes, at the therapist's discretion), the agency must give clients an opportunity to access, inspect, and obtain a copy of the client's designated record set (DRS).
- The right to request amendments of the individual's DRS--The client has the right to request the agency to amend the medical record or other information in the DRS. The request must be in writing and include the reason to support the request. (The written request will be kept for at least six years.) Within 60 days, the agency must either accept the request and make the amendment, or deny the request in writing.
- The right to request an accounting of disclosures--Although there are stated exceptions, the agency must give the client an accounting of the disclosures it has made of the client's PHI in the six year prior to the request (HIPAA Patient's Rights: University of California Policy, 2010).

In certain times and locations, there has been or is a stigma against receiving treatment for mental health. The confidentiality laws are in place to protect individuals from discrimination coming from this stigma. HIPAA protects not only disclosures made during treatment, but also the fact that the individual is in mental health treatment. This can also be a protection for family members and the therapist from potential danger should a violent individual who has intimidated the client learn that the individual is receiving support and from whom she's receiving it.

Confidentiality is generally counted on as a foundation of the therapist-client relationship. As a rule, therapy is most successful when the client trusts the therapist. The confidentiality laws help to preserve this trust. The therapist must never confirm or deny that an individual is or has been a

client, unless there is a legal exception to the confidentiality. In addition, every detail of written and verbal communication in the course of assessment, treatment, testing, or any other communications are also protected as private information.

But there are some legal exceptions to confidentiality: threat of harm to self or others, involuntary commitment, a court order, certain lawsuits, suspicion of abuse of a minor or dependent adult, and detention of a mentally disordered person for evaluation.

- Threat of Harm to Self or Others: This includes risk of suicide and plans to physically harm someone else. When the threat of either of these is significant, which is often a judgment call, the client should be hospitalized for further evaluation and stabilization. The therapist will give the hospital all information needed for the hospitalization. The therapist should urge the client to go voluntarily, but involuntary commitment may be necessary. The therapist should explain the nature of the hospitalization process, the client's rights, how the therapist plans to support the process, and the client's ability to return to the current therapist after the hospitalization. This may help the client to cooperate.

    - Involuntary Commitment: If the client does not cooperate, the therapist must notify the police to initiate evaluation by the resource the county designated to do these. Each state has a specific process to be followed for involuntary commitment. The therapist may give pertinent information about the client to appropriate authorities without client authorization in such situations.
    - Dangerous Clients and Tarasoff: When a client or a member of his family reveals that the client poses a threat of grave bodily injury to an identifiable victim, the therapist must immediately notify both the potential victim and the police. "Tarasoff" refers to a California case when only the police were informed and the client killed a woman. The therapist was sued successfully for failing to warn such a victim. The therapist is not liable for making these disclosures.
    - Criminal Activity: Criminal activity in itself is not required to be reported. Psychotherapy's worth to society would be significantly reduced if therapists were required to report all criminal activity, because this would prevent many from seeking treatment. The therapist must consider elements such as Tarasoff conditions and definitions of abuse.

- Detention of a Mentally Disordered Person for Evaluation: People who have become disabled to the point of not being able to adequately care for themselves are considered to be gravely disabled. In California these clients may be involuntarily hospitalized for 72 hours (more in some cases) for assessment. If it's determined that the individual continues to be gravely disabled, he may be held for an addition 14 days. Some circumstances, such as a threat of suicide, can cause another 14 day extension. At the end of that period, if the individual is determined to pose an imminent threat of harm, another 90-day extension may be given. Other states have similar rules.

Subpoena: A lawsuit may end in a subpoena for client information. Because a subpoena is not a court order, some folks believe it doesn't have the same force. The reason is that subpoenas are usually sent out during the discovery phase of trial preparation. Attorneys are looking everywhere they can for information, not yet knowing what information will be helpful to them.

On the other hand, there are those who believe a subpoena has the same force as a court order (Your MFT Ethics, n.d.a). Your agency should have a guideline as to how you and the therapist should respond to a subpoena for client information. The agency will have conferred with their lawyers regarding their response. There are too many legal variables for you and your supervisees to attempt to respond on your own knowledge. Potential responses to protect client privacy include attempts to:

- Quash the subpoena, probably on a technicality
- State that you can neither deny nor confirm that any specific individual is a client and cannot release information from any client record without a court order or client consent.
- Modify the subpoena
- Negotiate with the issuer of the subpoena

The one thing you should never do is ignore it.

Court-Order Disclosures: If the court orders a therapist to disclose client information when the client will not authorize a release, the therapist may cooperate with the court. Therapists are not expected to bear penalties for contempt of court; it's also assumed that the court has decided that society's needs in such a case override the values of confidentiality to either the client or society.

Reasonable Suspicion of Abuse of Neglect: People in certain professions are legally mandated to report suspected or alleged abuse or neglect of children, elders, or dependent adults. Therapists are in that group. In this case, children are defined as people under age 18; elders are defined as people age 65 or older. The definition of dependent adults is people between 18 and 64 whose mental or physical limitations restrict their ability to care for themselves.

- Reporting: Mandated reported does not require that there is conclusive proof of neglect or abuse; rather, when functioning in her professional capacity, there is "reasonable suspicion" of abuse. The report is to be made to either the police or to the Department of Social Services. It must also be given in writing--by mail, fax, or electronically--within 36 hours for children or within two working days for adults.

Contacting authorities such as a child welfare agency does not necessarily constitute reporting; the therapist may contact them to help determine if the situation fits the mandatory reporting law. The California Welfare and Institutions Code only requires therapists to disclose information they happen upon in the course of profession activity, and only when there is a present danger. It may be considered present danger if an adult client reports past sexual abuse by a person currently in a household with children--the children may be at risk of abuse.

The therapist is not required to report a claim of neglect or abuse if the person reporting it has a mental illness or dementia, there is no corroborating information or evidence, and the therapist reasonably believes that the abuse didn't occur.

- CANRA: In California, the law that pertains to abuse and neglect of children is largely in The California Child Abuse and Neglect Reporting ACT (CANRS). The purpose of the Act is "to protect children from abuse and neglect." Included in its intention is protection of the child's welfare during investigation: "In any investigation of suspected child abuse or neglect, all persons participating in the investigation of the case shall consider the needs of the child victim and shall do whatever is necessary to prevent psychological harm to the child victim."

(Source: Your MFT Ethics, n.d.a)

Releases of Information

The HIPAA laws protect the client's privacy. However, the client can overrule many of those laws by signing a release of information, a copy of which should remain in the client's record.

The laws allow for free use of client information for TPO, or "treatment, payment, or operations." The TPO uses of personal health information (PHI), as far as you and your supervisees are primarily concerned, might be summarized as free use within the agency that is providing the treatment, which includes:

- Use by the therapist that originated treatment notes for further treatment.
- Use or disclosure by the therapists for training programs under supervision to practice and improve their abilities in individual, family, joint, or group counseling.
- Use or disclosure by the therapist as defense in legal or other proceedings brought by the clients.

Without a signed release of information, the therapist cannot even acknowledge whether or not an individual is or has been in therapy, let alone any particulars about treatment. The release of information is generally quite specific as to the time during which information may be released to which person or organization. HIPAA rules for release of information beyond the TPO state that the document must:

- Be written in plain language
- Be written in 8-point typeface or larger
- Be separate from all other documents
- Specifically describe health information to be used or disclosed
- State the name or function of the person or organization authorized to make such a disclosure
- State the date after which the provider can no longer disclose information

- State the name or function of the person or organization authorized to receive the information
- State specific uses and limitations of the use of the information by the persons authorized to receive it
- Advise patient of his right to receive a copy of the authorization
- Inform client of her right to revoke authorization under California law.
- Include a statement that the information used or disclosed may be subject to re-disclosure.

Because, without a release of information, you can only advise a referring organization that you cannot release requested information, it's important that you or your agency be sure that the staff of referring organization are aware that this can happen. Employee assistance professionals can aid in such situations in several ways. They can help employers establish company policies and train staff regarding issues such as confidentiality in compulsory referrals. Employee assistance professionals who are also clinicians may also counsel with employers on interpersonal and mental health issues to improve management staff's ability to improve morale, interact with employees, and decrease legal liability.

Client’s Current Status

There are several aspects of what a client's current status can refer to. Those useful to the client's record might be summed up as the status of clinical outcome and quality status (Linkins, Brya, and Johnson, 2011). All of them should be reviewed periodically and a copy of that review placed in the client's file.

Clinical Outcome Status

Clinical outcome began with a mental status examination in the first clinical session or two, which resulted in a treatment plan, both of which become part of the client's record. The client's current clinical outcome status should be reviewed in terms of the client's status within the treatment plan and the current mental status.

Current Status within the Treatment Plan

The treatment plan should be reviewed often, with a focus on the current status of the client in relation not only to the therapy plan, but to any other services and supports that the client is receiving (Prior Authorization Utilization Review, 2007). Report the progress that has been made towards any of the treatment plan goals. Mention whatever has motivated the progress or impeded it. Although all of these are likely in the therapy session notes, it's helpful to group them together in this review. If necessary, revise the treatment plan to fit the current status.

Current Mental Status

The Mental Status Examination is for the purpose of determining how the client is functioning mentally, emotionally and behaviorally at the moment of the exam. As has been mentioned, much of this is accomplished through the keen observation of the therapist. There is actually a wide variation between agencies in terms of data that is actually measured and the strategies and instruments used to collect the data.

Some of the most commonly used mental status assessment measures, besides criteria in the DSM-IV, are the Duke Health Profile, the Global Assessment Scale (GAS) and the similar Global Assessment of Functioning Scale (GAF). Some agencies also use assessments of depression.

Duke Health Profile (DUKE): The DUKE has been popular among health and mental health researchers since it came out in 1998. Its popularity continues to this day, probably because it's a simple to take and score self-report instrument that has a record quite good validity.

There are only 17 items for the client to answer as "Yes, describes me exactly," "Somewhat describes me," or "No, doesn't describe me at all." Of the questions, seven are general attitude questions, two refer to how the client believes he can do two physical tasks, and the rest refer to how the client functioned during the past week.

The assessment covers six health measures (physical health, mental health, social health, general health, and perceived health), a "stand-alone" self-esteem score, and four dysfunction measures (depression, anxiety/depression, pain, and disability). The assessment and scoring forms are freely available online (Duke University Medical Center, 2005).

Global Assessment of Functioning Scale (GAF): The GAF is a revision of the Global Assessment Scale (GAS), a procedure for measuring the overall functioning capability of the client during a specified period of time. Both scales are a single-item rating scale to be filled out by the clinician. There is also a children's form of the GAF.

The GAF is used by the DSM in its "multiaxial" assessment system. The system has five axes for assessment (I: Symptoms that need treatment; II: Personality and developmental disorders; III: Medical or neurological conditions that may influence a psychiatric problem; IV: Recent psychosocial stressors; V: Client's level of function). The GAF is the Axis V component (Mezzich, J. E., 2002).

The GAF reflects the therapist's judgment of the client's ability to function in daily life. It looks at psychological, social, occupational functioning.

The scale ranges from 1 (theoretically very ill and unable to function at all in daily life) to 100 (theoretically very healthy and totally able to function in every area of daily life). The client's 5-axes diagnosis might read as:

Axis I: Adjustment Disorder with Depressed Mood, Alcohol Abuse, Cannabis Abuse
Axis II: No Axis II diagnosis
Axis III: Hyperthyroidism
Axis IV: Divorce on (date)
Axis V: GAF = 56 (on admission), GAF = 65 (on discharge)

Quality Status

Quality refers more to the treatment than to the client. Every agency is pressed for quality improvement in their services by government agencies, payment sources, and clients themselves. New assessment tools frequently appear. The Center for Quality Assessment and Improvement in Mental Health (CQAIMH) has an online "finder" of mental health treatment quality assessment measures (CQAIMH, n.d.). If you find one that fits the kind of treatment you're offering a client, you can include a periodic update as to the continuing improvement of the treatment quality you're giving.

Treatment Plans and Goals

A mental health treatment plan is a written document that outlines the expectations for therapy. Depending on requirements of payment providers and the agency, the therapist's preferences and the severity of the presenting problem, the plan may be quite formalized or may simply be composed of loose handwritten notes. If an electronic record system is used by the agency, this may dictate the treatment plan format.

Nowadays, formalized treatment plans are required more frequently than in the past. However, no matter how loses or how formalized the treatment plan is, it's always subject to change during the progression of therapy.

The plan is based on needs identified during the initial assessment and diagnostic process. The process used to choose the level of care needed should be documented. Depending on the problem(s), treatment plans may include family information (Council of Juvenile Correctional Administrators, 2007).

A formal treatment plan generally consists of four or five parts--objectives and goals sometimes being combined:

1. Presenting Problem--A brief description of the most significant problem(s) to be addressed. Problems that are not urgent may be set aside for later treatment.

2. Goals of Therapy--An annotated list of both the overall and the interim goal(s) of therapy. Long-ranged goals may not need to be measurable (Utah Division of Substance Abuse and Mental Health, 2009).
3. Objectives--A list of measurable objectives showing what the client will do to reach a goal. Action verbs are used with identifiable outcomes such as frequency and quantity.
4. Time Estimate--A brief estimate of the length of time and/or number of sessions needed to reach each objective
5. Methods and Interventions--A short, annotated list of techniques that will be used by the therapist and/or the client to achieve the objectives

Often achieved via informally discussion the situation, the client should always be included in developing the treatment plan and this should be recorded in the record. Some therapists give the client a written copy of the treatment plan; others believe this can cause an unnatural feeling to the therapeutic relationship. However, a copy of the plan should always be given to a client who requests it (Fritscher, 2011).

In addition to the treatment plan itself, often kept in the record is a full descriptive summary that combines biopsychosocial information and a summary of key clinical issues; it functions as a connection between the treatment plan and the assessment. The narrative summary pinpoints diagnostic signs for any existing mental health problems, and includes both the reasons for the assessed level of care and any substitution for that level of care (Utah Division of Substance Abuse and Mental Health, 2009).

Progress

In many ways, psychotherapy is to a certain degree an unstructured process. This causes many clients who are experiencing guided self-discovery and behavioral change to ask themselves if therapy is helping. Repeated taking of a self-report questionnaire to track progress gives both client and therapists a chance to see what is improving from the client's perspective--the most important perspective.

Self-report data given via a formal assessment has often been used to:

- Add to the accuracy of clinical assessments
- Give a basis for treatment planning
- Provide an objective way to track treatment progress
- Use clinically proven guidelines to warn therapists to get stubborn cases back on track
- Aid in preventing hospitalizations through warning guidance
- Give referral sources some outcome-based information to link patients to therapists with a proven track record of giving outstanding treatment to clients with similar needs

An example of such a self-report assessment is the Patient Health Questionnaire (PHQ-9), an assessment for depression that is available online (PHQ-9, (1999). Like other most successful assessments of this sort, it's short (ten questions) with easy-to-answer questions (check the level that best suits: Not at all, Several days, More than half the days, Nearly every day). The validity of the test over time is also good.

These sorts of assessments, grouped under "behavior health outcome management" (BOHM), can be used every session to track progress. With real-time scoring and report generation (which can be done in a very few moments) both clinicians and clients receive excellent evaluation about the course of treatment and whether or not adjustments to the treatment plan should be made (Lambert, 2005).

Although it has not always been the case, some of the newer, more advanced assessments can reliably document improvement on a single domain more than 50% of the time and, with a multi-dimensional analysis, more than 90% of the time (Kraus, Seligman, and Jordan, 2005). With payers and purchasers alike looking for documentation of client improvement, you may want to research and evaluate applicable assessments.

According to the Core Battery Conference (CBC), a core assessment battery should address three distinct areas:

- Quality of life, or general distress
- Symptom clusters (e.g., anxiety, depression, mania, psychosis, etc.)
- Functional domains (e.g., work and social functioning)

Kraus, Seligman, and Jordan (2005) identified only one battery that met all of the criteria defined by CBC with a short questionnaire, the Treatment Outcome Package (TOP Toolkit). The free package includes assessments for children, adolescents, adults, and substance abuse, as well as a couple of assessments of client satisfaction and a wealth of other information (Behavioral Health Laboratories, 2011).

As clients proceed through therapy, progress and treatment plans are reviewed and assessed, and needed changes in the treatment plan are made to reflect the progress or lack thereof. In addition to the continual assessment of progress, the process includes:

- Comparing progress to criteria for continued service or discharge
- Determination of when the client can be treated at a different level of care or treatment approach based on resolution of problems and/or priorities

Treatment often ends when a frustrated client leaves prematurely. Following the procedures outlined above will hopefully reduce the number of times that happens.

Problems in Not Meeting Treatment Goals

Assessments aside, there will be clients who just can't seem to meet treatment goals. This seems especially true in cases involving substance abuse. The treatment plan should include reports of lack of response to treatment or meeting therapy goals, or if the client is disruptive in treatment. As you would expect, the treatment plan needs to be appropriately revised (Office of Alcoholism and Substance Abuse Services, 2010).

Significant Actions Taken and Outcome

The main point in again mentioning "significant actions taken and outcome" is to emphasize their importance in the psychotherapy notes. Sometimes it's helpful to gather them from the individual

session notes and group them into a narrative. This can add perspective that will give good guidance as to where you should go next.

Documentation for All Issues with Legal Consequences

Whenever you document a therapy session or other communication with or about a client, always keep in mind the possibility that this documentation could very well sink or save you in an instance of litigation. Some tips to follow in making this documentation the most helpful it can be may sound mundane and unrelated, but with thought you'll likely see the sense of it.

Competent documentation (Lifson and Simon, 1998) should be unambiguous and cognizant of grammar essentials--a misplaced modifier is not your friend:

"The client is a 21-year-old admitted on 7-5-11 to ___ with a history of psychotic behavior, evaluated at the ___ Center and seen by a social worker there with a chemically induced psychosis."

If you didn't make progress notes, but instead kept "process" notes to remind you of your own associations and counter-transference reactions, as well as your theories about treatment, these may not be truly be private, but may be "discoverable" in the event of litigation involving your client or between your client and you.

You were reviewing your progress notes and noticed that at one point you saw a problem, evaluated benefits and risks of several treatment options, talked them over with your competent client, and outlined a treatment plan to which the client agreed. But you overlooked documenting some elements of the process. How should you handle it? Make a brand-new progress note, date it "today," and write, "As I reviewed my note for (date), I see that I overlooked indicating that. . ." This will give the needed information to any who may need to read the note, it makes no attempt to hide the error, and in the event of later litigation, it will be better than no note at all. This all

translates to the principle that corrections should be in real time, labeled contemporaneously, and transparent.

If you're bent on self-destruction as a therapist, one of the easiest ways to do this is to keep no notes or poor, incomplete notes. If you noticed something in therapy, you need to respond to it and then document that response.

Although preventing liability for your sake is important, the leading rationale for good documentation is that it contributes to, facilitates and enables, and is essential to client care. Documenting or charting weekly, biweekly, or monthly does you, your clients, and even your colleagues an immeasurable disservice.

These tips can be summarized in three basic rules that will minimize risk to both you and your clients (Lifson and Simon, 1998):

1. Write smarter, not longer.
2. If you didn't write it down, it didn't happen.
3. Never, ever change a record.

The North Dakota Department of Health (n.d.) gives several lists of what to do when "Charting with a Jury in Mind." Some of these are repetitious, which only emphasizes their importance:

- Basic Charting Rules:
    - What is documented, what is not documented, and how it is documented is vital
    - Sins of Omission: Don’t omit the obvious--e.g., failure to make an entry
    - Shadow of a doubt: Don’t allow inaccuracies
    - Tampering with the evidence: Don’t obliterate an entry
    - Relying on recall – Don’t wait to chart
    - Just the facts, Ma'am
    - Don’t chart conclusions
    - Record only what you see and hear
    - Describe, don't label, events and behavior
    - Don’t get personal

- Neatness counts
- Chronology of events: Give each entry its own page
- Failure to communicate – What you don't say may hurt the patient
- Juries can't read minds – Document intermediate steps
- The appearance of error: Being at fault versus appearing to be at fault--the outcome may be the same.

- In notes regarding the continuity of care, be sure to note:
  - Transfer of Health Information to hospital or specialty
  - Transfer of Health Information to prisons or jails
  - Discharge summary

- Daily do's and don'ts for charting:

DO:

- Check the name on the patient's chart
- Use ink or typewriter, not pencil
- Read the notes on the client before either providing care or charting
- Use concise phases
- Make entries in order of consecutive shifts and days. Write the complete date and time of each entry.
- Sign each entry with your title
- Indicate client non-compliance
- Be sure you know the meaning of all the terms you use
- Use direct patient quotes when appropriate
- Be accurate, factual, timely, and complete
- Use accepted medical abbreviations
- Don't backdate, tamper with, or add to notes already written
- Don't write general statements, make them specific: e.g., client is adapting to divorce; instead tell in what ways the client is adapting
- Don't chart procedures in advance

DON'T:

- Wait until end of shift to chart; either keep notes during sessions or write them immediately after the session
- Chart for someone else
- Throw away notes with errors on them, mark the error and include the sheet
- Erase, obliterate, or write in margins
- Skip lines between entries
- Leave a space before your signature
- Make derogatory remarks about the client

Client Fails to Follow Clinical Directives

It may be that your client--or that of your supervisee--will not progress, or will progress so slowly as to make no difference unless they follow the clinical directives, which will necessarily be part of the treatment plan. But the therapist is frustrated because a particular client continually fails to follow the clinical directives.

Three questions may be asked in such situations (Relaxed Therapist, 2006):

1. Why should your clients do anything you say?
2. Why should your client do what you're saying now?
3. Why wouldn't clients follow your suggestions?

The answer to "Why should your clients do anything you say?" may be found in the relationship between you and your client and within yourself. How you see yourself and your role in the therapeutic relationship will decide to what extent you expect the client to follow your advice. If you see yourself--and perhaps more importantly, if your client sees you--as the "bus driver" to take the him to his destination, you'll be the one frustrated if the client keeps challenging the route you take because he wants you to be only the travel agent.

Why should your client do what you're saying now? Because you've studied your heart out and continue to do so in order to know what direction you clients need to go in, you may have come to believe that there is only one right way to recovery. Or you may have a number of ways the client

can go towards recovery, but the client believes there is likely only one way and it doesn't fit any of the ways you're suggesting.

You may be the one with the therapy experience, but your client is the one with the "being me" experience. If you client says a certain way won't work for him, you'll save time, energy, and frustration if you don't try to convince him why it will work for him.

Instead, find out why she thinks it won't work for her, why she or her situation are different from everyone else. There may be no different but, then again, there may be. You won't know without asking; you need to ask the client what she thinks WILL work for her. She's more likely to follow her own advice, and perhaps you can lend a helpful hand in the process--which is the way therapy works in the first place.

The third question, why wouldn't your client follow your suggestion, has a number of potential answers:

- They don't believe it will work.
- They don't believe they can do it.
- They don't understand it.
- They don't want it.
- They fear it will make matters worse.
- They got a negative reaction when they first tried it.
- They couldn't do it at the first attempt.
- They couldn't do it consistently.
- They couldn't do it at all.

Any of those feelings is likely a deal breaker. All of this is reinforcement for the need for the client to be a major part of making the treatment plan.

However, there are times when the client should do what you say, and there will have to be grave consequences if they don't. Examples of these times include:

- If the client in therapy for alcohol treatment may have some mandatory guidelines that, if not followed, could cause harm to the client or another person. Or the therapist may be mandated to report such failures to legal authorities.
- The same is true for a client with a sex addiction problem, or any other problem with legal consequences.

If clients of these sorts do not follow clinical directives, follow the legal protocol that you must, and document the client's failure to follow clinical directives and what you did as a result.

Telephone Conversations with Client and Others

It may be difficult to get into the habit of writing therapy notes about telephone conversations with a client or with others, such as social workers, about them. However, it's just as important--sometimes more important--to document these calls as it is to document a therapy session. If you have a call with a social worker and that person keeps a record and you don't, there could easily be a time when your memory does not match their notes and it could lead to problems. It's especially important to document phone calls that are related to issues with legal consequences.

An example of a dilemma that could arise from not documenting a telephone call:

A former client is suing you. This individual attempted to commit suicide and was hospitalized after the failed attempt. She's now claiming that you didn't sufficiently intervene when she showed symptoms of suicidal ideation. After you received the lawsuit, you looked through the clinical record and discover that you had neglected to document a call you made to a psychiatrist just before the client's suicide attempt. You consulted with the psychiatrist about the woman's suicidal ideation. It would be unethical to insert a short note about the phone call at the end of the clinical note you had written just before the woman's suicide attempt. You can only hope the psychiatrist made a note that will prove it was this woman you called about; this isn't likely, because--in the name of confidentiality--you didn't mention the client's name.

E-Mails, Phone Messages, and Texts

A new aspect of record keeping has arisen because of modern digital technologies. These present new clinical, ethical, and legal issues in the field of mental health. We are warned frequently of the lack of security/privacy for e-mails, text messages, and mobile phone use. How using these means of communication with or about the clients affects confidentiality is still not clear. Thus, the by-word when using these digital methods is "caution."

Should the actual voice-mail messages, texts, and e-mails be included in the client's clinical record? A basic and simplistic answer is that at the very least, notes on the content of these messages if they have clinical or other significance should be in the record. Messages that it may be important to archive include those during a crisis or other high-pressure situations, or if therapists are flooded with messages from clients in ways that may be or become stalking, harassment, or threatening.

Phone messages from clients are not a new phenomenon. Ever since the advent of the answering machine the potential for clients leaving a message for their therapist has been a reality. There are several way to handle these messages, in addition to the aforementioned written notes about the content of the message.

- The message may be recorded and transferred to a CD that will be part of the client's file.
- If you have a digital answering system, it can give you the message as an MP3 or similar file. The file can be transferred as an e-mail attachment on some mail systems, which can then be stored on the agency's computers. If the file can't be transferred by your e-mail system, you can copy it to the same CD already mentioned.
- There are systems available, some free (such as Google Voice), that will save the voice-mails as recordings and e-mail them to you, along with a transcript (however inaccurate) of the message. You can then save it in a Web-based e-mail program or download it to the agency's computer system. The rub here is the issue of privacy. If you use a means such as this, you'll need to have your clients sign an Informed Consent form that explains risks involve in using this kind of communication because of the storage method.

E-mail is becoming a common and acceptable way to for therapists and clients to communicate. It can be a time saver for needed rescheduling of appointments, eliminating the game of phone tag, busy phone lines, being put on hold, and numerous other annoying problems of phone calls.

However, all is not gold when it comes to e-mail communication with clients (Zur, 2010a). What about the suicidal client that sends an e-mail you don't see for 18 hours? Or the client who, by the nature and length of their e-mail, extends the time of their session by half an hour? Or who wants a "short" answer right away to a therapy questions? Or--the list could be quite long.

Also, e-mails are fundamentally vulnerable because they can be accessed by unauthorized people fairly easily, compromising the confidentiality and privacy of the communications. Encrypting your e-mails requires the complexity of public and private encryption keys and teaching clients to use them. Or you can use an Informed Consent form that delineates privacy risks so clients can choose whether or not to use e-mails. This consent form would be included with others that clients are required to sign (Zur, 2010b).

The consent form may also include charges that may be incurred when the e-mails and their responses essentially extend therapy session, and any other guidelines you have for the use of e-mail with clients. All of this information must also be stated verbally in a therapy session--probably more than once. Zur (2010a) offers some excellent guidelines for using e-mail with your clients:

- Clarify to yourself your thoughts and feelings regarding e-mail communication with clients. What are your preferences, your limits, etc.?
- If you're considering using e-mails as an adjunct to therapy, make sure you become HIPAA compliant.
- Discuss the issue of e-mail communications with clients, when relevant, in the first session. Learn from them about their expectations and clarify your expectations and boundaries. Continue the dialogue as clinically and ethically necessary throughout the course of therapy.
- Make sure that your office policies include a section on the use of e-mails.
- If you're conducting tele-health, follow state laws, relevant codes of ethics, and have a separate informed consent, which is required in some states, such as California.

- Make sure your computer has a password, virus protection, firewall, and backup system.
- Make sure that each e-mail includes an electronic signature that covers issues such as confidentiality and security.

E-mails should be printed out and included in the client's file.

Texting is one of the newer methods of communication between clients and therapists. Some agencies may not allow therapists to give out their cell phone numbers, preferring that clients that call after hours be transferred to an answering service that will transfer the call to the therapist on-call. And many therapists may not want to offer 24/7/365 availability to their clients. Regardless, it's almost inevitable that there will be a time in the near future when, because of the health market becoming more and more consumer-driven, many administrative and simple communications between clients and therapists will be done via cell phones and texting.

In fact, on-call therapists for an agency might have a company cell phone for use during their on-call time. This may be a problem for those older therapists who can't or won't learn to text.

As with other electronic communications, issues of security, confidentiality, and privacy are an inherent part of texting. A signed Informed Consent form, like the ones mentioned above, or a list of Office Policies that the client receives on intake should be used.

At the very least text messages should be summarized, and the summary placed in the client's file. However, you can also have an actual record of the text itself to place in the file (possibly with a "translation" into "real English" for the sake of others who must read the file and who are not savvy to all of the texting abbreviations). Here are several ways to keep that record (Zur, 2010b):

1. A service such as *Google Voice* can record and save phone text messages. Therapists would set it up and give that number to clients; they will then have a record of all texts.
2. The service *Missing Sync* connects therapists' phones to their computers and backs up (archives) the text messages.
3. You can use an online for-fee service, such as *Treasure My Text*, that stores the text messages online by allowing for simple uploads of messages via text.

4. Some cell phones, such as iPhones, allow therapists to take screen-shots of their text messages and then send them to their e-mail address as an attachment.

All of these methods involve online services and will therefore have potential--sometimes inherent--problems of security, confidentiality, and privacy. Some programs may have security measure in force, but you'll want to check them out before you use them, and always employ Informed Consent forms.

HIPAA confidentiality rules are always to be considered. If you communicate with your clients through e-mail and if you store clinical records digitally, you must be sure that your computer has impeccable password, firewall, virus protection, logs, and backup systems, encryption if necessary, and other computer safety measures (Zur, 2010b).

You also need to be aware that HIPAA has some special rules for "a health care provider that conducts certain transactions in electronic form (called here a 'covered health care provider')" (HIPAA, 2005):

"In electronic form means: using electronic media, electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission."

If you're a covered entity, you must comply with HIPAA's Privacy Rule (HIPAA, 2003) and Security Rule (HIPAA, n.d.), which are different from the HIPAA rules that are discussed elsewhere in this course.

Consultations

Documentation about consultations with a social worker or another professional within your organization is just as important as documenting any other transaction or communication with or about the client. The only reason this topic has been given a section of its own is to emphasize that it's just as important as any other kind of documentation.

Gifts from Clients and Reasons Accepted

No blanket statement can be made that accepting a gift is either always acceptable or never acceptable. Accepting a gift from a client may be unethical at times, but there are times when it's the most ethical and/or helpful thing the therapist could do. Whether or not it's ethical may depend on several factors:

- The nature of the gift
- The cost of the gift
- The therapeutic relationship between the therapist and the client
- The transference or other issues that led to giving the gift

The therapist must address the issue in each individual case. The answers to a couple of questions can help find the answer:

1. Will the acceptance or refusal of the gift adversely affect the well-being and health of the client?
2. What is the meaning behind the gift?

The setting and the nature of the therapeutic relationship influence the decision as well. It may be permissible to accept certain gifts from a client that comes in once a year for a session, but accepting the same gift from a client that is currently having weekly therapy sessions may not be

permissible. The primary criterion by which to judge if the action is ethical is the client's best interest (Lyckhom, 1998).

All Information Related to Suicidal, Homicidal or Abuse Concerns

Even though it may be another time burden to suitably document a suicide risk assessment, it's something your supervisee sometimes must do, and you must see the he does it. It's best done immediately after a clinical evaluation of the client (Ministry of Children and Family Development, n.d.).

Although it's tempting to use a form with "Yes/No" check boxes (e.g., Is the client suicidal?) or a subjective rating scale from 1-5, it's better to do a thorough risk assessment and a step-by-step narrative of the clinical judgment and planning that followed.

Clear documentation that records the risk assessment, estimation of risk, approach to safety planning, treatment goals, and clinical consultation is important for a number of reasons:

1. To make relevant information for other professionals should they need it
2. To serve as a quality assurance checklist
3. To indicate that good clinical care often rests on good clinical documentation
4. To protect against malpractice
5. If documentation is poor, the risk of litigation is high even if the clinical care was good

Documentation of suicide risk in an outpatient setting should include:

- Initial interview
- Emergence or re-emergence of suicide ideation, plans, or attempts
- Significant changes in the client's condition

Essential principles to think of when assessing risk of suicide in a young person (Ministry of Children and Family Development, n.d.) include:

- To find out if suicide is a concern, we need to ask clients directly.
- It's not possible to predict individual suicides but we can estimate risk levels based on a thorough assessment.
- Approaches to assessing risk need to be developmentally appropriate and matched to the age and cognitive understanding of the client.
- The perspectives of parents, caregivers and other sources of collateral information should be actively sought out.
- Risk assessment requires an active consideration of the risk/protective factors ratio.
- In general, the greater the number of risk factors and the fewer the protective factors, the higher the potential risk.
- Risk status should be re-evaluated on a periodic basis.
- Treatment plans should correspond to the level of assessed risk.
- Document all clinical decisions and treatment plans.

Perhaps the most important helpful thing an agency can give its therapists to aid in dealing with suicidal, homicidal, or other serious dangers presented by a client is a clear, written policy of management of these clients. This should include policy regarding supervision when a patient presents such dangers (Cole, 2001).

Evidence of Continuity of Care

There are basically two kinds of situations for which documentation of continuity of care is required:

- Evidence of continuity of care from other providers
- Continuity of care upon transition to other providers

If consultations take place, a copy of the consultation should be present in the record as evidence of continuity of care maintained between the two providers (VA Premier Health Plan, 2007).

The non-profit National Committee for Quality Assurance is working with a number of federal and state agencies, as well as private businesses to improve healthcare quality. One of the areas in which they're striving to build this quality is in the area of continuity and coordination of care. The organization has a seal that is widely known as a symbol of quality. Medical organizations that wish to include the seal into their marketing and advertising must pass a rigorous review and report on their performance annually.

One of the requirements in this review is that there is continuity and coordination between medical and mental health care (National Committee for Quality Assurance, 2011). The two questions they must positively answer (and prove) are:

- Does the organization monitor the coordination of general medical care and behavioral health care?
- Does the organization collaborate with its behavioral health specialists in collecting and analyzing data and implementing actions to improve the coordination of behavioral health with general medical care?

Ways some of the medical providers (Excellus BlueCross BlueShield Connection, 2009) live up to these continuity and coordination of care issues are by:

- Evaluating and assisting as to when exchanges of information between providers are necessary
- Determining the content of the exchange
- Ensuring that after the intake assessment, follow-up is timely (no later than the third visit), and appropriate
- Ensuring that the patient’s written consent has been obtained

Records are kept as evidence of continuity of care between the primary care physician and the behavioral health provider. Essential collaboration includes sharing or acquiring a summary of recent behavioral health clinical outpatient or inpatient care in the previous 12 months and/or relevant treatment information via written or telephone communication that is included or documented in the treatment record. Records also include written communications and/or

documentation of telephone conversations that include an assessment, working DSM-IV diagnosis and a clinical plan of care.

A standard electronic document, the Continuity of Care Document (CCD) is being developed jointly by ASTM International, the Massachusetts Medical Society (MMS), the Health Information Management and Systems Society (HIMSS), and the American Academy of Family Physicians (AAFP). Its purpose is to promote and improve continuity of patient care, to reduce medical errors, and to make certain of at least a minimum standard of the transportability of health information when a patient or client is transferred or referred to, or is otherwise seen by another provider (Continuity of Care Record, 2003).

Confidentiality of Records

Questions sometimes come up in regards to access to records because of differences between state and federal laws. The Health Insurance Portability and Accountability Act of 1966 (HIPAA) laws are the primary federal laws in these differences. In California there are three main sources of law that may be involved:

- Confidentiality of Medical Information Act (CMIA) Civil Code (Sections 56, et seq.)
- Information Practices Act of 1977 (IPA) Civil Code (Sections 1798, et seq.)
- Patient Access to Health Records Act (PAHRA) at Health and Safety Code (Sections 123100 – 123149.5)

Patient Access to Records

An individual has a right to the confidentiality of her own mental health records. In most cases, this right of confidentiality stipulates that only the individual, her guardian, and her treatment providers may know the content of the record. However, whether or not an individual has the right to access her own records depends on what laws are applicable (M-POWER, n.d.).

HIPAA allows for psychotherapy notes to be withheld, although they encourage providers to give the information to the individual if they believe that is appropriate. HIPAA denies access to records

when there is danger to either the individual directly involved or to another person (HIPAA, 2011c), whereas California law only looks at significant risk of "substantial detrimental or adverse consequences" to the individual (California Health and Safety Code, 2010).

If this access to mental health records is denied, the client must be informed of the denial. Also, written records of both the request and the reasons for denial must be put in the client's file (California Health and Safety Code, 2010). If the individual affected directly by that disputes the decision, California's IPA law requires a state agency to re-examine its determination that that particular information is exempt from access (California Department of Health Care Services, 2007).

When there are differences between state and federal laws, the state laws preempt the federal laws. This statement is based on the Federal Register (Standards for Privacy….) statement, "…A state law may also not be preempted because it comes within section 1178(a)(2)(B), section 1178(b), or section 1178(c); in this situation, a contrary federal law would give way."

Inspection by Parents of Child's Mental Health Records

Discretion to Refuse Access to Parents: In most cases, parents and guardians are allowed access to the health and mental health records of the child or youth. However, in California at least, in the instance of minors aged 12 and older, if the health care provider determines that such access would have a damaging effect on his professional relationship with the minor client or on the minor's psychological well-being or physical safety. Under Section 123115(a)(2), this decision of the availability of the minor's records for inspection shall not attach any liability to the provider, unless the decision is established to be in bad faith (California Health and Safety Code, 2010).

Discretion to Not Inform Parents without a Minor's Consent: The California Family Code (2010) requires the health care provider to involve a parent or guardian in a minor's treatment unless the provider determines that this involvement would not be appropriate. This decision and any

attempts to contact parents must be documented in the minor's record. There will be some necessary sharing of certain confidential information if parents are involved in treatment. Nonetheless, participation in treatment does not mean parents necessarily have a right to access the confidential records. To whatever extent possible, providers should try to regard the minor's right to confidentiality while still involving parents in treatment (California Family Code, 2010).

Discretion to Inform Providers without Authorization: Records kept in connection with treatment or prevention of drug abuse that is regulated, conducted, or assisted--whether directly or indirectly--by the California Department of Alcohol and Drug Programs cannot be shared with providers who are not working for the same treatment or prevention program except in an emergency (California Health and Safety Code, 2010). Health care providers working for programs that are not state assisted may share information for treatment or referral services with other providers. However, without written client authorization, they may not share psychotherapy notes (California Civil Code Section 56-56.07, 2010 and National Center for Youth Law, 2010).

Disclosure of Record Keeping Procedures

Disclosure of record keeping procedures is potentially a part of informed consent (American Psychological Association, 2007). As you recall, an Informed Consent document is a statement of what will be happening in therapy, its risks, benefits, and alternatives, and signed by the client before beginning therapy and giving consent for therapy. A notice of HIPAA privacy laws that has been signed as having been explained to the client is also a part of the informed consent process. Also discussed were informed consent forms for using e-mail, texting and other electronic communications between client and therapist.

Sometimes, the client might want to know how the records will be maintained, and this may include disclosure of record keeping procedures. This may be particularly important if the procedures will probably affect confidentiality or if the client articulates expectations about record keeping that are different from required procedures.

It's possible that the way in which records are maintained could potentially affect the client in ways that she might not anticipate. It's encouraged that you and your supervisees inform clients about

such situations. For example, more and more often certain client records may become part of an electronic file that can be accessed by a wide range of institutional staff. In some educational settings, federal, state, and institutional regulations require record keeping procedures that could enlarge the range of people who have access to the records of a school psychologist.

When mental health client records are released with appropriate permission to do so, from that point it's possible that they might be distributed further without the therapist's or client's knowledge or consent. The client should be alerted of this possibility before the consent for release of information is signed. An example of this, records released in a context of litigation may be placed in the public domain and be accessible to anyone.

Maintenance of Records

To be clinically useful and legally safe, clinical records must be kept up-to-date and be well organized.
Records are only useful if efficient retrieval is possible. Records that are organized logically and updated systematically, and that are thorough and accurate accomplish this. The therapist and supervisor can more easily monitor ongoing care and interventions. If the client's care needs to be transferred elsewhere, for whatever reason, this sort of records allow for continuity and coordination of care.

Organizational Methods

There are a variety of methods for organizing the records to aid in storage and retrieval. Logical and consistent methods will generally be most useful. For example, a logical file labeling system will assist in recovering records (American Psychological Association, 2007).

Dividing the files into several sections may be helpful:

- Psychotherapy notes

- Client information that is intended to be shared with others
- Material generated by the client, client's family members, prior treatment providers, or other third parties
    - Behavioral ratings or logs
    - Diaries
    - Journals
    - Letters
    - Pictures
    - Videos
    - Greeting cards

Because psychological test data may require especially careful consideration before being released, and therefore may best be clustered within the file to make that perusal easier. A specific, often overlooked, area of concern is the re-release of data from previous therapist's records as a part of the record that should be released. Should the therapist decided not to release that information, having that in a separate part of the file will make it easier to carry out that decision.

When asked for legitimate release of information for which a release form has been signed, the therapist must still consider several items:

- HIPAA regulations regarding psychotherapy notes
- Breadth of records requested
- Client's wishes
- Situational demands

For example, the therapist has received a court order of "any and all records" that were used when the therapist formed certain opinions. It would likely be necessary to re-release some third-party information that is in the record. However, the therapist can give advance notification to the client, allowing enough time for an objection to be raised before responding to such requests for records.

Psychotherapy Notes

For privacy reasons, HIPAA has given its own definition of psychotherapy notes. A discussion of progress notes follows the outline of the applicable HIPAA definition and rules.

HIPAA Definition of Psychotherapy Notes

Some items that have traditionally been included as parts of the psychotherapy notes have been defined by HIPAA as something separate. HIPAA's definition of psychotherapy notes is:

"Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date" (HIPAA, 2003).

Note that items that this definition pretty much limits psychotherapy notes to anything relating to the contents of therapy session conversations and does NOT include:

- Medication prescription and monitoring
- Counseling start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests
- Summaries of:
    - Diagnosis
    - Functional status
    - Treatment plan
    - Symptoms
    - Prognosis
    - Progress

HIPAA states that psychotherapy notes are to be kept separate from the rest of the record. Only the provider who took the notes (or others within the provider's agency) can access them, unless there is a HIPAA complaint authorization from the client (American Psychological Association, 2007).

Providers are exempt from forwarding or otherwise sharing psychotherapy notes with other entities without client authorization, except for legally defined exceptions. Physically integrating information included in the above list into the psychotherapy notes does not automatically mutate it into protected information.

If a provider has integrated information excluded from the definition of psychotherapy notes with a psychotherapy note (e.g., results of clinical tests, symptoms), the provider is responsible for extracting information that is required to reinforce the reasonableness and necessity of a Medicare claim, or other legal request for information (Provider Inquiry Assistance, 2005).

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is responsible for enforcing the privacy protections and access rights for consumers. The HIPAA privacy rule does not require or allow any new government access to medical information, with one exception: the rule does give OCR the authority to investigate complaints and to otherwise ensure that covered entities comply with the rule. In order to ensure covered entities protect patients' privacy as required, the rule provides that health plans, hospitals, and other covered entities cooperate with the Department's efforts to investigate complaints or otherwise ensure compliance (U.S. Department of Health and Human Services, 2001).

Progress Notes

Psychotherapy notes are sometimes called progress notes. Some of the information that HIPAA excludes in its definition of psychotherapy notes are summaries. However, the specifics that formed the basis for the summaries are included in the psychotherapy, or progress notes. The progress notes:

- Include date and duration of the session
    - Document cancellations and no shows
    - Document gaps in service (incarcerations, hospitalizations, vacations, etc.)
- Include type of intervention
- Refer back to objectives stated in the treatment plan
- Record what was said or done in the session
- In a form that will be most helpful to the therapist, record:
    - Hypotheses
    - Personal reactions
    - Doubts, expectations
    - Possible interpretations
    - Supervisory recommendations
- Financial arrangements for payment and associated information

Face-to-Face Therapy

Anyone acquainted with the field of therapy is familiar with face-to face therapy. The client and therapist meet and have a session. This most often takes place in the therapist's office, but can also occur in hospitals, jails, or similar settings. But because of the experience of the years for this kind of therapy, record keeping and process notes easily fall into the descriptions above.

Electronic Therapy

Before the advent of the Internet, face-to-face therapy was the only type of therapy, except for crisis telephone services. In recent years, therapists have taken advantage of the Internet and the telephone to offer almost the whole gamut of therapeutic services. This kind of therapy not only has a number of names (e.g., TeleMental Health, Telehealth, E-Therapy, E-Counseling), it's also provided by a variety of means:

- Avatars
- Chats
- E-Mail

- Skype
- Telephone
- Texts
- Video-conferencing

A variety of client populations have eagerly sought these sorts of therapy, including those who:

- Don't want to be seen going into a therapist's office
- In rural areas that are some distance from a therapist's office
- Are incarcerated
- Are homebound
- Work better with frequent, intermittent conversation, rather than a block of time each week
- Are more comfortable with the anonymity of text formats than face-to-face formats

However, clinical, ethical, and legal facets of electronic therapy are in many respects still under construction. There is an ongoing discussion, for example, as to whether most of these formats conform to HIPAA privacy and confidentiality laws. Whole courses are available to train the "electronic therapist" in the ethical and legal considerations (including conducting therapy across state lines, HIPAA, reimbursement, etc.), as well as the delivery of electronic therapy with its practice, logistic, and technologic aspects (Zur, Ofur, 2011d).

Nonetheless, if your supervisees provide any kind of electronic therapy, records must be kept. The rules and regulations and other discussions above all apply.

Security

In light of confidentiality and privacy for every individual, there must be suitable protection against unauthorized access to or loss of the records. As a safeguard against electronic and physical breaches of confidential information, there needs to be limited access to the records. New challenges to

preservation of security have appeared because of advances in technology. However, there must be a plan in place to protect the records (American Psychological Association, 2007).

Two basics to consider are:

1. The medium on which the records are stored

Paper records must be kept in safe location where they may be protected not only from unauthorized access, but also from damage or destruction (water, mold, fire, insects). Condensed records, or a full copy of them, may be kept in separate locations to better protect them from disasters--natural or unnatural.

Electronic records may need protection from different kinds of damage--mechanical insult or electric fields; power outages or surges; attacks from viruses, worms, and other destructive programs. A plan for archiving files may include off-site storage of data or file and system backups.

2. Access to the records

Access to paper records may be controlled by storing files in locked cabinets or other such containers that are housed in locked offices or storage rooms.

Access to electronic records may be controlled via security procedures such as firewalls, passwords, authentication, and data encryption.

Retention of Records

There are numerous potential circumstances that might require a release of client records after termination of client contact (e.g., legal proceedings, requests from treatment providers or the clients themselves). They may also be needed at some time for the social worker or therapist to show the nature, quality, and rationale for services provided. It's also a possibility that the records might be requested to give light in resolving a legal dispute and administering justice when the

nature of the treatment provided or the psychological condition of the client at the time of services would be needed (American Psychological Association, 2007).

This gives rise to the question of just how long you *should* keep the records. Perhaps the most practical answer is, "As long as necessary for the future care of the client, and as long as the record may be used in the defense of the therapist" (Cole, 2001). The APA states that, unless there is an overriding requirement, it would be good to keep records for seven years after the last service delivery date for adults or until three years after a minor reaches the age of majority, whichever is later. However, they also state that you may want to keep them longer. These suggestions are the law in California; each state has its own laws.

In deciding whether to keep the records for a longer period of time, you would want to weigh the potential benefits associated with keeping the records versus risks associated with potential privacy loss or having information that is outdated/obsolete. Possibilities that you may want to consider when making the decision to continue to keep or to eradicate files include:

- ✓ Earlier records of symptoms of a mental disorder might be helpful for the client in later diagnosis and treatment.
- ✓ Or, the client might be better served if later diagnosis and treatment was not influenced by something more than seven years in the past.
- ✓ The client might have engaged in behavior as a minor that, if disclosed later (when, for example, he decided to run for Congress) could prove demeaning or embarrassing.
- ✓ Keeping the record over an extra-long time might be expensive and/or logistically challenging.

One other item to consider: The client has the right to amend his medical records as long as you have the record (Pritts, 2005).

Preserving the Context of Records

There are times for which the information in a client's record is specific to a given time frame or a particular situational context during which the services were delivered. Over time, as the context

changes, the meaning and relevance of the information may also change. The information in the record should be recorded in such as way as to preserve the context.

For example, if you or your supervisee assess or treat an individual who is under extreme external stress or who is in crisis, those stresses may affect the client's functioning in that setting, but the client's behavior in that situation may not be at all representative of the client's normal functional characteristics.

Or--a child who is being severely physically abused may show low scores in a cognitive assessment that may not be close to accurately predicting future functioning of the child. Or if you need to write a case summary of a client who had been violent, but only in the midst of one psychotic episode, you would want to carefully record the context in which the behavior took place. Always try to create and maintain a client's records in such as way as to show related information about the context in which the record is created (American Psychological Association, 2007).

Electronic Records

Issues pertinent to electronic records have already been discussed. But, because of the extreme importance and uniqueness of electronic records, it will be tied together here with some addition information.

Aspects of electronic record keeping that need to be kept in mind are:

- Limitations to their confidentiality
- Methods of keeping the records secure
- Measures needed to maintain the integrity of the records
- Unique challenges of disposing of the records

In many cases, those in the social work and mental health fields will be subject to the HIPAA Privacy Rules and Security Standards. This requires a detailed analysis of the risks associated

with your electronic records. It would likely be helpful to conduct that risk analysis even if you're not technically subject to the HIPAA rule.

These HIPPA requirements are also a means to help you to closely examine certain office practices:

- Assuring that you handle personal health information in a manner that will protect clients' privacy
- Defining acceptable deidentification if needed for research or other purpose
- Clearly defining required elements in a release of information authorization

Whether the Security Regulations apply or not, the swift changes in the technologies for service delivery, media storage, and billing necessitate frequent consideration of how to use these methods and media in terms of record keeping standards (American Psychological Association, 2007). The ease of creating, transmitting, and sharing electronic records can expose you to risks of unintentional disclosure of confidential information.

Some precautionary actions include:

- Use case identification numbers, not clients' Social Security numbers to identify records
- Use passwords and/or encryption to protect confidential materials
- Become aware of special issues raised when using electronic methods and media; get training or consult with a specialist when necessary

Record Keeping in Organizational Settings

Organizational settings, often present unique record keeping challenges. Record keeping requirements for organizations may be substantially different from requirements in other settings. You may run into conflicts between the organizations' practices and establish professional guidelines, legal and regulatory requirements, or ethical standards. In addition, ownership of and responsibility for a record is not always clearly defined. A number of service providers may access

and contribute to the record, potentially affecting the degree to which you may execute control of the record and its confidentiality.

This may be summarized as potential:

1. Conflicts between organizational and other requirements
2. Ownership of the records
3. Access to the records

You, your colleagues, and your agency's management may need to consult with one another to define record keeping procedures that serve the needs of different disciplines, while at the same time meeting acceptable record keeping guidelines and requirements. In this consultation, you'll need to review local, state, and federal regulations and laws that pertain to the organization. If there is a conflict between an ethics code and the organization's policies, you'll need to clarify the nature of the conflict, make your (and others involved) ethical commitments known, and resolve the conflict in a way that is compatible with those ethical commitments.

The nature of your legal relationship with the organization may dictate record keeping practices. The physical record of your services may be owned by the organization and you may not take it with you. However, if the relationship is one of consultation, you may be the one who owns and is responsible for the record. It will be helpful to clarify these issues when you begin your relationship with an organization, minimizing the possibility of misunderstandings.

If a team of people from different disciplines is involved in service delivery, there may need to be wider access to records than usual. Because others (e.g., nurses, physicians, paraprofessionals, etc.) may have access to and may make entries into the client's record, you may have much less direct control over it. This is another call for you to help in developing and refining organizational record keeping policies.

Note that because multidisciplinary records may not have the highest level of confidentiality, you and your supervisees will want to record only information that matches organizational requirements and that is necessary to correctly picture the service provided. Other information may then be kept in a separate and confidential file (American Psychological Association, 2007).

Multiple Client Records

Record keeping issues may be more complex when you provide services to multiple clients, such as in a group therapy session. If the records include information about more than one specific client, legitimate disclosure of information regarding that client may put another client's confidentiality in jeopardy.

It's the responsibility of you and your supervisees to keep records in a fashion that assists authorized disclosures but at the same time protects privacy of other clients. When you provide services to several people who have a relationship (e.g., spouses or parents and children), you must define at the beginning:

1. Which individuals are clients?
2. Your relationship with each person, including your role and the likely uses of the services you give or the information obtained.

If it looks like you may be asked to play potentially conflicting roles (e.g., family therapist and then witness for one part in divorce proceedings), you must take judicious steps to appropriately clarify, modify, or withdraw from a specific role or roles.

In a group therapy setting, you must describe at the beginning each party's role and responsibility, and the limits of confidentiality. If you're asked to provide services to someone who is already receiving similar services elsewhere, you must consider carefully any treatment issues and potential welfare of the client(s). Discuss these issues with the client (or the client's guardian or other legal representative) to diminish risks of conflict and confusion. Also, when appropriate, consult with the other service providers, always being cautious and sensitive to therapeutic issues (American Psychological Association, 2010).

Other precautionary steps you can take include:

- In the informed consent form, include whether information is kept jointly or separately and who can authorize its release.
- In couples, family or group therapy, clarify the identified clients, then create and maintain completely separate records for all identified clients.
- If the family itself is the identified client, you may need to keep a single record, dependent upon practical concerns, ethical guidelines, and third-party reporting requirements.

To successfully "pull all of this off," you'll need to be familiar with regulatory and legal requirements concerning the release of a record that contains information about more than one client (American Psychological Association, 2007).

Financial Records

Financial records are considered by HIPAA to be part of the protected psychotherapy notes; at least they're not on the list of unprotected information. As a rule, a fee agreement or policy will be part of the record, and is the foundation for documenting reimbursement for services. Precise financial records aid payers to evaluate the nature of the payment obligation, and also aid in knowing which services have been billed and paid. Records that are up-to-date can forewarn both the provider and the client of accruing balances that, if not addressed, could adversely affect the professional relationship.

Financial records include (American Psychological Association, 2007), as appropriate:

- Type and duration of the service given
- Client's name
- Fees paid for the service
- Agreements concerning fees
    - Fee agreements or policies identify the amount to be charged for service and the terms of any payment agreement. It will identify how missed appointments will be handles, acknowledge third-part payer preauthorization requirements, copayment

agreements, payment schedule, interest that an unpaid balance will accumulate, suspension of confidentiality when collection procedures must be used, and methods that may be used to solve financial disputes.

- Barter agreements
    - An accurate recording of bartering agreements and transactions ensures that the record clearly shows how the provider was compensated. Reporting the source, nature, and date of each barter transaction gives clear indication when needed about the exchange of goods for services. Because the provider could potentially have more power in negotiating a bartering agreement, painstaking documentation protects both parties. The documentation may include the provider's basis for initially concluding that the arrangement is neither clinically contraindicated nor exploitive.
- Balance adjustment issues
    - The rationale for, description of, and date of any balance adjustment made with either the client or a third-party payer should be part of the record. This can decrease the potential for misunderstandings or perceived obligations that might affect the relationship.
- Copayment issues
- Date, amount, and source of payment received
- Concerns about collection
    - Often also useful is documentation of collection efforts, including notification of the intention of using a collection service.

Disposition of Records

Certain events require collection, storage, transfer, or disposal of client records. These events are:

1. Unexpected events (disability, death, or involuntary termination of practice)
2. Planned events (retirement, closing a practice, voluntarily leaving employment)

Disposition of client records must be handled in such a way that confidentiality is maintained and client welfare safeguarded (American Psychological Association, 2007). This refers to all private information--written or unwritten--such as communications during the time of providing service,

computer files, e-mail or fax communications, written records, and video-tapes. This means that the therapist needs to have suitable plans in place from the beginning of her job. Also, to be planned for, in case of unexpected changes, are contingencies for continuation of services (Barnett and Zur, 2011).

In the circumstance of unexpected events, the plans might include control and management of closed records by an agency or trained individual. In the circumstance of planned events, depending on who the employer is, the provider may wish to retain custody and control of the closed records.

It may be helpful to have a method for notifying clients regarding any changes in the custody of their records, especially recently terminated services or open cases. You'll want to check legal and regulatory requirements to see if you should post a public notice about changes in this custody, such as a notice in the newspaper.

If records are to be disposed of permanently, they must be disposed of in such a way that they cannot be recovered, such as shredding. You must to provide for confidentiality in transportation to the shredding facility, as well as in that facility. This might require accompanying the records through the disposal process or having a confidentiality agreement with those responsible for the disposal.

Disposal of electronic records have unique challenges, because you may not have the technical expertise to fully erase or otherwise delete records before, as an example, disposing of an external back-up storage device or a computer hard drive or other electronic record repository. Even though efforts may be made to erase or delete records, they may still be accessible for some "geeks" with specialized knowledge. You'll possibly need to work with a technical consultant to find a satisfactory method for destruction of electronic records. These could include physical destruction of the entire medium or demagnetizing the storage device.

Evaluation of the Supervisee

In spite of the awareness that a big part of supervision is the supervisor's evaluation of the supervisee, it's apparently something that is often far from the favorite task of a supervisor. Some of the reasons for this include (Lichtenberg et al., 2007):

- Defining competencies in precise and measurable terms
- Reaching agreement within the profession about the key elements of each competence domain
- Establishing an armamentarium of tools for assessing all components of competence, including the knowledgebase, skills, and attitudes (and their integration)
- Determining appropriate, agreed-upon minimal levels of competence for individuals at different levels of professional development and when "competence problems" exist for individuals assuring the fidelity of competency assessments
- Establishing mechanisms for providing effective evaluative feedback and remediation

But Lichtenberg et al. (2007) believed that "the single biggest obstacle would be convincing those who are skeptical of the value of … implementation of comprehensive competence assessments across the professional lifespan."

However, no matter what problems are related to it, supervisor evaluation of the supervisee is an established fact and must be faced. Interestingly, unless things have dramatically changed in the 21st century, supervisees frequently receive no evaluation until the last day of the required training, and then receive some negative feedback about which they had heard nary a word in the course of training. You can see why the lack of performance evaluation has been the most common ethical violation reported by supervisees in supervision (Ladany and Lehrman-Waterman, 1999).

For contrast with the above list from Lichtenberg et al. (2007), the primary reasons given in 1993 of why supervisors often *don't give* negative feedback were (Robiner, Fuhrman, and Ristvedt, 1993):

1. Definition and Measurement: Supervisors reported concern about the methodology, reliability, and validity of the scales or measures they use, or they're concerned that anecdotal feedback does not meet criteria for accurate assessment.
2. Legal Liability: Supervisors were concerned with legal and administrative issues--legal liability if the supervisee would dispute the feedback (especially in light of the first concern, fearing the feedback may not be defensible).
3. Interpersonal Issues: Many supervisors feared that the evaluation might cause the supervisor to come under unwelcome scrutiny; they also feared that it might risk jeopardizing the supervisory alliance or interpersonal relationship established with the supervisee.

It's ironic that supervisees report that supervisors who give abundant constructive feedback and evaluation are their best supervisors (Falender, 2010). The Association of State and Provincial Psychology Boards (2003) suggested that summative evaluation be given to supervisees in written form four times during each training year.

Summative evaluations of supervisees would examine the outcome of their clinical work. It would include:

- Outcome evaluations that investigate whether the supervisee caused demonstrable effects on specifically defined target outcomes
- Impact evaluation is broader and assesses the overall or net effects--intended or unintended--of the supervisee as a whole
- Secondary analysis reexamining existing data to address new questions or methods not previously employed (Trochim, 2006)

A related type of evaluation is formative evaluation, which tries to improve or strengthen the person being evaluated. As it relates to supervisees, it examines their delivery of therapy or a social work program, the quality of this delivery, and assessment of the context. A formative evaluation includes:

- Praise or support
- Constructive feedback focused on suggestions or analysis

- Thinking about what other options might have been helpful
- Wondering about the rationale for particular interventions
- Thinking more about process than content, effect rather than content, or generally refocusing the therapy process
- Specific and directive for beginning level supervisees; more open-ended and thought provoking for more advanced supervisees

Current thinking is moving towards a 2-way feedback, where supervisees also evaluate supervisors. Supervisees might fear that summative feedback could influence their own evaluations negatively, and thus be cautious in giving summative feedback to supervisors. However, if you, the supervisor, are truly open to feedback and accepting of it, it can be very helpful to both you and the supervisee. If, however, you respond with dismissive behaviors, resistance, or even anger, it will obviously not be a helpful process (Falender, 2010).

Options to aid effective competency-based evaluations:

- Track for outcomes in client progress; examples of a tool for this are Lambert's Outcome Questionnaire (OQ) and its child and adolescent equivalent (Y-OQ) and the other measurements that were discussed earlier in the course can be uses, such as depression scales.
- A self-assessment to assess and extend one's areas of practice, or just to see how current the supervisee's knowledge and skills are. Belar et al. (2001) offer a template that a supervisor can use to devise pertinent self-assessments for his specific use.
- Use a multi-source feedback (also known as "360-degree feedback"). The individual being rated (supervisor should do on himself first, then the supervisee would follow suit) first rates himself, and then is rated by peers, administrators, clerical staff, clients, supervisors (who were first rated by the supervisee), and others in the setting. The coordinating supervisor integrates the results to make a comprehensive feedback.
- The supervisor(s) should be certain that the evaluation documents include every important performance area in the supervisee's setting. If something is overlooked in the evaluation documents, it should necessarily also be overlooked in the final evaluations.
- Use other evaluation measures such as alliance measures, supervision outcomes, and diversity/multicultural competence assessments.

If the supervisee does not meet performance standards, she can be given an action plan for improvement, or in most drastic situations, a longer period of time of required supervision. Supervisees who don't meet standards after the action plan approach are rare (Falender, 2010).

Red flags for performance problems include:

- Delinquent paperwork
- Chronic lateness
- Client cancellations (by client or supervisee)
- Changes in interaction style or behavior
- Inconsistencies between notes and descriptions of cases in supervision

Not meeting performance standards are reflected in professional functions in one or more of the following (Lamb, Anderson, Rapp, Rathnow, qne Sesan, 1986):

- Inability or unwillingness to acquire and integrate professional standards into one’s repertoire of professional behavior
- Inability to acquire professional skills to reach acceptable level of competence
- Inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that may affect professional functioning
- Supervisees don't acknowledge, understand, or address the problem even when raised
- The problem is not just a reflection of a skill deficit rectifiable through academic or didactics
- The quality of intern service is consistently negatively impacted
- The problem is not restricted to one area of functioning
- Disproportionate amounts of attention by training personnel is required
- The intern’s behavior does not change as a function of feedback, remediation efforts, and/or time

After you've determined that the supervisee is not meeting performance criteria, and you've given feedback directly to him, work with the supervisee to develop a plan (based on data you can find in regard to successful completion of the behaviors in the past and factors that facilitated those)

for change or completion. Construct a time-line with intermediate check-in points that are fairly close together, and document the meeting in which all of this took place (Falender, 2010).

The initial check-in should be within a few days of the meeting; be sure to follow up to see if appropriate progress is being made. Even with appropriate progress, continue monitoring even past indications that the behavior has changed. If the problem behaviors don't decrease, take appropriate steps that might include:

- Consultation with the school (a step that could even have occurred earlier)
- Consultation with Human Resources or Personnel Department
- Consultation with Administrative personnel on site
- Increased supervision or different supervision modalities
- Introducing a co-therapist
- Reducing workload or, if necessary, removing clients from caseload as needed
- Suggesting outside supports such as therapy or whatever is indicated
- Leave of absence

Continue with these steps until the problem is solved or until you determine that the supervisee's position must be terminated (Falender, 2010). All steps must be carefully documented.

THE SUPERVISEE

It's one thing to know your status and responsibilities as a supervisor, and to know what skills and knowledge your supervisee must gain under your sponsorship. It's another thing to know (perhaps "remember"?) what it's like to be a supervisee, and to guide them in their own experiences and stages of development, through their resistances into a variety of competences. This involves an evolution in the relationship between you and your supervisee. This section will give you some light on these aspects of supervision

THERAPEUTIC DEVELOPMENTAL STAGES OF A SUPERVISEE

Not only is there a developmental evolution in the supervisor-supervisee relationship, but the supervisee will experience therapeutic development within herself. It's important for you to be aware of how supervisees earn and establish a spirit of learning, how skills are developed over time, and the process of developing as part of an organization. Improvement in the supervisee's service delivery occurs best when she has freedom to practice new skills in an environment of mentoring and support rather than one of critical judgment (Center for Substance Abuse Treatment, 2007).

Cole (2001) reports four therapeutic development phases for the supervisee:

1. Learning the basics of what the supervisee should do
2. How to begin to understand the client
3. How the client and the supervisee can collaborate to increase the client's productive functioning
4. The supervisee learns to trust himself to be a beneficial agent of healing in a therapeutic relationship

Three developmental stages, each followed by a period of transition, were given by Cox, Phibbs, Wexler, Riemersma, and Bauman, Eds. (1990). Although the numbers differ from those given by Cole (2001), you can see similar stages of development.

1. Novice Stage: The supervisee is not sure what to say to the client, but believes that the client's survival is dependent on what the supervisee says. The supervisee is very dependent on the supervisor, wants to be shown techniques, and has difficulty synchronizing text book knowledge and practical applications. Focuses on issues rather than on the client, emphasizes "doing." Your task as the supervisor in this stage is to give general structure which may include procedures, forms, journaling, and reading materials.

2. Transition Period: Counter-transference issues will occur with almost every client. Supervisees will improve on matching intentions and interventions. They will begin to understand the deeper and more abstract components of doing therapy, but will still struggle with what to do. Your supervisor tasks will include helping supervisees understand things such as how the client may interpret body language (e.g., folded arms) and the impact it may have on them, and to give positive reinforcement to the supervisees' strengths and encourage them to develop their own theoretical framework.
3. Intermediate Stage: Supervisees become more aware of their own personal issues, and likely feel somewhat overwhelmed by the client's problems. The goal of this stage is to be able to work with the client even though the exact outcome is unknown, and to learn to use their own self (or "being," if you prefer) effectively in therapy sessions. Sometimes this requires some personal therapy. As supervisor, you can encourage journaling, and help supervisees look more closely at counter-transference issues. At this stage supervisees may express some self-righteousness and there is danger of client abuse at some level; you need to uncover this and work with the supervisees on it. You and the supervisees need to be aware of their beliefs. A good question to ask in a supervisory session is what the supervisee did in a session that they liked or were especially aware of.
4. Transition Period: Supervisees will experience increased confidence and comfort with both "being and doing," but may have problems connecting universal concepts between cases. Increased flexibility is needed in regards to what specific directives are being followed; support without advice on your part as supervisor is generally the most helpful process. Supervisees might not need to discuss individual case specifics as much as before, if at all. In fact, they need to realize that they don't need to see every single client and that it's often most appropriate to transfer a client to another therapist. Your task at this stage is to reinforce therapeutic skills and encourage further skill development.
5. Advanced Stage (Self-supervision): At this stage, supervisees are able to focus on their overall role and the complete process of therapy and the therapeutic relationship. They may be considering specialization in one area, and are preparing for license exams. Your supervisor tasks include incorporation of knowledge, role understanding, personal style, intentions, and responsibility. Supervisees need to be able to find their own answers; you can encourage advanced training through workshops, books, etc. Help supervisees conceptualize all treatment process phases. You'll focus now on generalities instead of

specific cases, and will help supervisees develop their personal counseling style and theory. Explore, integrate, and articulate what the supervisees believe.

6. Transition Stage to Professional: The supervisee makes the final transition from an uncertain, inadequate, and incongruous beginning to a confident, competent, and congruent professional. They will be preparing for licensing exams by overcoming fears and resistances, as well as reviewing facts and therapy methods. Your job is to aid them in exam preparation, termination with you as supervisor, and aiding a personal ritual for this transition.

CRITICAL ISSUES SUPERVISEES EXPERIENCE

Sometimes it helps to guide supervisees through the development stages and transitions by being aware of critical issues they experience during the process. According to Loganbill, Hardy, and Delworth (1982), these issues are:

1. Competence - skills and technique
2. Emotional awareness - knowing oneself, awareness of feelings
3. Autonomy - self directedness
4. Identity - theoretical consistency, conceptual integration
5. Respect for individual differences - tolerant, non-judgmental acceptance of others
6. Purpose and direction - structuring a therapeutic direction, setting appropriate goals
7. Personal motivation - awareness of the satisfaction and personal meanings inherent in practicing therapy
8. Professional ethics - values

Within this process they identify your supervisory functions as:

1. Monitoring client welfare
2. Enhancing growth within stages
3. Promoting transition from one stage to the next
4. Evaluating the supervisee

PROBLEM SUPERVISEES - RESISTANCE IN SUPERVISION

Even the most willing and compliant supervisee will probably have moments in which they resist supervision and your supervisory efforts. These occasional occurrences are not a problem. They are a problem if they delineate the whole process.

Resistant Behaviors

Supervisees resistant behaviors may boil down to two things:

- They don't want to do something that they were told to do.
- They feel they're ready to deal with situations that you don't believe they're yet equipped for.

Resistance is not uncommon. It may be annoying or even disruptive, but it's not synonymous with "bad behavior" or being a "bad person." Instead, it occurs because of the supervision process dynamics, and often is actually a fitting response to supervision (for example, if you slip into having therapy sessions instead of supervision sessions). Sometimes resistance is simply a response to anxiety; as supervisor you can deal with the anxiety, thus reducing or eliminating the need for resistance (Bradley and Gould, 2002).

Liddle (1986) came to the conclusion that the main goal of resistant behavior is self-protection against a perceived threat. A common threat is the fear of being inadequate--that the supervisee will not be able to measure up to the supervisor's expectations and standards.

Or the supervisee may be anxious because of the evaluation portion of supervision. They may fear that a negative evaluation will lead to dismissal or to not being given needed recommendations.

Another cause of resistance may be that supervisees don't accept the validity of supervision. They may perceive their skills to be at least equal, perhaps even superior, to the supervisor's skills.

Another potential cause is a reaction to loss of control. This can develop into a power struggle between supervisee and supervisor.

Additionally, supervisees may be threatened by change and thus respond with defensive behaviors. Regardless of the form of a resistant behavior, it's a coping mechanism with the goal of reducing anxiety.

A common form of supervisee resistance is playing games. Four supervisee game categories were defined by Kadushin (1979).

1. Manipulating levels of demand. The supervisee tries to manipulate the level of demands placed on her by the supervisor. This category includes inhibiting supervisory evaluative focus. Flattery may be used for this purpose.
2. Making the supervisor-supervisee relationship ambiguous. The supervisee may play a game of self-disclosure to expose herself rather than her counseling skills.
3. Reducing power differences. The supervisee may try to show that the supervisor is "not so smart," and will focus on his own knowledge. If this game is successful, the supervisee can diminish some of the supervisor's power.
4. Controlling supervision. Supervisees may develop questions that will switch supervision away from their performance. Or they may ask for unnecessary prescriptions for dealing with clients, look for reassurance through reports of how poorly work is coming along, or sharing only information selected to acquire a positive evaluation. An angry or hostile form of control includes blaming the supervisor for the supervisees' failure.

In addition to the four game categories, Bauman (1972) spoke of five types of resistance, which may be equated to game categories and compared with those given above:

1. Submission: Supervisees act as though the supervisor has all the answers
2. Turning the Tables: Supervisees try to direct focus away from their skills.
3. "I'm No Good": Supervisees plead fragility and seem brittle in order to keep the supervisor from focusing on painful issues.

4. Helplessness: A dependency game where supervisees absorb every speck of information the supervisor gives.
5. Projection: Supervisees blame external problems for their ineffectiveness.

Specific games supervisees may play, with steps you can take to avoid being part of the game, include (Malone, 2009; Munson, 1979):

- Us Against Them: The supervisee attempts to gain control in order to carry out her own agenda and beliefs by trying to form an alliance with the supervisor against the agency. Try to redirect the supervisee's efforts to working well within the organization.
- You Are the Best Supervisor Ever: Emotional blackmail for the purpose of reducing the supervisor's power. Maintain correct boundaries and keep the goals in focus to prevent falling into the trap
- A Little Therapy, Please: Supervisees try to manipulate the supervisor into focusing and solving their problems to distract them from the professional work. You can reframe the personal problems into the clinical work, and--if necessary--refer the supervisees to their own counseling.
- But We Are Friends: This is a manipulative action to get the supervisor off course and not hold the supervisee accountable for his actions. Stay out of the game by recalling that the role of "friend" was not a part of the supervisory contract.
- I Am Big Like You: This is another game for the supervisee to gain power. The supervisee will not feel obligated to do anything the supervisor might wish, since they're truly peers. You may need to remind the supervisee that it's your responsibility to evaluate his performance.
- You Don't Have All the Answers: Another form of "I Am Big Like You." Allow the supervisee to shine in areas where she's competent, and--when appropriate--share the platform of expertise, reminding both of you that your team members.

I Have an Agenda: A deluge of questions in the supervisory meeting is designed for the supervisee to control the meeting and prevent the supervisor from addressing the supervisee's weak areas. You'll need to interrupt the deluge and spell out your own agenda. There is usually room for some negotiation regarding to what questions will be addressed.

Counteracting Resistance

Knowing that resistance is common, and being aware of the games a supervisee may play to demonstrate that resistance is one thing. Knowing how to counteract that resistance is another. The process is not simple. However, your ability, as supervisor, to take resistance and turn it into a supervisory advantage may be the hallmark for determining success or failure in supervision (Bradley and Gould, 2002).

The major factors that affect the methods used are:

- The relationship
- How the relationship is viewed

It's essential that the supervisory relationship be grounded in respect, trust, rapport, and empathy (Borders, 1989). If the supervisor views the relationship as the focal point in supervision, then a full exploration of conflicts will be followed. If the supervisor views the therapeutic works as the focal point of supervision, then the exploration of conflicts will likely be more limited.

The literature offers a variety of ways to deal with resistance:

- Identifying the source of anxiety (or threat); then brainstorming to find suitable strategies for dealing with the conflict (Liddle, 1986)
- Refusing to play games--sharing awareness of game-playing with supervisees and focusing on inherent disadvantages in game-playing, not on the dynamics of the supervisee's behavior (Kadushin, 1979)
- Positive reframing to empower the supervisee, increase the supervisee's self-esteem, and to model effective ways of coping with feelings, thoughts and behaviors (Masters, 1992)

Bauman (1972) mentioned several techniques, the success of any being dependent on the interaction between the supervisor and supervisee and their personalities:

- Direct confrontation through describing and interpreting the supervisee's resistance

- Feedback
- Clarification by using restatement to help the supervisee understand his behavior
- Generalizing resistance to other setting to remove the focus from the supervisory relationship and aid the supervisee to recognize her unsuitable behaviors
- Ignoring resistance, although this should be done only if the behavior can be eliminated by so doing
- Role-playing and alter-ego role-playing, to help identify the cause of resistant behavior; this may initially be quite threatening
- Audio- or video-taping supervision sessions

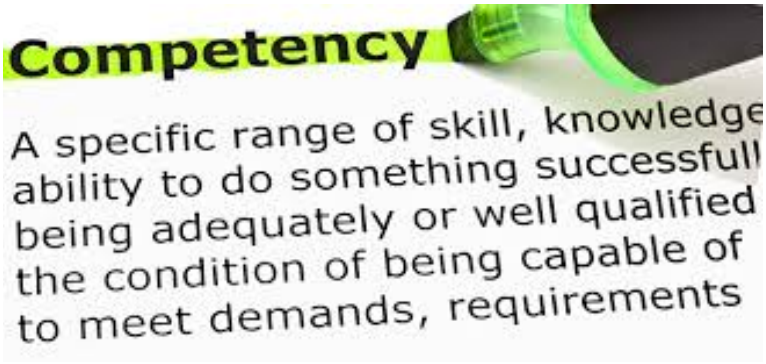
If these methods don't help, you may need to do a bit of "creative brainstorming" with the supervisee about how to get his needs met. The possibilities include:

  - Therapy
  - Mediation for conflict resolution
  - Development of realistic goals that don't overwhelm supervisees or negatively impact their self-esteem

All instances of supervisee resistance, and the attempts to counteract it and their results should be documented.

SUPERVISEE COMPETENCIES

Quite a bit of space was given to list competencies of supervisors. Supervisee competencies, while just as important, can be listed more succinctly. Tomm and Wright (1979) give a fair list that summarizes information about supervisee development already discussed:



- General Case Management: Complying with agency responsibilities

- Therapeutic Relationships: Establishing and maintaining ongoing relationships with clients
- Perceptual: Therapist's ability to observe interactions
- Conceptual: Therapist's ability to integrate observations with theory
- Structuring: Therapist's ability to adequately direct therapy
- Intervention: Therapist's ability to purposefully behave in a strategic manner to facilitate change
- Professional Development: Using resources to promote growth as a professional clinician; the focus of competency development changes depending on the developmental phase of the clinician's growth process.

THE SUPERVISION PROCESS

The American Board of Examiners in Clinical Social Work (2004), in their executive summary of clinical supervision, recognized two areas of the supervision process in the development of clinical supervision practice competencies: knowledge and skills. Most of these have been discussed earlier in the course, but they're presented here in outline form as a reminder and to tie it together with the full supervision process.

The three areas of knowledge that they listed were that the supervisor:

- Is aware of the parallel process in which the interaction with the supervisee can be acknowledged and serve as an appropriate teaching tool.
- Has the self-awareness to recognize her own emotional response to the supervisee's anxiety.
- Recognizes and understands how to addresses inter-ethnic and intra-ethnic issues that emerge in the supervisory relationship.

Several of the skills brought forward were:

- The supervisor demonstrates mastery of the methods of supervision utilizing skills in communications, relationships, learning styles and problem-solving.
- The supervisor uses the supervision process to model professional practice.

- Evaluates the need for adjunct services and arranges for them, in conjunction with the supervisee and client, when indicated.

The rest of the skills were specifics of areas in which the supervisor acts as a guide and evaluator. The supervisor guides and evaluates the:

- Supervisee toward better carrying out the treatment plan and greater effectiveness in working with a broad range of emotions and intensity of affect
- Supervisee's ability to use a range of tools (process recordings, memory work, audio- and video-tapes, and observation) to share the details of the practice for analysis with the supervisor.
- Supervisee's ability to respect the centrality of the therapeutic relationship and to sustain a therapeutic alliance.
- Ability of the supervisee to integrate feelings effectively into the professional function and role.
- Supervisee's ability to permit the client's expression of intense affect modes, both positive and negative, as he/she learns to manage extreme behaviors while maintaining a therapeutic stance.
- Supervisee's ability to engage the client and to develop a working agreement in the beginning phase of practice.
- Supervisee's ability to work in response to client results (direct and indirect) in the middle phase of practice.
- Supervisee's ability to assess readiness for termination (in collaboration with client) in terms of goals and objectives of the service and level of functioning.
- Supervisee's ability to recognize the potential significance of the termination process and to assist client in dealing with the issues it may provoke.

DEVELOPMENTAL STAGES BETWEEN SUPERVISEE AND SUPERVISOR

According to Littrell, Lee-Borden, and Lorenz (1979), there are four different models of supervision. These four

models actually give an image, and therefore a method for conceptualizing, of developmental stages of supervision. During supervision, professionalization takes place as the supervisee takes on increasing responsibility for the content of the supervision. These stages are:

1. Establishing the supervisor-supervisee relationship, setting goals and clarifying the contract

Both parties outline the part they are to play and what is expected of each. Rules, goals, and objectives are defined, and supporting measures are established. Specific teaching interventions will be detailed. The when, where, and frequency of supervisory meetings are established, as well as procedures for handling emergencies should they come up. Once both parties are content with all the details of these arrangements, this stage is completed (Malone, 2009).

2. The interpersonal dynamics in regards to the counseling/teaching aspect of the relationship

During this stage the supervisee is fairly dependent on the supervisee's advice and counsel for skill and insight development. It's during this stage that resistances are most likely to occur.

3. The transition from supervisor/teacher to a consultant's role of exploration and reflection

This phase is largely to increase the supervisee's autonomy. A more peer-like relation is developed, and each is less role-bound. The supervisee has developed enough expertise and skills that he needs less supervisory direction and is more confident. The primary foci of the relationship is coaching, support, encouragement, and tweaking of knowledge or skills that may come up (Malone, 2009).

4. The separation of the supervisor and the supervisee and change of model into one of self-supervision

During this termination phase, the supervisee's competency is quite firm. The supervisory purpose has been satisfied, and the supervisee demonstrates understanding of relationships between practice and theory as they related to specific clients. The relationship between the two parties may move into a peer-supervision style (Malone, 2009).

OBSTACLES TO LEARNING AND TEACHING

There are a number of conditions for effective learning and teaching (Kadushin, 1992):

- ✓ Principle 1: We learn best if we are highly motivated to learn.
- ✓ Principle 2: We learn best when we can devote most of our energies in the learning situation to learning
- ✓ Principle 3: We learn best when learning is attended by positive satisfactions--when it's successful and rewarding.
- ✓ Principle 4: We learn best when we are actively involved in the learning process.
- ✓ Principle 5: We learn best if the content is meaningfully presented.
- ✓ Principle 6: We learn best if the supervisor takes into consideration the supervisee's uniqueness as a learner.

Problems may come up during the supervision process that are obstacles to learning. If you observe certain phenomena, you can be fairly confident that at least one of these problems is appearing. Supervisee's actions that can alert you to these problems include (Falender, 2010):

- Change in supervisee behavior
- Withdrawal, aloofness
- Decreased verbal behavior, forthcoming quality of interaction
- Change in interaction
- Over-compliance with supervisor suggestions
- Supervisee appearing preoccupied
- Supervisee seeming distant or annoyed
- Supervisee seeming stressed or nervous
- Supervisee confusion

It's your job, as supervisor, to recognize these signs and address them. Failure to do so will only impede the necessary teaching and learning. You'll only be making your job harder if you (Malone, 2009):

- Ignore a vital problem. An ignored problem quickly grows and then is much more difficult to correct. Save effort, time, and perhaps money by addressing the problem when it's small.
- Procrastinate in addressing a problem. This will make you appear indecisive and inadequate to the supervisee.
- Minimize a problem. If you minimize problems, the supervisee may feel shortchanged, not heard, and as if you don't "have his back." On the other hand, don't overly criticize, as this will hinder the supervisee's creative undertakings.
- Lose your cool with your supervisee. If you lose your cool, and perhaps even yell and scream, you'll look like a fool, and who respects a fool?

Some suggestion that adds a positive approach to aiding teaching and learning include:

1. Don't to take things personally. Stay objective and work together to define the problem, bring out all issues and discuss them rationally.
2. Identify and investigate an issue to come to a common ground. Allow time for differences and disagreements.
3. Work towards mutual agreements, merging both parties' ideas, and coming up with a joint decision.
4. Exchange accurate information, not opinions.
5. Negotiate and be willing to give and take.
6. As the leader, your role is to educate and to facilitate growth, not to control, dominant, and win.
7. If things are not working, do something different.
8. Take some time out, sleep on the problem, and give yourselves time to ponder.
9. If all else fails, seek consultation or bring a mediator in to assist both parties in coming to a mutually satisfying agreement.

Recognize that problems between supervisor and supervisee are not always the supervisee's fault. Earlier we looked at games' supervisee can play; there are also games that supervisor play (Malone, 2009; Munson, 1979). The reasons supervisors play game are often the same or similar to the reason's supervisees play their games:

- Fear of losing control

- Anxiety about their competency
- Perceived threats in the hierarchy
- Wanting to be liked
- Seeking approval
- Passive-aggressive way to express hostility

Some of the games you may be tempted to play are:

- They Won't Let Me: Because of a wish to be liked, you blame your superiors as to why an action could not be taken, even though you never consulted your superiors.
- Poor Me: You can abdicate authority by being too busy to meet or discuss a problem the supervisee is having. You may be trying to not look less competent to the supervisee, but you're actually sending a message that you don't care.
- One Good Question Deserves Another: Although this can be a good teaching strategy, if your reason for doing it is to hide your lack of current knowledge, to keep from making a decision or be wrong, you're playing a game.
- Remember Who's Boss: This game defines your role as one of total power and allows no disagreements, contradictions, or negotiations. It would be better to focus on building a good professional relationship.
- Father/Mother Knows Best: Control is kept by acting like a parent, with an operating belief of, "Since this has always worked for me, it will also work for you." This hinders the supervisee's development and growth, and is actually an ethical violation.

COMMUNICATION IN CLINICAL SUPERVISION

Clear communication is mandatory in good clinical supervision. The best way to begin that communication is with the written supervisory contract that should be made at the beginning of any supervisory relationship. This is discussed more fully below.

For communication--written or spoken--to be effective, it must be clear and understandable to all the parties involved. But the person on the receiving end of the communication, whether it's a long

speech or a single element of a conversation, must also be a good listener. Communication is a continual two-way process. Questions to promote clarity are also an important part of communication.

As supervisor, you can clearly communicate needed information to your supervisee. You can watch to see if she appears to "get" what you said, and you can ask question to be sure she did "get" it. Although the supervisee has responsibility for learning, it's still your job to be sure your communications are understood.

APPROACHES TO AND STRATEGIES OF SUPERVISION

There is no one unifying theory of clinical supervision. Supervisors choose to follow different models which stress certain techniques. Every model has a central set of principles to guide the supervisor:

- Ethical and legal practice
- A commitment to improve programs and social policy
- Recognition of the client’s rights to self-determination, to respect for potential/limitations, and to be addressed as a whole person

In traditional models, the relationship of the supervisor and supervisee is based on the legal and professional jurisdiction of the supervisor for the performance of the supervisee, in the manner authorized by the employing organization (American Board of Examiners in Clinical Social Work, 2004). The supervisor constantly must deal with a complex set of responsibilities towards:

- The supervisee
- The client
- The employing agency
    - Fiscal constraints
    - Large caseloads
    - Administrative functions

First Stages of All Approaches

No matter what approach to supervision you might choose, there are two issues that you need to do at the very beginning. The first is designed for use with every supervisee. The second is specific for each individual supervisee.

Behavioral Contracting in Supervision

If you've ever played a game with a small child who makes up and changes the rules at will whenever it's in her interest to do so, you can imagine what it would be like if supervision took a similar tack. What are the "rules" that should be included in a supervisory contract?

In forming a contract, remember that it's a mutual agreement between supervisor and supervisee, and that both parties sign it (Malone, 2009). This contract can be identical for all of your supervisory situations. The contract will include:

- How often the contract will be reviewed (such as every 90 days) to identify and resolve problem areas
- What are the purpose, goals, and objectives of supervision?
- What ethical and agency policies guide supervision and clinical practices
- What the procedural considerations are, including the format for taping and opportunities for live observation
- What is expected of each party, including the scope of the supervisee's practice and competence
- What potential obstacles there are for progress (e.g., lack of time, limitations of resources, performance anxiety)
- Who is responsible for what?
- What are necessary requirements
- How long supervision sessions will be
- How the supervisor will evaluate the supervisee

- How the supervisee will evaluate the supervisor
- How problems between the two parties will be dealt with
- What rewards there are for fulfilling the contract (e.g., clinical privileges, increased compensation)
- What sanctions are for noncompliance by either supervisee or supervisor
- How long the supervisory relationship will last

This document will reduce misconceptions about the supervision process, minimize covert agendas by either party, aid in the supervisee's orientation, and help avoid power plays by either party. In short, the written contract will give clear instructions for how to play the game, thus satisfying both supervisee and supervisor.

Once this contract has been constructed, an individual development plan should be made.

Individual Development Plan

The Individual Development Plan (IDP) is a detailed supervision plan with the goals that you and your supervisee want to focus on for a given period of time, such as three months. It's dynamic, and--as the child's game rules--will change over life cycle of the relationship--not on the basis of a whim, but based on mutual agreement (Malone, 2009). Both of you should sign it and keep a copy for your records (Center for Substance Abuse Treatment, 2009a).

Goals are most often skills the supervisee wants to cultivate or professional resources she wishes to develop. Both the resources and skills are aligned with the supervisee's job in the program or with activities that would promote his professional development.

The IDP should designate:

- Timelines for meeting the goals
- Which methods of observation will be used?
- Expectations for both supervisee and supervisor
- Which evaluation procedures will be used?

Activities to be employed in improving the knowledge and skills

Areas of apparent overlap with the behavioral contract are more specific for the supervisee in the IDP.

As a supervisor, you should also have your own IDP that addresses your own training goals based on the lists of competencies given earlier in the course. Your IDP can be developed with your supervisor, peer input, mentorship, academic advisement, or in external supervision (Center for Substance Abuse Treatment, 2009a).

Supervision Modalities

Just as there are a number of modalities for therapy (e.g., individual, couple, family, group), there are also several modalities of supervision. They might be divided into two broad categories: in person supervision and distance supervision. Distance supervision generally takes place when the supervisee is working in a remote location. Most sub-modalities can be used in either of these categories. The list below categorizes the sub-modalities under the division to which they pertain.

In Person Supervision

Live supervision/Direct observation (In the same room, one-way mirrors)

Distance Supervision

Telephone supervision

Internet supervision

Avatars

Chats

E-Mail

Online forums
Skype
Texting
Video-conferencing

Either/Both
Delayed review (audiotape, videotape)
Case presentation (post-session)
Written reports
Verbal reports

Studies indicate that distance supervision generally has greater focus on training than on service or client needs. Supervisees reported that the multiple sensory aspect (audio, visual, and text) in computer-mediated models were very useful for documenting consultations and outlining supervisory content (Hurley and Hadden, 2005). In-person and distance modalities appear to be equally effective for establishing rapport with in the context of supervision (Lenz, Oliver, and Nelson, 2011).

Live Supervision/Direct Observation

Live supervision and supervision by direct observation are generally used synonymously, even though--strictly speaking--there is not 100% overlap. The terms are used interchangeably in this section of the course. In live observation, the supervisor sits in on a counseling session with the supervisee and client, thus observing the session first hand. Informed consent from the client is required. An alternative to actually sitting in on the session is observation through a 1-way mirror. Sometimes this is combined with videotaping the session for later review (Center for Substance Abuse Treatment, 2009a).

Direct observation is direct, intentional, and structured (Ackroyd, Beddoe, Chinnery, and Appleton, 2010)--a constructive tool for learning, not a weapon for criticism. It's an opportunity for the supervisee to do things well and correctly, so that positive feedback follows. When the supervisee "goofs," it's an opportunity to discuss other ways the situation might have been handled.

You should be aware of a number of things regarding direct observation in supervision (Center for Substance Abuse Treatment, 2009a):

- The dynamics of the session will change, as well as the behaviors of both the supervisee and client. To get the best picture of the supervisee's competence, you'll need to have frequent observations.
- Procedures for observation must be agreeable to both you and the supervisee--why, when, and how the direct observation methods will be used.
- Your supervisee should give the session's context.
- Before beginning counseling, the client must give written informed consent for observation, and must be notified of an upcoming supervisor's observation ahead of time. Before agreeing to counseling, clients should have been given all of the conditions of clinical supervision and profession development as they relate to the client's counseling.
- What sessions to observe should be chosen (including a variety of clients and sessions, challenges, and successes) because they offer teaching moments. Ask the supervisee to choose what cases you should observe and explain why he chose them.

Live supervision should be a collaborative process that is associated with experiential learning. It's not simply the supervisor watching the supervisee; it's purposeful and carefully planned (Maidment, 2000). Some of the issues you must considered when planning live supervision are:

  - Do we involve the client in the feedback? (Kemp, 2005)
  - How do we include the students self-assessment in the feedback?
  - How do we develop observational skills that are not focused on having our own values, interventions, skills, or potential biases reflected back to us?
  - Should observation be a summative assessment, a formative assessment, or both?
  - Observing both inner and outer worlds

The first stage is preparation. A trusting relationship should be established between the supervisee and supervisor. The two determine the observation criteria together in careful negotiation. There should be a clear understanding about which aspects of practice will be observed. This could include the behaviors, knowledge, and skills that are expected to be

demonstrated in practice. It should be determined whether or not the supervisor will participate in any fashions during the session and under what circumstances. All of this should be put into writing (Humphrey, 2007).

In determining what participation and intervention you, the supervisor, should exercise, keep in mind (Humphrey, 2007) that:

1. They're legitimate if they're designed to safeguard any of the parties from harm or to safeguard the observation for assessment purposes.
2. They're not legitimate if they might fall into a role of rescuer, teacher, or co-therapist.

The next stage is the actual observation. As supervisor, you need to exude calmness and compassion to counteract anxiety and add positive energy to the session rather than a judgmental aura. Questions that you'll be asking yourself during the session might include (Ackroyd, Beddoe, Chinnery, and Appleton, 2010):

- What is the supervisee doing well in the session's activities?
- Are there any areas of obvious weakness in the supervisee's performance?
- How was the supervisee's professionalism demonstrated?
- How did the supervisee build the relationship with the client?
- Is the supervisee making use of theory?
- What else could the supervisee do to have a more competent, robust performance?

The third stage is one of feedback and debriefing. Preferably, this should happen immediately after the session. Ask the supervisee to critique her work first. You may facilitate this critique with questions such as:

- What did you think went well here?
- What did you wish you could have done better?
- What would you be doing if you incorporated (the better thing) into this session?
- Is there anything else you needed to do or know to feel more confident in this situation?

When you offer your critique, keep in mind the agreed criteria. Try to make your statements (Cleak and Wilson, 2007):

- ✓ Accurate
- ✓ Challenging
- ✓ Confirmatory
- ✓ Congruent with the task
- ✓ Corrective
- ✓ Fair
- ✓ Motivating
- ✓ Specific

Point out what went well and areas of possible change. Ask the supervisee if she was conscious of aspects of any of the areas you brought up and if she has suggestions about different actions that might be taken. If the supervisee has no suggestions, offer your own and together work out the next steps to be taken (Ackroyd, Beddoe, Chinnery, and Appleton, 2010).

The final phase is to plan the next learning steps to be taken. Make them as behaviorally specific as you can. Plan for opportunities for the supervisee to practice the tasks that will make up their final observations. Set a time for the next observation.

Telephone Supervision

Supervision by telephone--or in the Internet world, by Skype--is becoming more common. It's a common practice for clinical supervision of junior doctors, and for supervising counselors and psychotherapist (Wajda-Johnston, Smyke, Nagel, and Larrieu, 2005), as well as nurses (Thompson and Winter, 2003). It's often used when the supervisee is in a remote location, and is used in group supervision situations when participants may be located in different portions of the country--or the world.

In 2005, the Psychoanalysis Division of the American Psychological Association (Manosevitz, 2006) had a roundtable discussion on telephone supervision, and made the following conclusions about it:

a) Some face-to-face contact to supplement telephone supervision is desirable
b) The process and rational fit between the supervisee and supervisor is more important than whether supervision is over the telephone or in person
c) Parallel process is important in supervision
d) The supervisory alliance is important
e) Telephone supervision is essential in distance learning programs
f) Telephone supervision permits exposure to diverse viewpoints that might otherwise not be available

Telephone supervision is not limited to individual supervision, but also is often used for group supervision. Feuerman (n.d.), a licensed clinical social worker and psychotherapist, was skeptical about telephone supervision because he thought that seeing the supervisor and other participants was necessary for group cohesion and connection, that emotional connections would be greatly hindered.

When he experienced group telephone supervision, he was amazed that so many people wanted to participate. Reasons given were not necessarily related to remote locations, but also to the amount of travel time in metropolitan locations. Some reported that they found telephone supervision more effective than in-person supervision.

Reasons given for more effectiveness were:

- We get right down to business.
- I am not distracted by what people look like.
- There is less competitive talking, people know intuitively when to let the other person talk
- There is good rapport that at times is almost instant
- I "feel" things from others over the phone that I seem to miss in person

Feuerman wondered what kinds of feeling were transmitted over telephone lines, especially if participants were not reacting to feelings generated by seeing the other participants. He discovered that seeing and perception are both biological processes, and some biological processes are redundant in that they overlap--they're similar to one another but with some differences.

When talking about missing facial cues over the phone, he concluded that that might be a good thing, at least in terms of supervision. "The mental dynamics evident in the speech pattern and verbal interactions with others are so manifest that when we concentrate on them only—we are able to “see” the person better."

Of course, if the telephone supervision is via Skype, you at least see the other person's face. However, if you agree with Fueuerman's (n.d.) conclusions, you may prefer to avoid Skype.

Internet Supervision

Modes of Internet supervision can each be best described under one or more of the other modalities listed. Skype was included under telephone supervision; video-conferencing can also be included there. Chats, e-mail, online forums, and texting fit well in the category of *Supervision via Written Reports*.

That leaves the least-known modality of avatars, which could fit in telephone supervision or supervision by written reports, but--because of its uniqueness--will be discussed here. The method uses free software, such as *Second Life*, which is called a "Massive Multiplayer Online Environment (MMOE) software.

The supervisor must set up a virtual setting for the supervision sessions. It's a fun, interesting way to approach this 2-way process, but it requires a great deal of initial preparation. So far it's used far more often for psychotherapy than for supervision. Because of the learning curve and setup time, that is likely to remain the situation.

Delayed Review Supervision

Delayed review supervision is considered one kind of direct observation or live supervision. This is because a therapy session is videotaped, or at least audiotaped. Obviously, the videotaped session is more complete as direct observation because you can see nuances that may not be indicated in an audiotaped session. It has been commonly used in both social work and in marriage and family therapy (Nichols, Nichols, & Hardy, 1990; Munson, 1993).

Video cameras are more and more common in professional settings, and are not expensive. This makes videotape supervision (VTS) simple and easily accessible. It's a complex, dynamic, and powerful tool--one that can at once be anxiety-provoking, challenging, humbling, and threatening (Center for Substance Abuse Treatment, 2009a).

Of course, the client must sign an informed consent form for either audio- or videotaping of a session. Some clients may sign only consent for audiotaping because it seems less threatening. Videotaping is not allowed in most prison settings or during Employee Assistance Program services. It also might not be recommended when working with patients with diagnoses such as some schizophrenic illnesses or paranoia. In all of these cases, either simple live observation or audiotaping may be better choices (Center for Substance Abuse Treatment, 2009a).

Audiotaping and videotaping are the most reliable forms for examining counselor-client session (Borders and Leddick, 1987). Supervision can immediately follow a counseling session or it may occur a few days later and the data will remain the same with no need for mental retention. It's recommended that both supervisor and supervisee review the tape before the counseling session. This allows the supervisor to plan an intervention strategy and the supervisee to prepare discussion topics and questions (Hart, 1994).

Case Presentation Supervision

There are times when the supervisee needs to make a case presentation of a client. You might want a succinct or more detailed summary of a client's case to date. You might be holding group supervision sessions where during each session you may have one or several supervisees

present a case for the group to review and discuss. A presentation may be made in a written report, to a referring colleague on the phone, in a peer-group review, in individual or group supervision, when preparing treatment plans, or in some other setting.

Whatever the reason for needing a case presentation, a supervisee needs to develop the skill of making and presenting them. If nothing else, making an effective, clear, and to-the-point case presentation leaves others with an impression of the supervisee's professional competence. No matter the reason or the setting, the art of making a case presentation is an ever-present challenge (Blatner, 2006).

The length and completeness of the presentation depends on the context in which it will be given. If it's in a setting where each case can only be given a few minutes' attention, then it should be reduced to only a minute or two--enough to orient others to the identity and key features of the client being characterized and the most relevant current issues.

In a setting where a more complete review of the origin, development and effects of the pathology or treatment course is required, a more comprehensive presentation is suitable. Clinicians should train themselves to present any given case at three levels (Blatner, 2006):

- Encapsulated form (less than two minutes)
- Brief form (approximately five minutes)
- Long form (about 20 minutes)

Before the presentation, supervisees should become clear about the purpose of the presentation

- To tell the supervisor who and what they're dealing with?
- To get answers to specific questions from the supervisor?
- To get help in making a diagnosis?
- To get help with therapeutic approaches for the diagnosis?
- To receive feedback about techniques or tactics that have been tried?

They need to determine what information they want to give to the audience. In most cases the audience only needs enough information to gain an internal picture of the presented situation. If all kinds of explanations and impressions are thrown out and the audience expected to put it all together, they will only be overwhelmed. What is presented should not contain a lot of information that is not essential or relevant to the presentation purpose (Blatner, 2006). The supervisees must put themselves in the audience's place and identify the basic facts needed to simply become oriented to the problem.

Because of a supervisee's nervousness about making a case presentation, there are some steps that can be followed to reduce anxiety and make it easier to include the best information (Munson, 2002).

1. The supervisor should present a case first.
2. The supervisee should be given sufficient time to prepare for the case presentation.
3. The presentation should be based on written or audiovisual material.
4. The presentation should be built around questions to be answered.
5. The presentation should be organized and focused.
6. The presentation should progress from client dynamics to practitioner dynamics.

There are a variety of templates available online for case presentations. Here are two very basic ones. The first is for a general social work case presentation in which the social worker is involved primarily in emergency interventions, discharge planning, and case management:

- Identifying data
- Presenting problem
- History of the presenting problem
- Significant medical/psychiatric history
- Significant personal and/or social history
- Impressions and summary
- Recommendations

This next one is for a person working in a therapy setting, and is more clinically focused:

- Identifying data
- Past and present psychiatric history
- Family history
- Presenting problem
- Treatment goals and objectives
- Course of treatment and intervention strategy
- Defenses, transference and counter-transference
- Impressions and summary

Supervision via Verbal Reports

Among different definitions to identify a variety of supervision forms, the definition for a trainee verbal report is "didactic discussion of a case presented in supervision by the supervisee" (DeRoma, Hickey, and Stanek, 2007), or "what the supervisee remembers and sees as relevant" (Hess, Hess, and Hess, 2008). Use of direct observation supervision is reported to be therapist oriented, whereas the verbal report process focuses more on generic, case-oriented issues (Hare and Frankena, 1970).

DeRoma, Hickey, and Stanek (2007) believe that supervision that does not include live material may focus less on strengths and more on weaknesses, because the supervisee is more likely to bring out obstacles and struggles in giving case progress. As supervisor, if you're aware of this, you can guide the supervisee's verbal report to include more than problems.

Green (2004) indicates that understanding of "therapeutic relationship skills are best acquired through close observation of the therapist's behavior in role plays and in sessions (i.e., via live, videotape, or audiotape-based case supervision). Such skills are not as easily learned—or maybe impossible to learn—through 'delayed verbal report' supervision because the latter's effectiveness is constrained by what the therapist was aware of during the session, remembers after the fact, and can report in words to the supervisor. Verbal report supervision always loses emotionally relevant information because a lot of what transpires between therapist and clients is automatic and not necessarily within the therapist's awareness, especially when the therapeutic alliance is

not functioning well. Paradoxically, the very areas where supervisees may need the most help are areas about which they're unaware and cannot articulate the relevant emotional information to their supervisors."

Green further states that the supervisor's ability to correctly picture and give feedback about the relationship of the supervisee and the client is limited if it's based on delayed verbal reports.

However, in a report of methods of direct supervision that supervisees endorsed (where they could choose more than one method), the first preference was "Any Type of Direct Supervision" at 85%, and "Traditional: Trainee Verbal Report" was close behind at 82.8% (DeRoma, Hickey, and Stanek, 2007).

Supervision via Written Reports

Giving information to a supervisor via writing is basically the same as giving it verbally. The differences are that the supervisee can write the information down immediately following a therapy session, whether or not the supervisor is available, and that there are a variety of written formats that can be used.

The report written after the session generally becomes a part of the client's record. It can also be the basis of a conversation with the supervisor or appropriate co-workers via:

- Chats
- E-mail
- Online forums
- Texting

If any of these Internet means of communication are used, the issues of privacy and security must be taken into consideration, as has been discussed earlier.

General Approaches

The two basic approaches to clinical supervision are individual and group. It's often encouraged that the supervisor combine both of these approaches, so as to include the "best of both worlds." Yogev (1982) believes this will allow three goals to be met for the supervisee:

1. Facilitation of personal growth and awareness
2. Acquisition of practical skills
3. Mastery of cognitive and theoretical knowledge

In both approaches, supervisee's needs are met in three stages:

- Role definition
- Skill Acquisition
- Practice solidification and evaluation

Individual Supervision

Although there are a number of benefits for individual supervision, they can perhaps all be boiled down to the statement that at each supervisory meeting, attention can be concentrated on one supervisee who can focus all his time to her own reflection (Kobolt, 1999).

Lee and Everett (2004) state that issues that benefit from individual supervision are:

- Privacy
- Time available for the needs of the individual therapist
- Intensity in the supervisory relationship

The relative privacy of individual supervision may allow the supervisee to reflect more profoundly and openly on interpersonal dynamics, evaluative issues, and "self-of-the-therapist." The

supervisor may be able to offer a wider range of potential interventions, as well as to nurture and/or challenge certain trainees better than in group setting.

The hallmark of individual supervision is individual attention, where the supervisor can focus on the unique training needs of each supervisee, including both process and content of the supervisory sessions. Beginning therapists often indicate confusion because of the many theoretical perspectives and interventions they experience in a group. The individual sessions allow the supervisor to more thoroughly and carefully address the learning style and developmental needs of each supervisee.

However, even those that most vocally support individual therapy, point out that there are some concerns regarding it. The presence of several supervisees offers some rich relational experiences that cannot be found in individual therapy (Lee and Everett, 2004).

Some supervisees may not be comfortable with the more intense supervisory relationship that can appear in the individual supervision settings. Supervisors sometimes feel freer to be more critical in individual supervision, and the supervisee may feel more intimidated. Supervisors have also sometimes stated that they are somewhat bored in individual settings, especially with particular types of supervisees. Supervisor who want to take more directive and active roles often prefer the interactive process of a group setting.

Additionally, a subtle, defensive collusion between supervisor and supervisee can develop. For example, an especially dependent or vulnerable supervisee may elicit a parental, protective response from the supervisor (counter-transference). This can erode objectivity of both parties to the extent that the protective collusion hides learning issues or clinical errors.

Boundaries between therapeutic and supervisory relationships may also be blurred (Anderson, Schlossberg, and Rigazio-DiGilio, 2000). Because there is no one to witness this process, supervisors need to be especially sensitive to their power relative to supervisees in regards to subjects related to sociocultural identification, gender, privacy and evaluation (Haber, 1996).

Individual supervision works best when both parties are conscious of the limitations. These should be specifically addressed in conversations at the beginning of a supervisory relationship, as well

as in formal training contracts that address needs and expectations of both parties. However, they will also need to be addressed periodically throughout the working alliance (Lowe, 2000).

Group Supervision

The tasks of clinical group supervision are similar to those of individual supervision. Some of the advantages of doing group supervision include (Malone, 2009):

- Greater economy of effort, expertise, money, and time
- Wider range of client situations can be looked at
- Increased vicarious learning from peers
- More varied perspectives from more supervisees
- Source of emotional support for supervisees when supervisor is unavailable
- Increased amount of encouragement
- Sense of belonging given
- Group members can fill voids that are unaddressed in individual supervision
- Opportunities for role play to practice interventions.

The benefits of individual supervision are the disadvantages of group supervision. In addition to those mentioned in the individual supervision section, the supervisor may be less experience in group work, with the result that the clinical supervision experience is less effective. The variety of interests, skill levels, and relevance of cases can reduce the usefulness of group supervision. A group may have dysfunctional dynamics (competition, scapegoating, power grabbing) that can eliminate the effectiveness of the group. Confidentiality problems are also more frequent in the format of group supervision (Malone, 2009).

It's recommended that a supervision group have no more than six members. This will give each member more opportunity to present their cases--one at least every other month, which is very good when combined with individual and/or peer supervision.

Several cost effective principles of a useful structure for supervision include (Center for Substance Abuse Treatment, 2009a):

- All counselors receive at least one hour of supervision for every 20-40 hours of clinical practice
- Group supervision is a practical and reasonable means of involving a number of staff in sharing ideas, dialog, and promoting team cohesion

Models of Group Supervision

A definition of group supervision is:

A setting in which a supervisor shepherds a supervisee's professional growth in a group of peers. The supervisor guides the group in a review of pertinent knowledge and feelings that are part of the group supervision process. An overview of models of skill acquisition is given, and the singular attributes of acquiring skills in a group environment are discussed. Suggestions are made for applying cognitive skills to group supervision and clinical situations (Hillerbrand, 1989).

Billow and Mendelsohn (1987) identified three types of supervision groups:

1. Case-centered
2. Process-centered
3. Dual focus

They also pointed out that the most successful groups were those that could shift focus as needed. Todd and Pine (1968) pointed out that a successful supervision groups involve efficient management in norm-setting, gate-keeping, and protection of the group contract; Counselman (1991) added the protection of the group's purpose and objectives.

A different focus on types of group supervision models looks at groups led by a supervisor and groups led by peers. Further discussions of these are in the next few sections of the course.

Group Process

Group process usually refers to what happens in a group in terms of growth and evolution of the relationship patterns among and between participants in the group. The same basic process occurs in a supervision group as in a therapy group. The supervisor should guide and facilitate useful growth without stifling that which can occur naturally.

These processes may not always be observable, but may also be inferred. Those processes which can be observed--overt processes--include verbal behaviors (e.g., content of speech; expressed affects), and nonverbal behaviors. Covert group processes are those referring to needs, wishes, motivations, and intentions (conscious or unconscious) that are acted out in the group. They may be acted out by individuals, pairs of individuals, subgroups, or by the group as a whole. These processes can serve for the good when they're work-oriented towards promoting supervisory ends, or they can serve to block the purposes of the group if they're defensive, resistive, and work-avoidant (Hartman & Gibbard, 1974).

The supervisory group is a social system with the supervisor as its manager. The supervisor's first function is to safeguard and monitor the work-ordered boundaries of the group so that the supervisees feel it to be a safe place to share and interact for the purposes of growth as therapists and social workers.

A bond or cohesion generally occurs in a supervisory group in which members feel a commitment to one another and to the group's supervisory tasks. It's often seen as being equivalent to the supervisory alliance in individual supervision or therapeutic alliance in individual psychotherapy. This is the group process most basic to positive supervisory outcomes.

As in therapy groups, a certain amount of transference and counter-transference is likely to occur between the supervisor and the group's members, and between members themselves. The necessary management of these reactions is self-care and self-awareness for each participant.

Supervisor as Group Leader

Viney and Truneckova (2008) label a supervisory group with the supervisor as the leader a "process of courage." In this model, the supervisor understands the processes of therapy, explains the makeup of therapists (Viney and Epting, 1997), and enters into a role relationship with the supervisees. In supervisor led supervision, groups depend on input from each member of the group. The supervisor actively promotes relationship building between members of the group, and shows an ability to comprehend the way each member views what is going on in the group processes (Viney and Epting, 1997).

The reason that Viney and Truneckova (2008) refer to this kind of group as a "process of courage" is because creative changes in supervision require "both the courage to confront experience at the most deeply personal levels and the integrity to bring those core constructions into form that can be explicitly considered, and thus shared, confirmed, disconfirmed, and ultimately revised" (Harter, 2007).

Viney and Truneckova (2008) also state that the supervisor must have the courage to develop an ability to influence the supervisory group processed and to take professional risks. The supervisor's courage also allows him to point out what could be keeping the supervisees from creating an open relationship with their clients. The process of courage also includes a willingness of both the supervisor and the supervisees to express with one another perceptions and observations they believe have clinical significance in these relationships.

In supervisor led groups, the supervisor tries to assist and encourages supervisees to develop a sense of their own abilities as therapists to positively influence the good things that happen in a therapy session (Viney and Epting, 1997). A strategy the supervisor may use in this process is to give supervisees the control over what is to initially be presented in the supervisory group session.

Even though a supervisor-led group has a good possibility that "saying what cannot be said" (Viney and Epting, 1997) will occur because of the number of people influencing the group

dynamics, the supervisor must also be aware of the danger that group members may hesitate to take risks, for whatever reasons.

The supervisor can encourage risk taking by supporting members that raise risky issues and by role playing taking risks. Because group supervision sessions are not primarily one-on-one relationships, but rather those of role-taking, each supervisee can demonstrate great courage and risk-taking by sharing professional thoughts, giving opinions, and accepting feedback. All of this happens when the supervisor is able to say, "I was able to help Lee Supervisee to express his/her deepest fears" (Viney and Truneckova, 2008).

Peer Supervision

In peer supervision groups, there is not a person, such as a supervisor, to model the professional role. As such, a peer supervision group should be an adjunct to, not a replacement for a supervisor-led group for trainees.

A more appropriate term than peer supervision might be peer consultation. Supportive and critical feedback is stressed and evaluation is given little emphasis. In contrast to supervision, consultation is typified by the group members' "right to accept or reject the suggestions [of others]" (Bernard and Goodyear, 1992). However, both "peer consultation" and "peer supervision" describe non-hierarchical relationships in which those who participate have neither the purpose nor the power to evaluate one another's performance (Benshoff, 2001).

Because of this, feelings associated with issues covered in the group session are less intense. A greater emphasis is placed on the commonality of what is shared in the group. Role relationships are usually developed more slowly than in supervisor-led groups, but can be just a productive once established (Viney and Truneckova, 2008).

Characteristics of group members that are functioning well (Leitner and Pfenninger, 1990) and may be collectively labeled "empathy," include:

- Committed

- Courageous
- Creative
- Discriminatory
- Flexible
- Forgiving
- Open
- Respectful
- Responsible

Facilitation of development of these characteristics is fostered when the supervisee/therapist experiences them as being applied to himself in supervision. When they're experienced in peer supervisory relationships, the supervisee can more easily use them in a therapy session.

In a therapy session, "if the client demonstrates that he's not seeing the problem as the therapist does, some reconstruing is required on the part of the therapist" (Fransella, 1993). The same is true of members--"joint supervisors," if you prefer--in peer supervision groups; "defense" and "resistance" are also experienced in the groups. The group should try to resolve these problems by recognizing them, investigating them, and working through them.

Still, there are unique problems for resolving resistance in peer supervision groups. At the beginning of the group, there is considerable dependency on members' readiness to be curious, but the boldness to follow through may be lacking. There may also be problems when offering personal information. Much of the group's development seems to be focused on managing resistance (Nobler, 1980).

Because there is always more than one way of looking at any event, members of a peer supervision group must act like scientists by testing hypotheses and assisting experimentation by group members and their clients. In these groups, the question is not, "Did I do this right?" but rather, "What did we learn when we said or did that?" or "Do we now have information that will allow us to make new hypotheses?" (Allstetter-Neufeldt, 1997).

The sum of the strengths--which can also be the weaknesses--of peer supervision groups is that the relationships are more equal, and the range of perspectives and hypotheses given is wide.

Support is given without the need to "fix things." This can be both powerful and strengthening in the understanding that all members are having much the same experiences (Viney and Truneckove, 2008).

SUPERVISION ISSUES/MATERIAL TO COVER

As a supervisor, with your supervisees you'll cover clinical issues that have been discussed throughout this course. There are times when you also need to aid them in non-clinical areas (Malone, 2009), such as:

- Preparation for licensing
- Managing the bureaucracy of the organization
- Working with burnout
- Avoiding risk factors for misconduct with client
- Project priorities
- Working with other professionals
- Managing conflicts with other employees
- Time management

Basic information about each of these will complete this course.

PREPARATION FOR LICENSING

Preparation for licensing will vary some from state to state. The information that follows is pertinent specifically to California, but other states' information will not be very different. The general path is:

1. Get your master's degree (Social Work, Marriage and Family Therapy, Counseling) from an accredited college or university
2. Register with the Board of Behavioral Sciences
3. Gain your supervised post-masters work experience

4. Complete any required additional coursework
5. Apply for Examination Eligibility
6. Pass the Standard Written Examination
7. Pass the Written Clinical Vignette Examination
8. Get your official license

Your supervisees will likely have a multitude of specific questions for you, questions such as:

1. When can my hours begin counting towards licensing requirements?
2. What is the maximum number of hours of supervision I can gain in a week?
3. What is the ratio of supervision hours to client contact hours that I need?
4. Are there other pre-licensure coursework requirements I must meet before applying for the licensure test?
5. Is a background check (and/or fingerprints) required for a license?
6. What about experience I gained in another state?
7. What is the requirement for post-master's experience?
8. What disciplines can provide my supervision toward licensure?
9. Do I need to be employed or can I count volunteer hours supervised towards licensure?
10. Can I obtain my supervision hours in a setting other than a private practice or government clinical setting?
11. How much money will this application process cost?

You can direct your supervisees to a site where they can find the answers to these and other questions for your specific state and for their specific license:

All Psychology Careers.com (http://www.allpsychologycareers.com/).

At this site they can find licensure information for every state in the fields of psychology, counseling, social work, and marriage and family therapy.

MANAGING THE BUREAUCRACY OF THE ORGANIZATION

Most folks who have ever held a job have likely at some time or other groaned about problems because of bureaucracy--perhaps without fully knowing what a bureaucracy is. *Dictionary.com* gives four definitions for it:

1. Government by many bureaus, administrators, and petty officials.
2. The body of officials and administrators, especially of a government or government department.
3. Excessive multiplication of, and concentration of power in, administrative bureaus or administrators.
4. Administration characterized by excessive red tape and routine.

Health care organizations, including mental health, have customarily used bureaucratic management because of the precision and consistency it can create. The original theory of management came into being to overcome management that had become "inefficiently managed, with decisions based on personal relationships and loyalty" (Barnett, 2006).

In the 1920s, Max Weber characterized his ideal bureaucracy as (Max Weber, n.d.):

- Hierarchical organization
- Lines of authority in fixed activities of labor
- Authority based on position, not tradition or charisma
- Formalized, written rules
- Impersonality
- Career advancement based on ability judged by organizations, not individuals

However, with time bureaucracies became over-organized, over-defined and over-run with confusion and red tape. Bureaucratization has become "a state in which employees work increasingly by fixed routine rather than through the exercise of intelligent judgment. With bureaucracy, narrowness in thinking emerges. There is a proliferation of hard-and-fast rules and fixed procedures—wrongly thought to contribute to efficiency and quality control. With

bureaucracy in place, the original goal of an organization fades into the background. Individuals within the organization begin building small bastions of power and devising ways of warding off any potential threats to their power. Change is usually interpreted as a threat" (Paul, and Elder, 2002a).

Unfortunately, this is all too true of many mental health agencies, as well as government agencies. What do you do to guide your supervisees to cope in the maze of your agency's bureaucracy?

The first thing you must do is recognize exactly what bureaucratic pitfalls are in your organization (Paul, and Elder, 2002b). You might ask yourself:

- To what extent is there a struggle for power underway in the organization?
- To what extent must we deal with "power hungry" individuals?
- What is the hierarchy of power in the organization? To what extent are those at the top easily threatened by thinking that diverges from their own?
- How does the organization present itself both within and without? Are there any important contradictions or inconsistencies between the two? To what extent do inconsistencies exist between how the organization represents itself and how it actually functions?
- To what extent is short-range thinking dominant in the organization?
- To what extent is there a problem of bureaucratic inefficiency within the organization?
- To what extent is there a problematic "ideology" that stands in the way of change?
- To what extent is the organization forced to compete meaningfully with other organizations?
- To what extent is the organization suffering from stagnation?
- To what extent is bad short-term thinking misleading the leadership of the organization?
- To what extent are ethical considerations ignored or denied in favor of vested interest within the organization?

The bigger question, once you've answered those above, is, "How does that affect my--and my supervisees'--ability to do our jobs?" Then you can determine how you can cope with them. Most times you'll find that the best way to cope is to ignore the bureaucracy and concentrate on the

clients, doing required paperwork, and attending to other specific requirements of the job. A hefty dose of humor is also a great help:

- Rules of Bureaucracy (Office Humor Blog, 2005):

1. Preserve thyself.
2. It's easier to fix the blame than to fix the problem.
3. A penny saved is an oversight.
4. Information deteriorates upward. The first 90% of the task takes 90% of the time; the last 10% takes the other 90%.
5. Experience is what you get just after you need it.
6. For any given large, complex, hard-to-understand, expensive problem, there exists at least one short, simple, easy, cheap wrong answer.
7. Anything that can be changed will be, until time runs out.
8. To err is human; to shrug is civil service.
9. There’s never enough time to do it right, but there’s always enough time to do it over.

WORKING WITH BURNOUT

Burnout is largely due to the many stresses in one's job. Some of the more frequent causes of stress related to a person's job are (Brusman, n.d.):

- Conflicting job demands
- Excessive bureaucracy, too much paperwork from higher-ups
- High interpersonal conflict
- Lack of sufficient acknowledgment, support, and reward
- No clear endpoint to one's efforts
- Value clashes between the individual and the organization
- Work overload
- Work with high emotional intensity

Dr. Brusman (n.d.) also offers some of the frequent signals of possible burnout that you might observe n your supervisee (or yourself!):

- Interpersonal Problems--Examples include overreacting to conflicts, isolating one's self from others.
- Emotional Fatigue--Normal feelings of frustration, anger, and dissatisfaction become predominant
- Low Productivity--Caused by unusual depression, disillusionment, cynicism, hopelessness, loss of enthusiasm and ability to concentrate.
- Health Problems--Feeling run down and tired; common symptoms include:

    - Back pain
    - Chest pains or palpitations
    - Colds
    - Gastrointestinal problems
    - Headaches
    - Insomnia, fitful sleep, or nightmares
    - Nervous tics
    - Rashes or hives

- Addictive Resolutions--Resorting to substance abuse, or addiction to TV, the computer, food (or loss of appetite)
- Obsessive Thinking--The job is on one's mind all of the time--generally focusing on problems instead of solutions, and he's unable to put it into a larger, more meaningful context.

Burnout does not happen "out of the blue." Rather it's a gradual wearing down, beginning with normal feelings that every working person experience from time to time of being a little tired of your job that grows to total exhaustion.

To prevent burnout, job stress must be dealt with; the provider needs to discover what is contributing to job stress and how to best take care of herself. Brusman (n.d.) makes the following suggestions:

1. Examine Your Denial about Your Job Stress.
2. Avoid Isolation.
3. Reduce Intensity/Pressures in Your Life.
4. Learn to Pace Yourself.
5. Minimize Worrying.
6. Take Care of Your Physical Needs (Diet, Exercise, Sleep).
7. Nurture Yourself as Much as You Do Others (Learn to Say No and to Delegate).
8. Take a Close Look at What Your Work Means to You.

However, if job burnout occurs, Bellafiore (n.d.) encourages us to think of it as a gift--one that lets us know that something in our lives has gotten out of order. We are motivated to look deeper within to resolve the burnout--and you're motive to help your supervisee do this. With no burnout crisis, what would prompt us to at last search for answers to some crucial life-questions? Questions such as:

- What am I trying to accomplish with my work life?
- What are my key interests and does my work fit with them?
- What are my key skills and does my work use them?
- What are my core values about life balance, about family, about money, about the treatment of people? Is my work in synch with these?
- Am I overworking? If so, why?
- Where is the balance in my life between work and play?
- How would I live my life if I no longer had to work?
- What does work accomplish for me and what is it preventing me from accomplishing?
- Can I shift the focus of my current work or should I look into another type of work?

Since you don't want to cross the supervisor boundary into counselor for your supervisee, you may need to see that she gets counseling to answer these questions. This focused examination of work-life issues can lead her to sort out the work-life stresses and return to blooming in the job and the rest of life.

AVOIDING RISK FACTORS FOR MISCONDUCT WITH CLIENTS

It's not uncommon for therapists to feel sexual attraction to clients at least once in their career. In fact, Pope, Keith-Spiegel, and Tabachnick (1986) related that 87% of psychologists (95% men and 76% women) reported that attraction. However, only 9% considered that they could talk to their supervisor about it. This suggests you need to be on the alert for a supervisee needing to talk about this sexual attraction.

A supervisor is obligated to investigate any and all indications of harm to clients, to say nothing of your own liability. Even if there is only an attraction, the possible counter-transference can compromise successful therapeutic treatment. You must warn supervisees against acting out such intense sexual feelings, and encourage him to discuss them by offering him a safe, open, and sensitive atmosphere for that. You should also document the discussion (Cole, 2001).

For starters, in California if you're the primary supervisor, you're required to review with all of your supervisees a pamphlet entitled *Professional Therapy Never Includes Sex*. You may find this booklet online and it can be used by supervisors and therapists in any state. This booklet is specially to give clients information about pertinent laws, warning signs that a therapist may be heading towards sexual exploitation, what they should do if something happens and who they should talk to, and what their reporting options are. If you see a supervisee giving signs of sexual attraction, a second (or third, etc.) review of this booklet might be good.

To aid your alertness in this direction, you might learn about the risk factors for therapist-client sexual misconduct as outlined by Hamilton and Spruill, J. (1999):

- Trainee Characteristics
    - Loneliness: The trainee may be somewhat isolated, have few friends, i.e., problems with personal relationships.

    - Prior "counseling" experience: Prior experience as a volunteer counselor, where volunteers often befriend clientele, may have caused a belief that a close personal relationship is therapeutic.
    - Professional inexperience: Because quality of therapy is hard to evaluate, supervisees might overvalue certain inadequate indicators of therapeutic progress such as friendliness on the part of the client, or the trainee may be fearful of alienating the client.
- Training Factors
    - Ethics training: Trainees will have all pretty much been given the information that therapist-client sexual involvement is unethical, but they may not have been taught to recognize the unethical intermediate steps to that involvement.
    - Failure to recognize ethical conflicts: Trainees have been given hypothetical, laboratory ethical situations to analyze; they may not carry that over real-life situations.
    - Doing what needs to be done: Trainees likely don't have an armamentarium of behaviors for responding to sexual overtures from clients.

Once you engage a supervisee in a conversation about their sexual attraction to a client, there are two main topics that you need to discuss with them (not give a "classroom lecture" about):

Such attraction is normal
Drawing the line between feelings and actions

PROJECT PRIORITIES

How do you determine which projects, daily tasks and activities, or steps towards your goals to do first? Your supervisees may need some guidance in this area. There have been many excellent books and articles on determining priorities; several potential methods are presented here.

Student services at the University of Minnesota give students a list of ten items to help define priorities (One Stop Student Services, n.d.). Although they're referring primarily to money management, the list is appropriate for determining any sort of priorities:

1. Narrow your objectives.
2. Focus first on the goals that matter.
3. Be prepared for conflicts.
4. Put time on your side.
5. Choose carefully.
6. Include family members.
7. Start now.
8. Sweat the big stuff.
9. Don't sweat the small stuff.
10. Be prepared for change.

One of the most common approaches is to list everything that you need to accomplish. You may have several lists, such as what needs to be done today, or what steps must be taken to reach a particular goal. Items on each list are given a number for the order in which things must be done. Number one is the first priority of the day, and so on for however many items are on the list.

Another approach (How to Set Priorities, n.d.) is to have three priorities, and list the items that fit into each priority:

1. High Priority--Must Do: Goals or activities that you must achieve in order to consider yourself "successful."
2. Medium Priority--Should Do: Goals or activities that should be achieved (but are not essential) in order to consider yourself "successful."
3. Low Priority--Nice to Do: Goals or activities you'd like to do, but that need not be done until things listed in the other two priority lists have been completed; if you don't do them, it's not a big deal.

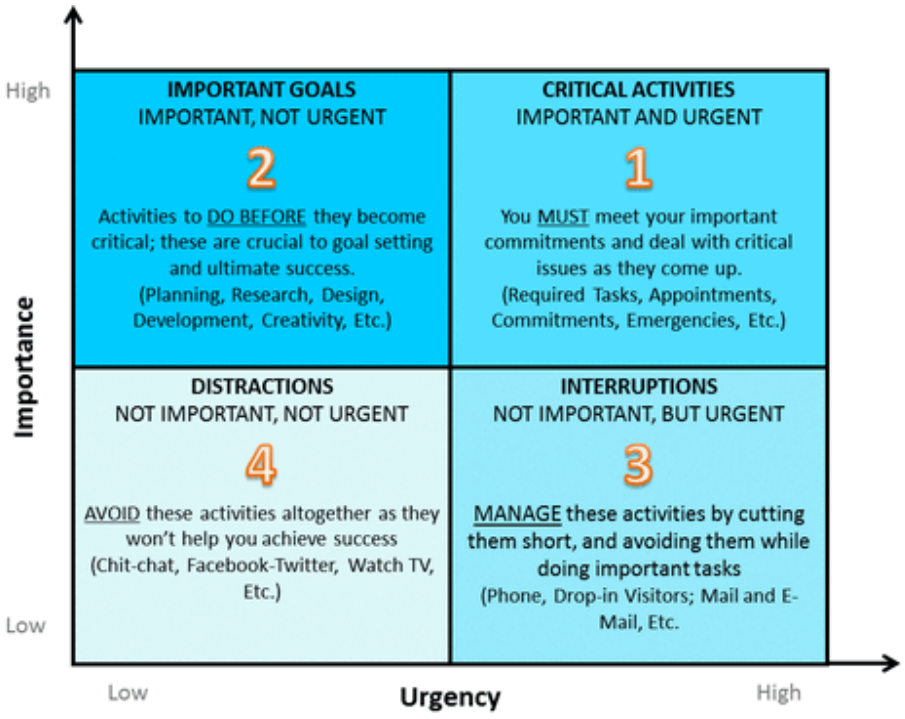
The "Urgent/Important" matrix is way of prioritizing actions that is quite different from the ways folks usually follow. President Dwight Eisenhower is said to have used this to organize his tasks, and it's sometimes called the "Eisenhower Matrix." Steven Covey popularized the method in *The 7 Habits of Highly Effective People* (Habit 4: Think Win-Win).

In this context, the difference between "Important" and "Urgent" is focal:

- IMPORTANT = Activities whose outcomes lead to achieving our goals.
- URGENT = Activities requiring immediate attention (meeting with a client at 10:00 a.m.), often connected to helping someone else meet their goals.

With these distinctions in mind, use these steps to prioritize your activities (Urgent/Important Matrix, n.d.):

1. List all activities and projects you feel you need to do, no matter how important or unimportant. Record everything that takes up your time at work.
2. On a scale of 1-5, designate the IMPORTANCE of each activity.
3. Evaluate whether each activity is URGENT or NOT-URGENT. (When you've completed this step, each activity or project will have both a number to indicate *IMPORTANCE* and an *URGENCY* designation.)
4. Schedule your priorities using the concepts on matrix that follows. The numbers in red on the matrix are the order in which your activities should be done.



TIME MANAGEMENT

Time management is closely tied to establishing priorities. Both are needed for a person to be as productive as possible. If a person has problems managing his time, he will spend the day in a frenzy of activity without accomplishing much of anything. In addition to getting more done in a day, according to Mayo Clinic Staff (2008), this will also give you some important health benefits, minimize stress, and improve your quality of life. Ward (n.d.1) offers some tips for managing one's time.

1. Realize That Time Management Is a Myth

You can be perfectly organized, and still not add one hour to the day. At best you can manage yourself and what you do with the time you have.

2. Find Out Where You're Wasting Time

What activities do you do regularly that are time thieves? Reading e-mail? Checking out Facebook? Surfing the Internet? Gossiping with your friends? For a week, keep a daily log of how much time you spend on activities. You don't need to go into detail; for instance, you might write "Did research on ADHD for client."

3. Make Time Management Goals

Since you can't change time, you must change your behavior. To begin, set one goal to not take personal phone calls when you're working. Ward (n.d.2) suggests the following wording for setting your goals (to aid your specificity of goals writing):

"(**Time**) from now, I will (**goal + performance measure**) BY (**specific actions**)."

An example might be, "**Two months** from now, I will **work three hours less per week** BY **becoming better organized**."

1. Implement a Time Management Plan

This is an extension of tip #3. You'll actually do what you said you would in your stated goal(s). Be sure to track them to verify that you're accomplishing them.

2. Use Time Management Tools

You'll need some way to help you plan and remember how you're going to spend your time in the future. It may be a Day-Timer, or the calendar that comes with your e-mail program. The software program not only allows you to easily schedule events, but it can be set to remind you of the events at specific times.

3. Ruthlessly Prioritize

Either end a day with prioritizing the tasks for the next day, or begin the day with planning its events. Set your performance benchmark. If you list 25 tasks for the day, how many of them must you truly accomplish (see the section above on prioritizing tasks).

4. Learn to Delegate and/or Outsource

There is seldom a need for a person to be a one-person team. As supervisor, you'll likely delegate some jobs to the supervisee. Does the buck always stop there, or can you show her times when she can also delegate or outsource?

5. Establish Routines and Stick to Them As Much As Possible

Although you can't avoid crises, if you can follow routines most of the time you'll be much more productive.

6. Get in the Habit of Setting Time Limits for Tasks

A good example of how this works is with your e-mail. You could spend half or all of the day reading and answering e-mail. Instead, set a limit of one hour a day for this, and then stick to it.

7. Be Sure Your Systems Are Organized

If you're wasting a lot of time trying to find files on your computer, take the necessary time to organize your files. You might manage them with a purchased document management system, or you can make your own system of files and sub-files in Microsoft Office programs (just don't go too many layers deep or you'll likely defeat your purpose).

8. Don't Waste Time Waiting

There is no way to avoid waiting for someone (client meetings, doctor's appointments, etc.) or something (telephone call, certain e-mail, etc.). You can choose to sit and twiddle your thumbs or read the year old magazines in the waiting room. Or you can take something with you that needs doing: a report to be read, a checkbook to be balanced, or simply a pad of paper to plan something for the job. You might take your laptop and do whatever work you need to do on that while you wait.

Mayo Clinic Staff (2008) includes a few additional tips in their list:

- **Say no to nonessential tasks.** Consider your goals and schedule before agreeing to take on additional work.
- **Take the time you need to do a quality job.** Doing work right the first time may take more time upfront, but errors from haste usually result in time spent making corrections, which takes more time overall.
- **Practice the 10-minute rule.** Work on a dreaded task for 10 minutes each day. Once you get started, you may find you can finish it.
- **Limit distractions.** Block out time on your calendar for big projects. During that time, close your door and turn off your phone, pager and e-mail
- **Get plenty of sleep, have a healthy diet and exercise regularly.** A healthy lifestyle can improve your focus and concentration, which will help improve your efficiency so that you can complete your work in less time.
- **Take a break when needed.** Too much stress can derail your attempts at getting organized. When you need a break, take one. Take a walk. Do some quick stretches at your workstation. Take a day of vacation to rest and re-energize.

WORKING WITH OTHER PROFESSIONALS

You've heard the famous quote from the English poet John Donne, "No man is an island." You've experienced, and your supervisees will experience the truth of that profoundly in the helping field you've all chosen, especially if you work with families and children.

For example, if you work with children that are in the state's Child Protective Services, sooner or later you'll need to work with people from the following professions or vocations:

- Attorneys
- Foster parents
- Judges
- Physicians
- Police
- Psychologists, counselors, and other mental health therapists
- Social workers
- Teachers
- Volunteers (e.g. Court Appointed Special Advocates)
- Support services

Even though you may never all meet together, you'll need to be a team, working together to the good of the child/client. There are 12 "C-Tips" (Heathfield, n.d.) to keep in mind as you play your role in the team. You and your supervisee will need to apply them to yourselves; you'll seldom be in a position to do more than that:

1. Clear Expectations--Although these are generally understood, every team member needs to know:
   - Why the team is in existence
   - What your role is in the team
   - What resources you and others on the team have to accomplish the goals
   - Priorities of the team as a whole, and each member individually
2. Context--Strategies that will be used by each member to care for the client
3. Commitment--Each team member must be committed

4. Competence--Each team member needs to be competent in their job for the team as a whole to succeed
5. Charter--The vision, mission, and strategies for caring for the client. This involves:
    - Goals are defined and communicated
    - Anticipated outcomes (e.g., reuniting children and parents, foster care, adoption)
    - Timelines
    - Processes to meet the task
    - Outcome measurement
6. Control--Does each team member:
    - Have freedom and empowerment to do their job?
    - Understand their boundaries?
    - Understand and experience the team's reporting relationship and accountability?
    - Have the freedom to make suggestions to any or all other team members?
    - Have accountability for meeting goals and timelines?
7. Collaboration--Do you:
    - Understand team and group process?
    - Cooperate and work effectively with other team members?
    - Understand your role and responsibilities and how they fit in with those of other team members?
8. Communication--Team members need to:
    - Keep other team members updated (within HIPAA regulations) as to where things stand in your team job
    - Give and receive honest feedback
    - Work together to resolve any conflicts
9. Creative Innovation--Often there is no opportunity for this other than what the supervisee does in therapy. However, at times, he may have a suggestion for one of the other professionals that might make their job easier or more effective.
10. Consequences--It's too often easy to take other team members and their accomplishments for granted. Give them the "consequence" of a compliment whenever possible. The "consequences" of your doing so will be improved relations with other team members.
11. Coordination--Usually it's the social worker in charge of the case who might be considered the coordinator for the team. But many team members are used to working as a team of one. The social worker is often loaded down with too many cases. Perhaps you and/or your

supervisee could ask if there is any part of the coordination you could to that would ease their burden.

12. Cultural Change--Do team members recognize that there is no hierarchy in a team such as this (even though their job may be part of a hierarchy), but that everyone is equal. Because of the difference of the person's job and her position on the team, it may be difficult for him to adapt to this cultural change.

MANAGING CONFLICTS WITH OTHER EMPLOYEES

There's probably something wrong with you or your supervisee if you've never encountered someone who frustrates you so much that you want to scream and pull your hair. Everyone has met at least one person like that, and most have found a colleague that fits that bill.

For example, your supervisee may:

- Turn in paperwork late or only after much prodding
- Habitually come late to supervisory meetings
- Vehemently stick to all of his views
- Refuse to collaborate

. . . and more.

Instead of getting frustrated, of thinking she's irresponsible or difficult, or wishing you didn't have to work with her, try these principles (Chua, n.d.) instead:

1. Be calm
2. Understand the person's intentions
3. Get some perspective from others
4. Let the person know where you're coming from
5. Build a rapport
6. Treat the person with respect
7. Focus on what you can change, not what you cannot change

8. Ignore when possible
9. If all else fails, escalate to a higher authority for resolution

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Now we return to the Treatment Improvement Protocol as found here:

Center for Substance Abuse Treatment. *Clinical Supervision and Professional Development of the Substance Abuse Counselor*. Treatment Improvement Protocol (TIP) Series 52. HHS Publication No. (SMA) 14-4435. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009, Revised 2014.

Chapter 4—Clinical Supervision Vignettes

In this chapter, through vignettes, you will meet eight clinical supervisors with a variety of skill levels, a number of their supervisees, and an administrator. The supervisors face counselors with a variety of issues. One is unfamiliar with supervision, one has ethical issues, one is resistant to change, and another is a problem employee. The supervisors also have issues of their own. One grapples with the challenges of a new position, and another works to create a legacy. The vignettes, which incorporate these issues along with the principles outlined in Part 1, chapter 1, are designed to show how clinical supervisors might manage some fairly typical situations.

Each vignette provides an overview of the agency and of the backgrounds of the supervisor and other individuals in the dialog. A list of the learning objectives for each vignette is also included. Embedded in the dialog are additional features:

Master Supervisor Notes are comments from an experienced clinical supervisor about the strategies used, what the supervisor may be thinking, how supervisors with different levels of experience and competence might have managed the situation, and information supervisors should have.

"How-to" Notes contain information on how to implement a specific method or strategy.

The master supervisor represents the combined experience and wisdom of the TIP Consensus Panel and pro- vides insights into the counselor's relationships with clients and suggests possible approaches. The notes pro- vide some indication of the breadth of the master supervisor's clinical skills as well as the extent to which the supervisor moves effortlessly among clinical, supportive, evaluative, and administrative roles.

"How-to" notes reflect the collected experience of the TIP Consensus Panel along with information gleaned from a variety of textbooks, manuals, and workbooks on clinical supervision. Not all "how-to" will apply in every situation, but this information can be adapted to meet the specific needs of your case.

This format was chosen to assist clinical supervisors at all levels of mastery, including those who are new in the position, those who have some experience but need more diversity and depth, and those with years of experience and training who are true master supervisors. The Consensus Panel has made significant efforts to present realistic scenes in supervision using clinical approaches that include motivational interviewing (MI), cognitive–behavioral therapy (CBT), supportive psychotherapy, crisis intervention methods, and a variety of supervisory methodologies including live observation, education, and ethical decision-making. In all of these efforts, basic dynamics of supervision, such as relationship building, managing rapport in stressful situations, giving feedback, assessing, and understanding and responding to the needs expressed by the counselor are demonstrated. The Panel does not intend to imply that the approach used by the supervisor is the "gold standard," although the approach shown does represent competent supervision that can be performed in real settings.

Vignette 1—Establishing a New Approach for Clinical Supervision

Overview

This vignette illustrates the tasks of a clinical supervisor in describing a range of supervision methods to clinical staff, including establishing a consistent model of direct observation. The vignette begins with the supervisor describing to staff how he will implement a new method of supervision.

Background

Walt has been assigned to redesign the supervision program for a community-based substance abuse treatment program, which includes an inpatient program, intensive outpatient program, family therapy, impaired driver treatment, drug court program, halfway house, and educational services. The decision was made to establish an integrated system of supervision. The agency's staff, with ten full-time equivalent counseling positions, has a broad range of professional training and experience, from entry level certified addiction counselors to licensed social workers and licensed professional counselors. All staff, regardless of degrees and training, basically have the same duties.

Until now, staff received primarily administrative supervision with an emphasis on meeting job performance standards. Walt wants to make the supervision more clinical in nature, using direct methods of observation (videotape and live observation). He anticipates program growth in the next few years and wants to mentor key staff who can assume supervisory responsibilities in the future.

Walt has been meeting with clinical staff in small groups organized along work teams into dyads and triads to describe the changes and new opportunities. The vignette begins with Walt meeting with two staff members to discuss their learning needs and to present the new clinical supervision system. Al is in recovery, with 5 years of sobriety and 3 years of experience as a counselor. Carrie has an M.S.W. degree with 6 years of work experience.

Learning Goals

1. To demonstrate a range of supervision methods, with an emphasis on direct observation through videotaping and live observation.
2. To illustrate the mentoring, coaching, and educational functions of supervision.
3. To demonstrate how these functions can be integrated into a consistent model of clinical supervision with fidelity to the methods and adaptability to the unique needs of each organization.

[*After greetings, Walt begins the discussion about the new supervision approach*.]

WALT : As you know, our CEO and senior staff have agreed that we need to establish a program of staff training and supervision that will help achieve the goals of the agency and, at the same time, help counselors improve their skills. We've done a good job developing other administrative systems, and the next step is to implement clinical supervision to address both agency goals and your individual goals for professional development. People are moving into new roles, so new skills will be required of us.

AL: I'm not sure what I need. How will supervision enhance my skills?

WALT: Al, I think that is a great place to start. We've had administrative supervision so far. As we continue to grow individually and together, we'll need new skills. Perhaps a place for us to start is to discuss what will be asked of us in the future, what skills we'll need. How would it be if we had that discussion now?

AL: That sounds a little frightening. We need to know and do more? How much more blood can they get out of us?

[*Laughter in the group*.]

Master Supervisor Note: A new supervisor might respond differently to Al's comment, in a more mechanical or authoritarian manner, asserting authority, wanting to be the expert, creating an "us vs. them" scenario. Such an approach might discourage staff from embracing the new supervision system. An experienced supervisor would be less confrontive and authoritarian and

would adopt a more consultative posture. He would be direct but not necessarily confrontational.

CARRIE: I remember the good supervision I had in my M.S.W. program. This sort of reminds me of that—that you're suggesting we have more clinical supervision. Not to sound selfish, but what's in it for me, to get more supervision?

WALT: That's a great question, Carrie. We all want to know what's in it for us. I'd like to hear about your experiences in supervision. How did you learn from that process? What direct observation did you have?

How To Provide a Rationale for Clinical Supervision

Clinical supervision has several benefits, which Walt can offer Carrie at this point:

1. Administrative benefits: ensuring quality care, providing a tool to evaluate the staff's strengths and learning needs
2. Clinical benefits: improving counselors' knowledge and skills and offering a forum to implement evidence based practices within an organization
3. Professional and workforce development: enhancing staff retention, improving morale, providing a benefit to enhance staff recruitment, and upgrading the qualifications and credentials of personnel
4. Program evaluation and research: providing valuable information to deter- mine program outcome and patient success

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CARRIE: In school I found observation both frightening and helpful. At first, I hated being observed and taped. Very quickly, though, I really saw the benefits of observation and learned a lot from the experience.

WALT: It's been my experience that almost everybody has some initial reservations about direct observation, but at the same time nearly everyone finds it beneficial, too. I think one thing to keep in mind is that good direct observation doesn't focus on the negative—on what

somebody did wrong. The objective is to help us look at what we do well, give us new options, build a bigger tool box of skills, and help us to look at the larger process of our counseling, rather than just getting stuck in applying techniques with people. As we look at our goals and what we need to learn, I hope we can see how supervision, and particularly direct observation, will help all of us.

CARRIE: I'm told I'll be doing more group counseling. I certainly need further training and feedback on my group skills. This is something we didn't focus on much in grad school. There are other areas that I'd also like to be more proficient in, such as doing marriage and family counseling.

WALT: Okay. That would be one place for us to begin, Carrie. How about you, Al?

AL: I'm excited. I've wanted to do more counseling, moving out of running DWI groups and doing assessments. I need more training but I have concerns about being videotaped or observed. I'm going to make mistakes. I'll be self-conscious about that. I think videotaping a session or having a supervisor sit in will make the clients nervous, too.

How To Help Counselors and Clients Become Comfortable With Live Observation

The following steps are recommended:

1. Acknowledge and understand the clients' and/or counselors' anxiety about observation or taping.
2. Listen reflectively to these concerns without being dismissive or ignoring the anxiety; noting that these feelings are common may help normalize the counselor's concerns.
3. Clearly state the value of direct observation and reinforce the idea that such methods are "part of how we do business at this agency. We want to be respectful of your concerns. And we believe strongly that it is important for us to do so for quality assurance and improved client service."
4. Keep the door open with the clients and counselors to continue to address their concerns and feelings as part of their normal clinical or supervisory process.

5. Help the counselor to allay clients' anxiety or concerns by coaching the counselor through methods for presenting the direct observation methods to the client.

WALT: I can sure understand your sense of feeling self-conscious and your concerns that clients will, too. You've never been either videotaped or observed before?

AL: No, I haven't. In the DWI program, my supervisor sat in a few times when I first started, but it was more a question of whether I was following the curriculum.

WALT: So, although you did have some observation before, this seems like it will be different for you. Perhaps we could look at your goals and how supervision with observation can assist us in meeting your goals.

[*A discussion follows where Al and Carrie present their ideas for supervision needs. They then discuss what skills they need to develop in the next year*.]

WALT: Perhaps we can discuss what the new supervision system will look like, how it will work, and what's in it for you. First, we're going to have regular observation of all clinical staff, through either one-way mirror (if we can get the audio working in the room), videotaping (my preferred method), or one of the supervisors will sit in and observe counselors with clients. We hope to observe each counselor at least once a month. We'll meet as a group for supervision for an hour a week, and we'll discuss the session that was videotaped or observed that week, with one of you leading the discussion. Each person will get a turn at bat over the course of 1 or 2 months.

[*Walt explains the "how-to" of live observation and videotaping, including the concept of saliency, bringing to supervision the one issue the counselor wishes to address. Walt presents a step-by-step process to begin doing direct observation*.]

How To Implement Direct Observation or Videotaping

1. Obtain written and verbal agreement from the clients and all concerned par- ties to be videotaped. Clients should be informed on admission that:

- Counselor–client contact may be observed by supervisors, and/or audio or videotaped.
- The conditions under which the tape will be used for training.
- How the taped material will be stored and destroyed after use.

2. Counselors should briefly explore client concerns about taping and observation, and respect their right not to be observed. If the client objects after the initial exploration, the counselor must respect that choice and ask another client.
3. On the visit before the observation occurs, remind the client that on their next visit, their session will be taped for quality assurance purposes. Ask them if they have any questions about that. If the client strongly objects to the taping, discuss those concerns. If the client repeatedly objects to any form of observation, the counselor should explore the client's resistance, and attempt to understand the client's concerns and point of view. Even though a client has signed an informed consent that discusses the possibility of direct observation by supervisors, a client always has the right to decline any aspect of treatment. Remember, no method of observation should ever exceed the client's level of comfort so as to be detrimental to the therapeutic process.
4. At the beginning of the taping or observation, restate to the client the limits of confidentiality and how the videotape or observation notes will be used by the clinical supervisor and/or the counseling team. Clarify whether or how the supervisor will observe and/or cofacilitate the session or simply observe and intervene only as needed.
5. Be attentive to the counselor's concerns about direct observation. It may be helpful to begin with the idea that "observation gives us a chance to learn from each other." Then you can move into a discussion about the benefits and cost-effectiveness of certain observation methods.
6. Ask the counselor to cue the tape to the most salient points of the session and bring that section to their next supervisory session. In the beginning, counselors might be encouraged to choose the section of a session in which they thought they did well.

CARRIE: I'd like to hear more about why you prefer videotaping.

WALT: I prefer videotaping for several reasons: First, it is the most cost-effective way for us to observe a session. Second, videotaping helps us allocate staff time better; we don't have to sit in on an entire session but can just look at the most salient points in the tape. It gives us all a chance to observe and learn from each other. Sometimes we get a tape where a counselor has done something really special, and we can use that tape again before destroying it, teaching a particularly powerful and effective technique. We can all learn from each other's experiences.

[*Walt describes how direct observation works, including the legal requirements such as signed releases by clients, preparation and procedures for observation, and procedures for using tapes and observations and maintaining confidentiality.*]

Master Supervisor Note: It is important for you to prepare the counselor for what will happen during the session. If you are sitting in the session to observe, you should explain if and/or when you might intervene in the session, seating arrangements for the session, nonverbal ways of communicating during the session, and how other interruptions, should they occur, might be handled.

AL: As I said before, I've never been observed or taped, and that makes me nervous.

CARRIE: Well Al, I think you'll get comfortable with it, and you'll find it to be very helpful when it comes to areas that you have concerns about. You said that you were concerned about mistakes, but it really won't be about mistakes. My supervisor in grad school had a motto I liked; she always tried to "catch counselors doing something right." I liked that. So, hopefully this is not about making mistakes but learning from each other. When you see yourself on the videotape and you have someone go over it with you, they can give you pointers about what worked and how you might have done other things differently. Over time

you become comfortable with it. Observation was very helpful to me. I think your misgivings will go away after a couple of sessions with Walt. You'll be surprised.

Master Supervisor Note: It may be helpful for you, as a supervisor, to find a "champion"—someone who's experienced direct observation and found it helpful. Hearing positive statements about supervision from a colleague is often more acceptable than hearing it from superiors.

WALT: That's been my experience, too, with videotaping and direct observation. Al, you said it would make the client nervous. Actually, we're the ones who're most nervous. We all want to know how we're doing, but often we're afraid to ask, to get feedback and be observed.

AL: Maybe it would be better if I saw tapes of others doing counseling first.

WALT: That's a great idea. I can present a videotape of a session I conduct. Then we can all sit and discuss what I did. How would that work for you if we were to look at a videotape of one of my sessions for our next supervisory meeting? I'd benefit from your reflections. It might be a good place for us to start the process.

How To Encourage Acceptance of Direct Observation

Since you should never ask a staff member to do something you are unwilling to do, it might be helpful for you to:

1. Be the first to be taped or observed.
2. Be open to feedback from staff, setting the tone of acceptance and vulnerability to feedback.
3. Solicit comments and suggestions from the counselors concerning what they might have done differently and why.

4. Model acceptance by committing to trying out these suggestions in future counseling sessions.

AL: Yeah, I like that idea.

CARRIE: That would be fine with me. I'll volunteer to be second. It's been a while since I was observed, but I don't have any problem with it.

WALT: Thanks, Carrie. So, since I'm up to bat first, let's talk about some of the processes of observation. [*A discussion follows about what will happen in supervision when Walt presents his case*.]

Master Supervisor Note: You will want to state clearly what is expected from counselors in supervision. A supervision contract forms the basis of this statement, and explains the ramifications of missing supervision sessions and what they can expect from you and each other. For example, if a supervisee repeatedly misses supervision sessions, this might be considered an administrative or disciplinary issue, much as if an employee was repeatedly late filling out paperwork or getting to work. Also, if the supervisee does not provide the required video- tape of a counseling session for review by the supervisor, the supervisor might need to take action, following the organization's policies for progressive discipline.

WALT: There are different methods that we can use, besides videotaping, that might work better for some clients or situations. We want to have an integrated supervision system, one that includes reviewing cases together; periodic review of our files, such as client progress notes and treatment plans; training that meets the needs of a variety of staff; and review of our client evaluation surveys. While I'm on that topic, we also want to receive more input from clients about how we're doing. There's a new tool we hope to incorporate that routinely asks for input from clients after each counseling session, and at the end of each day for our residential units.

AL: I have reservations about how useful information from clients might be. After all, for clients in early recovery, their brains are still foggy.

WALT: Good point Al. If we ask clients regularly, though, we should get useful information about our ability to address clients' needs and the quality of our relationships with them. This is helpful information when we link it to our direct observation and supervision. Sort of like watching a TV program and getting the Nielsen Ratings about the show at the same time. [*Laughter*.]

[*In the discussion that follows, Walt acknowledges Al's concerns, and Al, Carrie, and Walt talk about those concerns. Walt asks how they can get past those concerns, how they can work together to have further client input into the process*.]

Master Supervisor Note: At times it is necessary for a supervisor to openly address staff resistance. The skill is in knowing when to address and when to deflect the resistance. Sometimes, it is useful to talk about staff resistance, to soothe people's discomfort before launching into the specifics of how supervision will be accomplished. MI suggests that it is most helpful to "roll with resistance" by reflecting back to counselors both sides of their ambivalence about the new supervision format. Often it is best to return to the issue at a later time.

WALT: And that's what we want to see happen with an integrated system of supervision. It will help us identify what we need to learn, the skills and competencies. To start the process, each of us will bring in a counseling session that we think is going well, that we feel good about. How does that sound to each of you?

CARRIE: I like that: a chance for each of us to "show off" a bit.

AL: Well, if you go first, Walt, as you said. I'll go the week after Carrie. I have all kinds of sessions where I'm doing a good job.

[*Laughter*.]

CARRIE: I found it helpful in grad school for us to help each other, to avoid throwing anyone into the process alone. Will that be possible for us?

WALT: That's a great idea, Carrie. How did peer supervision work in grad school? [*Carrie discusses how peer supervision and team coaching work*.]

Master Supervisor Note: Peer supervision is an effective form of group super- vision. Supervisees confer in the group, discuss key topics of their counseling, and suggest solutions for difficult situations. The participants learn better ways to manage clinical issues, thus increasing their professionalism.

Peer supervision and team coaching have the following advantages and disadvantages:

1. The strengths and success of peer group supervision depend on the composition of the group, the individual members' strengths, and the clarity of the peer group contract. Members must agree on the time, location, and frequency of meetings, as well as the organizational structure and goals of the meetings and limits of confidentiality. In these dimensions, peer supervision differs from occasional and unplanned peer consultation, a more informal process
2. Peer group supervision decreases professional isolation, increases professional support and networking, normalizes the stress of clinical work, and offers multiple perspectives on any concern. Peer supervision has the added benefits of being of low or no cost, intellectually stimulating, and fun for supervisees. Vague, ambiguous, or ambivalent goals and structure often lead to difficulties in peer supervision. As with individual or clinical supervision, an inter- personal atmosphere of reasonable safety (including respect, warmth, honesty, and a collaborative openness) are critical.
3. Effectiveness and supervisee enjoyment diminish when competitiveness, criticism, inconsistency of members, and absence of support are prevalent.
4. The success of peer group supervision is affected by supervisees' varying commitment and irregular attendance.

WALT: So, we've identified how this works. This is a new role for me, too, so I can use your feedback and suggestions. Supervision involves a different set of skills than being a counselor.

CARRIE: Right. I took a course in school on clinical supervision and that's exactly what the professor said.

How To Choose a Course on Clinical Supervision

Look for the following components:

1. The training should be approved by credentialing organizations to fulfill the requirements for certification as a clinical supervisor.
2. It should meet the minimum training requirements of 30 hours.
3. The training should be provided by a trainer with the following skills: Level 3 counselor, Level 3 supervisor, excellent training experience, and ability to provide information on both administrative and clinical supervisory issues.
4. The training should teach practical clinical supervisory skills through role- plays and demonstrations, video- and audiotapes of supervision sessions, and opportunities to practice clinical supervisory skills.
5. The training should be provided by a reputable training individual or organization.
6. Online courses are also available. However, an organization should first verify if online courses are approved by their State certification board.

WALT: Let's summarize what we've said. We're moving into new treatment program strategies. Each of us has an Individual Development Plan (IDP) stating our individual learning goals. Mentorship is an important aspect of helping us all meet our IDP goals.

[*Walt describes the process of mentorship, that each staff member will have a mentor. Some staff will mentor each other. Walt discusses the relationship between the IDPs, clinical supervision, and the mentorship system. Walt also discusses the issue of stages of readiness and how that affects the form and extent of mentorship each person will receive.*]

Master Supervisor Note: Mentorship is a formalized relationship between a skilled professional and a mentee and is established to enhance the mentee's career by building skills and knowledge. In a series of structured sessions, a per- son of greater experience instructs, guides, advises, provides feedback, and coaches someone of lesser experience.

WALT: One of my tasks is to ensure that all of us get training so that any one of you could take over for me if need be. I love to surround myself with people who can take over my job on a given day.

CARRIE: I'd be happy to both be mentored and serve as a mentor to others, if that's what you wish. I'm feeling a lot better than when we began this discussion today.

[*Walt starts a discussion on clinical issues that might be topics for discussion in supervision, such as caseload size and complexity, work with clients with co-occurring disorders, the impact of dual relationships with clients, and confidentiality. The session ends with the group establishing the times for their group supervision and the procedures for tape review and live observation.*]

Vignette 2—Defining and Building theSupervisory Alliance

Overview

This vignette illustrates the tasks of defining and building a supervisory alliance, particularly when working with an entry level counselor with an academic background different from that of the supervisor. The dialog is the initial supervisory session. It illustrates how to introduce direct observation and the establishment of an IDP.

Background

Bill is a certified clinical supervisor who worked his way up through the ranks, starting as a substance abuse counselor 20 years ago, 3 years into his own sobriety. Ten years ago he enrolled in a part-time master's degree program in counseling and completed the degree in 5 years. Since receiving his master's degree, he has worked as a clinician and supervisor in

a community based substance abuse treatment program. In addition to his supervisory duties, he is director of the program's intensive outpatient program (IOP).

Jan is in her first month at the agency, right out of graduate school. She is a Level 1 counselor, her first employment since receiving her M.S.W. She had limited substance abuse treatment experience in a field work placement and sees her current employment as a stepping stone to private practice after she receives her social work license. Her supervision in the field placement assignment focused on social work skills and integrating field work learning with her academic program. She averaged ten cases during her second year of field work.

The agency is a private, nonprofit organization providing comprehensive addiction treatment and education services. Jan has been assigned to the IOP and is expected to participate in a structured internship program of 3 months wherein she will receive training in the substance abuse treatment field. The agency has a well-established system for clinical supervision.

Learning Goals

1. To illustrate how to initiate supervision with a new counselor.
2. To demonstrate how to establish a supportive supervisory relationship and build rapport.
3. To define goals and boundaries of supervision
4. To demonstrate how to identify supervision expectations and goals of the supervisee.
5. To illustrate how to address the developmental needs of a new counselor
6. To show the start of a discussion on an IDP.

[*After brief introductions, the discussion begins about what will occur in supervision*.]

BILL: We're excited to have you here, Jan. You may already know that supervision is an essential part of how we help counselors in the agency. Since this is our first session together, perhaps we can explore what you want from supervision and how I can help you. Building on your training and experience, maybe you can give me some ideas about the areas where you wish to grow professionally.

JAN: Well, I haven't thought about that yet. I had excellent training and experience at the EAP [Employee Assistance Program] in the county health clinic. I'm not sure where to begin or even what I need. I recognize the need for supervision, certainly for orientation to the agency.

I'd like to know about how much supervision I'll get and the focus and style of supervision here. I also need supervision to meet the requirements for licensure as a social worker.

BILL: I can understand that you're really excited about starting a new job and career. You had an excellent experience in your placement at the health clinic. I'd love to hear more about it, so perhaps you might tell me something about that placement, what you learned, and what treatment models they used there.

JAN: Wow, there is so much to tell you about that. I averaged ten clients on my caseload. Some were just assessments, but I did get to work longer term with several clients. I sat in on several counseling sessions, observed the senior counselor conduct the sessions, and co-led a group and several family sessions. I had weekly clinical supervision with my supervisor and the senior counselors. We used process recordings in school and that was really sufficient because I would write the verbatim, give it to my supervisor, she'd make comments, and we'd talk about it. So, I didn't really need to have her watch me work. I've heard from Margaret [another counselor in the agency] that in supervision you do direct observation of counselors here and that idea is new to me. Frankly, I'm not sure if I really need that. My model for counseling is eclectic, whatever is needed for the client. They used a lot of cognitive–behavioral counseling approaches at the EAP. I try to meet the clients where they are and focus my therapeutic approach to meet their needs.

[*Discussion continues about Jan's experience at her placement and academic training.*]

BILL: So, we have a good sense of your background and experience. If it's OK, I'd like to return to the earlier question about whether you have any thoughts about what you want from our supervision together.

JAN: I'm not sure. Do all counselors here get supervision and are they all observed? I'm not sure I need that observation, especially since the placement didn't do that.

BILL: I appreciate your concerns about supervision. All our counselors here receive supervision. Some agencies don't do much direct observation of staff, but we've found it very helpful for a number of reasons. Here, we see supervision as an essential aspect of all we do. We believe you have a right to supervision for your professional development. We have great respect for our counselors and their skills and also understand that we have a legal and ethical obligation to supervise, for the well-being of the clients.

Master Supervisor Note: Notice how Bill is laying the foundation and ration- ale for why clinical supervision is essential to this agency. Whereas every agency needs to develop its own, unique clinical supervision approach, there are models and standards of clinical supervision, as discussed in Part 1, chapter 1, which seem to be most effective. Agencies might benefit from adapting aspects of these models.

JAN: So, everyone must have supervision and observation?

BILL: We take our legal and ethical obligations seriously. We want all of our counselors—even the most experienced ones—to grow professionally, to be the best counselors they can be, for their own development and for the welfare of the clients. As you probably learned in your M.S.W. program, vicarious liability is an emerging issue for agencies. Counselors are legally liable for their actions. Vicariously, so are the agency and the supervisor.

We need to make a “reasonable effort to supervise.” JAN: OK, so what do you expect of me?

BILL: I’d like to explore that with you. I’m really interested in both what you expect of yourself and what you expect of us.

JAN: Again, I never really thought about that. I want to grow as a counselor and to develop skills that I can use in my future employment. I understood when I took this position that you do an excellent job of providing training opportunities for staff, something I really liked about the organization.

BILL: In our agency, clinical supervision is part of a larger package of staff development efforts. We try to help counselors improve their skills by offering the opportunity to work with a variety of different clients, using a variety of treatment modalities, such as individual, group, couples therapy, family therapy, and psycho-education. Also, we want staff to be able to obtain their social work or substance abuse license or certification in the future. We want counselors to develop new skills by attending training both in-house and in workshops around the State. We encourage and support any efforts you might make toward

professional development, such as get- ting your various levels of social work licensure. Our philosophy is that one of our greatest assets is our clinical staff and as they develop, the agency grows too. We believe clinical supervision is critically important in this mix. We both—you and the agency—benefit as a result.

[*A discussion continues about Jan's course work in school and her training in the field placement, and how she can continue that learning in the agency. She articulates her clinical strengths.*]

BILL: That sounds good. Those are the skills we saw in you that we thought would be helpful to our agency. In what ways do you wish to grow professionally?

JAN: I could learn other counseling techniques beyond CBT. What do you think I need?

BILL: That's what we can explore in supervision. I'll need to have a sense of what you've learned and where you see your skills. In addition to talking about your skills, we find it helpful to learn through observation of our staff in action, by either sitting in with you on a session or by viewing videotapes of counseling sessions. That way, we can explore your specific learning objectives. We all learn from watching each other work, finding new ways of dealing with clinical issues. What do you think of that process?

JAN: As I said, I wasn't observed in my placement and find it anxiety provoking. I don't really like the idea of your taping my session. It feels a bit demeaning. After all, I do have my M.S.W. I don't recall anyone saying anything in my interview about being videotaped. Now, that's intimidating, to me and the clients.

BILL: Being anxious about being taped is a fairly common experience. Most counselors question how clients will accept it. You might speak with Margaret and some of your other coworkers about their early experiences with taping, what it was like for them, and how they feel about it now.

JAN: How often do we have to meet for supervision?

BILL: Generally, I meet each counselor individually for an hour each week. Then we do weekly group supervision where each counselor, on a regular basis, gets a chance to present a case and videotape, and we, as a group, discuss the case, and talk about what the counselor did well and how other things might have been handled differently. When you present a case, we all grow and benefit.

JAN: I want to be a proficient therapist, ultimately, to work as a private practitioner. If supervision can help me professionally, that's good.

Master Supervisor Note:

TAKE NOTE

It is important for Bill to be aware of what feelings are arising within him, particularly concerning Jan's seeming desire to pass through and use the agency as a route to private practice. This has happened to Bill and the agency before. Bill acknowledges to himself his feelings of being used by these clinicians in the past. Bill's self-awareness of these feelings is critical and he does not respond out of anger or resentment but makes a conscious effort to remain present to what the issues are with Jan.

BILL: I'm glad you see the value of supervision. And I admire your professional goals of wanting to be in private practice although I must say that I have difficulties with people just "passing through our agency" on the way to something else. But, that's my issue, and I'll address those concerns if they come up in our relationship.

Master Supervisor Note: In his own supervision, Bill might explore his feelings about people passing through the agency, his anger or resentment, and how he can effectively address those feelings. For example, Bill's supervisor might wish to explore with Bill the following questions:

1. What feelings does Jan bring out in you? When have you had these similar feelings in the past?
2. How do you deal with negative feelings about a supervisee?
3. How do you keep from being drawn into a defensive posture where you are justifying the agency's use of direct methods?

JAN: Will I be criticized by others, perhaps those without as much formal training as I have? I understand you have several non-degreed counselors here—certified addictions professionals, with lots of life experience but without advanced degrees.

Master Supervisor Note: A Level 1 supervisor might respond angrily here. A Level 2 supervisor might get into an argument about the quality of counselors at the agency. Bill, as a Level 3 supervisor, does not react to Jan's seeming criticism of the non-degreed counselors. He responds in a supportive but direct manner, as you will see. But perhaps Jan is making this comment in response to Bill's previous statement that he has "difficulties with people just passing through" and this is another reason for Bill to address this in his own supervision.

As discussed in Part 1, chapter 1, just as there are levels of counselor development, there are also levels of supervisor development. Level 1 supervisors might have a tendency to be somewhat mechanical in their methods, perhaps needing to assert their leadership and position, and approaching situations somewhat anxiously. This is especially so for supervisors who have been promoted from within the organization. Their peers, with whom they have worked side by side before, know they do not know their strengths and limitations, and hence the new Level 1 supervisor may feel that she has to assert her authority (see vignette 6). A Level 2 supervisor is much like the Level 2 counselor, who is driven by alternating anxiety and self-confidence and who feels the need to be independent, even though she might not as yet be able to act independently. Finally, Level 3 supervisors have balanced their levels of self-awareness, motivation, and autonomy. For further descriptive information on levels of counselors and super- visors, see Part 1, chapter 1, pp. 9–11.

BILL: Perhaps it would be a good idea if you began by observing in one of my groups. Then, when you're feeling more comfortable with it, we can discuss what times work best for you to be observed, and what cases you'd like me to observe. This will give you time to schedule the observation. The first time, maybe I could sit in when you're working on a case that you have confidence about so we can see how you accomplish the session's goals.

JAN: OK, that makes sense to me. I like the idea of talking to others and getting their impressions of the process and their suggestions on how to best make it work.

BILL: We also need to develop a learning plan for you, an IDP that all staff have, so that you can continue to learn. That's part of a supervision contract that we work on together. How does that sound?

Master Supervisor Note: It is important to develop an IDP for each supervisee, and counselors should understand why an IDP is important for the supervisory relationship. Jan's IDP might focus on:

1. Increasing her understanding of addiction by reading texts on the subject and beginning the credentialing process.
2. Discussing this material in supervision, in reference to clients in treatment.
3. Finding a social worker within or outside the agency who can assist her in fulfilling the requirements for her social work licensure.
4. Beginning direct observation of her counseling sessions within 2–3 months with monthly videotaping and discussion of a session.

JAN: It will be a new experience for me but it sounds like it might be helpful. I'd appreciate your helping me look at my skills and growing as a social worker in substance abuse treatment.

BILL: I'll provide you with as much background in substance abuse treatment as I can and also try to help you develop as a social worker to meet your career goals.

Master Supervisor Note: Bill is working with Jan to establish a supervisory alliance, through listening, reflection, and mutual goal setting.

JAN: Good. I hope it will broaden my skills and further my career goals. I can learn more about working with clients' substance abuse. I think I can learn from people in other disciplines.

BILL: Although each discipline has its unique perspective, we have a multidisciplinary team approach and value each staff member's contributions. We teach one another. For example, Margaret has worked in this unit for 10 years and has a lot of experience working with the kinds of clients you'll be treating. She is a useful resource for you to use to improve your skills so that you can be successful here and in your career. How will that work for you?

JAN: I've heard about Margaret. People have a high regard for her clinical skills. So I'm sure I can learn some- thing from her. I still would like some more details about how the supervision works, who else is involved, and how do we do this together.

BILL: We do individual observation and group supervision where we find common issues in our counseling, using videotape and case presentation to trigger discussion of related issues. Everyone learns from the presenter's experience. Each counselor takes a turn presenting a case, including a videotape. We can cue the tape to the session segment you want us to discuss. After your brief introduction of the case, we discuss how the session went, what skills were effective, and what areas might be further developed. How does that sound?

JAN: That sounds great. Can I come to you at other times to review cases, especially while I am learning the ropes of how things are done here?

BILL: Yes. I appreciate your wanting immediate feedback. I have an open door policy. Although I may look busy, I'll try to find time when we can discuss whatever you want. You can also meet with others if you feel comfortable doing so. We encourage teamwork. Does that seem reasonable?

JAN: Yeah. I'm pretty autonomous at this point. I think it's great that there are other counselors and social workers I can collaborate with. It will be really helpful for me especially since I'm new at the job, and it's good to be able to work together. I'm OK with supervision, and I like the fact that we're both going to have an agenda, so that's fine.

BILL: So, let's go back to your experience. I'd love to hear more details about your internship and what you learned there.

[*Jan explains her work experience in her internship*.]

JAN: In my second year I was at an EAP clinic. I had a great supervisor, Jackie. Several of my clients were alcoholics, my first introduction to substance abuse. There was something that

attracted me, to understand more about the disorder and to contribute what I was learning in social work. Jackie was a social worker and a really good role model. I need to understand more about substance abuse treatment, and try to marry the social work and substance abuse fields.

[*Bill and Jan continue to discuss her experience with supervision, what worked best, what she found most useful and supportive*.]

JAN: I'm a little worried about how I'll meet my licensure requirements about being supervised by a social worker. Will that be a problem for me?

BILL: Not at all. Margaret is an LCSW and we can ask her to provide the supervision you need for social work licensure. This will allow Margaret to develop her supervision skills. I also think that an important part of developing a professional identity is receiving coaching from an experienced person, and perhaps Margaret can assist in that area too.

JAN: That sounds fair and helpful.

BILL: You mentioned that Jackie was a good supervisor. Can you tell me what she was like and what she did that made her a good supervisor?

JAN: She was really smart. I could learn from her. When I went to talk to her, she always gave me good advice. She trusted that I knew what I was doing and didn't micromanage me. She was open about her theories and made linkages to issues. She trusted me to just go ahead and implement what I learned. She was easy to talk to. If I had a problem, I could say so.

BILL: It sounds like Jackie and I have a similar orientation as supervisors, and that should make the transition easier. I hope you'll observe from your perspective how the supervision is developing, and give me feedback on the relationship, the process, and the outcomes from your point of view. Our first step will be to expand your training by introducing you to a broad range of substance abuse issues. Perhaps at our next session we can start developing a learning plan to apply your studies to clinical work. What do you think of that?

How To Write a Supervision Contract?

The following elements might be included:

1. The purpose, goals, and objectives of supervision.

2. The context of services to be provided.
3. The criteria and methods of evaluation and outcome measures.
4. The duties and responsibilities of the supervisor and supervisee.
5. Procedural considerations.
6. The supervisees' scope of practice and competence.
7. The rewards for fulfillment of the contract (such as clinical privileging or increased compensation).
8. The frequency and method of observation and length of supervision sessions.
9. The legal and ethical contexts of supervision as well as sanctions for non-compliance by either the supervisee or supervisor.

JAN: That'd be good. I like that you're interested in my experience, about who I am. I'd like to know a bit about you. Jackie would talk about who she was, her model of supervision, and why this work was important to her. I felt I could trust her because I knew where she was coming from. Would you tell me more about yourself?

Bill: I'd be happy to.

[*Bill provides an overview of his work, academic experiences, and primary model of counseling and supervision.*]

JAN: I have a beginning understanding of the type of supervisor you are. I like that you're direct so I don't have to guess at the agenda. So, we'll work on a training plan and I'll suggest times for you to observe a session and videotape. Is that correct?

BILL: That seems fair and clear. Any other concerns we should talk about today?

[*Further discussion follows about Jan's anxiety about supervision. They discuss how supervision would work to help reduce her anxiety about being scrutinized and critiqued.*]

BILL: So, although you're a bit nervous about the process, you're ready to begin. We'll start with your observation of me to give you an opportunity to get your feet wet. Then you can tell me when you're ready for me to come in and observe, maybe in the next 6 or 8 weeks.

JAN [*jokingly*] I think sometime in the next 6 months.

Master Supervisor Note: As a Level 3 supervisor, Bill doesn't react to this comment. A Level 1 supervisor might respond by saying "The timeframe is not negotiable. You'll begin the observation in 6 weeks." Another response might be to avoid the issue without affirming her. When she is noncompliant after 6–8 weeks, he'd blame her for her lack of follow through. Such responses might negatively affect the relationship. A supervision of supervision issue might be to explore what was happening for Bill and his possible ambivalence about Jan.

BILL: Thanks for your willingness to begin and try the process. JAN: OK. So, I can pick the client?

BILL: Yes. You can pick the client or group. We'll meet every week for about an hour.

[*Bill and Jan set the time for the next supervision session and discuss what is expected for the next session and end the discussion with both excited about the process*.]

Vignette 3—Addressing Ethical Standards

Overview

This vignette illustrates the role of the supervisor as a monitor of ethical and professional standards for clinicians, with the goal of protecting the welfare of the client. The vignette begins with a discussion about a potential ethical boundary violation and illustrates how to address this issue in clinical supervision.

Background

Stan has provided clinical supervision for Eloise for 2 years. He's watched her grow professionally in her skills and in her professional identity. Lately, Stan's been concerned about Eloise's relationship with a younger female client, Alicia, who completed the 10-week IOP 2 months ago and participates weekly in a continuing care group. Alicia comes to the agency weekly to visit with her continuing care counselor. She also stops by Eloise's office to chat. Stan became aware of her visits after noticing her in the waiting room on numerous occasions. Earlier in the day, Stan saw Eloise greet Alicia with a hug in the hall and commented that she will see Alicia "at the barbecue." Stan is aware that Alicia and Eloise see each other at 12-Step meetings, as both are in recovery. Eloise feels she is offering a role model to Alicia who never had a mother figure in her life. Eloise expresses no reservations about the relationship. Stan sees the relationship between Eloise and Alicia as a potential boundary violation.

Learning Goals

1. To illustrate monitoring professional boundary issues of counselors in clinical supervision.
2. To demonstrate supervisory interventions to help the counselor find appropriate professional boundaries with clients.
3. To help counselors learn and integrate a process of ethical decision-making into their clinical practice.
4. To demonstrate skills in addressing transference and countertransference issues as they arise in clinical supervision.

[*After brief introductory comments, the discussion begins with how Alicia is progressing in her recovery*.] STAN: If it's OK, I'd like to share some concerns I have about Alicia.

ELOISE: Sure, I'm always ready for feedback.

STAN: When I walked through the lobby a few minutes ago I heard you say something to Alicia about seeing her at a barbecue.

ELOISE: Right. Sarah is one of my sponsors in AA, and we're having a barbeque at her house for some people in recovery. She and Alicia have gotten really close, so Alicia will probably go, too.

STAN: And that's a barbecue you might be attending?

ELOISE: Yeah. I'm fairly active with all my 12 -Step friends and sponsors.

STAN: I would like to raise a concern I have about your relationship with Alicia. You take great pride in working with recovering people, helping them, and doing everything you possibly can to ensure their recovery.

ELOISE: Yes, it means the world to me. Alicia reminds me of myself when I was in early recovery. When I see her and how hard she's working, it inspires me because I know that struggle.

STAN: I'm pleased that you care so much about your clients and that you can identify with their struggles. I do have concerns though, when I hear you are going to see her at a barbeque. It seems like a possible dual relationship issue for you, and I would like to know what you think about this?

ELOISE: Well, I certainly know not to sleep with my clients, or borrow money from them, or hire them to mow my lawn, or take them on trips. But seeing Alicia at a barbecue? Come on, Stan.

Master Supervisor Note: At this point Stan might be feeling somewhat defensive and may need to restrain his urge to begin disciplinary action against Eloise for her attitude. A Level 1 supervisor might react angrily to Eloise's tone of voice, seeing this as a clear disciplinary issue. A Level 2 supervisor might get caught up in an argument with Eloise about the extent of the violation. The skill of a Level 3 supervisor is to be clear with Eloise about what a dual relationship is without responding out of anger. As shown below, Stan needs to help her ide tidy what a boundary violation is, how to make ethical decisions, and how to have this discussion in the context of a supportive supervisory relationship. It is important for Stan to help her be more aware in future situations with similar clients and dynamics.

STAN: I'm glad we agree on those kinds of extremes because dual relationships are a big concern of our agency and staff. A dual relationship occurs when a counselor has two relationships with a client, one personal, one professional. Our mission is to provide professional clinical services to clients. Within those services there is a scope of practice.

When a personal relationship with a client or former client intrudes on that professional clinical service, then we may have a relationship that is considered outside the parameters of what's considered solely professional.

ELOISE: What I understand about dual relationships is that it . . . well, help me here. For example, I know I'm not supposed to hire anybody for any personal services or any form of exchange of money or buy anything from a client. If they've been a client here, I can't contract with them for private practice or anything like that.

STAN: Let's talk about your relationship with Alicia and what the intent is now. You want to do everything you can to build a safety net for her recovery. I appreciate your concern for her recovery. One goal of recovery is for the client to achieve a sense of autonomy and make decisions on her own, to take care of herself. You play a role. So, if we can, let's discuss what that professional role is, and what it isn't. When I walked through the lobby and heard you say "I'll see you at the barbecue," I had some concerns.

ELOISE: You mean I shouldn't say that in a public place?

STAN: My concern is whether going to a barbecue with a client is appropriate behavior, to have a relationship with her outside your professional relationship as defined by our agency. When I heard your remark, I thought, "I wonder what Eloise's intent was and where that's going or what might that lead to? Let me check it out to see if I am being clear."

ELOISE: Are you saying I shouldn't see clients in other contexts? How reasonable is that? We live in a small town here and run into clients all the time in the supermarket and at 12 -Step meetings. So, what are you saying?

Master Supervisor Note: There is a difference between a dual quality to a relationship and a dual professional and personal relationship. Dual qualities are inevitable in certain communities. A dual relationship has the potential for the abusive use of power, where harm might be done to the client through manipulation or inappropriate self-disclosure. Actions in one context might be acceptable, whereas in another they might be harmful. A skillful supervisor would help Eloise

see this distinction and help her be better able to make sound ethical decisions concerning the line between dual qualities and dual relationships.

STAN: Great observation. Yes, we find ourselves in situations that potentially have a dual quality to them. The difference between running into clients in the supermarket and going to social activities together involves the potential impact that action might have on the client and our use of the power we have in the relationship. You were her counselor.

ELOISE: Yes, but I'm not her counselor anymore. She's in continuing care now.

STAN: Okay, but she's still a client of the agency. The ethical question is how long is a client a client? According to our substance abuse counselor's code of ethics, once a client, always a client in terms of our professional responsibilities.

ELOISE: Yes, but she just stops by when she's here. She pops in just to say hi, for not more than 5 minutes. I don't counsel her anymore.

STAN: Okay, that might be reasonable. Perhaps we can discuss that relationship and the impact of seeing her outside the agency at functions.

ELOISE: Well, she goes to the women's AA meeting that I go to. And she knows some of my sponsees. What should we do, leave our home group because clients attend the meetings also?

STAN: It is inevitable that we will run into clients at meetings. When does that cross over the ethical boundary and become a dual relationship? I'd like to hear your ideas about where you see that line for you.

ELOISE: I don't want to do the wrong thing, Stan, to hurt her. My intent is to be helpful.

STAN: Again, I know you don't want to hurt her, and I know you're trying to help her in her recovery. We have to be mindful of not being drawn into relationships that hurt the client or that could be perceived as dual relationships.

ELOISE: She doesn't call me or come see me. I want you to know I'm not sponsoring her. But I didn't know that going to the barbecue was wrong. So, I won't go.

Master Supervisor Note: Stan really wants to keep the focus on the larger issue of dual relationships. Once Stan and Eloise have clarified this larger perspective, then it might be more appropriate to come back to the specific issue of the barbecue. A more inexperienced supervisor might be tempted to just establish the boundary about socializing with clients with a comment like "That would be a wise decision (not to attend the barbecue)" but would possibly lose the potential of helping Eloise develop more effective ethical decision-making skills in the process.

It would, in effect, run the risk of making the decision for Eloise, rather than helping her come to an ethical decision on her own.

STAN: With your permission, perhaps we can talk about how we make ethical decisions about the nature of a relationship with a client or a former client, and what's not professionally appropriate. If it's okay, let's use the conversation with Alicia in the agency lobby. How do you think that conversation might be perceived by anyone who is walking by who hears you say you'll meet at the barbecue?

ELOISE: I've never really thought about it. Well, I guess if it was someone who didn't know me, they might think that I was personal friends with her. That's not a perception I want others to have.

STAN: So, you want others to see you as a professional, upholding boundaries and your code of ethics? ELOISE: Yes, of course.

STAN: I reread the code of ethics to help evaluate whether or not there might be an issue. I was reminded of the power differential in all counseling relationships and that as professionals in our field we need to be careful to not engage in social relationships (or relationships that might be seen by others as social relationships) with clients or former clients. You may recall we recently had a lawsuit over dual relationships that put the agency in jeopardy. It got resolved in our favor but we're particularly sensitive about our liability. It was a wakeup call to all of us. So how can we clarify this boundary issue with your relationship with Alicia?

ELOISE: Wow, I never saw going to the barbecue as pursuing a friendship, and I certainly would not want to jeopardize our agency's relationship with her. I certainly don't seek any personal gain from our time together. Although I must admit, she does remind me of myself when I was in early recovery. Besides, she has never had a strong, positive, maternal figure in her life. That's something I think I can help her with. What do you think?

STAN: I admire your concern for her and it sounds like you are becoming aware of some maternal feelings for her that might be coming close to stepping over that professional boundary. When our relationships with others, and particularly with clients or former clients, begin to even have the possibility of affecting their recovery in a potentially negative way, then we might be edging close to an ethical boundary violation.

ELOISE: I understand, but part of my recovery program is being in touch with other people in recovery, other people from meetings, like Alicia.

STAN: I agree. It's important for your own recovery that you stay connected to other people in recovery. So, the question is: What's the difference between seeing people in recovery at meetings, such as your sponsees or your sponsor, and relating to clients active in treatment at our agency whom you encounter at a meeting?

ELOISE: Do I have to cut off all my recovery relationships and not go for coffee after meetings?

Master Supervisor Note: It is important for supervisors to take into account cultural variables that might affect clinical relationships, such as differences in ethnic, religious, and geographic factors and their impact on the counselor–client relationship. This is not to condone unethical behavior but to be mindful of cultural issues as they affect the context of counseling. For example, in some Latino cultures some form of socializing may be expected. In Asian cultures, it is not uncommon for a client to ask the counselor personal questions as a means of establishing trust. Skillful supervisors assist counselors in understanding cultural variables while continuing to make sound ethical decisions.

STAN: I understand the dilemma we find ourselves in as counselors. We have to go on living our lives in our small rural community. So, how do we reconcile our daily lives with the Federal laws,

agency policies, and our code of ethics? We need to be mindful of those boundaries just because of the closeness of our community. The interesting thing is that the clients are not bound by the same rules as we are. So, they might not see it as a boundary violation. In fact, as often as not, clients and former clients are flattered by contact with their current or former counselor and invite such relationships. How will we reconcile these differences? How do we know what the ethical wall looks like before we hit it?

ELOISE: Well, I guess we need to be careful about what contexts we see clients in, whether they are actively being counseled by us or not. Is that what you're saying?

STAN: Yes, we do need to be mindful of the various relationships we develop with clients. I'd like to use the barbeque as an example to discuss. Okay?

ELOISE: Sure. First, I have six sponsees. They've all been in recovery for different lengths of time, and they like to get together every 3 months, all six of them, and do some kind of activity. And they invite over a bunch of people from the 12 Step group. Sarah was having this barbecue and asked me because we go to the same home group. She also invited Alicia. I'm not sponsoring Alicia. Does that mean I can't go?

How to Perform Ethical Decision-making?

Stan's task here is to help Eloise identify potential boundary issues in a broader context and aid her in her ethical decision making. The following are steps to ethical decision making:

1. Recognize the ethical issues by asking whether there is potentially some- thing harmful personally, professionally, or clinically. In what way might this go beyond a personal issue to the agency, the profession?
2. Get the facts. What are the relevant facts? What facts are unknown to us at this time? Who has a stake in the decision-making? What are the options for action? Have all of the affected parties been consulted?

3. Evaluate alternative actions through an ethics lens. Which options will pro- duce the most good and least harm? What action most respects the rights of all parties? What action treats everyone fairly?
4. Make a decision and test it. If you told someone you respected what you did, how would they react?
5. Act, then reflect again later on the decision. If you had to do it all over again, how would you react differently?

STAN: It might help to ask yourself what happens for you when you find yourself in such a dilemma, to be your own problem-solver.

ELOISE: Well, it's hard to not go to social activities in this small community when I'm invited. But I can see how some might see me in a different light because I'm a counselor. At one party, someone came up to me and started to ask questions about problems in their marriage. I guess she figured that since I'm a counselor, she could get some free assistance. I was really uncomfortable in that situation.

STAN: What did you do?

Master Supervisor Note: At this point Stan might:

1. Have Eloise consider her own solution.
2. Use her solution in a dialog to expand the context so she can generalize the solution to other situations she may encounter.
3. Conclude with Eloise's restatement of what she has learned for the future from this discussion.

ELOISE: I told her I could not be her counselor and was there at the activity in my "civilian" clothes. [*Chuckling.*] Ah, I see what you're getting at. It's hard to be in two relationships, a professional and a personal one, with the same person. And I can see what you mean by how a reasonable uninvolved person might view this situation. At the party, when that

woman wanted free counseling, it was clear that that was not the con- text or the relationship for that. That's unprofessional. But Alicia is different.

STAN: So, you see that it is unprofessional to counsel someone outside of a professionally defined relationship. I'd like to hear how it is different with Alicia.

ELOISE: Well, I really care for her. She reminds me of myself when I was younger. I am the mother she never had. I feel bad for her that she's never had a positive female, maternal role model in her life.

[*Eloise cries as she expresses her concern for Alicia*.]

STAN: This is difficult for you. You care very deeply for her. I can understand that in some ways she reminds you of yourself at that point in your recovery.

ELOISE: Yes, she does.

[*Her crying continues, and Eloise speaks of her concern for Alicia. After a few minutes, the two sit quietly*.] ELOISE: The last thing I want to do is to hurt her or to act in an unprofessional manner.

STAN: I value your concern for Alicia and your desire to be professional. It is difficult when we care so deeply for our clients. We're asked to show empathy and caring for clients, and sometimes it can be confusing if we care too deeply. It's like, as caring professionals, we're always living close to that ethical slippery slope. We can retreat into "professional white coats" and separate ourselves emotionally from clients. But that turns counsel- ing into a sterile activity, and we're detached and removed from their pain. But, when we care deeply, we are drawn into the emotional world of our clients. And the boundaries can become fuzzy for us.

ELOISE: I see what you mean. I guess we can rationalize a lot of our behavior when we care so deeply. We call that enabling behavior, don't we, when family members do that with the person in substance abuse treatment? So, how do we walk close to that ethical slippery slope without falling over the edge?

STAN: That's an excellent question. Ethical decision-making can be difficult at times. Intent is an important part of ethical decision-making.

How To Ask Questions in Ethical Decision-making

The following are key questions to ask at this point:

1. What would a reasonable person, counselor, or colleague do in a similar situation?
2. What are the relevant issues regarding justice, fairness, self-advocacy, non-malfeasance?
3. How would a person discern his or her intentions? How do you keep yourself from self-deception about your motives, remembering that the best test for your motives is time?

ELOISE: What do you mean by “intent?” It was my intent with Alicia to be helpful, certainly not to hurt her in any way or to be disrespectful of our agency or of me as a professional.

STAN: When we commit to a professional relationship with a client, there is always a power differential. When someone like Alicia comes with her need for a maternal figure, as you well described, we need to be careful of our role in offering to fulfill that need. The power differential alone can create some opportunities for people to misperceive what’s going on. What do you think?

ELOISE: Can it be that I took advantage of her because of my own need to be a mother figure in someone’s life? STAN: That is always a risk we have. It could be perceived that way.

ELOISE: I feel bad that I wasn’t being very professional with her and my own needs came out.

Master Supervisor Note: It is important to remember the power differential between supervisor and supervisee. How might key audiences (colleagues, the community, board of directors, the press, peers) see or experience the counselor’s behavior? What is the risk? There are many stakeholders involved who each view the situation from their own perspective. For example, stakeholders (such as the board of directors) might be concerned about the risks of legal liability for the agency, the media and community with the public image of the organization, and peers with the clinical implications of a possible boundary violation.

STAN: That's a key insight. It's great that you could step back from the situation and see how you're caring deeply for her spilled over in other ways.

ELOISE: You think I had power over Alicia?

STAN: As I said, when you're a counselor to a client, there is always a power differential that we have to be very cautious and very aware of. It may not be something we do so much as the power that the client gives us. Now, if it is okay with you, I'd like to summarize a little.

[*Stan and Eloise review what has been discussed and what actions might be appropriate for Eloise to take at this point. They express their concerns about Alicia and how she might be hurt if Eloise abruptly cuts off the relationship with Alicia. They strategize on how to best handle the situation in a way that would be clinically supportive of Alicia*.]

STAN: I want to talk a little about ethical decision making and how we can keep within certain guidelines. There are some questions to be asked, such as how that behavior is experienced by someone else. How would your actions be perceived by colleagues, the community, a supervisor, and clients?

ELOISE: I appreciate your saying that; I need to think about it. It makes sense. STAN: I'd like to review what we've discussed and your understanding of the issues.

ELOISE: I have a clearer understanding of how my relationship with clients after they're discharged is as important as when they are my active clients. I need to think and give more consideration to how that's perceived, to consider my role with clients from their perspective. In my relationship with Alicia, I've thought of myself primarily as a recovering person, but I need to remember that she may perceive me primarily as her counselor. In other words, I am wearing two hats—a counselor and a person in recovery—and I need to be clear which hat I am wearing and when those hats are on.

STAN: So, you have a sense of the potential conflict of interest depending on what hat you're wearing and how that might be perceived.

ELOISE: Yes. I need to think about how that reflects on the agency and how the community sees it.

[*The supervision session ends with Eloise making a commitment to rethink the relationship with Alicia and strategies for making ethical decisions in the future*.]

Vignette 4—Implementing an Evidence Based Practice

Overview

This vignette portrays supervision of two counselors at different levels of experience and orientation to implement an evidence based practice (EBP) into their clinical work. Both counselors have reservations about adapting the way they practice and have some resistance to undertaking the new EBP. The clinical supervisor has to address their resistance while achieving the mandate of the agency.

Background

The executive director (ED) of a mid-sized substance abuse treatment program has issued a statement to all staff that, according to State requirements, the agency must incorporate EBPs, now a necessity for State funding. Therefore, the ED has directed the three clinical supervisors to begin the implementation of MI as a primary treatment method for treatment staff, first on a pilot basis then agency-wide. Gloria, one of the supervisors, is meeting with Larry and Jaime, two program counselors, to discuss implementation of MI with their clients. Both Larry and Jaime are aware of the mandate but have not had an opportunity to discuss the change with Gloria until their regularly scheduled supervisory session this morning. Both have, in the last year, expressed some resistance to undertaking a new treatment approach when they were required to attend MI basic training.

Learning Goals

1. To demonstrate leadership by a clinical supervisor toward meeting agency goals and mission.
2. To demonstrate leadership in the face of staff who are resistant and reluctant to incorporate EBPs into their counseling
3. To model MI in the supervisor/supervisee relationship
4. To illustrate fostering a spirit of learning and professional development among counselors.

5. To illustrate how a clinical supervisor can help counselors build new clinical skills, especially those that are science-based practices.
6. To understand the resistance and impediments in the field to the implementation of EBPs.

GLORIA: I know you have some reservations about the MI implementation program. Today I want to spend time discussing your reservations and how MI can be good for our clients and for the agency. You have both done a tremendous service for our programs. We want to be responsive to your needs, not just impose some- thing on you. When you've been doing a good job and you know that what you're doing works, it's hard to take on something new that you're uncomfortable with. I know that you're concerned that taking on something new could, at least initially, potentially interrupt the normal flow you have with clients.

So, there are several things that I think are important for us to consider today. First, let's review why we are implementing MI for staff as a tool in their counseling. Perhaps we can explore any concerns you might have, then review why it is important to implement MI.

Second, let's look at your concerns about how those changes might affect client care.

Third, let's focus on how we can keep the strengths you have with your clients and be sure they don't get lost in the transition process. One of the beauties of MI is that it integrates well with what good counselors do naturally: active listening, respect for others' views, an appreciation of the role of resistance, good goal setting practices, and the like. Most important, MI aids in establishing and enhancing the therapeutic alliance between the counselor and the client.

Finally, I want to spend a little time talking about where we go from here and how we are going to make the implementation process as smooth as possible.

How To Introduce Changes in Clinical Practices?

Changes in counseling methods are difficult for staff who are attached to their model of counseling and know that it is working for them. When presenting new policies and directions to staff, it is important that you follow these guidelines:

1. Be respectful of staff's resistance. Instead of exhorting, arguing with, or threatening the counselor if they do not "play ball," seek to understand the counselor's concerns with words such as "Yes, this is difficult. So how can we resolve the issue?"
2. Show respect for counselors and for the experience each brings.
3. Depending on the individual counselor, you may need to be flexible yet firm in your approach with staff who are expressing resistance to or ambivalence about change, being clear that the change is needed yet allowing time for the person to adjust and providing the resources needed to aid the counselor in making that change.
4. Recall when you were in the counselor's role and perhaps how you experienced resistance to change in supervision. Consider using self-disclosure to address defensiveness with supervisees. You can either give an example from your own training or experience, such as, "I know it was difficult for me too when I was a supervisee," or by describing your own ambivalence in the present, such as, "I also have concerns about the change we have to undertake and want to ensure that it works in the best way for clients, now—what can I do?" These self-involving statements can engage supervisees in the discussion and problem-solving.

LARRY: Well, Gloria, we've had the MI training, and I like it focus on active listening, the attention it gives to the relationship and respect for the client's perspective. But, you know, I'm basically a 12 Step facilitation guy. That works for me and for my clients. I don't see changing horses in the middle of the stream to achieve political correctness.

GLORIA: Your 12 Step approach works for you, and we heartily endorse it, too. 12 Step facilitation is an essential part of everything we do at the agency. And I definitely don't want to see us throw out the baby with the bathwater. As you know, counseling is an ever-evolving process, and I think our task is to be able to take what we do well and build on it with new approaches. I think MI can add to your repertoire. I think your concerns are realistic, and we need to consider that as we move into adopting new methods. What about you, Jaime?

Master Supervisor Note: At times a supervisor might feel caught in the middle, representing policies and procedures coming down from funding sources, yet posing implementation difficulties. An effective supervisor plays this dual role of advocating for both administrators and leadership and the line worker and client. Whether working on a factory floor or in a clinical setting, it is difficult being in the middle. To aid you in this position, it is helpful to:

1. Understand the rationale of both administrators and line staff.
2. Never lose sight of where you came from. At some point in your career, you were a supervisee. It is useful to remember what it felt like being in that position.
3. In the example of MI, practice reflective and active listening to understand the concerns of those above and below, and to empathize with each group's concerns.

JAIME: All of this discussion is really above me. I just want my Latino clients to get good care and for their treatment needs to be respected. My clients need decent jobs and to be accepted as Latino men being sober in their community. That's what's important to me. I just want to serve my clients. I know that may not be what you want to hear, but that's how I feel.

Master Supervisor Note: A Level 1 supervisor might respond either in a defensive or overly directive fashion here, telling Jaime that this is something he must do. A Level 2 supervisor might get into a struggle over what really matters, defending MI as good for Jaime's clients, or disrespecting his statement about what matters most to him, his clients. A Level 3 supervisor listens to Jaime's statement, affirms and supports him in that, and tries to engage Jaime in the discussion. Further, Gloria is working with two counselors at different levels of proficiency, so she has different expectations for their contributions and recognizes that they have different learning needs. An effective supervisor understands the stages of counselor development and varies the approach depending on the stage of each staff member.

GLORIA: Jaime, I respect your commitment to the Latino clients. Larry is clear about one of the things he knows works, 12 Step facilitation. In your experience, what works with Latino men?

JAIME: I'd agree with Larry, 12 -Steps, because I go to AA myself, and I know AA works. But what's also important is jobs, not feeling discriminated against, not being asked for ID papers if you've lived here all your life. What helps is to be with a group of sober men. That's what helps my clients.

GLORIA: You both seem to be clear on what you see works for you and your clients. That's a good start for us. As you know from the recent ED's memo to staff, the State has required all agencies to implement an EBP to continue to receive State funds. There has been a lot of discussion at all levels about this. We've talked before about our desire to move from being a good agency to a great one, being one of the best in the State. Over the past year we've made incredible progress toward this goal, thanks to all the staff's efforts. And all through this process, we've been able to stay true to our 12 Step philosophy. Honestly, when I first heard about the new State policy, I, too, was skeptical, saying to myself, "Here we go again." But then I was reminded of the agency's mission to keep improving our skills for the well-being of the clients. So, discussing this together now is helpful. I'd like to hear more from you about your concerns regarding MI.

LARRY: I don't really give a darn about MI versus CBT versus 12 Step facilitation versus the next thing to come down the pike. I've been in the field for a long time, and I know what works is my relationship with people. I know 12 Step works, and I have to be convinced that this doesn't interfere with having a strong relation- ship with my clients. I think that's the most important thing. I'm not sure I need a new way to do this. I don't want to have to be worried about whether I have to use this science-based thing.

GLORIA: Wow, Larry! I really hear that the most important thing to you is building strong relationships with your clients, and it's not so important what method you use to build strong relationships, but that the method helps you accomplish that goal. Perhaps we can look at how MI's approach to active listening with clients and reflection enhances that relationship. If it builds the therapeutic alliance with the clients, that's good. I'm curious how you feel about that.

LARRY: What I want to be sure of is that we're not moving away from our roots: that this is not taking us away from 12 -Step. That's what this agency is founded on, and that's what we stood for all these years. I need to hear that from you.

GLORIA: That's a really excellent point. How do MI and other approaches keep us close to our roots of 12 Step work? What do you think?

LARRY: If an approach builds the relationship with the client, I'm all for it. I know that 12 Step facilitation does that. And I know from the course I took on MI that it also emphasizes the counselor–client relationship. But it is also a new way of thinking and a whole new vocabulary and I don't want to get so bogged down in catchy phrases that I lose contact with my client.

GLORIA: Larry, I clearly hear your concerns about interfering with your relationship with your clients and about us losing our roots.

LARRY: Maybe Jaime can do the MI stuff and I can do my 12 Step facilitation. JAIME: What?

GLORIA: There are several different ways we can approach the implementation. We may decide that MI works better with some client populations than others. A place to begin would be for us to learn more about how MI can be implemented in the program. I know you've been to the MI training. That's a great start. MI has some good strategies that are congruent with a variety of client populations.

LARRY: What I heard you just say is that it doesn't matter whether we're on board or not.

GLORIA: That's a dilemma. The State's said, "You have to do it." What they haven't said is how you have to do it. They said we have to do "something." We have something to say about how we're planning this, how we'll implement an EBP. I want to be sure that we hear and use your experience.

Master Supervisor Note: It is helpful to watch how Gloria handles the polarizing confrontation. A Level 1 supervisor might either come down hard on Larry for his suggestion, saying "No, we're not doing that." A Level 2 might argue about it. Note the Level 3 approach, not to confront the statement by Larry but to find a working alternative.

A master supervisor is able to manage staff confrontation and avoid becoming defensive. To do this, it is important for the supervisor to understand that struggle is a sign of staff ambivalence to change. Resistance and ambivalence are nor- mal in any situation involving change. A master supervisor works with the resistance, using its energy to promote change, not taking it “head-on.”

LARRY: I like the idea that we can implement the strategies that work best for our agency because that allows us to stay close to our roots of 12 Steps.

GLORIA: So, you see the value of implementing an EBP approach such as MI as long as it stays close to our 12- Step roots. Moving ahead, I recognize that this is going to change some of our approaches, how we think about treatment, how clients experience us.

LARRY: How are we going to do this implementation anyway? Who’s going to do the implementation, train us in MI?

GLORIA: Perhaps I can show a videotape of a counseling session I conduct when I think I am doing effective MI. What do you think of that idea? Would that help us all feel more comfortable with an EBP? I’m willing to stick my neck out if you’re willing to give me feedback on what you see on the videotape.

Master Supervisor Note: A basic rule of supervision is “do not ask a supervisee to do something you’re not willing to do first.” A second rule is that “leaders bear pain, they don’t inflict it.” Master supervisors are willing to take a risk by demonstrating their skills first before asking staff to do so. Effective supervisors are able to establish trust by serving as a team leader, inspiring staff by encouragement and motivation, communicating enthusiasm and capability, and taking appropriate risks to initiate change. Leaders also demonstrate vision, drive, poise under pressure, and maturity of character. They inspire rather than command staff. Since

leadership entails teaching, mentoring, and coaching, having the title “supervisor” does not necessarily make a person a leader. To earn respect, the supervisor should display qualities of honesty, responsibility, fair- ness, and understanding. In this vignette, Gloria provides direction and leader- ship by showing staff how they can implement MI together and how the training will work. She also gives them a say in the process and allows them to keep to their roots, learn new tools, and do so over time.

GLORIA: That’s a good question about implementation. Any approach we use needs to be respectful and build on the counselor–client relationship. So let’s start there. First, we want to implement MI over time. It’s not something that we’ll become instant experts at. I want to make sure that we’re well prepared and understand what we’re doing.

[*Larry and Jaime nod in agreement.*]

GLORIA: Again, let’s be clear. We need to implement EBP for State funding. Remember when the agency went smoke free: How difficult that was, how much resistance some staff expressed? But it was something we just needed to do, and in the end, being smoke free has had significant health benefits to staff and clients, and has reduced the health care premiums for all personnel. I’m interested whether you see the similarity to such changes.

LARRY: Yes, I do. The smoke free campus has been a real benefit to all. I hope implementing an EBP is also.

GLORIA: I agree. Maybe we can return to the training issue you raised earlier. Larry and Jaime, with your help and support, I’d like to establish a year-long training plan. First, I’d like to have an advanced trainer come in and provide several days more of training that particularly addresses the needs and concerns of the staff.

We’d also like to contract with the trainer to establish an MI coding system that will be part of what we do in our clinical supervision. Over the year, we’d continue our direct observation for supervision. Only now we’d look at the interactions through the MI lens. The coding system will help us in doing so.

JAIME: I remember hearing about coding in the basic MI course I attended. Can you tell me more about that?

GLORIA: Here is a coding sheet that the trainer of that course recommended. I like the form and find it simple and easy to use. I also think it's consistent with what we do as counselors, and it reinforces our efforts to listen better to clients. As in 12 Step facilitation, it helps to build an alliance with the client.

LARRY: So, you're convinced this is a good thing? You're not just doing this to get State money?

GLORIA: From what I know about MI and have read about it, I think MI is a very useful tool for us. We're concerned about our funding, of course. But client welfare always comes first. No, we would not be doing this sim- ply for money. I believe this will help our clients, and that's the bottom line, isn't it? So, perhaps we can discuss the skills we have as a team and how to proceed.

JAIME: I think we work well together and we seem to have good stable funding that allows us to maintain the quality of care we offer to our clients.

LARRY: Yes, we have good teamwork and support each other. Jaime and I work well together. We've got a lot of respect for each other. We've had the basic MI training. That's a good start.

GLORIA: Teamwork is important.

LARRY: We do good treatment. Our clients respect us. We have good credibility out there. That's a plus. GLORIA: I'd also add that we have experience at successfully implementing changes.

JAIME: Three years ago, we had few Latino clients and no Latino program.

GLORIA: Implementing a Latino program was a major positive step forward. The other thing I like is that we have a good supervision system which helps us assess how we're doing when we implement any new practice or program, like the Latino program. It gives us a way of assessing quality.

LARRY: So, what's going to change here?

GLORIA: We do have time for more training. It's difficult jumping into a new approach if we don't feel like we're adequately prepared for the change. One solution would be for us to devote more time in our normal clinical supervision sessions (individually and in group) to MI practices,

to use videotapes and role plays to continue our learning and practice our skills. We can phase in MI over time. I'm committed to supporting you in what- ever you need to do your job effectively. More than 150 studies have shown that MI is effective; this will enhance our skills and give us better client outcomes. It might be helpful for us to talk to an agency that uses MI and ask how they did it. We need to do training, as I said earlier, so we can be consistent with our core approach. I want to integrate this in a way that makes sense for all of us. Perhaps between now and our next meeting you'd think about two things you can do to help us write the implementation plan that will show how we're going to do this. We have an excellent team and do-good work. I value and trust the work that we do.

Learning a new strategy requires training, mentoring, and coaching. Our relationships with the clients and each other are the most important because that's how we serve the clients.

[*A discussion follows when they discuss the training system, who might serve as a consultant for the advanced training, and how the coding system works and can be incorporated into the clinical supervision system. The session ends with a mutual commitment to move to the next stage of implementation*.]

Vignette 5—Maintaining Focus on Job Performance

Overview

In this supervisory session, a counselor with marital problems carries this stress into the workplace. She feels overwhelmed by the complexity of her caseload, misses work, and cancels patient appointments. Observe how the supervisor must address the counselor's job performance, provide emotional support for the counselor, and, at the same time, not get involved in the counselor's personal life.

Background

Juanita has worked as a counselor at the agency for over a year and brings a number of valuable attributes to her job. She is bilingual, understands the stresses and cultural dynamics faced by recent Central American immigrants living in the United States, works well with female clients, and gets along well with other staff.

Her husband is a recovering alcoholic, and Juanita has been active in Spanish speaking Al-Anon. She recently received her addiction counselor credential.

Since receiving her license as a substance abuse counselor, Juanita has been given new job assignments that involve working with more complex and difficult clients. She now conducts educational and support groups by herself, does intake interviews, provides individual counseling to her caseload, and has recently increased her caseload to accommodate the increased number of clients at the agency. She is also seeing several clients with co-occurring disorders.

While she is friendly and outgoing with others, her natural response to stress is to withdraw and isolate her- self, rather than ask for help. To Melissa, her supervisor, Juanita seems more tentative and less energetic in their supervision sessions. She seems to be meeting most of her work performance goals established in the supervision, but the quality of discussion about her cases and her lack of vitality in the meetings concerns Melissa.

In the past month, Juanita has come late to work on a number of occasions and missed several client appointments. She has called in sick three times in the last 3 weeks. In supervision, she seems distracted, which is a change from her prior behavior. Melissa, in her concern, asked in supervision “is everything OK?” Juanita replied, “No, Jorge has been laid off his construction job, and he has been drinking.” She explains that she is quite distressed, having trouble sleeping, and feeling overwhelmed. Though clearly worried, Juanita did not elaborate, and Melissa did not pursue the questioning. Juanita did ask if she could talk to Melissa at another time to discuss her personal problems and to seek Melissa’s advice on how to handle her current situation at home. Melissa was uncomfortable agreeing to this but also was uncomfortable not responding to Juanita’s distress. She hesitatingly said that they could discuss this at the next supervisory meeting.

In the upcoming supervisory session, Melissa feels it is important to clarify the differences between providing help for personal problems and maintaining supervision goals. Melissa also thinks it is important to address Juanita’s job performance issues in the next meeting.

Learning Goals

1. To illustrate how work-related stresses and personal problems can interact and affect one another.
2. To demonstrate the boundary between clinical supervision and personal counseling.
3. To demonstrate how to help an employee get the help necessary to address personal (non–work-related) life problems that affect the work environment.
4. To illustrate how to monitor and maintain adequate clinical performance when an employee is facing difficult personal dilemmas that affect job performance.
5. To demonstrate awareness of and sensitivity to cultural issues that arise in the context of personal issues that affect job performance.

[*The vignette picks up with the beginning of the next clinical supervisory session*.]

MELISSA: Juanita, hi! Come on in. Before we start talking cases today, I would really like to go over some of what we discussed last week and see where things stand.

JUANITA: That's fine, but I think I owe you an apology about our last session. I really want to apologize for saying all those things to you about my family and how that is affecting me and all that, and I just want to apologize. I know it had nothing to do with anything work related. We were doing supervision and should just have talked about cases, and I just want to assure you that that will never happen again.

MELISSA: Well, Juanita, I'm sorry you have to cope with all that's going on, but I don't feel you need to apologize for anything last week. I know that what's happening is stressful to you. I hope we can work out a plan to help you get the help you need and also be sure that the pressures you are experiencing don't spill over into your work with clients.

How To Address Personal Issues That Affect Job Performance?

Consider the following points when you need to confront a supervisee in clinical supervision with problems of job performance that are exacerbated by personal difficulties, such as emotional, familial, interpersonal, financial, health, or legal concerns:

1. You can help your supervisees see the relationship between their personal difficulties and work-related problems. The key question you need to return to is “How is this personal issue affecting your job performance?” This pre- vents you from becoming the counselor’s counselor and turning supervision into therapy.
2. You can clarify the boundaries of what constitutes acceptable job performance, as some counselors may be uncertain where the boundaries lie.
3. You should continually focus on approaches to improve job performance, pro- viding useful suggestions and recommendations for improvement. It is also helpful to provide measurable benchmarks by which counselors can assess their own improvement.
4. You and your supervisee should develop a written work plan for how the employee will take the necessary steps to improve job performance.
5. You can help the counselor examine how personal stressors might affect interactions with coworkers or clients.
6. Finally, you and your supervisee can explore how you and the agency can support the employee in confronting and resolving personal issues that are affecting job performance, such as a referral to the EAP, use of personal or sick time, rescheduling of the counselor’s time, and the like.

JUANITA: I appreciate that. I just want you to know that that’s not me. That’s not me.

MELISSA: And I appreciate that, and I want you to know that I value your work. You’ve worked hard. You’ve really worked hard in learning not only your job, but also as a professional counselor and you’ve made a valuable contribution to working with our clients.

JUANITA: I love my job. I love it.

MELISSA: Juanita, I want to be really clear with you that I am concerned about what is going on in your personal life, and I want to work with you to get help for that. I don’t feel that it’s something that we should address in supervision though, except to the extent that it affects your job performance. The goal of our supervision time is to help you to be the best counselor possible. When personal issues come up, those may keep you from being the best *person* you can be. These are important issues for you to address in your own personal

counseling and therapy. I hope that distinction is clear for you. But I really want you to hear my concern for you.

Master Supervisor Note: Although the distinction between personal counseling and supervision may be contingent on the supervisor's theoretical orientation, and both are interpersonal relationships, there are differences between the two, as summarized in the table below.

Personal Counseling	Supervision
. The goal is personal growth and development, self-exploration, becoming a better person.	. The goal is to make the counselor a better counselor.
2. Requires exploration of personal issues.	2. Requires monitoring of client care and facilitating professional training.
3. The focus of exploration is on the origins and manifestations of cognitions, affects, and behaviors associated with life issues and how these issues can be resolved.	3. The focus is on how issues may affect client care, the conceptualization of the client problems and counseling process, and accomplishment of client goals.

To help the counselor and the supervisor differentiate between therapy and supervision, the supervisor needs to continually ask him- or herself, "What does this have to do with your counseling functions? How is this affecting your relationship with clients?"

JUANITA: I'm still kind of worried that I told you about my personal life, but I do want to be the best counselor I can be.

MELISSA: I'm concerned about the time you have been missing from work and especially the times you have had to cancel patient appointments as a result of your situation at home.

JUANITA: I know I've missed a couple of sessions, but I called. The clients were okay with me rescheduling, and I've continued to meet with them. I don't think there's any problem. It was the first time I ever had to reschedule those clients, and we caught up on their visits later in the week.

MELISSA: I hear that you were concerned about missing some sessions so you made a strong effort to reconnect with your clients later. I really appreciate your effort. I had a chance to review a videotape of a session you did last week. I'm pleased with the skills you've developed in group counseling. In the middle of the session we videotaped, there were some issues that came up about men that I thought might be a concern and might illustrate what we're talking about. Can we view that section of the tape and discuss what was happening for you at that point?

JUANITA: Sure, if you have the tape there.

[*Together, Juanita and Melissa watch the tape, cued to the segment about clients actively drinking while in treatment. Juanita appears surprised to see her response to the client on tape and notes the impact she might be having on clients. For example, there was an interaction between Juanita and a male client in group where she saw herself being judgmental and overly critical. Melissa and Juanita continue to discuss the tape and the meaning of counter-transference in the counseling relationship. From the discussion of being angry at clients who continue to drink, Juanita becomes aware that the sessions she has cancelled with clients were all with drinking men*.]

MELISSA: I'm glad you can stand back objectively and see the relationship between your personal issues and your clinical functioning. So, what do you think you need to do now?

JUANITA: Well, first maybe I shouldn't see any more male patients?

MELISSA: That is an option. But I think we can find a better resolution. For right now, let's focus on what else needs to change.

JUANITA: Well, I just won't cancel any more appointments. I didn't realize rescheduling was such a problem. But I just won't do it anymore. And about the missed days, I think that is beyond me now. If I need a day off for personal reasons, I'll schedule them in advance from now on.

MELISSA: OK. I think I would like you to go through me for the next few months if you need either time off or if you have to cancel patient appointments. I know emergencies happen, but just let me know if you need time off and we'll see where we go from there.

JUANITA: I understand. I am so sorry that my personal life is intruding on my counseling. I never thought that would happen. And I'm going to get back to my work. I'm going to make sure I get the paperwork and everything done, and I will be on time tomorrow.

MELISSA: Let's put the paperwork aside and talk about your work with the clients and what you need to do to maintain your high level of work performance. Let's get back to the countertransference. I'd like to hear more about the clients you work with. Let's go back to the videotape and discuss what else is happening in the session.

JUANITA: Basically, I've moved into working with some of the more difficult clients in the last several months. It's been very challenging developing plans with them and encouraging their attendance and working with their treatment plans on a more active level because I'm definitely sensing the resistance.

MELISSA: So, not only are you working with more complex clients but you also have a higher caseload than you had not so long ago. So your job responsibility has increased significantly recently. I think you'll see some different features of supervision as you continue to see clients with more complex problems and as you begin to work in other treatment modalities, such as group. Let's discuss how you're dealing with the more complex clients.

[A discussion follows, using the videotape, about how Juanita has been working with these clients, some of her concerns about working with clients with more difficult co-occurring disorders, some specific points about counseling interventions and her counter transferential reactions to men who are drinking. She acknowledges that her reaction to the client who has

relapsed is in part a response to her current life situation with her husband. Now that Juanita recognizes where her work is being impacted by her personal issues, Melissa returns to the issue of the EAP and re-introduces the possibility of a referral.]

Master Supervisor Note: It is important for the supervisor and counselor to understand the impact of countertransference in a counseling relationship, including:

1. It can distract from the therapeutic relationship.
2. A counselor's personal issues may contaminate how he or she sees the client's issues.
3. The counselor may distance him- or herself or avoid discussion when the client's issues come too close to home, or conversely, the counselor may focus on client issues that resemble her own.
4. The counselor may have negative reactions to the client, based on the counselor's current life issues, as Juanita did with the men in her group who were actively drinking.

MELISSA: Juanita, you may remember that, as part of your professional development plan, we talked about a personal care plan: knowing when you need support and where you could get it. Your Al-Anon program has been a strong support for you, and you've used it in a very effective way. I'm wondering if you have used or would consider using our EAP to help you address the crisis you are experiencing now. I think it would be helpful if you had the opportunity to sit down with someone and assess how things are going and what could help. I hope you'll use our EAP for that. As you know, using the EAP is optional. I'm not mandating that you go. But if you think it would help, I hope you'll take advantage of it. This booklet has some information about the EAP and how to access their services. As you know, the EAP is strictly confidential, and nothing is reported back to the agency. I'm also wondering how I can be of support to you.

JUANITA: Just be there for these sessions. Just be there as the supervisor when I come and have questions. I'll call the EAP this afternoon. Do you think they would also be willing to help Jorge if he is willing to come with me?

MELISSA: The EAP is for the whole family, and I'm sure they would be available to see Jorge too, either with you or separately. I'm glad you are going to follow up on that.

Master Supervisor Note: Note that Melissa doesn't ask Juanita to report back to her about using the EAP. The EAP referral is to address personal life issues that are not the concern of her employer. It is Melissa's role to monitor job performance and to use all of the resources that are available to help Juanita improve her job performance. In most organizations, an employee's use of the EAP is not the concern of the supervisor. The focus of the supervisor needs to be on improving job performance. Statements such as "Let me know if you use the EAP" are not within the supervisor's scope. Remember, the goal of clinical super- vision is not necessarily to make the supervisee a better person, but a better worker. It is tempting for clinical supervisors to focus on the personal issues of staff—after all that's what they do for a living. However, personal issues are a part of clinical supervision only insofar as they affect the counselor's interactions with clients.

[*Melissa and Juanita continue to discuss some of her cases and her efforts to work with more challenging clients. At the end of the supervision session, Melissa and Juanita schedule two sessions in the coming week for Melissa to sit in on Juanita's sessions again. Melissa reaffirmed that she hoped Juanita would consider using the EAP to address some of the issues in her personal life*.]

Vignette 6—Promoting a Counselor from Within

Overview

In this vignette, a counselor has been promoted from within a work group to a supervisor position over the counselors she worked with as a peer. Issues addressed include how the new supervisor handles staff resistance and works to build a new relationship with the counselors she will now be supervising.

Background

Kate has been a counselor at the agency for 3 years. She, Maggie, and Kevin have worked together as outpatient counselors, supervised by Gene, who left the agency last month to take another position. Kate has a master's degree in counseling, is licensed as a drug and alcohol

counselor and, for the past year, has been taking continuing education courses to develop her supervisory skills, hoping that a supervisory position would open up in this or another agency. But the courses only gave brief reference as to how to work with and supervise counselors who last week were her peers.

Maggie has worked at the agency 2 years longer than Kate, is a licensed drug and alcohol counselor, recently completed her bachelor's degree and has started working on her master's degree. She understands that Kate got the promotion partly because of her advanced degree but still feels she was treated unfairly in the selection process because she has been with the agency longer.

Kevin, also a counselor, is in process of becoming licensed. He has a bachelor's degree and has worked in the field for about a year. He has concerns that someone who was a counselor and his peer last week can be an effective supervisor for him now. He likes Kate and has turned to her numerous times for advice and support, but wonders about her competence as a supervisor. The agency director announced the promotion yesterday afternoon and suggested to Kate that she meet with Maggie and Kevin soon. The director offered to sit in on the meeting, but Kate declined, feeling that she would rather discuss the promotion and changes alone with Maggie and Kevin first. Since everyone had appointments already scheduled for the morning, lunchtime was the first available opportunity for the meeting.

Learning goals

1. To demonstrate how a new supervisor can establish a leadership position and demonstrate a leadership style with former peers.
2. To show how a new supervisor handles the potential conflict of her promotion over others with whom she has worked.
3. To give some guidance to recently promoted supervisors to clarify their roles, develop opportunities to learn new supervisory skills, and establish rapport with supervisees.

[*Kate, Maggie, and Kevin meet over lunch to discuss Kate's new position*.]

KATE: Thanks for being willing to sit down with me and discuss how we are going to proceed in face of the changes that were announced yesterday. I'm pleased with the

promotion and excited about getting my feet wet in this new role. I hope we can work together to continue doing the good job we have been doing.

[*Long pause while Kevin and Maggie wait for Kate to proceed.*] KATE: I hope you see this as an opportunity for all of us. [*Another pause while Kate waits expectantly.*]

KEVIN: Well, Kate, it's going to be strange having you as a supervisor. Gene and I had a good relationship. He was my boss the entire time I've been here, and I learned a lot from him. I knew there were going to be changes. I guess I'd rather see you or Maggie get the promotion rather than having someone new come in from the outside. This is quite a shift. Two weeks ago, when Gene announced he was leaving, all three of us were in group supervision together. Now you're our boss.

[*Another pause.*]

KATE: Yes, Kevin, it seems strange for me too, I have to admit. I've enjoyed our collegial relationship. I've learned from you and appreciated your input too. I've even enjoyed our "grousing sessions" when we've felt overworked and underpaid. [*Laughter.*] And I know there is going to be a shift in our relationship, but I still want us to see ourselves, as well as new staff, as a team, focused on the best patient care we can offer.

Master Supervisor Note: It is important for new supervisors who are promoted from inside not to try to be something they're not. Everyone knows you don't know the job. Don't try to fake it. Instead, acknowledge to staff that this is new, that you have things to learn, and that, with their assistance, you can work as a team. The worst mistake you can make as a new supervisor promoted from within is to try to take the reins of leadership abruptly and without consideration of staff reaction to your promotion.

KEVIN: I'd like to hear about any changes you are planning or how things might be different now that you are running the show.

KATE: Great question, Kevin. In the past, we've all sat around in the lunchroom and spoken of what needs to be different in the agency. Now, together, perhaps we have an opportunity to make some of those changes. For example, we've spoken before about how we'd like to streamline the paperwork process. I know we're all buried in forms. How can we reduce the strain of administrative tasks we all face? How do we deal with our burnout? So much is asked of us, and that places great strain on us. We've spoken about that together, how tired we can become. How can we take better care of ourselves and of the team?

But I want that process to unfold together. I need your help and input. Also, I want a few weeks or a month of breaking in time before any changes are made. So, perhaps we can sit together as a group and think about what needs to be different. I will then "run those changes up the flagpole" with the director and do what needs to be done to bring about the changes we deem necessary. How does that sound to you?

How To Demonstrate Leadership

It is important for a new supervisor to demonstrate leadership without being controlling or condescending, especially if promoted from within. Perceptions of quality leadership have shifted from the traditional hierarchical, command and control model to a networked, team-based approach that values participative leadership and staff empowerment, bottom-up management, team input, and collaboration. Qualities of this leadership style include:

1. Taking responsibility for decisions made, never blaming others for something you've done, and giving credit to others when things succeed.

2. Always putting the well-being of supervisees above personal accomplishments.

3. Not being afraid of taking appropriate risks that are in the best interests of the organization, staff, and clients.

4. Protecting and advocating for supervisees, defending them to senior administrators and buffering them from rapid changes.

5. Not playing favorites. Most important, not giving orders just to prove who's boss. If you have to prove who is the boss, you are not.

MAGGIE: I have to say that I'm not very happy about this. I met with Gene and Susan [the agency director] about ten days ago and expressed an interest in applying for the position. I didn't hear a word until I found out yesterday that you got the job. I want to be clear that I'm not upset with you. I'm glad for you, but I'm not happy about the way this was handled, especially how Susan made the announcement. It makes me wonder how decisions are really made around here.

KATE: I think if I were in your situation, I'd be unhappy too. It doesn't feel very good when there's no communication. I understand that you were interested in the position. I am sorry about how the communication was handled.

MAGGIE: Like I said, I'm not upset with you, but with Gene and Susan. I felt disrespected after my years of service to the agency. That really doesn't feel very good, like not being valued.

KATE: Yes, it feels like you should have had some communication at the least, and not have been surprised by the decision.

MAGGIE: Yeah, it feels lousy. I wonder what my future is with the agency: if I'll be passed over for other pro- motions. And, quite honestly, I regret that I didn't go back to school and finish my degree years ago, if that's required for a supervisory job. It makes me angry though, because they never told me that education would be a deciding factor. I don't even know what the criteria were for the decision.

KATE: Maggie, I can sure understand your feeling that way. And to be honest with you, I think I would have felt much the same as you do if the decision had gone the other way. I'm sorry that's the way this happened. If it would be helpful to discuss your concerns with Susan, either together or alone, I'd be willing to help you with that.

Master Supervisor Note: It would be easy for Kate at this point to triangulate the communication, making Gene and Susan “the bad guys.” However, Kate skillfully identifies Maggie’s feelings, provides self-reflection on how she’d feel if in a similar situation, without polarizing the process and the others involved.

KATE: In the future, perhaps we can make suggestions to administrators on how we’d prefer the process and communication to flow. How could this situation have been handled differently? What would have been more helpful to you, Maggie?

[*A healthy discussion follows between Kate, Kevin, and Maggie about how to improve the communication process in the future. Maggie feels like she has a voice in the process and feels listened to and understood. Kate asks Maggie what she needs now.*]

MAGGIE: Thanks for this conversation and for your concern. Let me think about what I want to do now and what I need. Can I get back to you on that?

KATE: Sure, we can discuss it when you’re ready.

KEVIN: I’d still like to maintain our friendship. I understand it is going to be a little different, for instance, calling you “boss.” But the three of us have had a good thing going here. It’s been fun for this last year. I want to keep that.

MAGGIE: Our friendship has been fun: something I’ve treasured, too. As you say, things aren’t going to be the same. Kate is the supervisor now. And when we hire a new counselor, you are no longer the new guy on the block. More is going to be expected of you.

KATE: I am going to miss some of what we have had together too. It would be hard to act as if we’re peers and then have any objectivity when it comes to management decisions. We’d risk claims by others of favoritism. So, as hard as that will be for me, I’ll need to stop doing as much socializing as I did before. I don’t understand fully what I mean by that, but I know things will be different. I also will experience a sense of loss of some of my clinical duties. I’m giving up some of the real satisfaction that I found in counseling, working with clients. And I’m swapping that for new tasks. So, I likely will also go through some grieving as well.

KEVIN: Thanks for your honesty, Kate. This means changes in a number of ways, for all of us. Kate, I have confidence you'll do a good job. Although you'll have to get a new wardrobe and dress more like a manager. [*Laughter.*]

KATE: Thank you so much for your patience and understanding. I was nervous coming into this meeting, given how this all unfolded. I feel like we're heading in the right direction. How do you feel we're doing so far?

MAGGIE: I appreciate your listening to my venting and I think you understand how I'm feeling.

KEVIN: I am cautiously optimistic, which, for me, is saying something positive. After all, you know what a cynic I am. [*Laughter.*]

KATE: You, a cynic, Kevin? No way! [*Laughter.*] There's one more thing I would like to address before we stop today: how we proceed. Gene had a really good system in place for clinical supervision. I would like to return to that system and schedule that includes the efforts Gene was making to improve our supervision process. What do you think? [*The discussion continues about what to do in clinical supervision, returning to the effective system formerly in place*.]

Master Supervisor Note: It is important to move forward, saving what was working before, not seeking to make radical, hasty, drastic changes. Also, this is an opportunity for Kate to demonstrate leadership by not languishing in the present situation, not "badmouthing" administrators for how this decision was made, while also acknowledging the emotional and professional concerns of staff.

[*The session ends with a group decision to move forward in their clinical supervision*.]

Vignette 7—Mentoring a Successor

Overview

This vignette illustrates the process of mentorship as a supervisor faces retirement and needs to mentor a successor from within the agency. Mentorship is an urgently needed process in the

substance abuse field as a significant number of current leaders in the field face retirement in the near future.

Background

Margie is a certified clinical supervisor with 25 years' experience in the field. She is in her early 60s, has worked at the agency her entire career, and is, in fact, the longest-term employee at the agency. She is approaching retirement in the next 2 years. It is agency policy to promote from within whenever possible.

Betty has been in the field for 10 years and has been employed by this agency for 3 years. She is an excellent counselor and is well respected by colleagues in the agency. She has the potential to be promoted to Margie's position as clinical supervisor. However, she has professional development issues that need to be addressed before she could be promoted. For example, she would need training in clinical supervision skills and eventually will need to get her certification as a supervisor. She also has a managerial style that needs to soften a bit. She sometimes comes off as too authoritarian and abrupt. Previous attempts by other supervisors to address this style have not been successful in changing the behavior. Margie has worked with Betty for 3 years as her clinical supervisor but without a mentorship training plan.

The vignette focuses on how Margie can mentor her successor and the next generation of personnel so they could be promoted upon her retirement. The vignette addresses the necessary systems of mentorship that can be involved, what ought to be in Betty's IDP, and the coaching Margie will provide to Betty.

The dialog begins with a discussion about current and future personnel issues and Margie's pending retirement. Margie's goals in this session are to begin to define Betty's learning needs, to establish a mentoring relationship, and to pave the way for Betty to be accepted as a supervisor by others in the agency. Margie's approach is to be a positive, supportive coach and to encourage Betty to begin the professional development and training required to be a supervisor.

Learning Goals

1. To illustrate how to design a mentorship program for personnel, including the writing of mutually agreed upon IDPs for potential successors and all clinical staff. To illustrate the

process of establishing a supervisory alliance that incorporates principles of mentorship and training.

2. To suggest how to develop and maintain a strong collaborative and professional supervisor–supervisee relationship.

MARGIE: Betty, as you know, I'm beginning to wind down my career and am looking forward to retirement in 2 years. Our agency strongly believes in the idea of fostering our own leaders and promoting people from within. You and I have had a great relationship over these past few years. I've seen your skills and feel you have great potential to grow professionally and as an important professional in this agency. Your clinical skills are excellent, you always complete your paperwork on time, and you're a joy to supervise.

Master Supervisor Note: It takes a Level 3 supervisor to be able to mentor someone else. Level 1 and 2 supervisors might find it difficult to let go of the reins, to essentially work themselves out of a job, and might feel threatened by helping others develop to their own level of competence. A Level 3 supervisor needs superior vision: the ability to look ahead and see what's needed for the sake of the agency and staff. This requires maturity, serenity, and wisdom.

BETTY: Thanks so much, Margie. That really feels good. I really like my job and would like to continue working here.

MARGIE: I hope you continue working here. You're a great asset to the agency. You've just implemented some innovative ideas, and you're enthusiastic about the work. Whenever I ask you to take on an assignment, you're always the first to complete it. I like that. You've worked hard to become an excellent counselor. So, I'd like to have an idea where you want to be in 5 years. Would you be willing to discuss that with me?

BETTY: Sure. I hope I'm still here. I like the clients, my colleagues, and this agency. I like that I get to try new things. You've been supportive of that. This is a place where I'm able to make a contribution to my community.

MARGIE: So, this is “home” for you: That is so evident. It’s working really well for you. Perhaps we can discuss what’s ahead for you. What would you like to be doing differently here in the future?

BETTY: I don’t know. I’d like to continue to improve my counseling skills, maybe even advance up the ladder a bit. I think I have good individual and group counseling skills, but I also know administration involves another whole set of competencies.

MARGIE: You’re right, there are different skills in administration and that’s important to recognize. And I’m excited that you want to move up.

BETTY: Oh, that scares me a bit. I like seeing clients and wouldn’t want to become a paper-pusher, not that that’s all you do. [*Laughter*.]

MARGIE: I like that you want to stay anchored in clinical work. I think that is important and I appreciate your concern for clients. That’s one reason you’re so good at counseling. You have a real caring and compassionate nature for the people you work with.

[*A discussion follows about Margie’s job and what it means to be in a supervisory position at that agency. Margie outlines the roles and requirements of being a supervisor*.]

MARGIE: Another way to look at your contribution to clients and legacy in counseling might be in the fancy word used by Erik Ericson, who spoke of “generativity”: getting to a stage of life when you want to give some- thing over to the next generation of people to follow you. You’re having a great impact now on your clients. As you progress into a supervisory role, you have the potential of affecting even more clients and staff, as you train and supervise counselors.

BETTY: What do you mean?

MARGIE: Remember years ago in school? Can you recall any teachers that left their mark on you, people that helped you become the professional you are today?

BETTY: Yes, there were many.

[*A discussion follows about these mentors and how Betty benefited from their teaching*.]

MARGIE: As you supervise, you have the opportunity to touch more people’s lives. Yes, there is more dreaded paperwork. But, at the end of my day, I go home with a rich sense of legacy that I’ve had the chance to touch even more people’s lives as a result of being a supervisor, even more than I might have as a counselor alone.

BETTY: Yes, I see that in you. You've had a profound impact on my life and that of so many counselors here.

Master Supervisor Note: One of the most effective ways to lead is by example. Mentorship should include something of attraction; people should see something in you that they want. "Whatever she has, whatever she does, I want to have and do that." People are imitative; they find role models they want to be like. So, when mentoring, use personal examples for the potential to grow and impact on others. It is important to identify the qualities and characteristics of a positive mentor and role model for staff, such as eliciting, rather than imposing, their judgment; drawing ideas from the supervisee, and being positive and affirming.

Mentorship is a special kind of professional growth opportunity, differing from other supervisory models. In mentorship, the mentee asks questions, shares concerns, and observes a more experienced professional in a safe learning environment. Through reflection and collaboration, the mentee can become more self-confident and competent in his or her integration and application of the knowledge and skills gained. Mentorship addresses the unique needs, personality, learning styles, expectations, and experiences of each person. Mentorship can be defined in numerous ways. One definition is a working alliance offering regular opportunities for discussion, training, and learning to occur between less experienced and more experienced people in various settings, addressing practical, hands-on work experience to enhance the knowledge, skills, attitudes, and competencies of everyone.

MARGIE: So, perhaps we can discuss how you can increase your skills, both clinically and in supervision. This is the beginning of our developing and updating your IDP. One place to start would be for you to attend clinical supervision training. There are online courses, self-study programs, and classroom programs. I have a list of upcoming training events. I'd encourage you to take a look at these options and see whether you'd be interested in one of them.

BETTY: Sure, of course. I'm always open to training, especially if it's held on the beach, in a nice location. [*Laughter*.] Will the agency pay for the training? You know a counselor's salary will only stretch so far.

MARGIE: Yes, it would be part of your IDP. We fund professional development as much as possible.

BETTY: Thanks for the vote of confidence.

MARGIE: Further, I'd like you to start doing more staff training, using your clinical experience and conducting sessions for other staff.

BETTY: You mean like some of the presentations I do in the community, to staff here? That's a little intimidating, presenting to my peers.

MARGIE: It can be intimidating, presenting to people you
work with. BETTY: I assume you'll help me with that?

MARGIE: Yes. I also think you have the potential to present at State and national conferences. This would expand your repertoire of material, hone your speaking skills, build your confidence, and help you become better known outside the agency. We know you're good. It's time for others outside to see in you what we see.

BETTY: Really?

MARGIE: Really. I have a call for papers for a counselors' conference in Cincinnati this fall. I think you should submit a proposal. The conference's theme is PTSD and substance use disorders. I've heard you present here at the agency on this topic. The people attending the conference will be your peers. That's a good place for us to take another step in the mentorship process, and you can begin with an area where we know you're especially strong. I'll attend the conference, too, and we can discuss afterward how it went for you. I'm interested if you've ever thought of being acknowledged outside of the agency for what we all know you know.

BETTY: If I'm really honest with you, yes. I've gone to conferences and thought "I can talk on that subject." But it's always seemed immodest to say that out loud.

MARGIE: Yes, it's difficult stepping forward, not wanting to seem arrogant, but also acknowledging that you might have something others would benefit from hearing. So, how about putting your thoughts together for a proposal? It's due in 3 weeks. You and I can review the proposal together. I'm confident it will be accepted for presentation. When it comes to your actual presentation, you can do the outline and slides and we can discuss your ideas.

BETTY: So, is this what you meant by mentorship?

MARGIE: It's a good place to start. I'll never forget my mentor, Todd. He saw in me something I couldn't see in myself at the time. He believed in me when I was feeling uncertain and insecure about my abilities, when I wasn't even sure I wanted to stay in counseling for the rest of my life. He got me to do things I didn't think I could do. He made me really stretch and taught me some invaluable lessons I still remember. Perhaps I can discuss what I mean by mentorship. Would that be okay with you?

BETTY: Sure, I want to hear.

MARGIE: Well, this is my own view and from my own experience, but it seems to me that mentorship is when someone with more experience and professional maturity helps someone coming along to want to reach out for more and develop new skills. There are lots of new opportunities for mentorship that weren't available just a few years ago. Mentorship is different from our supervision relationship. Together we can identify areas of growth for you, and then we'll meet to discuss what we need to do so you can achieve your goals.

BETTY: I am honored (and a wee bit embarrassed) that you see that potential in me, and want to invest in my professional growth. I'm not sure anyone else has expressed that interest to me before. I'm really flattered.

MARGIE: It has been an honor for me to work with you these last 3 years. It also gives me great joy to see you grow professionally, and perhaps advance into supervisory and administrative positions here in the future.

Speaking nationally will give you better exposure. We'll start with that, if that's okay. Then we'll move on into other areas that we identify together on your IDP.

BETTY: Okay, if you really think I can do this.

Master Supervisor Note: One of the four foci of supervision is supportive, which includes at times cheerleading and encouragement. Often counselors may lack the confidence in themselves to step forward. Supervision should build on strengths, nurture assets, and support and encourage all personnel to grow.

Identifying staff with high potential for advancement is a key function of a supervisor. Through mentorship, personnel can grow professionally, and leader- ship succession can become a key aspect of the organization and field.

MARGIE: You can help our agency. We will see the scope and the focus of how you want to shape your career as it moves on.

BETTY: And you would be willing to make that kind of investment in me, Margie? MARGIE: I sure am. The agency surely is.

BETTY: You know how exciting this is? I am fluttering inside.

MARGIE: It's exciting for me too. I enjoy seeing staff use their potential to the fullest. It's something I can leave behind when I retire that will last far beyond my years of service. It's like looking into the eyes of children and seeing the future in them that I will never realize myself. If I can help mentor you and others, that will be the icing on the cake of my career.

BETTY: If I can grow to become a representative of the agency and to work more closely with you and learn from your experience and your wisdom, I'd love that.

MARGIE: Here are some other ideas where you might consider growing professionally: learning about leader- ship, creating a vision, business and financial management, continuous quality improvement, organizational development, conflict resolution, and on and on. I know that might all sound rather intimidating at this point, but there are many areas we can address. I'll be there with you throughout the learning and mentorship process.

[*Discussion continues about the next steps for Betty. First, they arrange to begin to revise and update her IDP and the strategies to reach her learning goals. The supervision session then turns to the future needs of the agency and how Margie and Betty can be part of the evolving future. The session ends with an agreement to begin writing an IDP and decide on the next steps for their mentorship.*]

Vignette 8—Making the Case for Clinical Supervision to Administrators

Overview

This vignette illustrates how a clinical supervisor can justify a system of supervision, along with time and resource allocations, to agency administrators in the light of recent pressures from the administration to increase billable hours. (Clinical supervision is not a billable expense at this agency.)

Background

Ella, a Level 2 supervisor, was recently hired to be the clinical supervisor of this agency, overseeing the work of six counselors. Jonathan is the agency's CEO and Ella's immediate boss. Jonathan has directed Ella to maintain supervisory functions "the way your predecessor did." Jonathan does not want to introduce any significant tasks into the workload, especially those that are not billable or revenue generating.

Ella, on the other hand, recently attended a 30-hour class on clinical supervision and is seeking her certification as a clinical supervisor. During the class she learned the importance of "making a reasonable effort to supervise," and the legal and ethical obligations of the agency to supervise. She learned about her and the agency's vicarious liability for the actions of the clinical staff. In the class, Ella was given the 20-to-1 guideline: for every 20 hours of client contact, staff should receive a minimum of 1 hour of clinical supervision.

Until now, staff has received primarily consultation and support with case management. To justify more in- depth clinical supervision, Ella needs the support and endorsement from Jonathan of the new supervision system. Given his emphasis on billable hours and reducing non-reimbursable activities, Ella knows that introducing these changes in the agency will not be easy, but she comes to Jonathan with her plan for supervision, asking for his endorsement.

Learning Goals

1. To describe the benefits and rationale of clinical supervision.
2. To design a system of supervision that is efficient and effective, without greatly increasing staff and supervisory time and resources.

3. To explore a system in which the supervisor can balance management and administrative duties, maintain a clinical caseload, conduct training, and perform other duties as assigned.

[*The vignette begins with a meeting between Jonathan and Ella to discuss her supervisory tasks and her plan. After a short introduction in which Ella discusses her feeling of being overwhelmed by her tasks, the dialog continues*.]

JONATHAN: The last time we met you were to look at how to improve the quality of our counseling and design a new plan for supervision. What did you come up with?

ELLA: Well, first I looked at what makes us a quality agency: our strengths and skills and our weaknesses and liabilities. We want to be the best agency possible. There are four issues that came to me. First, after the client suicide last year, concerns were raised about our liability as an agency. Even though we took the right action, we need to be mindful of our vicarious liability for what our staff does. I think we're both concerned about that issue.

Second, we're now required by the State to eventually have all counseling staff be certified addiction counselors. Our accrediting body is pushing us to provide better quality assurance systems with more clinical supervision.

Third, I know our organizational development plan calls for us to expand services in the near future. We need to attract high-quality counselors. That's difficult in a highly competitive market, with many agencies vying for good staff. We've had significant staff turnover in recent years for several reasons. I found that the average tenure of a counselor in our agency is 2 years, which, by the way, is consistent with the national average. We know from the exit interviews that the majority of staff who leave complain that we didn't provide as many good training and supervision opportunities as other agencies do to support their learning and self-care needs. It's costing us a lot of money to have such high staff turnover.

Finally, we need to increase our billable hours. Research tells us that the better the supervision, the better staff morale and in turn, the better the client services. This has a direct impact on our bottom line if we retain clients in treatment longer.

[*Ella gives Jonathan copies of various studies she's compiled from her training on the cost of staff turnover, the CSAT Manpower Study* (CSAT, 2003)*, and a synopsis on staff development issues from the agency's development plan*.]

Master Supervisor Note: Notice how Ella is well prepared for her presentation to Jonathan, providing a rationale in language and terms that appeal to administrators: concerns about liability, credentialing of personnel as mandated by the State, staffing needs and turnover, and billable hours. When presenting a proposal for a clinical supervision system to senior administrators, it is wise to:

1. Use terms and language that apply and appeal to administrators
2. Be prepared with facts and figures (e.g., the CSAT Manpower Study)
3. Be clear, direct, and succinct; most administrators value clarity, directness, and results oriented presentations
4. State clearly the goals, objectives, timelines, and costs for the system and have the data to support them

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JONATHAN: Wow, I'm impressed. You've done your homework. So, what is it you're suggesting? You know money is a key issue right now.

ELLA: Money *is* an important issue. I'm suggesting that we look at our current supervision system and that we design and offer a new system that will help counselors become credentialed, meet the requirements of our accreditation body, reduce our high turnover rates, protect our liability concerns, improve morale, and in turn, bring more money into the agency.

JONATHAN: That's a tall order. And you're going to do this without spending any money? [*Laughing*.] Let me go back to what you said. I thought after last year's suicide that we beefed up our oversight.

ELLA: Yes, we trained staff on how to deal with suicidal ideation and what actions to take. We were really sensitive to suicidal symptoms and documentation of issues. We have done a good job addressing that issue.

However, I have concerns about our liabilities in general. What is going on right now that we don't know about? What are our counselors actually doing behind closed doors? Is there another legal issue waiting for us that we don't know about? That's what I mean by our vicarious liability.

Without a sound, consistent system of supervision, it will feel like we're constantly putting our fingers in the dike.

Master Supervisor Note: When conceptualizing, justifying, and implementing a new comprehensive supervision program each level of staff—agency administration, supervisory staff, counselors providing direct services, and support staff—have unique concerns about the needs and effects of clinical supervision. Administrative staff are most likely to be concerned about some of the issues noted below:

1. Legal and ethical requirements for supervision, such as vicarious liability, scope of competence and practice requirements, and recent court rulings requiring clinical supervision. It is useful to stress the agency's fiduciary responsibility to ensure the quality of services provided.
2. Relevant Federal, State, and credentialing or accreditation requirements for supervision.
3. Staffing costs, such as personnel retention and turnover rates, hiring costs and expenses associated with retraining of personnel, and impact on staff morale. It is useful to provide any research data available in the field or from your agency.
4. Costs associated with implementing a supervision system, such as material and time costs and the impact on billable hours.
5. The cost benefit for implementing a supervision system, addressing: "What's in it for the agency? Why should we do this? What are the ramifications and costs if we don't?"
6. A timeline for implementation, with dates and deliverables, including bench- marks to measure success.

It is important that support in the form of data or relevant resource materials supplement these points.

JONATHAN: I agree. Are you telling me we're not doing our job? That our supervisors are not supervising?

ELLA: Our counselors are working very hard. We have fine staff here. Yet, we've got to give them more tools to do a better job, to continue to enhance their skills, and to ensure they recognize what they don't know. And, as we grow, the skills needed by staff will also grow.

JONATHAN: We're not doing that now? We have money in the budget for training. We send people to summer institutes every year. We have weekly training sessions. Isn't that supposed to address those issues?

ELLA: It does, but only partly. Much of what we do in these sessions is administratively oriented, addressing new policies, procedures, and paperwork, compliance issues, and personnel concerns. We're not doing *clinical* supervision.

JONATHAN: I'm confused. Maybe I don't have a good understanding of what clinical supervision is. I thought that's what we were doing. Are we better off than we were a year ago? I need to assure the board of directors that we're doing a better job, that the legal concerns of last year have been addressed.

[*Ella presents a brief and clear description of what clinical supervision is and how it differs from what they have been doing, which is primarily case management*.]

ELLA: We've made significant progress. You can assure the board of that. We've minimized some of our legal risk. We've addressed compliance issues. That's good! When you asked me to look at a quality assurance plan, it was clear our weekly staff meetings and training sessions only address some of the needs. We must increase our clinical oversight of staff. That's not just administrative in nature. In the course on clinical supervision, you sent me to, I found a definition that I think really makes my point. First, clinical supervision is a process where counseling principles are transformed into practical skills. Second, there are four focuses in clinical supervision: administrative, evaluative, supportive, and clinical/educational. We've addressed the administrative aspects of supervision well. We now need to increase the amount of evaluation we give staff, support them in their clinical duties, and train them by watching them work with our clients more closely.

Master Supervisor Note: In many agencies, administrators may not have a clinical background and thus may not understand the differences between case management and clinical supervision. A skillful supervisor patiently educates administrators about the distinction and stresses clinical concerns.

JONATHAN: I think I understand the difference. I'm not a clinician so I am not always familiar with terminology. So, what are you proposing we do?

ELLA: I need your endorsement and support for a system of supervision involving direct observation of counseling staff, so we shift the balance of our supervision from mostly administrative to include a clinical focus, too.

The supervision will address each counselor's skills, what competencies they need to develop further, and how each can best address the needs of the clients.

How To Demonstrate the Importance of Administrative Support for Clinical Supervision?

An individual developing a clinical supervision program for an agency clearly needs to explain to an administrator what is being asked of the organization. It is essential that administrators understand and support the supervision system. Without that endorsement, supervision systems will not be successful. Critical steps in this process include:

1. The endorsement of supervision to all staff should be both verbal and in writing.
2. Clinical supervision systems need the support of staff at all levels of management and in a manner, they will understand: how it will benefit them, the agency, and the clients.
3. Staff should hear a consistent message about supervision over time, lest they see the supervision system as the current "flavor of the month," and believe "this will pass as soon as another priority comes along." Staff need to hear that administrators have a long-term commitment to a consistent program of quality assurance in their supervision program.
4. It is essential that administrators understand that systemic change takes time. Although some immediate results will be seen, long-term results can best be measured over the long term. Many staff have settled into their ways of doing counseling and might take time to adjust to receiving clinical super- vision and make noticeable improvements in their skills.

JONATHAN: This is making me nervous. It's sounding like money. [*Laughing.*] You know the pressure we're under to increase billable hours and decrease activities that don't generate

revenue. Now you seem to be adding more activities and expenses. Where's the time coming from to do this?

ELLA: I understand the concern about increasing expenses. There are two answers. Remember the oil commercial years ago, that went something like: "Pay me now or pay me later, but you're eventually going to pay me." We're paying a lot for staff turnover and decreased productivity because people are feeling unsupported by administrators. Staff morale is lower, too. If we can provide better training and supervision, we can save the agency considerable expense. Second, if we can train our staff better, we can perhaps increase both the quality of our care and the number of clients we can serve. That goes right to the bottom line.

JONATHAN: Are you sure you didn't get an M.B.A. somewhere along the way? You sound like a business per- son. Are you saying we're not as productive as we might be? Isn't that an administrative issue if people are not doing their jobs?

ELLA: If we support them further, they could do an even better job. Our counselors are excellent at what they do. They work very hard and for long hours. Often that leads to burnout and eventually staff turnover. If we reduced that burnout through supervision, we'd keep them here longer, and their treatment of clients would improve. That would help our credibility in the community and eventually lead to more services and revenue. "Pay me now or pay me later." The choice is up to you.

JONATHAN: Okay. So what are you proposing, and what will it cost?

ELLA: For an agency our size, with only a few counselors, two clinical supervisors can do the job. At the same time, they can attend to some administrative issues too, in addition to their own clinical work. At the training, I learned of a system where a supervisor would spend about 3 hours a week supervising her counselors. Some of the time is observation, and the rest is individual and group supervision. I can show you the matrix we'd use to do this. Each counselor would be observed in action with a client at least once a month. The supervisor would meet with the team every week and review the case presented by the counselor of the week. We'd use videotape of counseling sessions to demonstrate the counselor's skills and actions. The group would view sections of the videotape, and we'd have an hour-long discussion of the tape. In some cases, instead of videotaping (it may not be appropriate to videotape some clients), the supervisor would sit in on the actual session

and observe. They'd then follow the same individual in small group supervision discussion. To do this, I need you to provide funds to purchase video cameras, tripods, and DVDs. We need $1,000 for this purchase. That will ensure we're making a reasonable effort to supervise and will significantly increase our clinical supervision system here. What do you think?

How To Implement a Clinical Supervision System

To clarify the above statement by Ella, if a supervisor oversees the work of one to five counselors, it typically requires 2–3 hours per week (see Figure 3 on p. 11). This entails relying on group clinical supervision and direct observation through audio- or videotaping or live supervision. Supervisors might need to provide additional time for close supervision of trainees, interns, or counselors needing specific attention. The critical aspects in rolling out a clinical supervision system include:

1. Administrative support. This should be in the form of both written and oral communication to all personnel showing administrators' support for clinical supervision.
2. Training of supervisors. Credentialing organizations require a certain number of hours of training to be certified as clinical supervisors. Simply because a person is a good counselor does not qualify them to be a supervisor. It requires another body of knowledge and skills to be a supervisor.
3. Educating staff about what quality supervision is and what to expect in the new system. A session for clinical staff should be held (1–2 hours duration), explaining the rationale for supervision, the policies, procedures, techniques, and expectations of supervision.
4. A system of supervision of supervision, monitoring the progress of supervisors in implementing the system, and providing feedback on how they are doing. This is sorely lacking for most supervisors, at least initially. This can be done through internal supervisors overseeing other supervisors, peer supervision of supervisors, or externally by contracting with a master supervisor to oversee the work of supervisors.

5. Consistency of the message that supervision is here to stay and that clinical supervision is a requirement of the agency.
6. Time to implement the system, acknowledging and working through staff resistance to change. Attitudes and behaviors about supervision change slowly. Thus, administrators need to understand that it takes time to work with personnel, to be clear about what's expected of them, and to overcome staff resistance.

JONATHAN: We can do that. That's a modest expense we can afford. How do I sell this to the board?

ELLA: What did the potential law suit cost us last year in legal fees? Surely more than the cost of three cam- eras. What does it cost us to train a new counselor when someone leaves? Surely more than the time we're investing in their training. Perhaps you could tell that board that if we can retain a staff member for 6–12 months longer, we'll save the agency far more than you've invested in supervision. By being careful, by providing quality supervision, in the long run, it will in fact save us money by being preventive.

JONATHAN: What else can I tell the board about this supervision system?

ELLA: You can tell them that when a counselor leaves, clients react and the quality of their care decreases. The board is interested in client satisfaction and treatment outcome. This supervision system will help with that.

JONATHAN: Okay, I'm sold. What's next?

ELLA: First, I want to submit to you this plan I've developed for the supervision system. I'd ask that you read it and next time we meet, if we concur, I'd like a written statement from you endorsing the plan. I'd also like you to introduce the program at our next all staff meeting. How does that sound so far?

JONATHAN: That's fair. Then what?

ELLA: Second, we need funding for the equipment. Third, we need to identify potential supervisory candidates from within the organization. If none can be found, we will have to look outside the agency to recruit a qualified supervisor. Fourth, we will begin to train our supervisors in this model of supervision. This can be done through a number of low-cost

media. Fifth, we will provide an in-service training for all staff on the supervision system. We need to be clear with staff that we're going to be observing them with videotape and/or direct observation. Some won't like that. Some staff will be quite resistant to the change. This will take time—likely about a year for everybody to be on board. You and I have to be consistent over time, reinforcing the message that this is how we're doing clinical supervision here, regardless of staff's credentials or years of experience. There's going to be a learning curve.

Master Supervisor Note: Again, it is important to be prepared for this presentation with a clear statement of funding requirements, training needs, mechanisms of how these needs will be met, and benchmarks for success. Further, it is essential to get a firm commitment to the plan from administrators before the supervisor proceeds. The supervisor should also stress the barriers and obstacles to be overcome and how those will be addressed.

JONATHAN: Some of the distinction between case management and clinical supervision will hopefully become clearer to me and staff as we implement the system. You're going to have to continue to educate me about it. I'd like to meet regularly with you, perhaps once a week during the roll-out, to discuss how we're doing. Since the State now requires our counselors to eventually be certified, will this help in that process?

ELLA: Absolutely. As you might recall, to be certified as an addiction counselor, the person must be supervised by a certified supervisor. This system will meet that requirement. It will help our counselors to be certified.

[*Jonathan and Ella summarize the advantages of a model for clinical supervision that includes workforce development and a means to implement evidence-based practices, address risk management issues and vicarious liability, create consistency within the agency, minimize reactivity, address accreditation issues, and support counselor wellness*.]

JONATHAN: Can you bring me a budget for what this will cost in person hours and hardware by next week? Talk to our accountant if you need costing data. How are we going to train our supervisors? What will that cost? What's the most cost-effective way of

conducting the staff and supervisor training? I'd like to see a 3-,6, and 12-month implementation and financial plan for this. Can you provide projections as to potential cost off- sets and savings on the other end? Can you have that for me by next week?

ELLA: Yes, I can do that by next week. I'll also give ideas as to how supervisors can balance management and administrative duties, maintain a caseload, and perform other duties as assigned.

Chapter 5: Creating a Clinical Supervision System

Clinical supervision should be an essential part of all … treatment programs. Every counselor, regardless of skill level and experience, needs and has a right to supervision. In addition, supervisors need and have a right to their own clinical supervision. Unfortunately, many agencies place a higher priority on administrative tasks (such as case recordkeeping and crisis management), than on clinical supervision. This guide for administrators will assist in developing a rationale for and designing a clinical supervision system for your substance abuse treatment organization. provides strategies and tools for implementing effective supervision along with advice on allocating resources for best results.

Benefits and Rationale

A successful clinical supervision program begins with the support of administrators. You communicate the value, benefits, and integral role of clinical supervision in quality care, staff morale and retention, and overall professional development within the context of the organization's mission, values, philosophy of care, and overall goals and objectives. Being able to discuss specific benefits of clinical supervision will increase the likelihood of internal support, enhance your organization's ability to deliver quality supervision, and add marketability for funding opportunities.

Administrative Benefits

Clinical supervision enables organizations to measure the quality of services. It ensures that employees follow agency policies and procedures and comply with regulatory accreditation standards while promoting the mission, values, and goals of the organization. Supervision provides administrators with tools to evaluate job performance, maintain communication between administrators and counselors, facilitate conflict resolution, and hold personnel accountable for quality job performance. Clinical supervision is a risk management tool that increases an organization's ability to respond to risk, thereby reducing overall liability. It also addresses human resource issues, including staff satisfaction and retention of personnel. Finally, supervision provides marketing benefits by improving the overall reputation of the agency in the community and among other service providers.

Clinical Services Benefits

The goal of clinical supervision is to continuously improve quality client care. Supervision by trained and qualified supervisors helps staff understand and respond more effectively to all types of clinical situations and prevent clinical crises from escalating. It specifically addresses assessment, case conceptualization, treatment strategies, and discharge planning. Supervision aids in addressing the unique needs of each client. It provides a mechanism to ensure that clinical directives are followed and facilitates the implementation and improvement of evidence-based practices (EBPs). "Quality supervision will become a major factor in determining the degree to which EBPs are adopted in community settings" (CSAT, 2007, p. 12). Clinical supervision also enhances the cultural competence of an organization by consistently maintaining a multicultural perspective. "Supervision encourages supervisees to examine their views regarding culture, race, values, religion, gender, sexual orientation, and potential biases" (CSAT, 2007, p. 27).

CSAT's Technical Assistance Publication (TAP) 21A, *Competencies for Substance Abuse Treatment Clinical Supervisors*, defines supervision as a "social influence process that occurs over time in which the supervisor participates with supervisees to ensure quality care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self motivation, learning, and professional development" (CSAT, 2007, p. 3). Also, supervision can improve client outcomes (Carroll, Ball, Nich, Martino, Frankforter, Farentinos, et al., 2006). Finally,

supervision increases staff members' sensitivity and responsiveness to diversity issues among staff, with clients, and between staff and clients.

Professional Development Benefits

Quality clinical supervision has been shown to increase staff retention through professional skills development and increased competency (Bernard & Goodyear, 2004). Supervision provides the forum for expanding current clinical practices, intellectual stimulation, emotional support, and improvement in critical thinking (see CSAT, 2007). Supervision is part of an organization's career ladder, as it supports staff in obtaining and maintaining professional credentials. It also provides information and guidance about key contextual factors that may influence their work performance such as culture, lifestyles, and beliefs.

Workforce Development Benefits

Supervision by trained and qualified supervisors is an essential tool in the recruitment and retention of personnel, as counselors often rate training and development as critical factors in their selection of employment. In addition, supervision has been shown to improve staff morale and motivation by making staff feel valued and appreciated (Bernard & Goodyear, 2004). It also assists in promoting counselor wellness, and promotes the overall development of the substance abuse treatment field by upgrading the credentials, knowledge, skills, and attitudes of personnel.

Program Evaluation and Research Benefits

Implementation of program evaluation and/or research is often misunderstood by counselors and viewed as more work that is unrelated to quality client care. Supervision can mediate in this area by providing staff with the rationale for the initiative, connecting it to client outcomes, and communicating achievements and challenges to the evaluators. Clinical supervision can also provide the mechanism for data gathering and information retrieval in support of the new projects and programmatic innovations.

B. Key Issues for Administrators in Clinical Supervision

Administrative and Clinical Tasks of Supervisors

Supervisors wear many hats. In most organizations, the administrative and clinical supervisor is the same person (see also the section that follows, Administrative and Clinical Supervision, p. 89). Most clinical supervisors still carry a client caseload (albeit reduced somewhat from that of a line counselor), perform administrative duties, write grant proposals, serve as project managers, and supervise the clinical performance of counselors. Each role involves different expectations and goals. It is important for administrators to be aware of each of these roles and for supervisors to be prepared to perform effectively in administrative, organizational, and clinical roles.

Kadushin (1976) outlines multiple administrative tasks for a clinical supervisor: staff recruitment and selection; orientation and placement of employees; work planning and assignments; monitoring, coordinating, reviewing, and evaluating work; staff communication both up and down the chain of command; advocating for client and clinician needs; acting as a buffer between administrators and counselors; and acting as a change agent and community liaison. Munson states, “As part of their administrative responsibilities, supervisors are often required to manage program transitions and modifications. Departments and programs can be altered, restructured and merged” (1979, p. 72).

Assessing Organizational Structure and Readiness for Clinical Supervision

In implementing a clinical supervision program, an important first step will be to evaluate the agency’s preparedness to support the functions of clinical supervision by identifying the agency’s culture and organizational structure. Organizational readiness scales and attitude inventories can be helpful in the process of assessing and adopting EBPs. You need to assess the following:

- How decisions are made within the organization (centralized versus decentralized, vertical or horizontal).
- How authority is defined and handled (top down, bottom up, through the chain of command, or ad hoc).
- How power is defined and handled (reward, coercion, legitimate power through status, prestige, titles, expert power through skills and experience, or referent power through respect for an individual—or all of the above).

- How information is communicated (structured/formal/informal, on a need-to-know basis, bidirectional feedback and communication).
- How the organizational structure influences supervisory relationships, process, and outcome.
- The overall cultural proficiency of the organization.

The following organizational issues should be considered by an agency before a clinical supervision system is implemented:

- *Organizational context.* How consistently do staff adhere to agency philosophy and culture? To what extent will clinical supervisors teach and support this philosophy?
- *Clinical competence.* What specific knowledge, skills, and attitudes are expected of substance abuse counselors? What is each counselor's baseline competence and learning style? What is the level of cultural competence of staff?
- *Motivation*. How should the staff's motivation and morale be characterized?
- *Supervisory relationships.* What is the nature of relationships between administrators and frontline workers? How healthy or unhealthy are those relationships?
- *Environmental variables.* To what extent do administrators expect supervisors to proactively teach ethical and professional values? Do staff have a common set of goals? How does the organization promote professional development? How is progress toward those goals monitored and supported? What is the cultural, racial, religious, gender, and sexual orientation mix of the clients served by the organization?
- *Methods and techniques.* How familiar is the organization with individual, group, and peer supervision? How familiar is the organization with case progress note review, case consultation methods, direct observation, live supervision, audio or videotaping, and role playing?

Assessing an organization's readiness for a clinical supervision system may also include such questions as: "What stage of readiness for implementing a clinical supervision system are the

board of directors, other administrative staff and clinical supervisory staff (if any), direct care staff, and support personnel? What are some of the organizational, administrative, and clinical barriers to implementing a clinical supervision system?" Potential barriers include lack of familiarity with supervision methods and techniques, the need for further training of supervisors, and lack of technical equipment such as video cameras. It is helpful to develop a timeframe for addressing the most important barriers. What would you as an administrator like to see happen and who should be part of the process for implementing clinical supervision? (See Tools 1 and 2 in chapter 2.)

Administrative and Clinical Supervision

This section is a comprehensive look at the issues facing supervisors in their dual roles. In the substance abuse treatment field, one of the major challenges facing supervision is the reality that most supervisors perform both administrative and clinical supervisory functions. The numerous conflicts and ambiguity that result from these roles can pose serious problems for administrators, supervisors, and supervisees. Determining the distinction between the roles of clinical and administrative supervision can be difficult because there are no uniform definitions of these functions. Most writing on administrative supervision is in the context of the evaluative and recordkeeping functions of a supervisor.

To the extent possible, administrative supervision should be distinguished from clinical supervision. Bradley and Ladany (2001) state that administrative supervisors "help the supervisee function effectively as a part of the organization," with an emphasis on "organizational accountability, case records, referrals, and performance evaluations" (p. 5). In contrast, clinical supervisors focus on the services received by the client, including the therapeutic relationship, assessment, interventions, and client welfare. While these tasks may be seen as substantially different, many are complementary. Therefore, you and the supervisors need to be mindful of the different roles and of the inherent ethical, relational, and role conflict issues. Best supervision practices will work to keep the dual roles as clear as possible.

Legal and Ethical Issues for Administrators

You play a vital role in clarifying legal and ethical issues for your organization, especially for clinical supervisors and counseling personnel. You are invaluable in providing information and support for supervisors and staff.

You and your supervisors need to define and document (in writing) the legal and ethical standards for the agency. You can draw from the staff's professional codes of ethics as well as accepted best practices. All personnel should be consistently and continually trained in the agency's legal and ethical standards, as well as in changing case law and legislation affecting clinical practice. You need to reinforce your support for supervisors who face situations where legal and ethical issues may arise. You should help supervisors develop a process for ethical decision making as supervisors as well as a process for teaching ethical decision making to counselors.

Among the key issues for you and your supervisors are the following:

- *Direct and vicarious liability.* Important factors affecting liability include the supervisor's power of control; the counselor's duty to perform a clinical service; the time, place, and purpose of the service; the motivation for responding the way the counselor responded; and the supervisor's expectations for action. Critical legal questions for administrators are: Did you make a reasonable effort to supervise? Was there any dereliction of duty? Did treatment create any harm, wrongdoing, or damage to the client, the organization, or the community? Did you and the supervisor give appropriate advice concerning the counselor's actions? Were tasks assigned to staff that were outside their scope of competence?

Confidentiality. Has the organization adhered to all laws of confidentiality (i.e., the Health Insurance Privacy and Portability Act [HIPAA], 42 CFR, Part2)? To what extent has the organization balanced the counselor's and client's right to privacy and performance review? Has the organization adhered to its duty to warn, to report, and to protect?

- *Informed consent and due process.* This requires that supervisees and clients be fully informed as to the approach and procedures of the agency's actions (see Tools 4 and 19). Have the clients and counselors been informed about treatment parameters and supervision requirements? Have all required forms and documents been read and signed by all relevant

parties? Is there a fair process that encourages conflict resolution and ensures the person a process of appeals?

- *Supervisor and counselor scope of competence.* Are supervisors and counselors operating within their scope of practice and competence? Are supervisors and counselors meeting minimal standards of competence regarding cultural and contextual awareness, knowledge, and skills? Are they effectively working within the wider client systems and networking appropriately with wider community services and institutions?
- *Dual relationships.* A dual relationship exists when a supervisor and supervisee or counselor and client have an additional relationship outside the primary professional relationship. Guidelines for supervisory relationships prohibit supervising current or former clients (a difficult issue in the substance abuse field where it is not uncommon for an agency to hire and supervise former clients in recovery). Do any supervisors have current or former romantic or sexual partners, business associates, family members, or friends among their supervisees? Is the distinction clear between the teaching and supervisory roles when students are being supervised? Are supervisors mindful of crossing over from the supervisory relationship to social activities with supervisees that may impair objectivity? Do supervisors avoid excessive self disclosure in supervision and avoid comments or actions that might be interpreted as sexual? Do you and your supervisors respect and recognize professional boundaries in all aspects of your relationships? When in doubt, do you consult with colleagues?

You should provide comprehensive legal and ethical orientation to all employees, review codes of ethics at the time of hire, and require employees to sign a statement that they will abide by these codes. You will want to review agency adherence to these codes periodically under the umbrella of a quality assurance or compliance program. Clinical supervisors should be proactive and provide documentation that describe and conceptualize client problems addressing potential legal and ethical dilemmas, document all clinical directives given, and offer counselors a written summary of recommendations. Finally, you should review liability insurance coverage and suggest that supervisors and counselors maintain their own personal professional liability and malpractice insurance.

For further legal and ethical issues, the reader is referred to the forms in this section.

Diversity and Cultural Competence

An important responsibility for supervisors is to continually improve their cultural competence in order to teach and support staff. Cultural competence is gained through education and training, supervised clinical work, and ongoing exposure to the population being served. All potential supervisors should be required to receive training in cultural competence. It is the supervisor's responsibility to initiate discussions of differences in race, ethnicity, gender, religion, socioeconomic status, sexual orientation, or disability regarding both clinical work with clients and supervisory and team relationships. This promotes the acceptance of diversity and cultural issues as appropriate topics of discussion and allows the supervisor the opportunity to model culturally competent behaviors.

To appreciate the importance of cultural competence, counselors must first recognize "the power of their own cultural assumptions to influence their thinking and their interactions with others" (Bernard & Goodyear, 2004, p. 118). From there, supervisors can help supervisees understand how their own diversity variables affect their interactions with clients. Administrators should be watchful for problems that can arise in the supervisory relationship when supervisors are of a different race, culture, or ethnicity than their supervisees. Fong and Lease (1997) have identified four areas that might present challenges:

1. *Unintentional racism.* Well intentioned supervisors who are unaware of how their racial identity affects their relationships with supervisees may avoid talking about race or culture.
2. *Power dynamics.* The power differential in the supervisory relationship may be exaggerated in dyads where the supervisor is part of the dominant group and the supervisee is a member of a minority group.
3. *Trust and vulnerability.* Supervisees who are in a vulnerable position are, at the same time, encouraged to trust their supervisors, when they may have little reason to do so.
4. *Communication issues.* Differing communication styles among cultural groups can result in misunderstandings.

An excellent exercise for you and your supervisors is to evaluate how supervisors measure up to multicultural supervision competencies. Bradley and Ladany (2001) list the following in what they term the “supervisor focused personal development” domain:

- “Supervisors actively explore and challenge their own biases, values, and worldview and how these relate to conducting supervision;
- Supervisors actively explore and challenge their attitudes and biases toward diverse supervisees;
- Supervisors are knowledgeable about their own cultural background and its influence on their attitudes, values, and behaviors.
- Supervisors possess knowledge about the background, experiences, worldview, and history of culturally diverse groups; and
- Supervisors are knowledgeable about alternative helping approaches other than those based in a North American and Northern European context” (pp. 80–81).

Developing a Model for Clinical Supervision

An organization must develop a model for clinical supervision that best fits its needs. What are its underlying needs, goals, and objectives? What models are available to assist in reaching your organizational goals? The model should be selected in light of the organization’s mission, philosophy of treatment, and orientation. You need to assess the organization’s readiness for implementing a supervision system and barriers that might impede the process. What are the organization’s capacities for implementation? Once implemented, how will the program’s quality be evaluated? How will continuous quality improvement strategies be incorporated into the supervision model? And if the program is successful, how will it be sustained?

An effective model for clinical supervision will keep the target clear: ensuring that the client receives better treatment as a result of the clinical supervision system. In addition:

- It will begin with the supervisors’ unique management or leadership style, their levels of proficiency in supervision, the organization’s philosophy about clinical supervision, and the specialized client needs for clinical services.

- It will improve counselor competence, make work more manageable, encourage staff to stretch beyond their current capabilities, build mastery and growth, and meet the needs of the client, counselor, agency, and credentialing bodies.
- It will encourage supervisees to grow professionally in their understanding of culture, race, religion, gender, and sexual orientation as these issues are present clinically.

Implementing a Clinical Supervision Program

TAP 21A (CSAT, 2007) describes the importance of using a clearly articulated process for implementing a new model of clinical supervision in both State and local agency settings as follows: “If agencies are to improve their supervisory practices by adding activities identified as clinical supervision competencies, a set of guidelines is needed to support the development of an implementation plan” (p. 7). To ensure a smooth transition to the new supervision program, an agency will need to perform the following tasks: defining or clarifying the rationale, purpose and methods for delivering clinical supervision; ensuring that agency management fully understands and supports the changes that need to be made; providing training and support in supervisory knowledge and skill development; and [o]orienting clinicians to the new supervision rationale and procedures” (p. 7). These tasks are part of an implementation process whereby the changes are introduced over a limited period of time that allows for procedures to be developed and tested and clinicians to provide feedback and adjust to the supervisory process. “The broad goal is to create a continuous learning culture within the agency that encourages professional development, service improvement, and a quality of care that maximizes benefits to the agency’s clients” (p. 8).

More detailed guidelines for implementing and phasing a clinical supervision system into existing processes include:

1. You need to be clear as to the organization’s goals of supervision, viewing supervision as a way of supporting and reaching the agency’s mission.

You should be familiar with the skills and competencies outlined in TAP 21A (CSAT, 2007) and other experience and/or credentialing requirements. The competence of the designated supervisors is central to the successful design and implementation of the program. In some cases, agencies will need to invest in additional training for potential clinical supervisors. Ask yourself the

following about your supervisors: Has the supervisor had formal training and is he or she credentialed in counseling, substance abuse, and clinical supervision?

At what level of supervision proficiency are the clinical supervisors?

Has the supervisor received supervision of his or her clinical skills?

What is the supervisor's relationship with staff?

What is his or her level of cultural proficiency and ability to work with culturally diverse clients?

It is essential that a clear statement of support from senior administration be provided both verbally and in writing to all levels of administration, counselors, and support staff. This statement should provide a rationale (see p. 95) for implementing clinical supervision. The importance of this step cannot be overemphasized.

4. The next step in implementing a clinical supervision system is to create a Change Team from within your organization to spearhead the effort. Selecting the appropriate agency representatives to be the link between you and the supervision system will ensure internal communication and support. The Team should comprise individuals committed to quality care and the supervision process. They need to be somewhat familiar with the process of supervision and have a clinical background. Supervisors need to have a thorough understanding of the agency's model and techniques of supervision. The Change Team leader will ensure participation and follow-up with the organization's clinical supervisors. Planning specific steps to ensure sustainability of the system is integral to long-term success.

5. You, the Change Team, and clinical supervisors should read and understand the importance of the standards outlined in TAPs 21 (CSAT, 2006) and 21A (CSAT, 2007). Each counselor should have a copy of TAP 21 (*Addiction Counseling Competencies—The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 2006]). It is important for clinical supervisors to meet with the Change Team to discuss the skills and competencies in TAP 21A, and to identify both the organization's strengths and areas needing improvement. The Team should draft formal policies and procedures to articulate expectations and guidelines.

6. An all-staff meeting should feature the organization's view of clinical supervision and how it will implement the supervision system. The formal policy and procedure should be distributed and

discussed. All clinical staff involved in the system should attend this briefing, presented by the Change Team leader and key clinical supervisors.

7. Provide necessary training, time, and funding for supervisors. Because the training requirement for credentialing as clinical supervisors is typically participation in a 30 hour class on supervision, you need to ensure that all supervisors receive training before proceeding to comprehensive implementation.

8. If the organization is sizable or the clinical staff is large, it is sometimes helpful to initiate a pilot supervision system in selected units of the organization. This is an issue that can be addressed by the Change Team. If organizational staff are particularly resistant to implementing the supervision program, it may be helpful to demonstrate the efficacy of a quality supervision program via a pilot program.

9. Supervisors should prioritize discussing the supervisory agreement or contract with each supervisee and invest time to determine the training needs and goals for each counselor. This is the beginning of an Individual Development Plan (IDP), outlining the counselor's knowledge, skills, attitudes, and cultural competence. It is essential that the supervisor observe the counselor in action before rating her or his abilities. Rating scales provide the baseline from which to begin supervision. Both supervisors and counselors should develop and complete rating scales and IDPs. Dialog on areas of agreement and disagreement at the outset form a vital part of the supervision process. This discussion also provides the supervisor with an opportunity to praise staff members for their strengths.

10. Supervisors should schedule formal, frequent, and regular individual supervisory sessions. These sessions, similar to individual sessions with clients, need to be respected and protected from unnecessary interruptions or distractions. The supervisory sessions should be documented and follow the prescribed focus outlined in the IDP.

11. To begin direct observation, design an implementation strategy (assuming the organization has recognized the value of direct observation; see Part 1, chapter 1), and establish a weekly rotation schedule for the observation of each counselor over the next 3 months. Initially, the clinical supervisor can provide direct observation feedback to counselors individually and then move toward a group supervision model whenever practical and possible to promote team building and efficiency. To help with sustainability, the supervisor should discuss supervision at every opportunity. Staff needs to see that supervision will be conducted on a regular basis, and

that frequency will be determined by the agency's needs and those of the individual counselor and team.

1. Provide feedback and review the IDP. Through the observation, the supervisor and counselor can discuss the strengths and challenges of the counselor's performance. The developing IDP should outline in detail the areas for improvement and how these changes will be further observed and monitored. Learning goals evolve as continued observation leads to further suggestions for improving performance.

2. Supervisors should document their direct observation using various forms that exist for this purpose. The documentation should include times of meetings and observation, a brief statement of the content of the clinical session observed, review procedures (audio or video tape), feedback provided, and mentoring and teaching offered.

3. Incentive plans can be developed to encourage counselors to become seriously involved in their professional development.

4. Create a sustainable treatment team. Over time, some staff will leave and others will join the team. It is important for you and your supervisors to work with the team to create an atmosphere of learning that supports the agency's commitment to clinical supervision. This means including the clinical supervision policy and procedures in the orientation of new staff. It definitely means that the team will continue to meet for supervision on a regular basis.

5. Develop a system of supervision of clinical supervisors, particularly for those who are new to their role. Supervisors need to continually build and improve their supervisory skills as well as have a forum to discuss staff challenges. Some agencies have created supervisory peer groups where the supervisors present and receive feedback on their supervision, other agencies hire a consultant to provide supervision, while some regional coalitions have established monthly forums.

Some of the primary elements in a supervision of supervisor's system include:

- *Direct observation.* This may best be done by periodically (e.g., once a calendar quarter) videotaping a supervision session and having the supervisor's supervisor review the

videotape. They then discuss what occurred during the supervision, with the supervisor's supervisor providing feedback and recommendations.

- *Competencies.* It is important that the supervisors of supervisors be Level 3 counselors and preferably Level 3 supervisors (see Figures 5 and 6 in Part 1, chapter 1). They need to be certified clinical supervisors and to have had supervision as supervisors themselves so they have experience with this type of supervision. Administrators should give them the responsibility and authority to perform this task and to require that tapes be provided for review in a timely fashion. Supervisors should develop the competencies sufficient to attain their credentials as a certified clinical supervisor.

- *Recordkeeping system.* A logging system should maintain records on the initial counselor–supervisor sessions and the supervision of supervisors sessions.

- *Recruiting personnel.* If your agency does not have an internal person to provide the supervisor's supervision, it is recommended that you contract for such services with external sources. Over time, the external supervisor should train an internal person to assume this role.

E. Phasing in a Clinical Supervision System

The steps below have been found to be helpful in phasing in clinical supervision systems in an orderly manner. Although the list is provided sequentially, the needs of an agency will determine the timeframe and selection of objectives.

Phase I: Organization and Creation of a Structure

- Assess and describe the agency culture (including assets and deficits), selecting assets to build on and/or deficits for remediation regarding clinical supervision.

- Assess the facility's policies and procedures to determine the feasibility and practicality of a clinical supervision system (i.e., presence of clinical supervisory staff, availability of direct observation technology, etc.).

- Examine job descriptions to determine staff scope of practice and competence.

- Reach consensus among the Change Team about the definition of clinical supervision and its key components for that agency.
- Publicize this consensus statement to all personnel, introducing staff to the new supervisory model and clearly communicating expectations for the delivery and outcomes of clinical supervision before program implementation.
- With all personnel, discuss and introduce clinical supervision policies and procedures.
- Review the organization's cultural competence as it relates to the client populations served.
- Develop documentation and accountability systems.

Phase II: Implementation

- Implement a supervisory contract, including informed consent, with all staff to improve the supervisory working alliance.
- Assess the quality of the supervisory relationship and devise interventions to strengthen the learning alliance.
- Conduct counselor assessments to establish competency baselines.
- Design initial supervisory goals and measurable objectives for each counselor.
- Use strengths-based approaches where appropriate and possible in clinical supervision, supporting counselors' positive actions with clients.
- Develop a system of supervision of supervision. Some programs use the same taping and monitoring systems for supervisors that are used between counselors and clients, with supervisors expected to videotape their supervision sessions at least once a month, and receive supervision of their supervision by the team of supervisors and/or their supervisor.

Phase III: Establishing a Training Plan and Learning Goals

- Complete a written IDP for each counselor.
- Provide focused, on-the-job training.

- Identify clinical supervision quality indicators to monitor the quality assurance program for the agency.
- Periodically review job descriptions and evaluation procedures to ensure that counselor competencies are sound. Review the counselor's ability to perform the TAP 21 competencies, the activities and functions performed by a substance abuse counselor that form the basis of the standards required in many States for credentialing. Also see the Northwest Frontier Addiction Technology Transfer Center Performance Rubric at http://www.attcnetwork.org/documents/ Final.CS.Rubrics.Assessment.pdf.

Phase IV: Improving Performance

Proficiency in the Addiction Counseling Competencies (CSAT, 2006) and the International Certification and Reciprocity Consortiums 12 Core Functions should be the subject of continuous assessment and professional development during clinical supervision. Additional specific performance concerns include:

- Continually align the clinical supervision goals to the agency's mission, values, and approach;
- Create risk management policies and practices and monitor adherence;
- Address the cultural competence of personnel in supervision;
- Consistently address a deepening of counselor knowledge, skills, and attitudes about legal and ethical issues;
- Use formative and summative evaluation and feedback procedures to inform the clinical supervision process;
- Develop quality improvement plans for the agency, including clinical supervisory procedures;
- Overtly address and encourage counselor and staff wellness programs;
- Invest in counselor and staff training; and
- Foster your staff from within, continually seeking individuals with the potential to become tomorrow's supervisors.

Documentation and Record Keeping

Overseeing documentation and record keeping is an essential administrative task, as maintaining a supervisory record has multiple purposes for administrators, supervisors, and counselors. One of the primary purposes of documentation is to serve as the legal record for the delivery of supervision: a reasonable effort was made to supervise. The supervisory record is also important in developing a thoughtful plan for both quality client care and professional development. The supervisory record serves to:

- Improve client care.
- Model good recordkeeping procedures for personnel.
- Afford and enhance ethical and legal protection.
- Provide a reliable source of data in evaluating the competencies of counselors.
- Provide information concerning staff ability to assess and treat clients.
- Reflect staff understanding of the dynamics of behavior and the nature and extent of the problems treated.
- Assess staff cultural competence and proficiency.
- Provide information about the clinical supervisor's ability to assess counselor competencies and the nature of the clinical supervisory relationship.
- Provide information about the clinical supervisor's clinical and supervisory competence.

A good clinical supervision record should include the following elements:

- Requirements for counselor credentialing (certification/licensure) and the extent to which each counselor meets those requirements.
- The counselor's regularly updated resume and a brief summary of his or her background and clinical expertise.
- A copy of the informed consent document, signed by the supervisor and the supervisee.
- A copy of the clinical supervision contract, signed by the supervisor and the supervisee.

- The IDP, updated minimally twice a year and preferably every 3 months.
- A copy of the formative and summative evaluations the supervisor has given to the supervisee and all relevant updates to these evaluations.
- A log of clinical supervision sessions, dates, times; a brief summary of key issues discussed; recommendations given by the supervisor and actions taken by the counselor; documentation of cancelled or missed sessions by either the supervisor or supervisee; and actions taken by the supervisor when supervision sessions are missed.
- A brief summary of each supervision session, including specific examples that support learning goals and objectives.
- A risk management review summary, including concerns about confidentiality, duty to warn situations, crises, and the recommendations of the supervisor concerning these situations.

The entire documentation record can be brief and in summary form.

Evaluation

Although training in how to conduct productive and constructive evaluations of personnel is rare, evaluation of personnel is a critical administrative task of supervisors and administrators. The goals of evaluation include, but are not limited to, reviewing job performance; assessing progress toward professional development goals; eliciting future learning goals; assessing fitness for duty and scope of competence; and providing feedback to staff on adherence to agency policies, procedures, and values.

There are a number of issues that shape the feedback process, including:

- How does the agency define a “good” counselor? What knowledge, skills, and attitudes are critical? What level of cultural competence is needed?
- How does a supervisor measure general affective quality, such as counselor’s empathy, respect, genuineness, concreteness for clients?
- What standardized tools will be used to support the evaluation? There are few evaluation instruments with psychometric validity or reliability.

The IDP can be the basis for evaluation. Each counselor should have a development plan that takes into consideration her or his counseling developmental level (see Stoltenberg, McNeill, & Delworth, 1998), learning needs and styles, job requirements, client needs, and the agency's overall goals and objectives. A sample IDP is provided in chapter 2 (Tool 15).

How do administrators and supervisors evaluate personnel and assess job performance? There are two forms of evaluation: formative and summative. Formative evaluation focuses on progress, is regularly provided, and gives feedback to the employee regarding his or her attainment of the knowledge, skills, and attitudes necessary to the job. It addresses the question, "Are you going in the right direction?" The quality of the supervisory relationship determines the success of the formative evaluation process. Summative evaluation is a formal process that rates employees' overall ability to do their job and their fitness for duty. It answers the question, "Does the employee measure up?" In substance abuse counseling, summative evaluation takes into account many variables: the range and number of clients seen, the issues and problems addressed by the counselor, the general themes in training and supervision, skill development, self-awareness, how learning goals have been translated into practice, and the employee's strengths, expertise, limitations, and areas for future development. Summative evaluation also addresses the nature of the supervisory relationship and goals for future training.

The best evaluations occur when there is open exchange of information and ideas between the supervisor and counselor, where specific examples are gleaned from the ongoing supervisory documentation, and expectations are again reviewed and agreed upon. Some organizations have moved to 360 degree assessments, with input from many layers of the organization. Tool 13 in chapter 2 is a counselor evaluation of a supervisor. The quality and quantity of feedback from a supervisor is an important part of supervision, according to supervisees (Bernard & Goodyear, 2004). Formalized feedback and evaluation is designed to review the ongoing, frequent feedback provided over time in a supervisory system (see Tool 14).

Conducting an evaluation involves exercising authority and power. When supervisors evaluate counselors, they are also evaluating themselves and their effectiveness as supervisors with particular supervisees. The evaluation process brings up many emotions for both parties. In providing feedback, supervisors should:

Provide positive, as well as constructive, feedback:

- Differentiate between databased and qualitative judgments about job performance.
- State observations clearly and directly.
- Prioritize key areas for review rather than flood the counselor with an all-inclusive review.

Supervisees prefer:

- Clear explanations.
- Written feedback whenever possible.
- Feedback matched to their counseling development level.
- Encouragement, support, and opportunities for self-evaluation.
- Specific suggestions for change.

Feedback should be:

- Frequent.
- As objective as possible.
- Consistent.
- Credible.
- Balanced.
- Specific, measurable, attainable, realistic, and timely: SMART.
- Reduced to a few main points.

Supporting Clinical Supervisors in Their Jobs

Being a supervisor in any setting is a difficult job. The supervisor represents the concerns of administrators, counselors, and clients. Supervisors advocate on behalf of those above and below

them in the organization chart. Hence, it is imperative that you provide support for the clinical supervisor in the agency and in the job.

To show support for clinical supervision, review the organization's receptivity to supervision: Is its climate for change, tolerance, and commitment conducive to efficient implementation of a clinical supervision system? Also, assess the magnitude of the proposed supervision system and the critical factors needed for success. "The agency structure and the supervisory program within it define the parameters of the supervisory relationship. Decision-making processes, autonomy within units, communication norms, and evaluative structures are all relevant to the supervisory function" (Holloway, 1995, p. 98).

To assess the organization's receptivity to supervision, you should address the following issues:

1. To what degree does the organization value accountability and have clear expectations of its personnel?
2. How is supervision tied to an employee's ongoing performance improvement plan or performance incentive program?
3. To what extent does the organization have efficient and effective systems in place to manage day-to-day operations?
4. To what extent does the organization view itself as a learning environment, encouraging inquisitiveness, creativity, innovation, and professional development?
5. To what extent does the organization value upward and downward communication and relationships by creating opportunities for staff to be heard? Does the organization understand that the learning alliance and relationship is key to successful supervision?
6. In what ways is the organization a dynamic, growing organism that values everyone's contribution?
7. To what extent does the organization "provide diversity training and other experiences that empower [a counselor] to become an advocate for the organization's target population and an agent of organizational change"? (CSAT, 2007, p. 31)

8. How does the organization view teamwork, and what structures are in place to support the teambuilding process?
9. How do lines of authority and communication operate in the organization? How do formal and informal decision-making processes that influence the supervisors' functions work?
10. To what extent do administrators know about and understand the process and practices of clinical supervision? What training do they need in this regard?
11. What is the common ground in understanding the relationship between the administrative and clinical functions of the supervisor?
12. If the organization does not have trained and motivated clinical supervisors, what is your plan for recruiting new supervisors and/or training current supervisors who will be able to take on this new responsibility?
13. Are the job descriptions and roles clear, current, and accurate for all personnel?
14. How much supervision of their supervision will the supervisors receive from administrators or other consultants?

You support clinical supervision when you help supervisors build an organizational climate in which they can do quality work. This entails the following factors:

1. Allocating time for clinical supervision. Since supervision is not (in most cases) a revenue generating activity, administrators may tend to minimize the importance of quality clinical supervision and fail to provide the needed time to "make a reasonable effort to supervise." A matrix presented in Part 1, chapter 1 gives guidelines to supervisors for organizing their time and providing quality supervision.
2. Making clinical supervision an agency priority. You can support the clinical supervisor with a clear statement of the importance of supervision and provide the resources needed to perform this function. This might include the acquisition of taping equipment, provision of one-way mirrors, etc. Staff need to hear unequivocally that supervision is a necessity and a requirement for all personnel, regardless of years of experience, academic background, skill and counselor developmental levels, and status within the organization. Supervisors also need supervision.

3. Supporting creative methods for supervision. As this TIP advocates for direct methods of supervision through one-way mirrors, video/audio taping, and live observation, you can state clearly that “at our agency we observe.” Other methods for clinical supervision might include group or peer supervision models (see Part 1, chapter 1).

4. Building and supporting a recordkeeping process for clinical supervision. This entails providing time and tools for the documentation related to clinical supervisory and administrative functions. Supervisory notes need to be integrated with clinical notes and human resource files. One good documentation system is the Focused Risk Management Supervision System (FoRMSS; Falvey, Caldwell, & Cohen, 2002). Assisting in organizing the supervisory process by investing in activities that will increase productivity over time, setting and adhering to priorities, and increasing coping skills repertoire to manage multiple tasks through cross training and team building. You also need to periodically review job descriptions, personnel strengths and aptitudes, and cultural competence, and reorganize workloads accordingly. You should periodically review the purpose and function of every meeting and seek to streamline meeting times for economy and efficiency.

5. Assisting supervisors in implementing agency priorities, such as the adaptation of EBPs to fit the agency’s goals and objectives. Hence, if an organization is implementing an EBP, it is imperative that supervisors also be trained in how to supervise that practice, perhaps even before counselors are trained.

6. Assisting supervisors in other personnel functions, such as working with impaired professionals and providing an employee assistance program (EAP) as a resource to supervisors and supervisees. You and your supervisors need to work together when staff are involved in ethical or legal issues that might impair the organization’s function and credibility, and the supervisor needs to keep the administrator informed of all actions taken throughout the process.

7. Supporting supervisors in developing cultural competence within the organization. This entails hiring culturally competent clinical supervisors and staff and providing personnel training on cultural issues. It also requires supporting supervisors in developing and improving cultural competence in counselors.

Professional Development of Supervisors

You both support clinical supervisors in their function and monitor their professional development and performance by:

- Building a system to monitor, evaluate, and provide feedback to clinical supervisors. Supervision of one's supervision is lacking in many organizations. Every clinical supervisor is entitled to and needs to have some form of supervision of their supervision, either live or online.
- Creating IDPs with all supervisors. Even as every client needs a treatment plan and every staff member needs an IDP, every clinical supervisor also needs an IDP. Supervisors' IDPs are jointly developed and monitored by the clinical supervisor and his or her supervisor.
- Helping supervisors develop a professional identity as a supervisor. This entails encouraging the supervisor to be credentialed as a clinical supervisor. They should also receive ongoing training required for recertification.
- Providing time for them to work with a mentor (either someone within the organization or an outside consultant).
- Requiring an annual minimum number of clinical supervision training hours.
- Offering time and resources for supervisors to participate in State or local support groups for supervisors.
- Providing job performance evaluations on a regular and timely basis.

The End

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