

Supervision Essentials for the Practice of Competency-Based Supervision

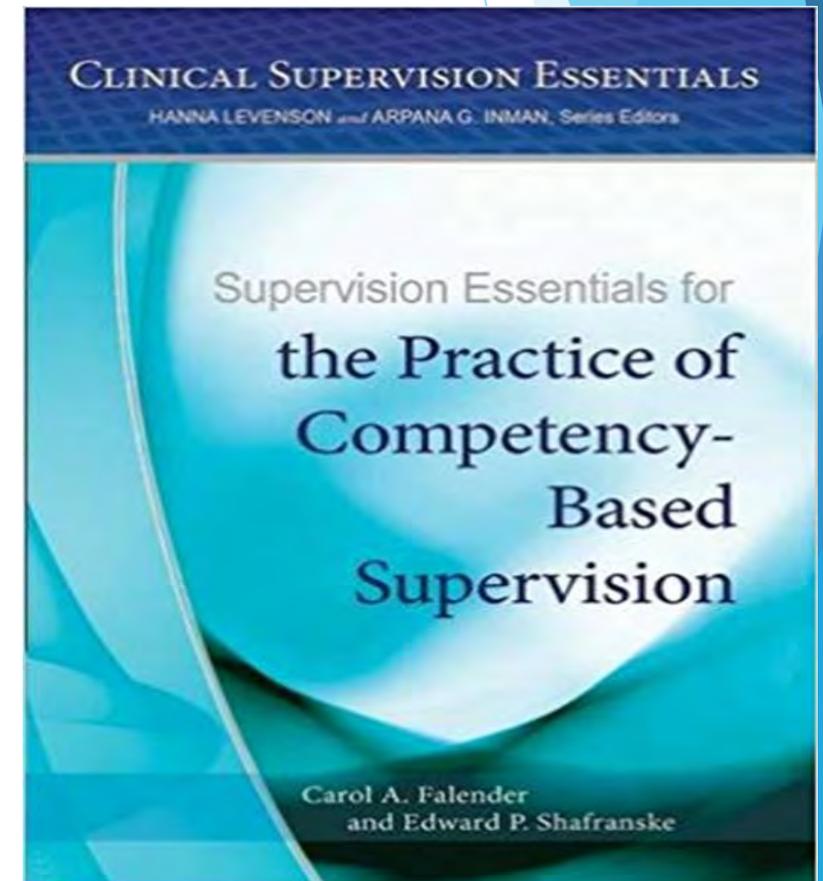
Adapted from the book by Carol A. Falender
& Edward P. Shafranske

PRESENTED BY Shannon McCabe, MA, LCAS,
CCS, CCJP, CPS



CE TRAINING WORKSHOPS

Training for Professional Excellence

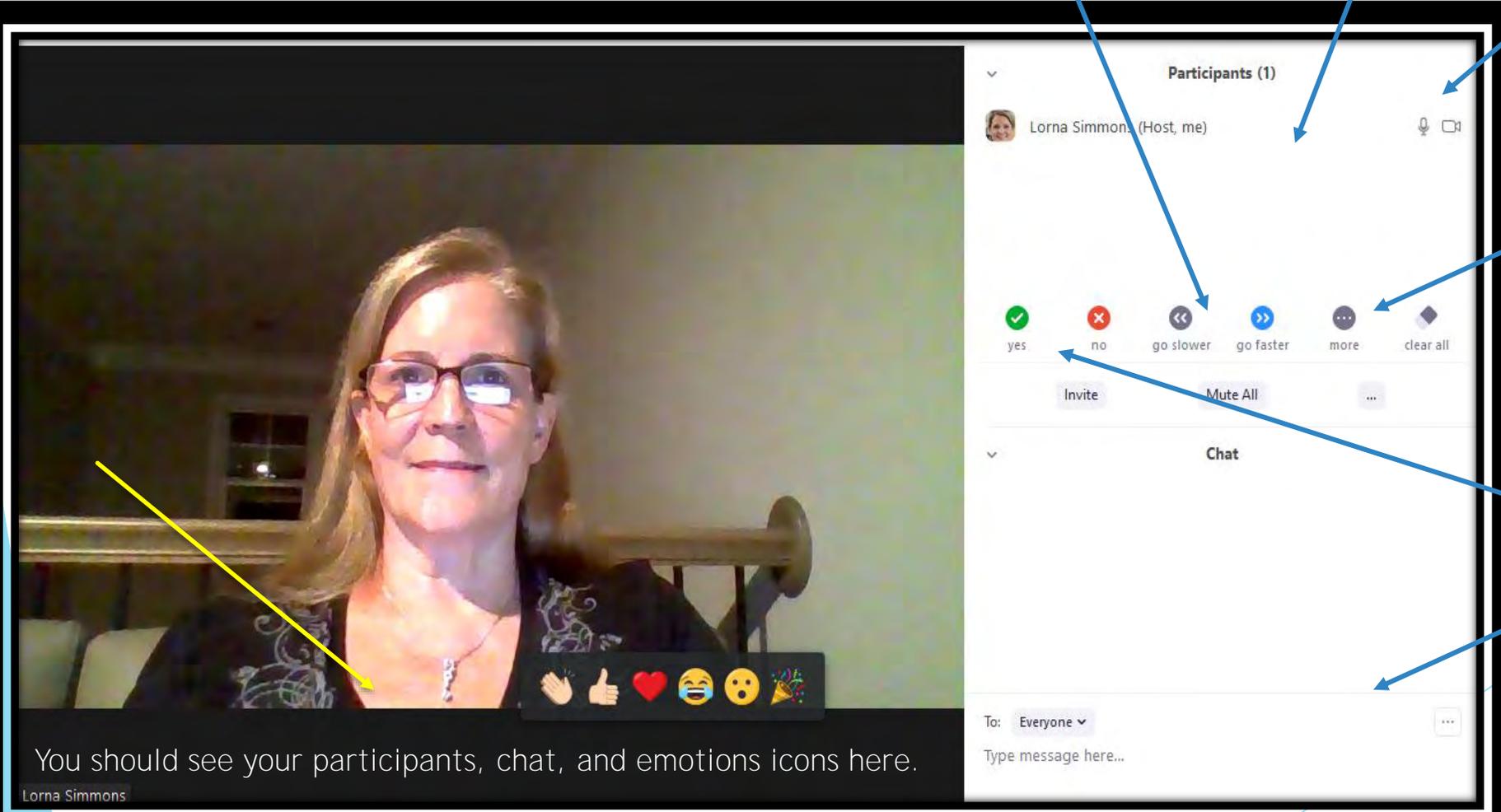


Let's practice some Zoom features before we get started

If you need Shannon to slow down or speed up.

Right click on your name and you will have the option of **'rename'**.

Click the microphone to mute or unmute. Click the camera to turn video on or off.



Select **"more"** and you see symbols for break (clock), or a cup of coffee if you want to let us know that you need to walk away.

If Shannon asks you a question, you can either type your answer into **chat** or use the **"yes"** **"no"** buttons.

You should see your participants, chat, and emotions icons here.

Learning Objectives

- Analyze definitions of clinical supervision
- Describe the benefits of Competency-Based Clinical Supervision
- Models of Supervision & Theory-Based Supervision
- Define significant roles of clinical supervisors
- Discuss components of a supervisory contract/assessment
- Discuss Ethical complications that can arise during supervision
- Dealing with difficult or competence-deficient supervisees

What's instore for the next two days?

Day One - Foundations of Competency-Based Clinical Supervision (CBCS)

- ▶ What is Competency-Based Supervision (CBS)?
- ▶ Groundwork & Rational
- ▶ Implementing Competency-Based Clinical Supervision & Best Practices
- ▶ Difficult Supervisee Scenarios
- ▶ Unraveling Supervisee/Supervisor Responsibilities

What's instore for the next two days?

Day Two - Core Competencies & Applications in Supervision

- ▶ Multiculturalism & Diversity
- ▶ Psychotherapy Models of Supervision (supplemental material)
- ▶ Addressing Personal Factors, Responsiveness, and Reactivity
- ▶ Ensuring Legal, Ethical, and Regulatory Competence
- ▶ Ethics & Boundaries in Clinical Supervision
- ▶ Supervisees Who Do Not Meet Professional Competence Standards

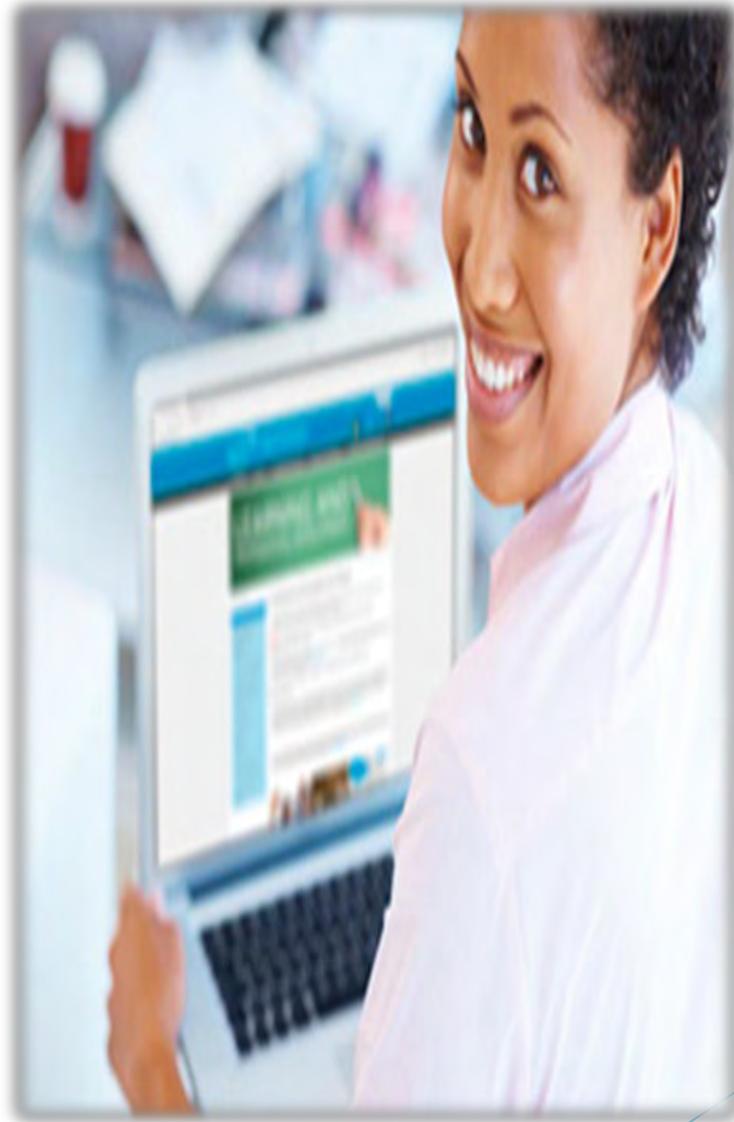
Solve That Riddle!

We are going to practice using all the fun communication tools in the Zoom meeting room. I am going to ask a series of riddles and you all will answer using the **'raise your hand', chat, and speaking (mic on) functions.** Riddle one, use your **'raise your hand'** to answer the riddle. When a participant answers correctly, we will move on to the next riddle. You will use the chat box for this one and for the third, you will unmute your mic and to answer (and see what happens when everyone talks). 😊

This will be an exercise to get our minds tingling, begin the group bonding, and **push those few of you who normally don't communicate during these webinars to do so** because we are ALL ABOUT PARTICIPATION and this is how we are going to encourage you! You can also use your emotions button to share your feelings!



Let's
get
started!



A scientist went to visit a famous Zen master. While the master quietly served tea, the scientist talked about Zen. The master poured the visitor's cup to the brim, and then kept pouring. The scientist watched the overflowing cup until he could no longer restrain himself. "It's overfull! No more will go in!" the scientist blurted. "You are like this cup," the master replied, "How can I **show you Zen unless you first empty your cup?**"

How does this proverb reflect the supervisory relationship?

On the next slide we are going to look at the results of a study of graduate students regarding their top concerns in the supervisory experience.

If you are currently supervisee, reflect on what you can relate to and be prepared to discuss.

If you are supervisor, did anything surprise you or make you consider what you may need to look at in your own supervision. Be prepared to discuss.



TOP CONCERNS AS A GRAD



TOP CONCERNS TODAY

What is Your Definition of Clinical Supervision?

Write down your own definition of supervision

- What elements would your definition include?
- Is your definition based on your experience as a supervisee?
- What was missing in your supervision that you feel is important?



Let's Discuss Your Definitions

What elements or skills did you identify?



Day One:
Foundations of
Competency-Based
Clinical Supervision

Graduate Student Survey Top Concerns Conducted by the Authors (ranked in order):

- Cultural Insensitivity
- Inadequate Understanding of Performance Expectations for Supervisee/Supervisor - Role Conflict
- Failure to Address Needs of Supervisee
- Supervision Approach & Supervisee Learning Approach Mismatch
- Additional Counterproductive Experiences
- Inadequate Attention to Ethics/Unethical Behavior
- Boundary Crossings/Violations
- Supervisor/Supervisee Theoretical Orientation Mismatch
- Inappropriate Supervisor Self-Disclosure

Supervisee Perceptions

Favorable

- 3 alliance components— bond, goals, and tasks — need to be present
- Supervisor ethical behaviors
- Supervisor self-disclosure behaviors
- Task and goal clarity
- Agreement on the importance of cultural/diversity issues in treatment/supervision
- Supervisor/supervisee interactional complementarity

Unfavorable

- **Supervision conflict**
- Supervisor gender role stereotyping
- Stress and burnout
- Dissatisfaction with supervision
- Supervisor unethical practices

What is Competency- Based Clinical Supervision?

Competency-**based supervision's** intentional, systematic approach contrasts with psychotherapy-driven or other supervision approaches as they are not comprehensive in all the components essential to clinical supervision.

What is Competency- Based Clinical Supervision?

Competency-based clinical supervision was developed to enhance the quality and effectiveness of supervision by providing a systematic and comprehensive approach to assess and develop specific clinical and supervision competencies and to perform the interrelated functions of observation, evaluation, feedback, and gatekeeping.

What is Competency- Based Clinical Supervision?

Competency-**based supervision's** intentional, systematic approach contrasts with psychotherapy-driven or other supervision approaches as they are not comprehensive in all the components essential to clinical supervision

What is Competency- Based Clinical Supervision?

The model is unique in its deliberative focus on the constituents of a specific competence as expressed in observable behavior and its focus on competence throughout the supervision and clinical training process.

What is Competency- Based Clinical Supervision?

Essential is the interplay of self-assessment, supervisor collaborative assessment and feedback with the collaborative development of a training contract articulating discrete competencies to be attained and means to achieve those.



Groundwork & Rationale

Responsibilities and Functions of Clinical Supervision



Cornerstone of developing clinical competence as a provider



Guide to honing skills



Assimilate the supervisee into the profession



Help them internalize the principles, ethics, and values



Establish a foundation for life-long practice



Guidelines for Competency- Based Supervision

Please refer to preface page
IX in your book.

Guidelines for Competency-Based Supervision

These guidelines are built on several assumptions, specifically that:

- ▶ Requires formal education or training
- ▶ Prioritizes the care of the client and the protection of the public
- ▶ Focuses on the acquisition of competence by and the professional development of the supervisee
- ▶ Requires supervisor competence in the foundational and functional competency domains being supervised
- ▶ Occurs within a respectful and collaborative supervisory relationship that includes facilitative and evaluative components and is established, maintained, and repaired as necessary
- ▶ Entails responsibilities on the part of the supervisor and supervisee
- ▶ Intentionally infuses and integrates the dimensions of diversity in all aspects of professional practice
- ▶ Is influenced by both professional and person factors, including values, attitudes, beliefs, and personal biases
- ▶ Is conducted in adherence to ethical and legal standards
- ▶ Uses a developmental and strength-based approach
- ▶ Requires reflective practice and self-assessment by the supervisor and supervisee

Guidelines for Competency-Based Supervision (cont.)



- ▶ Incorporates bidirectional feedback between the supervisor and supervisee
- ▶ Includes evaluation of the acquisition of expected competencies by the supervisee
- ▶ Serves as a gatekeeping function for the profession
- ▶ Is distinct from consultation, personal psychotherapy, and mentoring

Clinical Supervision Defined

A disciplined tutorial process wherein principles are transformed into practical skills with four overlapping foci (p. 9):

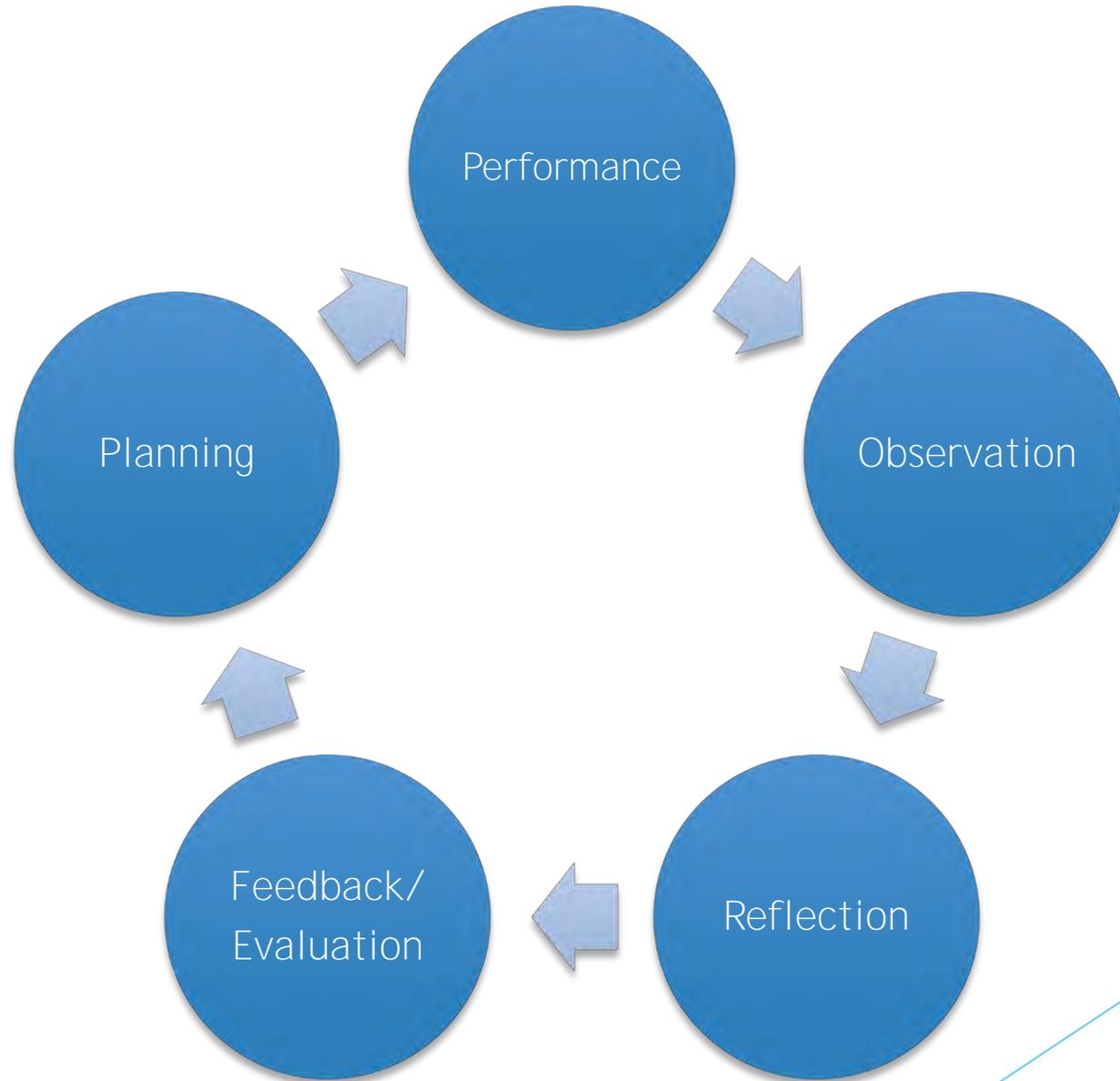
- ▶ Observation
- ▶ Evaluation
- ▶ Feedback
- ▶ Gatekeeping



So let's look at the Learning Cycle

- With the establishment of a developing supervisory alliance, a measure of trust, and mutual understanding of supervision parameters and expectations discussed in the contract, the learning process commences.
- Supervision involves several sequential processes or cycles.
- **It is important to note that as with any cycle, if one process is 'left out' or not performed correctly, the cycle can be 'broken' and become an ineffective experience for your supervisee, creating frustration for both supervisor and supervisee.**

The Learning Cycle



Learning Cycle Explained:

Performance: i.e., supervises the performance of clinical services for the benefits of clients.

Observation: i.e., supervisee and supervisor, individually and jointly in supervision, observe clinical interaction focusing on the knowledge, skills, and attitudes assembled to form the competence.

Reflection: i.e., supervisee and supervisor, individually and jointly in supervision, reflect on their observations and construct an understanding of the clinical experience related to the therapeutic process, the treatment plan and goals, and the associated competencies.

Evaluation/Assessment/Feedback: i.e., supervisor encourages supervisee self assessment and provides feedback, including evaluative and summative comments.

Planning: identifies interventions/procedures to be performed. Provide instruction and experiential learning activities.

As we explore a case study and apply concepts of the learning cycle, keep in mind as you go through the breakout exercise that level-one counselors who are very uncertain about their counseling effectiveness, tend to exhibit the following:

- ▶ Highly anxious and highly motivated to learn
- ▶ More focused on their own feelings and thoughts about what to do next in sessions and subsequently, less aware of clients' needs and process dynamics
- ▶ Highly dependent on the supervisor for direction, instruction, and support

Breakout Session!

Each group will be assigned the same new supervisee (case study after this slide in your manual) and will apply the elements of the learning cycle and impacting factors to the case to determine how you will supervise this supervisee. Breakout rooms will be randomly assigned. You will have 15 minutes to discuss the case assigned to your group. Please decide amongst yourselves who will be your spokesperson when you return. Use the page in your manual for notes.



CASE STUDY OF KAREN

Karen is a 26-year-old counselor who recently completed her master's degree in counseling. Two months ago, she was hired as an outpatient counselor for adults and adolescents at a community mental health center, and you have been contracted to serve as her clinical supervisor for state licensure. You are in private practice, and Karen's agency has agreed to pay you to provide 2 hours of supervision weekly for the next 2 years, or until Karen fulfills her requirements for licensure. One of these hours will be spent in face-to-face individual supervision at your office. The other hour will involve such activities as reviewing progress notes, observing counseling sessions, reviewing taped counseling sessions, and researching educational resources. You have established clear procedures for contacting you between scheduled meetings as needed. Before accepting the contract, you learned that Karen had completed her internship at the same agency in which she was hired, had a solid academic record, and shared a counseling philosophy similar to yours.

Approximately one month into the supervision relationship, you receive a somewhat urgent message to call Karen as soon as possible because she has a question about an upcoming intake appointment with a suicidal client. Before returning her call, you find it helpful to review several important factors about Karen and your own reactions to and strategies for working with suicidal clients. You realize that Karen, being in the early stage of her development (i.e., level one) as a counselor, is still lacking in confidence and tends to be highly anxious in new situations. You also are fairly certain that she has never worked with a suicidal client and has limited didactic training in crisis intervention.

When considering your feelings about the situation, you realize that your anxiety is heightened more than usual because you are in the unusual position of relying on someone else to respond adequately. You are also very aware that you do not want your anxiety to filter into the supervisory relationship because it would only heighten Karen's anxiety and hurt her confidence. Thus, keeping your own anxiety in check and knowing that Karen is going to want some clear instructions about how to proceed, you mentally review the steps in assessing lethality and forming a safety plan. Before picking up the phone, you remind yourself that Karen is going to need support and answers rather than challenges and questions.

You begin the phone conversation with Karen by telling her that you are glad she called when she felt the need for immediate backup. In terms of choosing the topic, Karen has already established that she needs help with a particular case. Knowing that you need more information to assess suicidality, you direct the topic specifically to conceptualizing the client's current situation. Because you are most interested in the client's immediate status, you move into the consultant role by asking Karen what she knows about the case. Karen reports that the parents of a 16-year-old adolescent girl are bringing her in at the advice of her school

counselor because the girl has related that she just wants to die since her boyfriend broke up with her. The girl has even mentioned the possibility of slitting her wrists.

Karen, who is still feeling highly anxious, asks what she should do. Keeping in mind that Karen is a level-one counselor who is handling her first crisis, you realize that she needs to know what to do and expects you to give her direction. Therefore, you follow her lead in shifting the focus to intervention skills, and you move into the teaching role. You suggest that Karen take the following steps: assess the suicide risk (specificity of plan, lethality of plan, availability of means, and proximity of help and support from family and friends); obtain a no-harm/no-suicide contract: devise a coping plan with the girl and her parents; and plan treatment follow-up, including psychiatric evaluation for medication if needed. You elicit questions from Karen about any part of the plan that seems unclear and clarify any uncertainty about how to implement it. As a final supportive function, you assure Karen that it is normal to feel anxiety in this situation, express confidence that she is well prepared, and ask her to let you know how it goes.

Learning Cycles & Factors that can Impact Effectiveness: Breakout Room

Cycles:

- Performance
- Observation
- Reflection
- Evaluation/Assessment/Feedback
- Planning

Elements to consider:

- Multiculturalism & Diversity
- Personal Factors
- Legal & Ethical Competencies and Professionalism
- Evaluation & Feedback

Learning Cycles & Factors that can Impact Effectiveness: Breakout Room Discussion

Cycles:

- Performance
- Observation
- Reflection
- Evaluation/Assessment/Feedback
- Planning

Elements to consider:

- Multiculturalism & Diversity
- Personal Factors
- Legal & Ethical Competencies and Professionalism
- Evaluation & Feedback

Refer to the book beginning on page 37 for this discussion using Exhibit 2.3 on page 42 to guide your discussion



What makes
someone
competent?

CBS aims to transform approach from reliance on assumptions of competence to demonstrations of competence (p. 8)

Competence is not absolute nor an end point; it is always relative to the demands of the setting or the context.

Different settings, just as different patients or clients, require different competences, and at times levels of ability, for treatment or supervision to be effective.

What do we mean by competence?

Reflect for a moment on a supervisor you have experienced who you felt was highly competent?

What abilities did they exhibit to make you feel this way?

Competence can be defined as one being capable and qualified to perform a specific professional function in an effective manner.

Good start, right?

It is so much more. It is more than performance of specific technical tasks.



What do we mean by competence?



Translation of knowledge into practice



Critical judgment



Interpersonal skills



Meta-competence



Ethical conduct

What do we mean by competence?

- The 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 the community being served.
- Competence builds on a foundation of basic clinical skills and scientific knowledge as well as moral development.

Competence of Ethics in Competency-Based Supervision

A supervisor's actions or the ethical climate of the training setting may have greater impact than what is taught about ethics in courses.



Let's talk about KNOWLEDGE

Effective supervision requires that supervisors be highly knowledgeable about the scientific literature in all clinical areas in which they are supervising as well as the literature regarding clinical supervision which informs the practice.

This is a tall order considering.....

- The half life of knowledge is 7 years
- The number of scientific publications doubles every 20 years
- It takes about 17 years for the dissemination of empirically supported treatments from the research lab to practice





What old beliefs do you feel that many supervisors are enacting in their methods?

“Being a supervisee will make me a good supervisor” Myth of Fact?

- ▶ Most supervisors believe they will be effective supervisors because they were supervised and, therefore, by indirect modeling will know how to supervise.
- ▶ The presumption ignores that, without formal training, the complexity of the supervision process and may in fact lead to the perpetuation of inadequate or poor practices.

Myths Regarding Clinical Supervision

- Supervision is a process that is known by many but understood by few. Many misconceptions and misunderstandings exist regarding the nature of clinical supervision.
- While supervision is an integral part of professional training and improvement of service delivery, few supervisors and supervisees fully understand the process.
- Misconceptions have been perpetuated by individuals who have been unprepared for acting as a supervisor and have received little or no formal training in supervision.
- As a result, when supervisees became supervisors, many of the same misconceptions became perpetuated and further muddled.

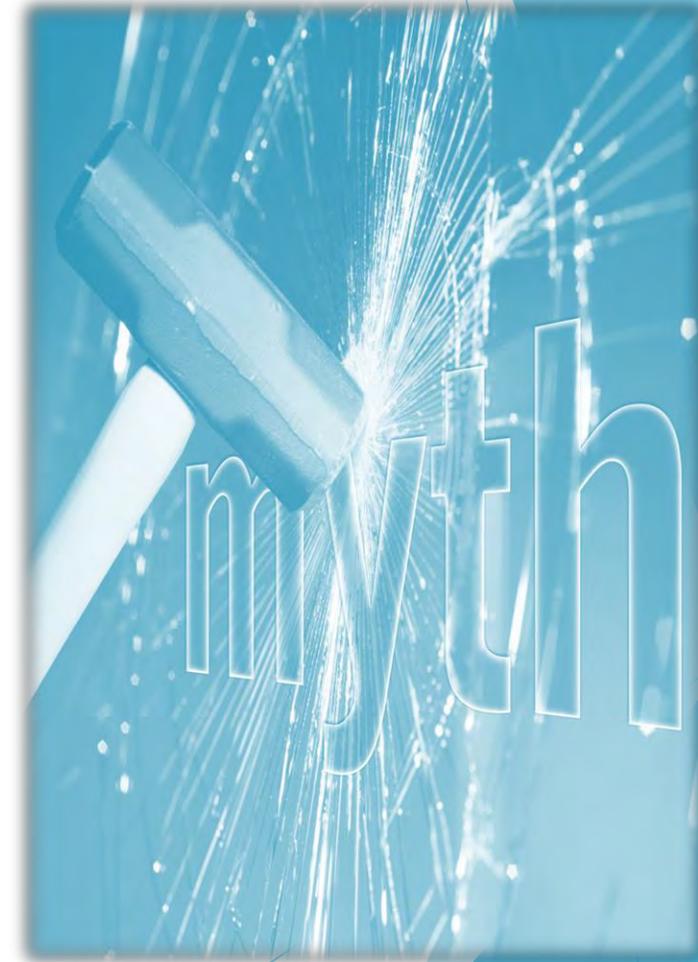
Top 10 Supervision Myths (Campbell, 2006)

- If I am an experienced counselor or therapist, I automatically will be successful and effective as a supervisor.
- True clinical supervision is strictly for the review of cases. If you give handouts or teach, that's training, not supervision.
- If supervision is not going well, it's the supervisee's fault.
- Supervision is only for the beginners or inexperienced. If you have to be supervised, you must be deficient/ incompetent.
- Because supervisors are professionals, diversity issues do not have to be addressed.



Top 10 Supervision Myths (cont.)

- The best feedback is direct. Tell it like you see it. There is no need to coddle supervisees.
- A supervisee's thoughts and feelings are not relevant to learning.
- Supervisors are experts, so it is important to make that clear and never admit to mistakes or that you don't know the answer.
- Because supervisors are totally responsible for **the actions of their supervisee's, the supervisor's** directions should not be questioned.
- In order to avoid a dual relationship and becoming your supervisee's therapist, you should not use your therapy skills in supervision.



Let's take
a quick
break!!!





Implementing Competency- Based Clinical Supervision & Best Practices

Complexity of Supervisor Competence

- **Concept of “Entrustability”** of supervisee
- Competence
- Reliability/conscientiousness
- Truthfulness and honesty
- Recognizing limitations and asking for help
- Empathy, openness towards patients
- Skill in intercollegial/Interprofessional collaboration
- Habits of self-evaluation, reflection, development
- Responsibility
- Knowing how to deal with mistakes by self and others
 - (Ten Cate et al., 2016)

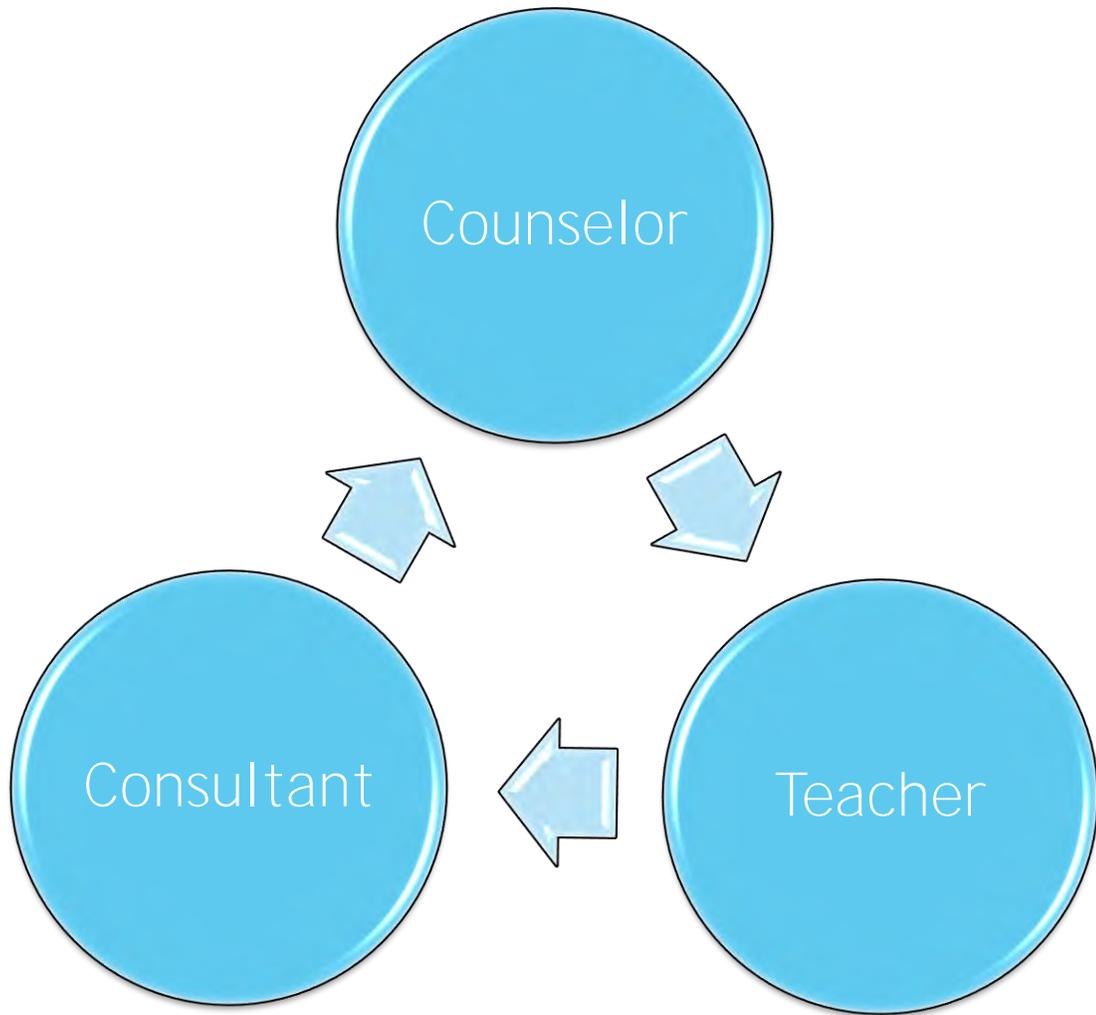
Let's look at a scenario:

Dr. Hass, a 57-year-old Caucasian male, is meeting with his supervisee for the first time, Alberta who is a 27-year-old self described “**African-American**”. He immediately explained to the supervisee that he has **been supervising for over 20 years. In response to Alberta's persistent** efforts to structure supervision, Dr. Hass told her he simply works from theory and all else falls into place. He finds goals cumbersome and urged her simply to begin discussing her client cases. Quickly he began reflecting about several aspects of client dynamics and they have only covered the one case in the first three weeks, her efforts **notwithstanding. He refers to her as “Amanda”.**

Discussion Questions:

- ▶ If you were Alberta, how would you feel?
- ▶ What competency(s) did he fail to implement?
- ▶ While supervisors can and often do supervise from a theoretical approach (which we will discuss later), how could he have approached this with his supervisee differently?
- ▶ Do you see a positive outcome for this supervisory relationship?
- ▶ Yes - why? Or No - why not?





Three Key Supervisory Roles

Supervisory Roles Defined: Counselor

- Although, it is important to remember the supervisor is not the **supervisee's therapist, the supervisor may interact with the** supervisee in ways that are therapeutic and thus also facilitate insight and offer the supervisee opportunity for experiential learning.
- **The creation of a safe space for the supervisee's own experience** working with clients and the impact on the personhood of the counselor/supervisee is important. Empathy is of course a key skill in this role.
- A study on effective and ineffective supervisors revealed that some of the practices of effective supervisors involved demonstrating skills sometimes that occurs when a supervisor demonstrates with a supervisee in the process of supervision.

Supervisory Roles Defined: Teacher

- Just like students completing practicums or internships may be required to submit video recorded sessions for feedback and discussion during supervision, supervisors may request the same practice during residency.
- Reviewing video recorded or audio recorded sessions, the supervisor may give the supervisee feedback and direction on how to insert a solution-focused technique in a future session such as the search for exceptions (i.e. Was there ever a time when the problem was not occurring? What was different at that time?) Or the supervisor may provide some training on an intervention that the supervisee is not familiar with.

Supervisory Roles Defined: Consultant

- A supervisor and supervisee may collaboratively discuss a treatment plan, case conceptualization, or perhaps do an empathy building activity.
- effective supervisors encouraged the autonomy of their supervisees. For example, if a supervisee is wondering what relaxation techniques may **work best for a client with anxiety the supervisor may ask, “What has been effective with similar presenting problems in the past? Let’s take a moment to reflect on some of your previous cases.”**
- This may encourage the supervisee to participate in the process of decision making via self-reflection and subsequent self-directed thinking. This may also help a supervisee to develop the practice of reflecting on skills and techniques that have been resources in the past and may also serve as resources in the present.



GIVING FEEDBACK IN DIFFICULT SITUATIONS ROLEPLAY

- ▶ Savior
- ▶ Know-it-all
- ▶ Old Enough to have done it all
- ▶ Chicken Little

If you are a supervisor and have complaints about a supervisee, look first to yourself and then consult with an experienced supervisor.

Founder of "Development Counts"
Ruby Blow, MA, LPC, NCC, CPCS, ACS, DCC, BC-TMH



The “Savior” Supervisee

What are some of the potentially challenging characteristics of the “Savior” Supervisee?

- They only feel good about themselves when helping someone
- They believe helping others is their purpose
- They expend so much energy trying to fix others that they end up burning out
- **They have an urgent need to “save”** people by fixing their problems



The “Know-it-all” Supervisee

What are some of the characteristics of
the “Know-it-all” Supervisee?

- They can dominate conversations
- Offer unwanted or unsolicited advice
- They can be argumentative/resistant
- They can be condescending
- They can be impulsive
- They can have poor listening skills and unable to read social clues



The “Old Enough to Have Done it All” Supervisee

What are some of the potentially **challenging characteristics** of the “Old Enough to Have Done it All” Supervisee?

- Offer unwanted or unsolicited advice
- They can be dismissive
- They can be condescending
- **They can be “set in their ways”**
- They can display an over/under exaggerated sense of sincerity



The “Chicken Little” Supervisee

What are some of the potentially challenging characteristics of the “**Job Filler**” Supervisee?

- They can be overly anxious
- They can be fearful of acting
- They can be self condemning
- They can be impulsive - must act now
- They can be hypervigilant with the client

Group #1 Case Study: The “Savior” Supervisee

Your supervisee shares with you she has become stuck during her work with a 5-year-old boy and his family during the boy's treatment for sexual abuse. She works on a long-term protection team at a local Child and Family Services Agency. A dynamic woman in her late twenties, the therapist appears to center her expert knowledge about the boy and his experience, confident that she can “save” him, only to become bewildered when he refuses to engage in treatment in ways that she had expected (open, forthcoming, appreciative of her concern). Her problem, she says, is being “stumped,” the therapeutic process stuck, even though the boy seems content to visit the therapist and play. She reports that she “just wants to the child feel better, to get him back on track.” She closes her recap by asking you “what have I done for this child? What do I have to offer? Other kids I'd know what to offer, where to go. But what is it about this kid that's gotten me so stumped?”

You observe a session with her and he, interestingly, does not appear to be stuck. As a new story for the boy emerges, the therapist reconsiders her role as a clinician with so young a child, having to respect his expertise regarding his life as she would any other older child or adult.

What is the supervisor’s role in the case study?

Supporter, Advocate for the client, mentor, teacher, role model?

Group #2 Case Study: The Know-it-all

Your supervisee needs to discuss a client with you as he is feeling frustrated with the client who is not 'listening to my advice even though I have told him that I understand – I have been there.' Your supervisee is a White, 29-year-old heterosexual male in his first year of post graduate work and is currently providing individual counseling at a substance use treatment center. Your supervisee is also in long-term recovery from heroin and reports that "this is why I do what I do".

His client, Mr. B, is a homosexual man, 38 years of age, of multiple ethnicities. (His mother was born to a Jamaican father and a white mother, and his father was of Dominican origin.) Mr. B is in early recovery from heroin and alcohol and has been clean for a little over 3 months now. After trying rehabilitation programs several times, unsuccessfully, his last attempt seemed to stick, following his diagnosis with hepatitis C.

Taking an open mind to recovery, Mr. B has expressed to your supervisee that he "really loves working with others as it give me [him] a renewed sense of purpose in life" and that he "wants to start school to get a degree so he can do this." Your supervisee "knows from experience that he is too soon in recovery and will fail which will make him [the client] return to using. He reinforces this conviction by repeating in a louder voice and pounding his leg with his fist, "I just know it, but he won't listen to me. I keep telling him to slow down and just focus on recovery or his going to fail because I know what I am talking about." You, as the supervisor, have tried to interject during this one-way communication; however, the supervisee will not let you finish your thought or allow you to make observations. The supervisee shared with you during your initial discussion at the onset of supervision that he is in long-term recovery from heroin "and a bunch of other stuff". He appears visibly concerned that his client might relapse and expresses that "I just don't want him to fail because he wouldn't listen to me." You allow him to finish his thoughts and then you begin by saying...

What is the supervisor's role in the case study? Supporter, Advocate for the client, mentor, teacher, role model

Group Case Study #3: The Old Enough to Have Done it All

You are a 32-year-old supervisor for an outpatient clinic that works with families in hospice care. You are the only member of the staff who is a Certified Clinical Supervisor and your direct report has asked you to assist Ms. T. in supervising her for the remainder of her associate hours.

Ms. T is an African American woman, 50 years of age, who recently completed her Master's degree in social work. Because of her experience, Ms. T was grandfathered into being a licensed social worker in her state before formal licensure laws came into effect; she worked her way up the ranks in the medical social work department at a hospital near her hometown. Around 40 years of age, she became restless in the "paper pushing" culture of her hospital and decided it was time to make some changes.

She thought about going to school for another profession, like nursing, but ultimately decided to complete a bachelor's degree in social work and stay on for her Master's. She enjoys working with clients in an individual manner, conducting therapy; she feels that she has a great deal to share because of her rich life experience. However, after reading her resume, you see that she has no experience with hospice or palliative care. You meet with Ms. T. to discuss the supervision contract and expectations for engagement, allowing her to tell you what she is seeking out of the experience as well. She begins by telling you that "honey, I've been doing this for so long, I am sure I can teach you a thing or two if you just watch and listen. I'm just doing this because all of a sudden I need to go through all of this official stuff to do a job I already know how to do." You are quiet for a moment as you ponder her response, and then you begin by saying...

What is the supervisor's role in the case study?

Supporter? Mentor? Teacher? Counselor? Role Model?

Group # 4: The “Chicken Little” Supervisee

Mary is a 29-year-old Asian student in her final year of obtaining a dual masters in Addictions Counseling and Social Work. Her university has provided your organization’s information to the student as a potential for placement as they have hosted students before. You meet with the student to discuss the concept of clinical supervision, the terms of the learning contract, and information about the organization which is a dual-diagnosis program, offering out patient services to clients diagnosed with a substance use disorder (primary) with a co-morbidity of a mental health diagnosis (secondary). She presents professional, engages easily, and seems eager to learn and interact with clients, but professes that she is also “very nervous because I [she] don’t want to mess someone up.”

After three weeks of her observing individual and group sessions, you assign a case to Mary: client A, a 32-year-old White female who is in her third recovery period from heroin and also has a diagnosis of borderline personality disorder. Mary meets with her client for the intake process with you observing the interactions. After a few questions into the intake assessment, Mary begins asking questions that are outside the scope of the intake so she can “get to know you [the client] better so I don’t miss something and mess up.” You make a note of this discuss with her in your next supervision session which is two days away.

Mary meets with her client individually and independent of your supervision and, on the day prior to the schedule supervision session, comes into your office in a frantic state, blurting out “I think [client A] wants to kill herself and I don’t know what to do”. “She told me that she has thought about how much she has hurt her family and feels like they would be ‘fine without her’.” She looks at you with tears in her eyes and asks “what do I do? What if she kills herself before I see her tomorrow? I would just die if that happens!” You sit down with Mary and begin by saying...

What is the supervisor’s role in the case study?

Supporter? Mentor? Teacher? Counselor? Role Model

Breakout Session!

Each group will be assigned a type of supervisee (descriptions are after this slide in your manual) and will apply the elements the supervisory roles to supervise this supervisee. Breakout rooms will be randomly assigned. You will have 15 minutes to discuss the case assigned to your group. Please decide amongst yourselves who will be your spokesperson when you return. You will discuss how you would address the supervisee.

Use the page in your manual for notes.



Group #1: “Savior” Supervisee

What is/are the
supervisor’s role(s) in this
case study?

How would you move
forward with the
supervisee?



Group #2: The “Know it all” Supervisee

What is/are the **supervisor’s role(s)** in this case study?

How would you move forward with the supervisee?



Group #3: The “Old Enough to Have Done it All” Supervisee

What is/are the
supervisor’s role(s) in this
case study?
How would you move
forward with the
supervisee?



Group #4: The “Chicken Little” Supervisee

What is/are the supervisor’s role(s) in this case study?

How would you move forward with the supervisee?



Do you have any feedback for the other group's suggestions?

SO, AT THIS POINT IN THE TRAINING,
WHAT DO YOU BELIEVE IS/ARE THE
MOST IMPORTANT FOCUS(ES) OF THE
SUPERVISOR?

CLIENT WELLBEING ALWAYS COMES FIRST!!



It is Time for
Lunch! You can either
log out and log back in
or you can keep the
zoom open with your
audio and video off.
Please return
in one hour.
Enjoy!

Unraveling Supervisee/Supervisor Responsibilities



Supervisee Responsibilities:

- To provide service to clients in an ethical manner and adhere to ethical standards of profession.
- To follow rules of confidentiality and protect clients from harm.
- To avoid all harmful relationships with clients, especially sexual relationships.
- To work always within the limits of competency, skill and training.
- To be open to new and different clinical techniques and approaches.

Supervisee Responsibilities (cont.):

- To seek supervision if there is any question of biases or problems working on a particular case.
- To commit to making changes that will promote therapeutic effectiveness and professional growth.
- To give honest self-report to supervisors of one's weaknesses inability, biases and problems working with clients.
- In situations of supervisor incompetence. (Substance abuse, sexual harassment, etc.) seek consultation and guidance on how to proceed.

Supervisee Responsibilities (cont.)

- To be open to feedback from supervisors and willing to follow advice and direction.
- To accept referral to outside therapy if indicated. To submit documentation of clerical work in timely and accurate form.
- To maintain the confidentiality of group members (both client and personal issues).
- To prepare for supervisory sessions and participate actively in the supervision process.
- To provide supervisor with honest feedback about supervision and the supervisory process.
- To want to become the best professional possible.

Supervisor Responsibilities

- Protecting clients by ensuring the quality of the care they receive.
- Promotion and protection of the profession and community.
- Be able and consistent in offering supervision.
- Provide regular individual and/or group supervision.
- Delineate roles, relationships, and expectations of supervision.
- Be tolerant of different approaches and therapeutic models.
- Provides fair evaluation and honest feedback.

Supervisor Responsibilities

- Promote development of clinical skills and professional identity.
- Protect clients and help supervisees avoid unethical decisions.
- Avoid or limit scope of dual relationships and potential for harm.
- Provide supervisee with means to give you feedback and resolve difficulties.
- Maximize the use of techniques to protect and monitor client care.
- Model best practice for supervisee.
- Recognize limits - seek consultation/training.

ASSESSMENT



Why do we conduct a Supervisee Assessment?



- Evaluate Supervisee Competence
- Monitor Quality of Professional Performance
- Determine Readiness to Practice Independently
- Act as a Gatekeeper for the field
- Provide Remediation and Recourse
- What else would you add??

Let's review the 2 Supervisee Competencies
Assessment Tools in your manual.

Appendix A: Evaluation Tools

Several tools for evaluation of the supervisor and supervisee exist. Various examples are offered below to facilitate the evaluation and development of the supervisee. In addition, the competencies of the supervisor are critical. Thus, a self-assessment for the supervisor is offered to promote ongoing competency development. These documents may be modified according to organization requirements as well as consideration of the supervisory model (e.g., process, competency-based, CBT, psychodynamic, etc.) being applied in practice.

- Therapist Evaluation Checklist:
<http://www.cfalender.com/assets/therapist-evaluation-checklist1.pdf>
- Supervisor Evaluation Form
<http://cfalender.com/assets/supervisor-evaluation-form3.pdf>
- Supervisor Competency Self-Assessment
<http://societyforpsychotherapy.org/wp-content/uploads/2016/10/Appendix-Special-Feature.pdf>

- Key Areas for Evaluation of Clinical Supervision form:

This tool is intended to be used as a framework and guide for clinical supervision. The intent is to provide feedback to supervisors regarding their quality of supervision. The tool is broken up into two sections: Specific skills competencies, and Theoretical models. To best use this tool, a supervisor will record a supervision session with their supervisee, after obtaining the supervisee's consent. The session will be reviewed with the supervisor during a supervisors' group meeting. All supervisors participating in this meeting will receive a copy of this tool and rate each domain as the pre-recorded session is being viewed. The supervisor is encouraged to share feedback, answer questions, and rate themselves during this process. Please note that this process is intended for growth and support and should be done through a strengths based approach.

Key Areas for Evaluation of Clinical Supervision

COMPETENCIES	RATINGS / COMMENTS			
	<u>Comment</u>	Exemplary	Standard	Unaccept- able
Supervisor's communication uses counselling interventions with supervisee, such as:				
a. Open-ended questions				
b. Closed questions				
c. Paraphrasing				
d. Summarization				
e. Reflection of feelings				
f. Tuning into nonverbal language				
g. Information giving				
i. Use of Motivational Interviewing				
j. Problem identification				

COMPETENCIES

RATINGS / COMMENTS

COMPETENCIES	RATINGS / COMMENTS			
	Comment	Exemplary	Standard	Unacceptable
Supervisor's communication uses counselling interventions with supervisee, such as:				
k. Mutual goal setting				
l. Use of humor, role playing, etc.				
m. Creating therapeutic climate/alliance (e.g. trust, rapport)				
n. Overall empathy				
o. Skillful feedback				
p. Focuses/connects to professional development				
q. Ensures that service to client is safe, ethical and competent				
r. The capacity to recognize and facilitate the co-evolving relationships between the worker-client and supervisor-worker-client relationships, identifying and addressing problems that arise. Explore various relationships of staff; supervisor/staff; management, etc and issues are addressed as needed.				

COMPETENCIES	RATINGS / COMMENTS			
	Comment	Exemplary	Standard	Unacceptable
Supervisor's communication uses counselling interventions with supervisee, such as:				
s. Culturally sensitive approach				
t. Knowledge of the service delivery protocol and treatment standards as well as the ethical mandates of relevant professional bodies and the ability to provide such information, as relevant in supervisory session.				
u. Use of supervision log constantly				
v. Advanced knowledge of the major issues experienced by clients (e.g. mental illness, alcoholism, drug abuse)				
w. Emphasis on self-care/staff wellness				
x. Supervisor has printed and brought to supervision, Caseload Performance Report and referred to it during supervision session.				

MODELS OF SUPERVISION MATRIX

MODELS	COMMENTS
Psychotherapy-based Models of Supervision	
Psychodynamic Approach to Supervision	
Supervisee-Centered Psychodynamic Supervision	
Supervisory-Matrix-Centered Approach	
Cognitive-Behavioral Supervision	
Person-Centered Supervision	
Developmental Models of Supervision	
Integrated Development Model	
Ronnestad and Skovholt's Model	
Integrative Models of Supervision	
Technical Eclecticism	
Bernard's Discrimination Model	
System's Approach	
Reflective Practice/Supervision	

<ul style="list-style-type: none"> - Supports self-reflections of the supervisee. 	
<ul style="list-style-type: none"> - Discusses awareness of one's individual and cultural beliefs, values and biases. 	
<ul style="list-style-type: none"> - Continues to provide feedback during collaboration. 	
<p>Use of Self</p>	
<ul style="list-style-type: none"> - Supports supervisee's initiation of ideas. 	
<ul style="list-style-type: none"> - Expects the supervisee to have clear, rationales for theoretical approach. 	
<ul style="list-style-type: none"> - Discusses and plans how to talk to parents about the strengths and vulnerabilities of their child. 	
<ul style="list-style-type: none"> - Continues to give direct input and evaluative feedback. 	



Supervisor: _____

Supervisee: _____

Check all Topics Discussed:				
Duties & expectations		Comprehensive skills evaluation	Cases & Assessment	Information & referral
Professionalism		Process recording	High Risk issues	Evaluation issues
Judgment		Decision making	Progress notes	Termination
Communication skills		Problem solving	Goals & objectives	Diversity issues
School topics & deadlines		Initiative	Treatment planning	Mezzo practice issues
Attitude		Flexibility	Crisis intervention	Macro practice issues
Time management		Self-awareness	Practice/intervention skills	Ethical issues
Learning plan		Accountability	Specific EBP techniques	Other:

Comments:

Supervisee Strengths:

Challenges:

Tasks to be completed by the next supervision session or date specified:

Supervisee Signature: _____ Date _____

Supervisor Signature: _____ Date _____

Checklist for Supervisee Competencies

Competencies	Poor	Below Average	Average	Above Average	Excellent
Knowledge					
Has knowledge of theory and intervention strategies					
Has knowledge of screening, assessment, and diagnostic standards					
Understands cultural and ethnic issues					
Has knowledge of resources in the community					
Has knowledge of current ethical guidelines and legal issues					
Practice					
Demonstrates mastery of intervention techniques					
Is timely and thorough in documentation					
Is able to develop rapport					
Is able to conceptualize problems					
Can respond to multicultural issues					
Is able to formulate treatment goals					
Personal					
Demonstrates ethical behavior					
Demonstrates use of good judgment and counseling skills					

Competencies

**Poor Below
Average Average Above
Average Excellent**

Is interpersonally competent

Is able to identify own strengths and weaknesses

Is able to accept and learn from feedback

Is an asset to the profession

SESSION BRIDGING FORM

Supervisee: _____

Date: _____

Part A (To be completed shortly after supervision session)

1. What stands out to you about our last supervision? Thoughts, feelings, insights?

2. On a 10 point scale, how would you rate the following items: (a to d)

<u>Not at all</u>		<u>A little bit</u>		<u>Moderately</u>		<u>Much</u>		<u>Very Much</u>	
1	2	3	4	5	6	7	8	9	10

a) Helpfulness/effectiveness of supervisor: _____

- What was helpful?

- What was not helpful?

b) How connected you felt to your supervisor: _____

c) How engaged/involved you felt with the topics being discussed: _____

d) How present you were in the supervision: _____

3. What would have made the supervision more helpful or a better experience?

4. What issues came up for you in the supervision that are similar to your daily life problems?

5. What risks did you take in supervision?

Part B (to be completed just prior to the next supervision session)

1. What were the high and low points of your clinical work this week? _____

2. What items, issues, challenges or positive changes do you want to put on the agenda for our next supervision? _____

3. How open were you in answering the above questions? (0 to 100%) _____

4. Anything else you'd like to add? _____

Potential Stumbling Block Identified through Assessment

	Unclear, or unchanging, expectations
Supervisee	Supervisor who is inconsistent, harsh, or lacking empathy
	Lack of consistent feedback

	Unclear programmatic expectations
Supervisor	Non-supportive environment
	Lack of clear communication



Most Important Element

Feedback, including that which is corrective, allows supervisors to transmit knowledge to supervisees and communicate evaluations of supervisee performance.

We are Very Poor at Self-Assessment

Self-Assessment
Bias

25% of mental health professionals viewed themselves in the top 10% and none viewed themselves as below average.

We do not systematically teach supervisees self-assessment or provide feedback to increase accuracy

Core component of CBS is competence of the supervisor to assess and create trust through entrustability

Please find the Supervisory Self-Assessment in your manual (after this slide)



This will be an exercise in self-assessment of your skills as a supervisor. Take about 10 minutes to complete the assessment and then we are going to come back and discuss as a group. For those of you who feel comfortable doing so, we would love to here about what you discovered about your supervision skills through this exercise. What surprised you? What could you improve on? What did you do well?

Not a supervisor? Assess your supervisor!

CLINICAL SUPERVISOR SELF-EVALUATION
Christopher Ebbe, Ph.D., ABPP

Supervisor _____ Date _____

Your self-evaluation of supervision-related skills, abilities, and attitudes may give you opportunities to recognize things you would like to improve as a supervisor and a chance to plan your next steps in development as a supervisor.

	GOOD	OK	COULD STAND IMPROVEMENT	PLAN FOR NEXT SUPERVISION SESSION
my attitude about supervision	_____	_____	_____	_____
comfort with the responsibility of supervising	_____	_____	_____	_____
introduction of supervisee to supervision, and setting of goals (take enough time? help supervisee to be candid and at ease?)	_____	_____	_____	_____
establishing supervision "contract"--agreeing on the basic elements and goals of the supervision, in writing if needed or desired	_____	_____	_____	_____
not supervising when interfering dual relationships exist	_____	_____	_____	_____
assessment of supervisee in order to plan specific learning	_____	_____	_____	_____
confidence in my abilities with regard to supervising	_____	_____	_____	_____
my authority in directing the actions of supervisees	_____	_____	_____	_____
my authority regarding caseload, case assignments, relative to that of the system (clinic, etc.)	_____	_____	_____	_____
clarity about my model of supervision	_____	_____	_____	_____
clarity about the type of supervisory relationship I want to have	_____	_____	_____	_____
ability to nurture supervisee's trust in me	_____	_____	_____	_____
providing appropriate support for supervisee	_____	_____	_____	_____
keeping supervision appointments and providing amounts of supervision promised	_____	_____	_____	_____
protecting supervision time (not answering phone, etc.)	_____	_____	_____	_____

protecting supervisee's
privacy

balance of making supervisee feel safe versus
reporting problems to training director or management

ability to quickly identify case issues in supervision

ability to teach/advise in response to case
problems/difficulties

ability to supervise adequately all of the types of
clinical activities that I am expected to supervise

ability to help supervisee connect theory with
practice

demonstrating and modeling useful clinical skills

keeping up-to-date in knowledge about all of
supervisee's cases

ability to identify supervisees'
countertransference issues

ability to discuss countertransference issues
comfortably and productively

ability to supervise with respect to client diversity

knowledge about ethical/legal matters for use in
supervision

knowledge of licensing requirements for
supervision (hours, clinical experiences, etc.)

encouraging professional identity development of
supervisee

providing a good role model as a professional
psychologist

encouraging high standards for mental health care

encouraging high ethical standards

ability to confront supervisee with needed feedback

ability to discuss my relationship with supervisee,
when needed

ability to handle supervisees' transference feelings toward me _____

handling my own negative and positive feelings toward supervisees _____

ability to give useful oral feedback to supervisee _____

ability to give useful written feedback to supervisee _____

ability to separate my emotional reactions to supervisees from objective reality when evaluating supervisees _____

ability to evaluate supervisees on job requirements and professional consensus regarding desirable behaviors and traits, rather than with respect to my own values and preferences _____

comfort tolerating supervisee's inadequacies/problems during the learning process _____

comfort implementing remediation plan _____

comfort requiring tapes, process recording, etc. of supervisee _____

taking the time to use tapes, process recordings to create learning value for supervisees _____

comfort dealing with supervisees' ethical/professional criticisms of agency _____

plan for enhancing my supervision skills _____



A Supervisory Session

What if you have a supervisee who decides that the helping profession **just isn't for them?**

Once we have reviewed the scenario, we are going to break it down by the competencies that we will be discussing such as judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection.

Read through the case study entitled

“Ms. V is not sure if she wants to help people anymore”.



Breakout Session!

Breakout rooms will be randomly assigned. You will have 20 minutes to discuss the topic. Please decide amongst yourselves who will be your spokesperson when you return. The case study is in your manual following this page.



Ms. V is Not Sure She Wants To Help People Anymore

Ms. V is a white, heterosexual woman, 26 years of age. Assigned to a public mental health agency, she is in the internship phase of a Master's degree program in clinical counseling at a small, Christian university. Ms. V opted to go to graduate school immediately after finishing her Bachelor's degree in psychology. Her initial motivation for studying psychology was to help people, and she chose to do this despite the protests of her upper middle-class parents, who believed that there was no "future" (financially) in the psychotherapeutic professions. Partially to ease their protests and partially to "get on" with a career, she entered graduate school. Ms. V has found working with clients to be quite a struggle. She went into the field with every good intention of helping people, and she believed it was part of her spiritual path. However, the first time a client from a background different to hers, a tall, African American man on welfare, towered over her and told her that she "didn't know what she was talking about," Ms. V melted down and spent the rest of the day in her office crying. She called off from her site duties for the rest of the week, citing illness. At this point, Ms. V is wondering if a career in counseling the best fit for her because of her discouraging experiences working with clients. Yet the thought of going through a Master's degree program and not using it, especially when her parents paid and supported her through the program, is a shaming prospect to her. At this point, she is at a juncture and feels trapped.

Let' review the conversation and talk about your reactions

Supervisor: V, I got your email about the session you had with L (client in question) and that it took a toll on you. How can I best help you with this?

Ms. V: I don't know. I just feel in over my head.

Supervisor: Okay...Can you help me understand a little bit more about what you mean by "over your head"?

Ms. V: I mean, I have thought about it...I've really been thinking about it for the last several days, and I think he's right. I mean, what do I really know about real life? I'm just a privileged little white girl who has a degree.

Supervisor: Wow, that's heavy...Is that what L said?

Ms. V: More or less.

Supervisor: And you've been thinking about this for the last several days since it happened?

Ms. V: That's all I've been able to think about.

Supervisor: Wow, that's heavy stuff, V. I'm sorry that you've been beating yourself up about this issue. I just want to assure you that you are not alone here. We have all been told off or talked down to by clients at one point or another during our careers.

Ms. V: Really?

Supervisor: Absolutely.

Ms. V: It just seems to come so easy for so many people.

Supervisor: I hear that it can seem that way. You may have heard that cliché before that everyone who's an expert at something was once a beginner. That applies here, too, V.

Ms. V: I just feel like I'm not cut out for this.

Supervisor: Can you tell me more about that?

Ms. V: Well, yeah. I mean, the people that we're dealing with here in the city. I've just never had to deal with this kind of pain before. I can't even imagine what it's like to be on welfare, or to have parents that ran off on you, or to be addicted to drugs. I want to help people, but I just don't know what to say.

Supervisor: I hear that. What seemed to bother you the most about what L said to you?

Ms. V: I don't think it was what he said as much as how he said it. Just that he towered over me and I felt paralyzed to say or do anything. I get that I can never really understand what's going on in his life, but he was so harsh about it.

Supervisor: Interesting. There are a couple of ways we can approach this. We can look at what about this interaction with L triggered things for you. Or we might re-examine what you remember saying in the conversation that seemed to set L off. You tell me, V, where do you need to go with this?

Ms. V: I don't think it was what he said as much as how he said it. Just that he towered over me and I felt paralyzed to say or do anything. I get that I can never really understand what's going on in his life, but he was so harsh about it.

Supervisor: Interesting. There are a couple of ways we can approach this. We can look at what about this interaction with L triggered things for you. Or we might re-examine what you remember saying in the conversation that seemed to set L off. You tell me, V, where do you need to go with this?

Ms. V: I'm not sure.

Supervisor: Well, just take a minute then. You can close your eyes and get silent if you need. Ask yourself where you most need to go today.

Ms. V: Okay. (She briefly pauses) It's the way he just got up and stood over me. I felt very unsafe.

Supervisor: Okay, V. That's very honest. If I can ask, being towered over like that and not feeling safe, what is that really about?

Ms. V: Wow, I didn't think of that parallel. Whenever my parents doubted my opinion on something, especially about my career choice and field of study in college...whenever I fought them on anything, they would stand up, even if we

were at the dinner table. It's like it was their way of making me feel small. Even if we were all standing during an argument, it would seem like they became 10-foot-tall giants when they started to argue.

Supervisor: How interesting. Is there a chance that your interaction with L triggered this dynamic with you?

Ms. V: Oh, absolutely. And I think it hit me even harder because my parents never really wanted me to go into this field in the first place, even though they financially supported my education. It's like L telling me I don't know what I'm doing is hitting me even harder because that sounds like something they would say.

Supervisor: That's really fascinating, V. Is this something you're comfortable continuing to talk about with me or do you feel you may want to address it with someone else?

Supervisor: I can see that this whole situation with L has brought up a lot of things for you. What do you feel you need to do to best take care of yourself in the wake of all of this?

Ms. V: I don't know...Drop out of the counseling program? (Laughs)

Supervisor: Take a moment and ask yourself if that's what you really want.

Ms. V: Of course not. I still really want to be a counselor.

Supervisor: Okay, if I may be so bold, let me ask you this. When's the last time you went through your own counseling?

Ms. V: Well, I saw one of the campus counseling center professionals when I was an undergraduate, but since then, nothing.

Supervisor: Would you consider perhaps getting some counseling for yourself again, especially since we've concluded that this situation with L triggered a lot of personal stuff for you?

Ms. V: Am I allowed?

Supervisor: Well, you couldn't do it here, but I have a list of some providers. I can refer you to people that I trust to work with other professionals. Rest assured, V, if you are going to work in this field, there is no shame in getting your own

therapy. A mentor of mine told me once that to be a good therapist, you ought to have a good therapist!

Ms. V: That makes me feel better. And you're right; it's probably a good idea.

So, how did your group respond?



Now, let's review the actual dialogue and see how it compares to your group's perspective (refer to your manual for the dialogue). We are going to do a little role playing!



Addressing attraction to a supervisee (9 min)



Addressing counselor burnout (9 min)



Example of a bad supervision session (6 min)



Countertransference (7 min)

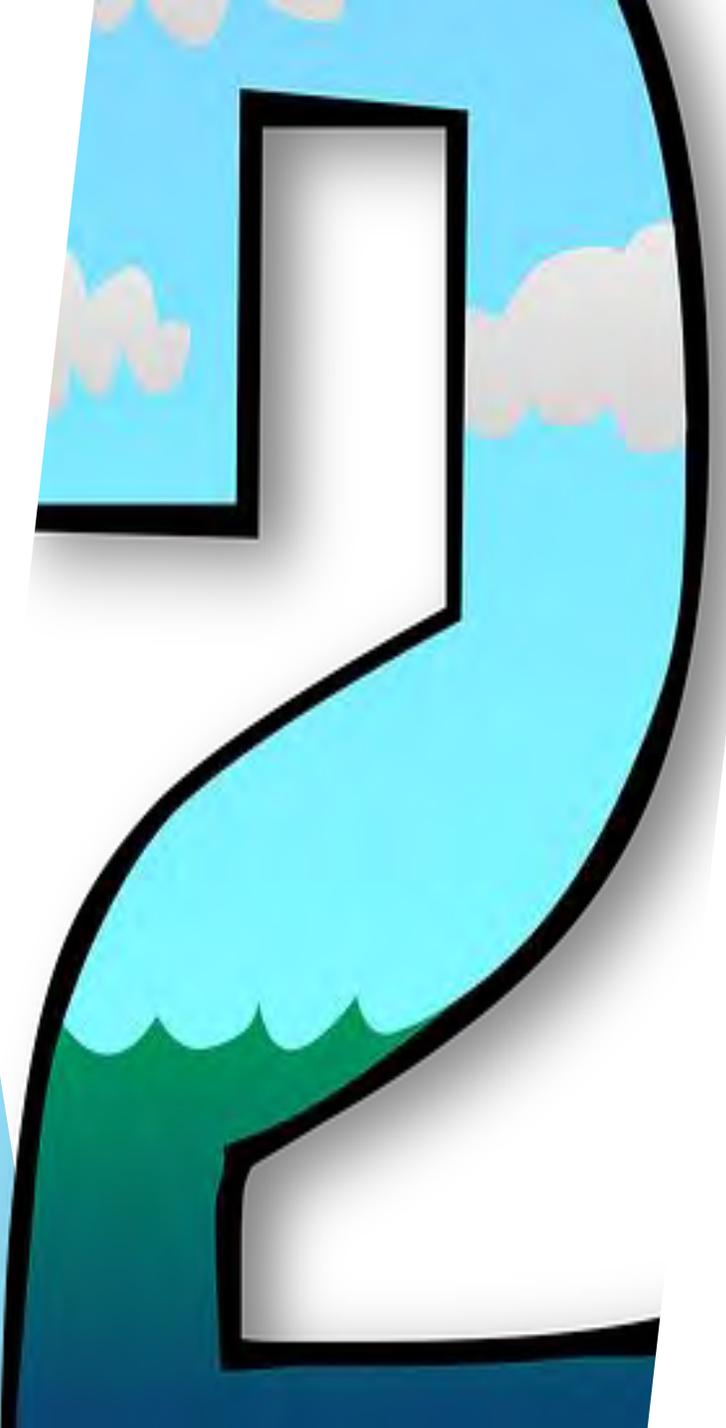
That
concludes
today!!!

We will see you
tomorrow at 8 a.m.
You will receive a
reminder email with
the zoom link again 1
hour prior to start
time.





Day Two: Core Competencies & Applications in Supervision



Today we are going to cover....

- ▶ Multiculturalism & Diversity
- ▶ Addressing Personal Factors, Responsiveness, and Reactivity
- ▶ Models of Supervision & Theory Based Supervision
- ▶ Ensuring Legal, Ethical, and Regulatory Competence
- ▶ Ethics & Boundaries in Supervision
- ▶ Supervisees Who Do Not Meet Professional Competence Standards



Multiculturalism & Diversity

CONCEPTS TO CONSIDER MULTICULTURALISM & DIVERSITY

- ▶ It is an ethical imperative!
- ▶ It is *during* the supervision that the supervisee learns to put into place what they have learned regarding sociocultural perspectives.
- ▶ It is crucial that the supervisor models attitudes and practices of respect to diversity and multiculturalism competence.
- ▶ INVOLVES SELF-ASSESSMENT!!!
- ▶ Supervisors tend to overestimate their multicultural competence or may not perform in keeping with the competent treatment.
- ▶ Supervisees have reported that any discussion regarding diversity is initiated by them versus by their supervisor.

Expectations of Multicultural Competence or “Diversity”



Explicitly acknowledges both competence (knowledge, skills, and values/attitudes) and attention to multiple diversity identity statuses of supervisor, supervisee, and client.



“Planfully” strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of the supervisee.



Supervisors aim to be knowledgeable about the effects of bias, prejudice, and stereo-typing and model advocacy and promotion of change in organizations and communities in the interest of their clients/patients.

Managing Biases in Supervision

You must do more than not just be biased yourself; it is incumbent on supervisors not simply to be respectful, self-aware, up-to-date on literature and research but also to infuse multiculturalism & diversity throughout all aspects of clinical and supervision practice (p. 62).



Let's look at an example in the book.

Pg. 63 (beginning with the bottom paragraph starting with “frequently”). Who wants to read for us? Stop at the “Vignettes” and we will break out into two rooms and explore the two vignettes.

Breakout Session!

Breakout rooms will be randomly assigned. You will have 20 minutes to discuss the vignette assigned to your group. There are only going to be two groups for this exercise. Please decide amongst yourselves who will be your spokesperson when you return. The vignettes are in your manual after this page.



Multiple aspects of diversity that can influence identity and interpersonal relationships

A supervisee in presenting one of her cases to her supervisor, a 28-year-old white Californian, and the supervisee began by saying that the father in the case migrated from South Africa and the mother was from the Midwestern United States. The supervisor interrupted and angrily asked why the supervisee would begin with that information rather than the presenting problem. The supervisee explained that she conceptualized the couple's issues in a cultural frame, as did the couple, who were seeing the world so differently, due in part to being in an interracial marriage period the supervisor reflected that those were assumptions and that they were biasing the supervision and potentially the treatment.

The supervisor asked the supervisee to simply present the data and not discuss the clients themselves. The supervisee was upset because she was trying to explain that part of the essential dynamic of the case was that the husband was Black, an immigrant, and significantly older than his wife. He held highly traditional views of women, and his wife had become increasingly depressed and isolated and was finding it increasingly difficult to be with him because he did not want her to go back to school to obtain the grad graduate degree she desired , although he promised her that she could when they married two years prior . The supervisee further wanted to explain that, as a Black woman herself, this was a complex client constellation for her, and she wanted to address her own feelings about the clients as a means of gaining greater insight into how to proceed.

If the **supervisor** came to you for consultation on supervision, what would you say? What questions would you ask? Some potential questions to the supervisor might be:

- Are you approaching this particular supervisee and or case differently than you usually do in supervision? If so, why?
- What about the description of the diversity of the clients caused you to become angry and to interrupt? What triggered your reaction? When you are triggered in supervision, how do you usually address it?
- (Don't forget to commend the supervisor for coming to you for consultation)

Consider your own competence dealing with supervision of the multiple diversity identities in the clients, supervising, and yourself . Think of your knowledge, skills, and attitudes and the intersections of these. For example, if you share cultural Borderlands of gender and age with the supervisee and the supervisee shares borderlines of race with the husband, but there is vast diversity in the country of origin, traditional value systems, beliefs about gender roles, educational levels, and likely multiple other identity's, consider the impact the similarities and differences will have on your supervision of this particular trainee.

Other questions you might ask to encourage the supervisor to respond to the supervisee could include the following:

- Had the supervisor previously discussed expectations for case description and presentation in supervision?

- Should the supervisor request an immediate meeting with the supervisee to repair the rupture or strain?
- How can the supervisor move forward to ensure that the supervisee is receiving appropriate supervision of the case? The supervisor was correct in needing to know more information about the depression of the wife and the presenting problems, but why was it so distressing that the problem was framed in a cultural context?

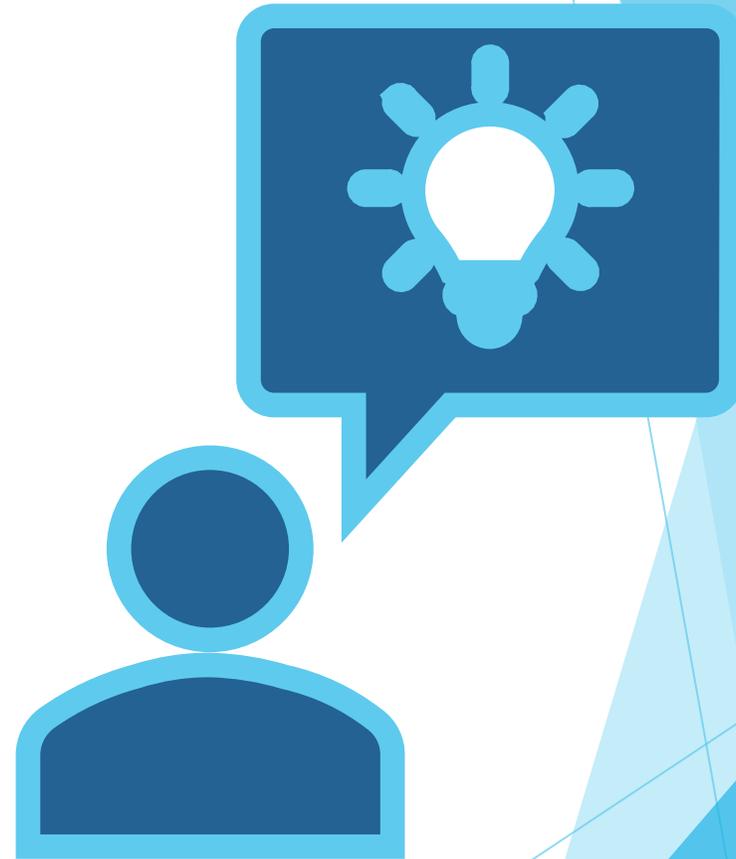
Multiple aspects of diversity that can influence identity and interpersonal relationships

Vignette 2 – Page 67 in the book

The supervisee was an international student from the Philippines . The supervisor was a 55-year-old White male psychologist. The supervisee described his new clients, a Filipino family with two teenage sons who were rebellious and failing in school. the supervisee said that the family wanted him to visit their home because they wanted to pray about the problem and felt that the supervisee had to do this with them to proceed with therapy. Further, the therapist could thereby meet the extended family members, including the 97-year-old great grandfather, the patriarch of the family who does not go out of the home but is instrumental in every decision made. Further, the family wanted the therapy to be conducted in Tagalog, a language the supervisee/therapist and family shared. The supervisor stated that none of this was possible because it would constitute a multiple relationship and, thus, was ethically untenable. Further, there was no capacity to supervise in Tagalog because there was no supervisor at the agency who spoke that language.

- What are some of the supervisory issues raised in this situation? Next paragraph what are the cultural borderlines, worldviews, and competence?
- What are the tensions that arise among institutions, supervisors, supervisees therapists, and clients and how could these be addressed?
- How could cultural boulder borderlands be transformed into a strength rather than a liability?

What do you do when a supervisee's or clinicians' multicultural commitments and loyalties conflict with the client needs or the values of the profession? An example would be religion. This is rarely discussed in clinical supervision nor it is it addressed in graduate education or clinical training.



Respect for an individual's diversity can create complex challenges

Increasing values conflicts have resulted in legal action when supervisees declined to work with a particular client because of the supervisee's religious beliefs and values .

Let's look at the examples beginning on page 68-71. Everybody take 5 minutes to read these pages and then we will resume discussion.

Reflective Questions

- Why do supervisors bear the responsibility of assessing & cultivating within themselves and the developing in their supervisee's multicultural competence?
- How can supervisors help their supervisees develop self-awareness regarding the multiple cultural identities and perspectives that influence understanding of their clients and the values that animate their work?





Why is it
CRITICAL for the
supervisor to
adopt a
reflective and
value-neutral
stance?



Addressing Personal Factors, Responsiveness, & Reactivity

Interpersonal Qualities & Personal Background of a Clinician

Each of us, well before we ever entered Graduate School or met our first client, formed fundamental ways of relating to others.

We assimilated family and culture bound styles of interpersonal relating, internalized attitudes and beliefs about human nature, and absorbed the worldviews and more of the ethnic, social, political, cultural, intellectual, gendered, and spiritual communities in which we inhabited.

These inescapable frameworks of identity, forged out of interaction with our surroundings, establish fundamental assumptions about us and others, ethical values, and instill a feeling sense of being at home in the world. Not solely products of internalization, our personal identities reflect dynamic, emergent sources of meaning and motivation... We may question and even reject the initial constituents of our multicultural identities; however the imprint of these influences remain, strongly influencing later developments of our interactions with our clients. (pp 74-75).

What does this mean?



Key
Fundamentals
that impact
the
experience

Personal factors

Emotional Reactivity

Skills

Attitudes

Personal contribution (disclosure) to therapy & supervision

Supervisees are not required to disclose information regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others unless:

- ▶ The program or training facility has clearly identified this requirements in its admission and program materials.
- ▶ The information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them for performing their training and/or professionally related activities in a competent manner or posing a threat to students and others.
 - Ethical? What is Reasonable? Who decides this?

Isn't this countertransference?

- The authors propose that disclosure be addressed in a more phenomenological manner. In other words, they believe that a host of personal factors, including multicultural identities and values as well as unresolved personal conflicts, contribute to the fundamental ways in which we understand to relate to ourselves and others.
- Thereby, all clinical understanding and conduct is, by definition, influenced by professional and personal factors which include personal and culturally based values.
- Awareness of the perspectival nature of understanding and relating is **an important competency to develop in our supervisee's.**

Emotional Labor & Reactivity - Personal factors always affect us

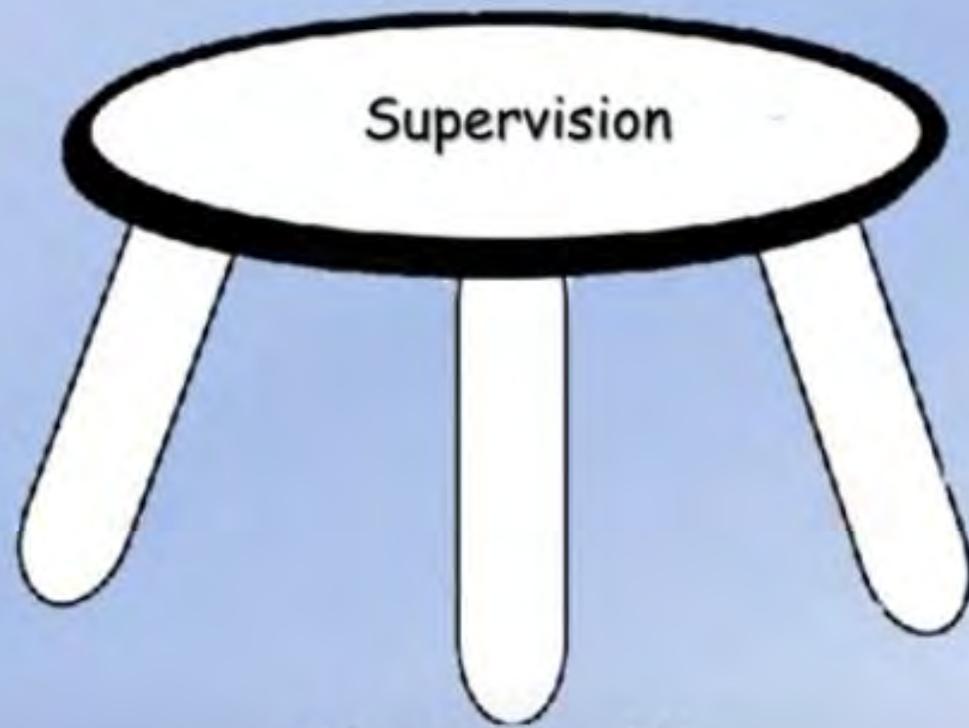
When a client is in a heightened state of emotion - grief, trauma, loss, guilt, or interpersonal conflict, a measure of emotional arousal in a supervisee is normal and appropriate for the therapeutic alliance.

- Emotional Labor - the ability to emotionally engage to facilitate and convey understanding to the client. We feel their pain. Involves empathy.
- Emotional Reactivity - over/under arousal that provokes reactivity **and forecloses empathy with the client's experience limits** attunement and loss of psychological contact with the patient precluding the therapeutic alliance.

Gatekeeping

Supervisors assist the supervisee by providing perspective on the role of personal factors and developing skill in recognizing the contributions of personal factors as well as managing both subtle and dramatic manifestations of reactivity.

Close attention by the supervisor is required when emotional reactivity affects the therapeutic relationship. In such situations, the supervisor must carefully balance responsibilities to ensure patient welfare by, for example, providing an effective therapeutic relationship in enhancing supervisee competence.



Supervision

Ensuring client
welfare

Facilitating
supervisee
development

Ensuring public
welfare
(gatekeeping)

4 Primary Tasks of Creating the Supervisory Alliance (p. 77)

1. Bring an empathetic interest to the supervisee's personal impact on the therapeutic process.
2. Reinforce the supervisee's developing self-awareness.
3. Avoid inducing shame.
4. Maintain the clear boundary between the supervision and psychotherapy.

Attitudes (pp. 77-78)

Managing reactivity rests on the personal and professional attitudes of the supervisee.

Self-awareness & value of self-knowledge leads to committed patient welfare and reflective practice.

Professional attitudes & different theoretical orientations should be respectfully considered.

Attitudes should focus on empirical literature or common factors that influence alliance & therapeutic relationships.

Professional ethics inform attitudes encouraging reflective practice across all theoretical lines.

The Supervisory Process (p. 78)

Alliance

Supervisory contract

Explicit orientation to personal factors

Personal factors in supervision and parallel process

Modeling

Alliance

- ▶ Alliance has been found to play an integral role in both comfort and likelihood of disclosure of personal reactivity or countertransference in supervision.
- ▶ Close attention should be placed on the establishment of a *collaborative* working relationship and alliance before initiating exploration of personal factors.



Supervisory Contract

The expectation that personal factors will be a component of the supervision is mutually discussed in developing the supervisory contract.

Includes:

- ▶ Developing Self-Awareness
- ▶ Engaging in Reflective Practice
- ▶ Using Supervision Effectively
- ▶ Managing Personal Reactions

In your manual are several examples of supervisory contracts ranging from basic to more in-**depth**. **Let's review & discuss**. Do you identify correlations with what you use?



**Basic Supervision Contract
(Falender)**

Defining supervision

- Collaborative and supportive
- Strength-based {identifying strengths of system, supervisees *and* supervisors}
- Developmental focus promoting life long learning
- Agreement that highest duty of supervisor and supervisee is protection of and working in the best interests of the client

This agreement serves to verify and describe the supervision provided by _____ (supervisor name and degree) to _____ supervisee.

Effective Date: _____

Structure of sessions _____

Frequency _____

Duration _____

Mutually determined goals and tasks by Supervisor and Supervisee to accomplish

Goal 1.

Task by Supervisor:

Task by Supervisee:

Goal 2.

Task by Supervisor:

Task by Supervisee:

Goal 3.

Task by Supervisor:

Task by Supervisee:

Strategies and methods to achieve these goals:

Supervision Contract 08

I agree to adhere to the ethical standards of my workplace and profession and to the regulations and personnel practices. I understand that personal factors are relevant to supervision and are valued.

I have read the above agreement and agree to operate in compliance with it.

Supervisor signature _____

Date _____

Supervisee Signature _____

Date _____

Sample Supervision Contract
Carol Falender, Ph.D.

Introduction to Supervision Contract

This document is intended to establish parameters of supervision, assist in supervisee professional development (whether licensure, post-licensure, or developmental supervision), provide clarity in supervisor responsibilities including the responsibility of the supervisor to protect the client.

This contract between _____ (supervisor) and _____ (supervisee) at _____ (site of supervision), signed on _____ (date) serves to verify supervision and establish its parameters.

I. Competencies Expectations

- A. It is expected that supervision will occur in a competency-based framework.
- B. Supervisees will self-assess clinical competencies (knowledge, skills, and values/attitudes)
- C. Supervisors will compare supervisee self-assessments with their own assessments based on observation and report of clinical work, supervision, and competency-instruments.

II. Context of Supervision

- A. _____ hour(s) of individual supervision per week.
- B. _____ hour(s) of group supervision per week
- C. Review of videotapes and/or audio tapes is part of supervision process
- D. Treatment notes complete for all sessions for the past week and available in the supervision session for review
- E. Supervision will consist of multiple modalities including review of tapes, progress notes, discussion of live observation, instruction, modeling, mutual problem-solving, and role-play.

III. Evaluation

- A. Feedback will be provided in each supervision session. Feedback will be related to competency documents.
- B. Summative evaluation will occur at ____ (number) intervals per year: _____ (specify dates)
- C. Forms used in summative evaluation are or available at _____.
- D. Supervisor notes may be shared with the supervisee at the supervisor's discretion and at the request of the supervisee.
- E. In order to successfully complete the sequence, the supervisee must attain a

rating of ____ (on the evaluation Likert scales).

- F. If the supervisee does not meet criteria for successful completion, the supervisee will be informed at the first indication of this, and supportive and remedial steps will be implemented to assist the supervisee.
- G. If the supervisee continues not to meet criteria for successful completion, the steps in place and procedures laid out will be followed.

IV. Duties and Responsibilities of Supervisor

- A. Oversees and monitors all aspects of client case conceptualization and treatment planning
- B. Reviews video/audio tapes outside of supervision session
- C. Develops supervisory relationship and establish emotional tone
- D. Assists in development of goals and tasks to achieve in supervision specific to assessed competencies
- E. Challenges and problem solves with supervisee
- F. Provides interventions with clients and directives for clients at risk
- G. Identifies theoretical orientation(s) used in supervision and in therapy and takes responsibility for integrating theory in supervision process, assessing supervisee theoretical understanding/training/orientation(s)
- H. Identifies and builds upon supervisee strengths as defined in competency assessment
- I. Introduces and models use of personal factors including belief structures, worldview, values, culture, transference, countertransference, parallel process, and isomorphism in therapy and supervision
- J. Ensures a high level of professionalism in all interactions
- K. Identifies and addresses strains or ruptures in the supervisory relationship
- L. Establishes informed consent for all aspects of supervision
- M. Signs off on all supervisee case notes
- N. The supervisor distinguishes administrative supervision from clinical supervision and ensures the supervisee receives adequate clinical supervision
- O. Clearly distinguishes and maintains the line between supervision and therapy.
- P. Discusses and ensures understanding of all aspects of the supervisory process in this document and the underlying legal and ethical standards from the onset of supervision

V. Duties and Responsibilities of the Supervisee

- A. Upholds and adheres to APA Ethical Principles of Psychologists and Code of Conduct
- B. Reviews client video/audio tapes before supervision
- C. Comes prepared to discuss client cases with files, completed case notes and prepared with conceptualization, questions, and literature on relevant evidence-based practices
- D. Is prepared to present integrated case conceptualization that is culturally competent

- E. Brings to supervision personal factors, transference, countertransference, and parallel process, and is open to discussion of these.
- F. Identifies goals and tasks to achieve in supervision to attain specific competencies
- G. Identifies specific needs relative to supervisor input
- H. Identifies strengths and areas of future development
- I. Understands the liability (direct and vicarious) of the supervisor with respect to supervisee practice and behavior
- J. Identifies to clients his/her status as supervisee, the supervisory structure (including supervisor access to all aspects of case documentation and records), and name of the clinical supervisor
- K. Discloses errors, concerns, and clinical issues as they arise
- L. Raised issues or disagreements that arise in supervision process to move towards resolution
- M. Provides feedback weekly to supervisor on supervision process
- N. Responds non defensively to supervisor feedback
- O. Consults with supervisor or delegated supervisor in all cases of emergency
- P. Implements supervisor directives in subsequent sessions or before as indicated.

Procedural Aspects

- A. Although only the information which relates to the client is strictly confidential in supervision, the supervisor will treat supervisee disclosures with discretion.
- B. There are limits of confidentiality for supervisee disclosures. These include ethical and legal violations, indication of harm to self and others (and others as specific to the setting).
- C. Progress reports will be submitted to _____ describing your development, strengths, and areas of concern.
- D. If the supervisor or the supervisee must cancel or miss a supervision session, the session will be rescheduled.
- E. The supervisee may contact the supervisor at (contact #) _____ or on-call supervisor at _____. The supervisor must be contacted for all emergency situations.

Supervisor’s Scope of Competence:

Include supervisor’s training, licensure including number and state(s), areas of specialty and special expertise, previous supervision training and experience, and areas in which he/she has previously supervised.

The contract may be revised at the request of supervisee or supervisor. The contract will be formally reviewed at quarterly intervals and more frequently as indicated. Revisions will be made only with consent of supervisee and approval of supervisor. We, _____(supervisee) and _____(supervisor) to follow the directives laid out in this supervision contract and to conduct ourselves in keeping with our Ethical Principles and Code of Conduct, laws, and regulations.

Supervisor _____ Date _____

Supervisee _____ Date _____

Dates Contract is in effect: _____

Personal factors in supervision & parallel process

Supervisor affirms that personal factors influence supervisory as well as therapeutic relationships



Provides examples of how factors such as interpersonal style and individual differences or multi cultural factors may affect supervision



Describe the nature of the parallel process and provide examples of how supervisors and supervisee's can address such clinical dynamics in supervision

Modeling

The supervisor models appropriate disclosure in briefly sharing how their personal factors, including multicultural identities, contribute to clinical practice and supervision.



All topics we just discussed are part of the Introductory Supervisory Process

Following this introduction, the supervisor encourages the supervisee to reflect on his or her own personal reactions - **“to reflect-on-action”** - and to consider how personal factors are influencing engagement with the client.



Let's discuss
the Process
Recording
Template as
a tool to
help teach/
manage
supervisee
reactivity

An example is in your manual after this page



PROCESS RECORDING

Process recording is a tool used by the student, the field instructor, and the faculty advisor to examine the dynamics of a particular interaction in time. The process recording is an excellent teaching device for learning and refining interviewing and intervention skills. The process recording helps the student conceptualize and organize ongoing activities with client systems, to clarify the purpose of the interview or intervention, to improve written expression, to identify strengths and weaknesses, and to improve self-awareness (Urbanowski & Dwyer, 1988). The process recording is also a useful tool in helping to explore the interplay of values operating between the student and the client system, through an analysis of the filtering process used in recording the session.

Students in the BSW WOW degree program are required to submit 12 process recordings to the assigned faculty advisor during the senior year field placement. Students in the BSW degree program are required to submit 7 process recordings per semester to the assigned faculty advisor each term during the senior year. Students in the MSW degree program are required to submit 7 process recordings per semester to the assigned faculty advisor during the Foundation Year. In the Advanced Year, students who selected the interpersonal concentration are required to submit 7 process recordings per semester to the assigned faculty advisor; students who select the Innovation in Community, Policy and Leadership concentration are required to submit 7 PRACSIS instead.

EXPLANATION

When creating a process recording, use this format:

Field Instructor's (supervisor) Comments: statements provided by the field instructor to help the student grow and develop. Because the process recording serves as a tool for self-discovery and continued growth, there are no right or wrong answers. The process recording is a powerful tool for analyzing difficult situations; a way of stepping outside one's self, recording a situation on paper, and analyzing it with the assistance of an objective person. This section is for comments by that objective person. There are no requirements as to the length, type of interview, etc. of a process recording. It is solely detailing a point in time that is analyzed to strengthen student growth and development. The process recording should be complete and thorough. You need not record an entire interview, meeting, or interaction; however, the portion that is recorded should include a "beginning, middle, and end phase" that completely addresses one problem or issue.

Dialogue: word-for-word description of what happened (to the extent that it can be recalled).

Student's Gut-Level Feelings: describes feelings about the specific dialogue. Use feeling words, such as anxious or happy. These help identify some of the non-verbal messages that may be affecting the interaction between the student and the client system, thus helping the student develop a better conscious use of self. Analysis: describes what has happened and why. This section allows you to identify type of response and reason for selecting the response. Student should state what they think client may be thinking or feeling and also to analyze the feelings described in the student's gut-level feelings column.

Analysis: describes what has happened and why. This section allows you to identify type of response and reason for selecting the response. Student should state what they think client may be thinking or feeling and also to analyze the feelings described in the student's gut-level feelings column.

Supervisor's Comments	Dialogue	Your Feelings Must be your feelings only. The rest belongs in Analysis	Analysis Identify the type of response you make and your reason for selecting it. State what you think the client is feeling or thinking. Evaluate your skills
	<p>Client's Name: Fred Flintstone (pseudonym) Age 51 Marital status: Single – Divorced Occupation: unemployed – disability</p> <p>Mr. Flintstone came to see me today because he is concerned about his current financial situation and discouraged about getting any help.</p> <p>I am hoping that he will open up to me and I will help him understand the problem in a way that can lead to effective problem solving.</p>		
	SW: Hello Mr. Flintstone, I am _____ and I am pleased to meet you.	I am feeling anxious because I am new at this type of interviewing and I want to do a good job.	I used a standard greeting to get the meeting started.
	Cl: Hello, I am pleased to meet you also. Please call me Fred.		He greeted me in a friendly way but he didn't smile and he looks sad.
	SW: Ok, Fred, please tell me about your decision to come and talk to me today.		I used an open ended response to help him get started today.

	Cl: I have not worked in four years because I have physical problems and I just wish they would either fix me or pay me.	I feel bad for him because he sounds so down in the dumps.	He seems discouraged and defeated.
	SW: Fix or pay you?		I used a furthering response because I want him to continue telling me his issues.
	Cl: yes fix or pay me. I have applied for disability benefits but they keep denying my claim. I need surgery but the doctors are not sure it will help me.		He seems frustrated and scared
	SW: You sound discouraged and dejected because you cannot get the help that you need.	I feel sad for him because he sounds so hopeless.	I used an empathic response to see if I am interpreting his feelings accurately.
	Cl: They say you can control your destiny but that is not true. My health and my life are in the hands of other people and I have no control over anything		I was on track with my empathic response and he is talking more about how he feels.
	SW: You seem to feel defeated in your ability to change your life in a direction that would be productive for you.	I am nervous about this response but I am trying to stay with him and on topic.	I used an empathic response to show my concern and my willingness to listen.
	Cl: This is true. I feel like every time I take a step forward and think I am moving in a positive direction, I take three steps back. I only have negatives in my life right now.		
	SW: Only negatives?		I used an open response to stay with him and let him unfold his story.
	Cl: Yes, I am broke. I can't do anything that is fun because of my finances and my health. I can't get help	I am concerned that he is so discouraged. I like him	He seems to be feeling like a failure financially

	from my government and I am afraid I am becoming a burden to others.	and I hope that we can find some way to help him.	
	SW: You sound like you are angry about not getting help from the government and it leading to you being more dependent on others.		I used an empathic response to keep him revealing his feelings.
	Clt: I should be getting help from the government. I should be getting SSI or something. I have applied for SSI and SSD but it has not gone through.	I am also feeling angry about the way he is being treated.	
	SW: You also mentioned financial burdens.		I used another furthering response to help him disclose more of his issues.
	Clt: I can't work because I cannot stay in any one position for any length of time. I need a nap after doing something as simple as going to the grocery store.	I am concerned about these limitations	He still sound hopeless and helpless
	SW: So your stamina is limited as is your ability to stay in one position.		Paraphrasing to help him continue talking without changing the subject by asking a question
	Clt: Yes and I have to be dependent on my sister and her husband because I do not have the money to get my own place. I try to help out at home but that has its own issues.		This seems to lead back to him feeling like a burden.
	SW: Issues.		I used furthering to keep him on this topic and learn more about what he is thinking.
	Clt: My brother-in-law is also off work from an injury and my sister needs help around the house and with the kids.		
	SW: Your brother-in-law is injured too?		I used an open response to learn more about his situation.

	<p>Cl: yes he was injured at work also but I believe he uses his injury as an excuse not to do anything.</p>	<p>I was happy that he said his brother-in-law was injured at work also because now I know more about his own injury.</p>	
	<p>SW: So he uses his work injuries as an excuse but you don't so you sound frustrated with him and his behavior.</p>		<p>I used an empathic response in hopes that he will continue revealing his issues.</p>
	<p>Cl: Yes, I am frustrated. I was really injured badly when I was pinned between two pallets at the printing shop where I worked.</p>		
	<p>SW Nodding and listening</p>		<p>I used a nonverbal response so that I would not interrupt his process.</p>
	<p>Cl: I worked for my ex-wife's family. I tried to continue to work but I just couldn't. When I tried to collect worker's comp, they denied that it happened there because an incident report was not filled out. They know it happened there. They are just worried about the money they might have to pay out.</p>		<p>Pt. seems angry with the situation but under it he sounds hurt that they would treat him that way.</p>
	<p>SW. You seem hurt that they have denied your injuries even though they know that you have had severe consequences because of that injury.</p>		<p>I used an empathic response to let him know that I am understanding his issues.</p>

Provide an evaluation of your overall skill during the session:

I was pleased with the way this session went. I was happy that I used several of the skills we are learning. They worked well to keep him talking without my having to ask questions. I would like to work on using more of the skills we are learning. I think that I could have used summarizing but I did not do that and I would have liked to use silence more. I was still finding myself concerned with what I would say next and therefore I was not listening as carefully to him as I would like to do. I will keep working on developing these skills

How do you see yourself as being effective during the session? What skills would you like to improve?

I would like to work on using more of the skills we are learning. I think that I could have used summarizing but I did not do that and I would have liked to use silence more. I was still finding myself concerned with what I would say next and therefore I was not listening as carefully to him as I would like to do. I will keep working on developing these skills

What questions do you have for the reader so you can receive feedback on your skills? (Note: General questions are not acceptable they must be specific questions and they must have depth).

Did I use empathy too often in this session. I find that emphatic responding really helps to keep my client talking but I don't want to overuse it.

I am working very hard to be able to gather information without asking questions. Am I getting enough information this way.

I am not always aware of the feelings I am having, is there a way for me to become more aware of them?

Please identify the theory/theoretical perspective(s) or intervention model that you used in your work with this client/client system. In order to demonstrate your understanding of the application of theory to social work practice, please identify and explain the specific theory-based interventions you used with the client/client system. Discuss why you used each intervention.

I provided responses that aligned with agency training and provided support through empathy and education. However, in the next session I will utilize empowerment theory to help the client feel less defeated and more confident and in control of his life and well-being so that he will continue to build confidence.



PROCESS RECORDING

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Supervisor's Comments	Dialogue	Your Feelings Must be your feelings only. The rest belongs in Analysis	Analysis Identify the type of response you make and your reason for selecting it. State what you think the client is feeling or thinking. Evaluate your skills

Provide an evaluation of your overall skill during the session:

How do you see yourself as being effective during the session? What skills would you like to improve?

What questions do you have for the reader so you can receive feedback on your skills? (Note: General questions are not acceptable they must be specific questions and they must have depth).

Please identify the theory/theoretical perspective(s) or intervention model that you used in your work with this client/client system. In order to demonstrate your understanding of the application of theory to social work practice, please identify and explain the specific theory-based interventions you used with the client/client system. Discuss why you used each intervention.

Processing Reactivity

- Processing draws on what has been learned through identifying the marker of reactivity and exploring the contextual, relational, and personal factors (including client factors) that contributed to the supervisee's reactivity.
- For example, when Mary (the student) said that she felt **“foreboding” when the client paused before speaking, explore why? What does she recognize as a factor of emotional reaction?**

Please refer to page 82-83 as we review the points that inform the approach and discussion

- Supervisor and supervisee discuss what steps or interventions, if any, should be initiated to enhance the alliance and to ensure the progress of treatment as the supervisor engages in a discussion of the supervisory experience and normalizes and addresses any discomfort the supervisee may be experiencing.
- The supervisor reinforces the supervisee's professional attitude and openness, application of knowledge, and development of reflective skills as in components of competence as a supervisee reestablishes emotional responsiveness with the client.



Let's take
a quick
break!!!





Models of Supervision & Theory-Based Supervision

Models of Supervision Rationale

A generally held assumption regarding competent supervision is that there is an underlying philosophy, a set of principles, and defined techniques that guide this activity called supervision. In the literature it is frequently referred to as having a Model of Supervision.

Models of Supervision Rationale (cont.)

Unfortunately, if you ask most supervisors, “What is your Model of Supervision?” you may receive blank stares, stuttering, or a rambling set a verbiage that provides little coherence or understanding. Having a model of supervision, being able to discuss your model intelligently, and being able to demonstrate some level of training in a specific model can be a way of establishing prima facie competence in supervision and supervisory activities.

Models of Supervision Styles

“No Model” of Supervision	
	Apprentice-Master
The Expert	
	The One-Size-Fits-All
The Therapist-As-Patient	
	The Parallel Process
The Interaction/Relationship	
	The Developmental
The Holistic	



“No Model” Model of Supervision

“No model” Model of Supervision The “No-Model” Model of supervision is typically another way of saying, “I supervise the same way my supervisors supervised me.” Whatever was good in my experience as a supervisee, I’m replicating; whatever was bad in that experience, I’m also replicating.

The No-Model Model ensures that you have no theoretical or evidentiary basis for what you are doing and are more likely to flounder due to a lack of a guiding basis.

In addition to lacking direction, purpose and documented effectiveness, the No-Model probably replicates the same mistake your supervisor made, while adding in a few of your own mistakes.

Apprentice-Master Model

Another ineffective model of supervision is the Apprentice-Master Model. This model has an assumption that the supervisee knows very little, has very few skills, and is generally incompetent to practice the profession.

This model is one that clearly emphasizes the power differential and may even encourage the supervisor to rely on and reinforce the feeling of incompetence on the part of the supervisee.

An assumption is made that if the supervisee simply “hangs out” with a skilled professional long enough and under close observation, by the process of osmosis, the supervisee will magically develop the skills of being the good clinician. This assumption in many instances turned out to be false.

The Expert Model

This model is frequently practiced in medical settings. It starts with several questionable assumptions, which may become problematic in the supervision process.

Supervision is a “top-down” model with the expert holding all the power and the ability to be very punitive/does not create a very safe learning environment and many supervisees may resort to “hiding their mistakes” rather than suffer ridicule or a negative evaluation from the expert.

The “right-wrong” atmosphere implies that the supervisee has little to offer and due to their incompetence needs to be closely directed and monitored.

This model does not sit well with experienced clinicians who feel like they are already competent but are looking for supervision to refine their existing skills.

The One-Size-Fits-All Model

The supervisor approaches all supervisees the same way despite their level of professional development or their individual growth needs. Supervision should look and feel different with the relatively inexperienced person versus the interaction with an experienced veteran where the focus is polishing skills.

The supervisor who doesn't make that kind of distinction operates in a One-Size-Fits-All Model. This approach ensures that neither the experienced nor inexperienced supervisee's needs are met as supervision is not tailored to meet the needs of the supervisee.

The supervisor must recognize that there are two different skill sets that are being addressed and that supervision and supervision style needs to fit the needs and experience level of the supervisee.

The Therapist as Patient Model

The Therapist-As-Patient Model was widely used in the 70s and 80s. Part of the role of **the supervisor was to “therapize” the supervisee and identify their hidden idiosyncrasies,** their psychopathology, and their Axis II Disorders. Once identified, the role of the supervisor was to purge them of their individual issues.

The assumption was that the supervisee's issues may be getting in the way of their being a good therapist. While this may have produced generations of emotionally healthy therapists, it did not impart a lot of concrete skills.

The focus unfortunately became assisting the supervisee with personal issues, rather than assisting the supervisee to serve the client effectively and safely.

The Parallel Model

Supervision looks at both relationships with an assumption that relationships on any given level influence those on another level. Whatever is going on between the client and the supervisee will be reflected in the relationship between the supervisee and supervisor.

This approach assumes that whatever dynamic exists between the supervisee and their clients, the same dynamic exists in supervision. The supervisor can use the dynamics **observed in her supervisee's cases to talk about the dynamic of what's going on in supervision** and how that might be preventing supervision from being effective.

The flip side is, that whatever issues the supervisee and the supervisor have going on (i.e. difficulty handling conflictual situations), there is a significant probability those issues are showing up in therapy. This approach examines how you are with clients and look at the supervisory relationship and recognize that there are parallel processes in existence.

The Holistic Model

The Holistic Model focuses on providing an atmosphere of safety, trust, and learning. The Holistic Model also looks at the idea of parallel processes, but a major focus of the holistic model is achieved by building on the strengths of the individual supervisee, rather than focusing on problems or deficits. "Catch a supervisee doing something right."

While the supervisor is still concerned about errors, mistakes, or sub-par services, the focus **is on growth and development. The supervisor's personal goal is to be able to help the supervisee develop.** The supervisor desires to identify the things that the supervisee is naturally good at and then develop those abilities so that they can be used therapeutically in the room with clients.

If a supervisee is a "natural joiner," that is, they have never met a stranger and can talk easily to almost everyone, develop that ability to relate to people in a way that it enhances the delivery of services.

The Interaction/Relationship Model

Examines the quality of the relationship between the supervisor and supervisee. Supervision is seen as a way of creating a reciprocal relationship based on mutuality of needs.

The assumption is that when the supervisory relationship is going well and meeting **the supervisee's needs, clients will receive excellent service.**

The supervisory relationship is the medium by which supervision occurs and viewed as the most important aspect of high-quality supervision.

The four key elements of an effective supervisory relationship: accountability, personal awareness, trust and power, and use of authority.

The Developmental Model

Not everyone should be supervised the same way. Through an assessment process, the **supervisor identifies each supervisee's skills and then supervises them in a fashion that** helps the supervisee attain the next level of their development. Based on supervisee experience.

The level of the supervisee's skills should be very apparent based on the way a supervisor is interacting with a supervisee. In all Developmental Models, the supervisor will be called upon to individualize supervision plans and methods and to tailor supervision to the developmental needs of the supervisee.

Developmental Models are based on the premise that the supervisor, supervisee, and supervisory relationship change over time consistent with the growth and development of the supervisee.

Breakout Session!

Breakout rooms will be randomly assigned.

You will have 20 minutes to discuss the various models. Talk amongst each other about which model(s) you identify with and why.

You will automatically return to the main room and whomever wants to share can provide a brief summary about what model(s) with which you identified, why, and one thing or perspective you may have learned about a Supervision Model from another group member.

Room 2



Theory-Based Supervision

Client(Supervisee)-Centered,
Behavioral, and Cognitive Behavioral

Client/Supervisee-Centered Model of Supervision

- Based on Carl Rogers development of the client-centered model of psychotherapy.
- Posits the use of the four facilitative conditions of the theory which are warmth, empathy, respect, and genuineness are essential for effective supervision.
- Supervisees are assumed to have the ability and motivation to learn and advice and direction are minimal with this approach.
- Supervisors must avoid asking questions and instead use reflective comments to draw out supervisees.

Ethical Considerations in Supervisee-Centered Supervision

- Critiqued for its non-directive approach; does not provide adequate direction.
- Supervisors are charged with significant ethical responsibilities for both their own behavior as well as the supervisee and, therefore, must ensure that supervisee adhere to professional behavior and ethical codes.
- Supervisees are novices and will need more monitoring and direction.
- Supervisors are liable for their supervisees actions and cannot rely solely on self-reporting.

Supervisee-Centered Supervision

Case:

“I just want to help”

look in your manual for this case study



Supervisee-Centered Supervision Case: I Just Want to Help

The supervisee, Dr. Amador, recently completed her doctorate in clinical psychology and is accruing supervised hours toward licensure. As a Christian, she is committed to helping disenfranchised people who otherwise would not have access to psychological services. Her internship in a college career counseling center has left her with a desire for closer connections with more needy clients, so she is grateful to have found employment in a setting offering in-home psychotherapy. She shares her supervisors, Dr. Jackson, client-centered orientation and is eager to demonstrate respect and positive regard for those whose difficulties do not always allow them to experience these qualities in others. Dr. Jackson has expressed confidence in her ability to know when she needs his input, and Dr. Amador appreciates his respect for her.

One of Dr. Amador's first clients is a rural family struggling with poverty, alcoholism, and children with academic and emotional problems. Her heart goes out to the mother, but she has more difficulty empathizing with the father, who does little to help with household chores or childcare and who seems to resent Dr. Amador's presence. The four children are emotionally needy, but the mother has little time or energy for them. Reflecting Maslow's (1998) hierarchy of needs, Dr. Amador concludes that this family's ability to benefit from psychotherapy cannot be realized when more basic needs are unmet.

To ensure that her treatment is client centered, Dr. Amador asks the mother how she can be most helpful to the family. The mother identifies a list of practical

problems with which she needs assistance. Dr. Amador attempts to help by doing laundry, feeding the baby, and showing the mother how to clean the house. She encourages the mother to pursue a dental assistant training program, and because she cannot afford books, Dr. Amador lends her \$150 to buy them. When the husband objects to his wife pursuing further education, Dr. Amador helps her conceal her schooling by providing psychotherapy for the children when the mother is in class.

Dr. Amador knows that her supervisor trusts her judgment, but she is not confident he shares her commitment to go the extra mile with people in need, so she tells him only that the case is going well. He is surprised when the husband, on discovering his wife's secret, schedules an appointment with the supervisor to express his outrage.

Supervisee-Centered Case Discussion

Lacking a method for tracking Dr. Amador's cases, Dr. Jackson risked being blindsided by her errors in judgment. Reliance on supervisees' ability to discern what they need to discuss in supervision is not necessarily enough to meet supervisory obligations. Particularly, but not exclusively, novice clinicians may have blind spots rendering them unable to determine exactly which elements of a case should be reviewed. Possible naiveté, along with Dr. Amador's reluctance to share this case in supervision, resulted in misapplications of client-centered theory. If Dr. Jackson had had a method for monitoring cases or if he had provided Dr. Amador with clear guidance about the types of cases and circumstances that should trigger a case presentation, he might have avoided or at least minimized the clinical and ethical pitfalls encountered in this case. For example, Dr. Jackson might have

discussed with his supervisee each decision point in the treatment in terms of its possible risks and benefits. Dr. Amador might then have reached different conclusions about how to proceed in a way that would have addressed her clients' needs within the parameters of counseling services. An exploration of complementary resources might have helped the family meet its other needs as well as benefited the developing clinician. Allowing the supervisee to explore and perhaps diffuse her own feelings about the client and her difficult circumstances would have afforded the supervisor access to potentially problematic endeavors as they were unfolding. It might also be argued that such a scenario is unlikely, given that graduate students typically take an ethics course and generally would be unlikely to engage in such behavior. Knowing that some multiple relationships are unethical (American Psychological Association [APA], 2002, Standard 3.05, Multiple Relationships) and understanding the applications of the standard in real-life cases, however, are not the same thing. Application of the standard is a skill developed through clinical experience coupled with careful guidance and supervision. Freeman's (1993a) assertion that interns can be expected to function as well as professionals is questionable.

Case Discussion Notes

- Lacking a method for tracking the intern's case, the supervisor risked being blindsided by her errors in judgment.
- **Reliance on supervisees' ability to discern what they need to discuss in supervision** is not necessarily enough to meet supervisory obligations.
- **Possible naiveté, along with the intern's reluctance to share this case in supervision,** resulted in misapplications of client-centered theory.
- An exploration of complementary resources might have helped the family meet its other needs as well as benefited the developing clinician.

Behavioral Supervision

Four tenets



Proficient performance is a function of learned skills and not personality fit.



The therapist's role consists of identifiable tasks, each requiring specific skills.



Skills are definable and responsible to learning theory.



Supervisors should employ learning theory in their procedures.

Behavioral Model of Supervision

- Described as a Learning Theory and supervision in the context of this model is the primary source of experiential learning and personal growth, developing a working alliance, and an atmosphere of trust.
- Goal is to teach the supervisee the skills needed to conduct behavior therapy and to help them extinguish inappropriate counseling behaviors.
- Strategies applied typically parallel those used in behavior therapy.



Five-step Sequence for Behavioral Supervision

BEHAVIOR



1. Establish a supervisory relationship, and then conduct a skill analysis and assessment.
2. Based on the outcome of these measures, execute the third step:
3. Establish goals and objectives.
4. Construct strategies to accomplish these goals.
5. Design plans to implement.



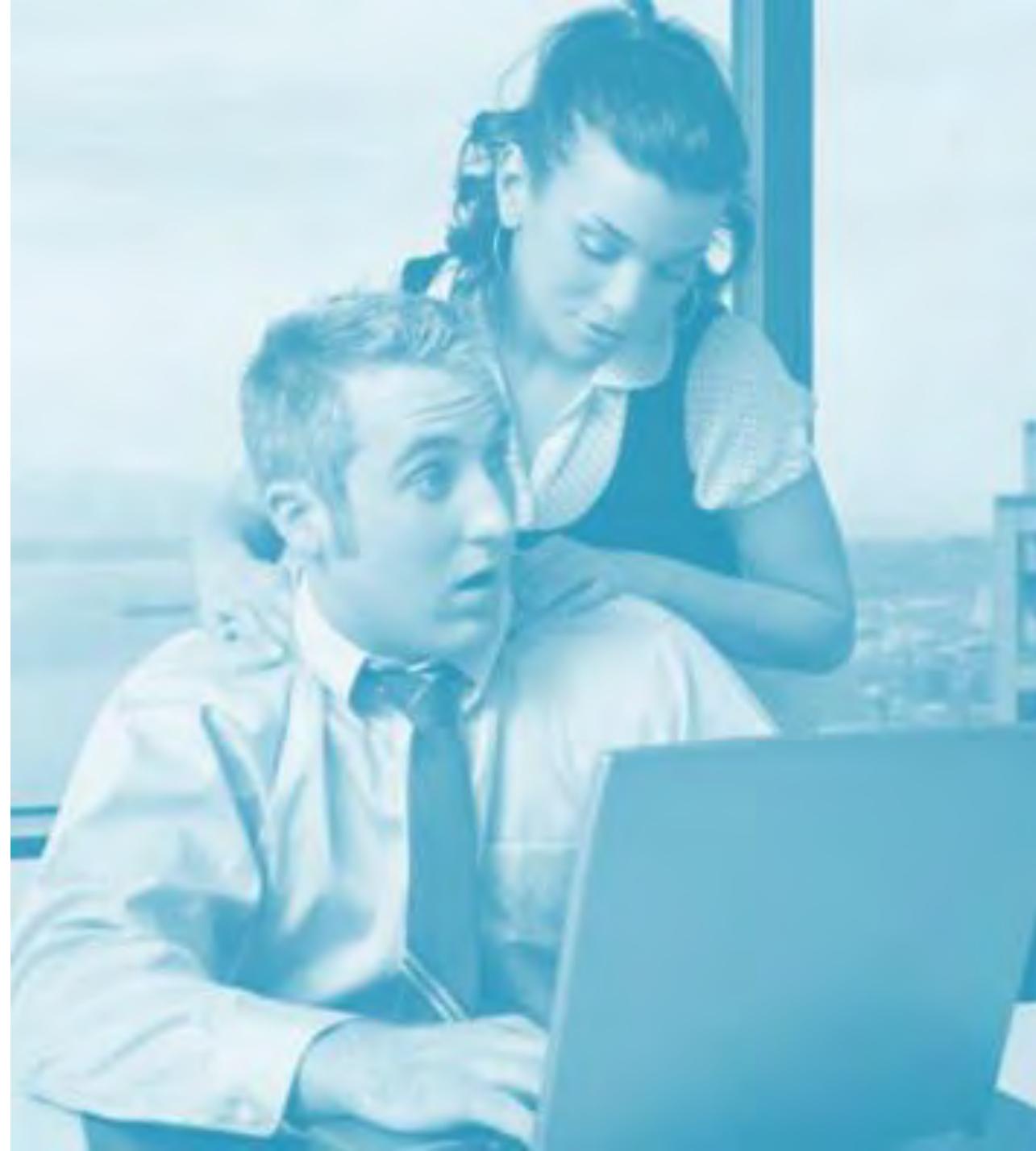
Ethical Consideration in Behavioral Supervision

The primary emphasis of behavioral supervision is on helping supervisees learn techniques and develop skills in their application. Behavioral supervisors, like other psychotherapy supervisors, are not oblivious to interpersonal dynamics in these relationships; as mentioned, a working alliance is considered an important component.

Behavioral Supervision Case Study:

“I don’t do transference!”

locate the case study in your manual



Behavioral Supervision Case: I don't do transference!

A psychology intern at a Behavioral Health Clinic request help with a case involving a client who presents with anxiety about public speaking. The supervisor helps the intern to identify target behaviors, therapeutic goals, and strategies the client might use to manage her anxiety.

The supervisor also discusses with the intern the potential for professional development and discuss the potential opportunities for practicing his skills in behavior therapy. The client is assigned to chart her progress using an online form and to email the records to the intern each week prior to the session. The client also begins (spontaneously) to enter commentary on her feeling about the treatment.

The commentary begins with expressions of gratitude for the intern's assistance, which he appreciates, the comments shift to focus on the intern himself in a more personal manner. The supervisor concurs with the intern's decision to avoid reinforcing the expression of personal feelings by focusing exclusively on the records.

Contrary to the intern's theoretical predictions (transference) and his decision to not directly address the client's communications exacerbate rather than defuse her feelings.

The client's next communication discusses her pleasure in how much interest he [the intern] is showing in her, that she believes he recognizes the 'special connection' that is developing between the two of them, and the client hopes that

she hopes they will get to 'know each other better'. The intern who is committed to ethical behavior, is very disturbed by this communication and he becomes anxious and begins to question his decision to enter this field.

The supervisor determines that the intern is no longer the best person to work with the client. Upon this discussion with the supervisor, the intern sends the client a termination letter stating that "because of your recent comments I can no longer work with you and here are the names of 3 other therapists who may be able to help you. Good luck."

In his haste to end the uncomfortable encounter, he fails to review this termination letter with his supervisor rationalizing that the supervisor is 'equally content with the termination of the client relationship and does not ask for details'.

Throughout the next few weeks, the client leaves a series of remorseful, apologetic messages, begging him to reconsider. This plaintive tone turns into anger. The intern feels that due to the termination of the client relationship and does not want to reinforce the inappropriate behavior, he does not return her calls and eventually does not even listen to the messages. The client eventually stops.

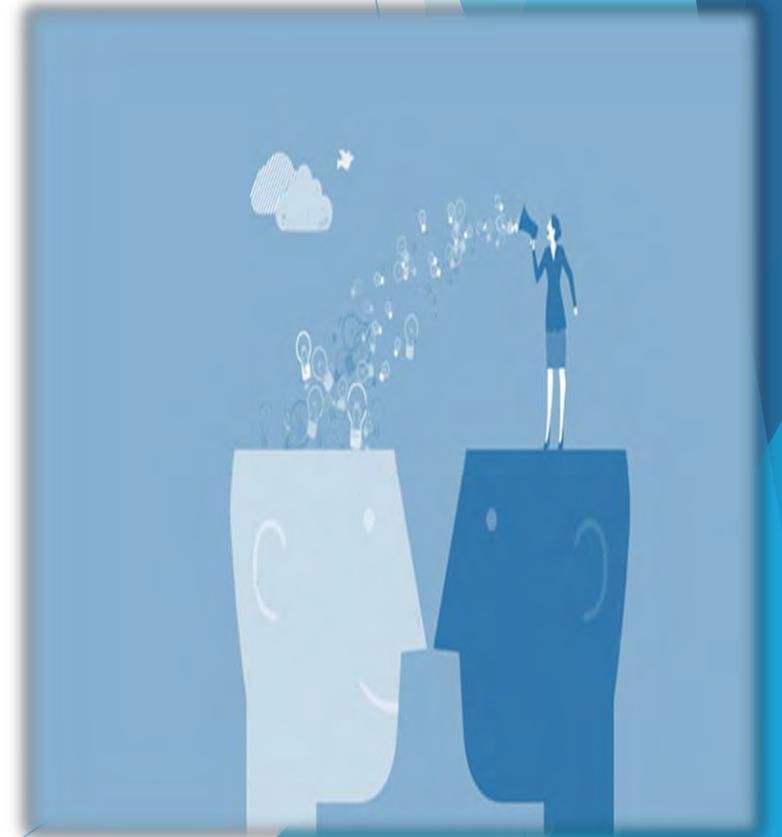
Two months later, the supervisor receives a letter from the board stating that the client had filed a complaint against her for her supervisee's abandonment of a client.

A subpoena for treatment records is enclosed.

Behavioral Supervision Case: I don't do transference!

Case Discussion

- What went right with this case? What went **wrong**?
- From a Behavioral Supervision approach, how should this situation have been handled or how would you coach the intern?
- Is there something (again, from a behavioral supervision approach) that the supervisor could/should have done differently to prevent this scenario?



Case Notes Discussion

- Clearly, the situation called for more direct intervention than just “not reinforcing the behavior” and he should have been coached to address the behavior.
- Behavioral supervisory techniques, such as role-playing, didactic instruction about establishing clear boundaries, and the assignment of relevant reading, could have been used to help the intern respond effectively and sensitively to **the client’s feelings while continuing the treatment.**
- It could have been used as an opportunity to teach effective and sensitive execution of an appropriate termination.

Closing thoughts on Behavioral Supervision

Behavioral supervisors overseeing behavior therapy can remain true to their principles while accurately identifying and effectively managing interpersonal dynamics that sometimes arise in either the treatment or the supervisory relationship.

Yet, behavior theory does not specifically offer a mechanism for addressing these challenges, and behavioral supervisors must find ways to extrapolate and to creatively apply their skills to ethically manage them.



Cognitive-Behavioral Model of Supervision

- Many of the concepts and strategies of behavioral supervision are evident in cognitive-behavioral therapy (CBT) supervision. Further, techniques used in CBT are also used in supervision.
- Examples include setting and prioritizing the agenda, structuring sessions, assigning homework, and applying standard techniques such as role-playing.
- CB supervision also emphasizes the identification of the **supervisee's pertinent thoughts and beliefs.**

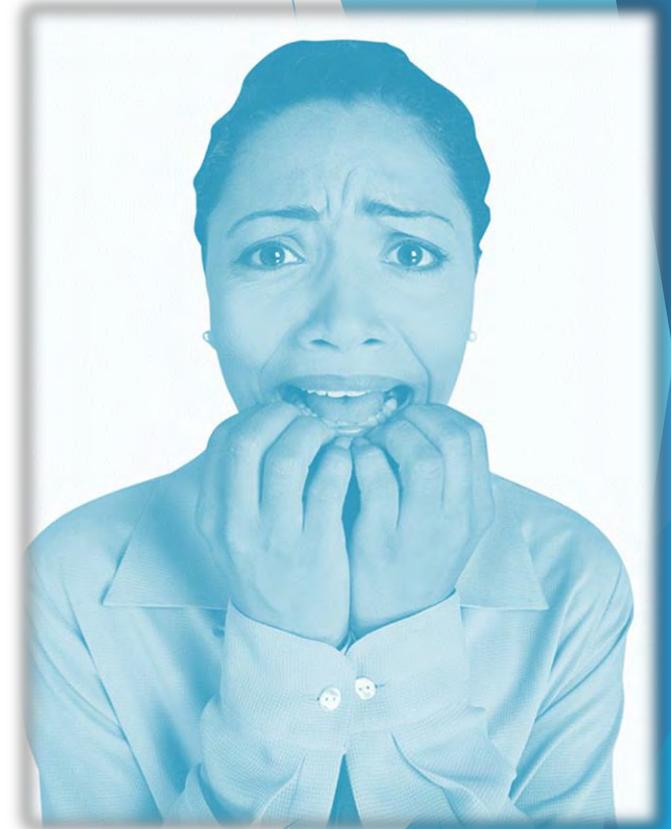


Examples of erroneous beliefs that novice therapists commonly hold:

“I must show the supervisor how perfect I am at therapy.”

“I must make the right decision or something terrible will happen.”

“I must love doing therapy to be a good therapist.”



YOU fill in the blank.

What are some statements you have heard from your supervisees?

Goals of Cognitive Behavioral Supervision

- To produce a clinician who can respond in a relatively anxiety-free way, who **can develop hypotheses about the nature of the client's problematic cognitions, emotions, and behaviors**, and who can help choose and test appropriate techniques to change them.
- To help therapists adopt the philosophy of CBT as the basic approach for **changing clients' cognitions, emotions, and behaviors.**
- To teach therapists specific techniques.
- To listen to recorded sessions to circumvent the problem of supervisees not always being able to identify and report problems.

More Discussion on CB Supervision

- While the similarities between the techniques of cognitive-behavioral treatment and supervision are significant, one distinction is that CBT supervisors, unlike therapists
- have responsibility for two individuals; they are charged with examining the relevant cognitions of supervisees as well as helping them to identify and analyze the cognitions of their clients.
- The primary focus in supervision is on the cognitions related to the **supervisee's work performance.**
- Part of the goal is to demonstrate how CB techniques are applied, and part is to decrease anxiety and other negative emotions that contribute to a negative self-concept and thereby compromise work performance.

Ethical Considerations with CB Supervision

- Supervisors who address work-related personal issues introduce the risk of blurring the boundary between supervision and psychotherapy, potentially creating confusion for the supervisee about the nature of expectations appropriate to the relationship.
- Problematic interpersonal dynamics that could go unnoticed in the context of supervision due to the focus on establishing a working alliance with the supervisee.
- Because the supervisory relationship itself is not a primary focus, however, problematic dynamics may be unseen, misunderstood, or deliberately go unaddressed.

Cognitive Behavioral
Supervision Case:
“I want to be just like you!”



Cognitive Behavioral Supervision Case Study: I want to be like you!

Anna's supervisee is a 22-year old master's student in counseling with a concentration in women's studies. Anna is a self-proclaimed feminist and as such, enjoys helping women with their careers.

Anna is interested in learning about other cultures so is especially excited to learn that Rosa is a Mexican American and bilingual.

Anna describes her supervisee as 'bright, energetic, and highly skilled and was please to find out that she has experience as a political activist working on behalf of women's rights.

When the supervisee came out to Anna as lesbian, Anna told her supervisee that she was honored to be trusted and expressed admiration for her supervisee's courage and commitment.

The supervisor (Anna) is a Caucasian, heterosexual, married mother of three sons and has had minimal contact with lesbian women and is excited to have the opportunity to get to know her supervisee.

About 4 months into supervision, the supervisee presents a case involving a 33-year-old mother who is separated from her husband, whom she describes as emotionally and physically abusive. The client was depressed at the onset; however, is responding well to the strategies to modify negative cognitions that saddened her and kept her feeling 'stuck'.

Unfortunately, as soon as the client's divorce is final, she will lose her insurance and cannot afford to continue with therapy.

The supervisee tells her supervisor that she is very concerned about the possible negative repercussions of terminating the client's treatment at such a crucial time in her life and wants to find some way to continue.

The supervisee learns that the client is a very good charcoal drawing artist and loves to draw women from many different cultures. The supervisee proposes to her supervisor that the client be allowed to bring in a drawing each month to pay for her therapy that can be displayed in the office to show the organization's commitment to welcoming and providing multicultural services to women.

Moreover, the supervisor tells her supervisee, this will go a long way to reinforce the client's fledgling self-concept.

The supervisor hesitates briefly as she considers possible complications of the arrangement, but she doesn't want to crush her supervisee's enthusiasm. She also is determined to be sensitive and respectful of Rosa's cultural background and so is reluctant to be critical.

The supervisor also considers how difficult it is for women to leave destructive relationships, and she certainly doesn't want to be viewed as part of what sometimes feels like a conspiracy against women. With all that in mind, she congratulates her supervisor for her creativity, innovation, and commitment to going the extra mile to help a woman in need, and she encourages her to give it a try.

Case Notes Discussion

Do you believe that in this case the supervisor's idealization of the supervisee as a lesbian and a Mexican American created an ethical blind spot?

Was the supervisor naive desire to be sensitive and respectful born of true multicultural sensitivity OR more likely from a desire to be liked and perceived as well informed?

While the supervisor was well intentioned, did she miss an opportunity to help the supervisee explore possible risks, benefits, and alternatives to her proposal which is a process that would have served her well in the future?

Do you believe that the supervisor was unaware of her countertransference and even transference to her supervisee and the potential for a multiple-relationship was ignored?

Let's take
a quick
break!!!





Ensuring Legal, Ethical, & Regulatory Competence

Key Points for Supervisory Ethical & Legal Conduct

Practice/decision making follow COE, guidelines of any other applicable professional organization, and relevant federal, state, provincial, and other jurisdictional laws and regulations.

Primary ethical and legal obligation to protect the welfare of the client/patient.

Gatekeepers to the profession entailing assessing supervisee's suitability to enter in remain in the field.

Clear expectations for and parameters of supervision to supervise; preferably in the form of a written supervisory contract.

Maintain accurate and timely documentation of supervisee performance related to expectations for competency and professional development.

Ethics (an overview)

It is important to assess the supervisee skills at ethical decision-making at the beginning of supervision considering that during their education process they may have only had one or two courses in ethics.



Positive ethics entails aspiring to moral excellence, encouraging practitioners to integrate personal ideals into one's professional life.



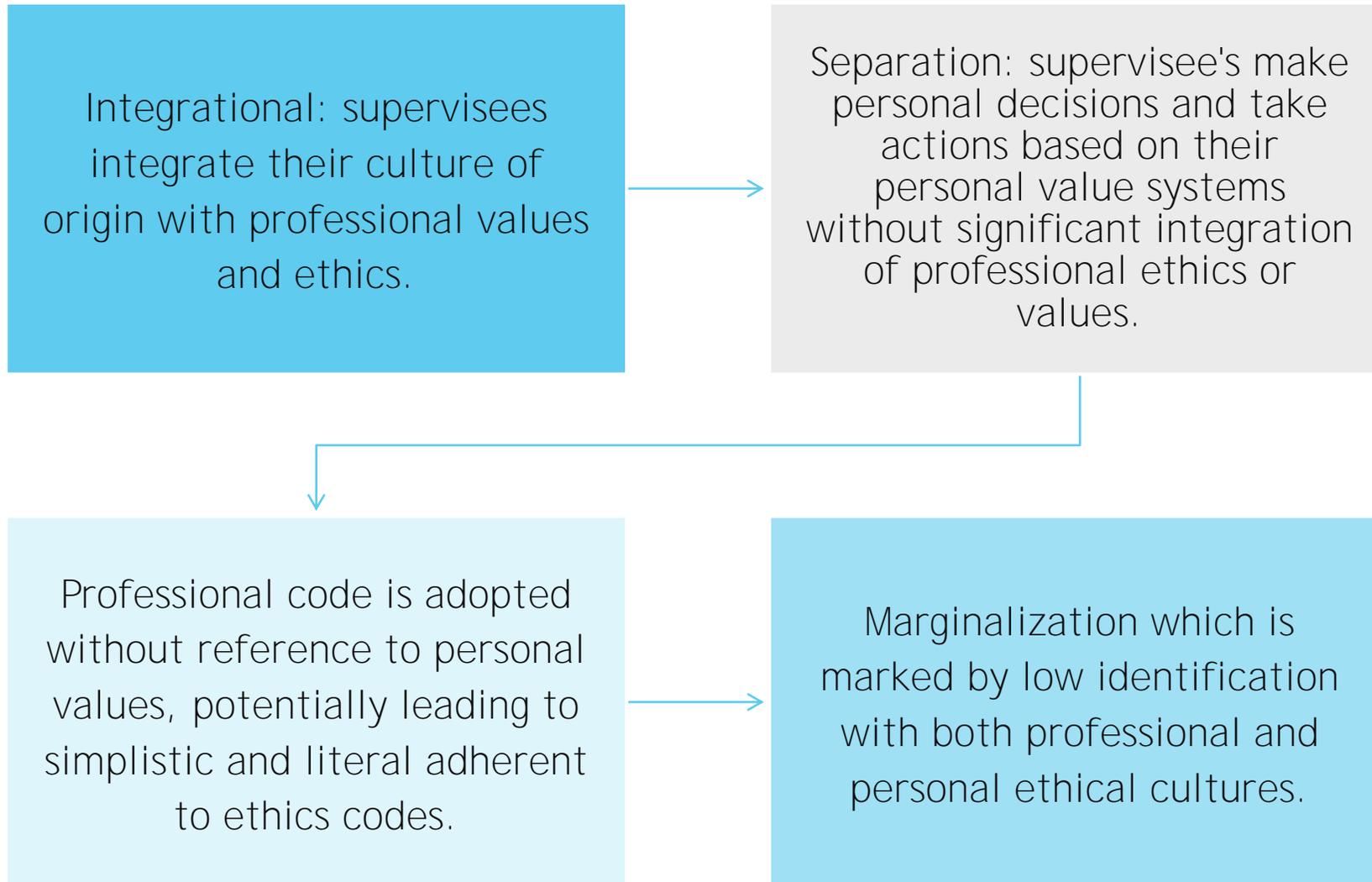
Disciplinary codes represent a minimal standard for practice, and deviation from those may result in misconduct. Professionals may believe they satisfy moral requirements by fulfilling the letter of the code of ethics, but codes have little emphasis on moral principles such as veracity, justice, and respect for autonomy as they are not in the enforceable sections.

Ethics Acculturation Model - Two Processes

Maintenance or retention of the ethics and values traditions of the culture of origin

Contact and participation or the degree to which students adopt the values, norms, traditions of the professional culture

Four Quadrants of These Two Processes



Universal Declaration of Ethical Principles



Developed to inspire practitioners to attain their highest ethical ideals in their professional and scientific work and defines principles based on shared human values.



The Universal Declaration calls for knowledge of the social and cultural context and adequate self-knowledge of how one's values, experiences, culture, and social context might influence one's actions and interpretations, choices, and recommendations.



This code highlights the significances of values and morality in ethical decision making.

We are going to breakout in groups again to discuss the Ethical Decision-Making Model so **let's review each step.**



Another General Ethical Decision-Making Model



Breakout Session!

Each group will be assigned a case study and questions regarding applying the Ethical Decision-Making Model to the case study. You can record your groups responses after each question on the note sheet provided in your manual. Breakout rooms will be randomly assigned. You will have 20 minutes to discuss the case. Please decide amongst yourselves who will be your spokesperson to provide a summary of the decision-making process and how you will approach this situation with



How would you approach these scenarios in supervision? Consider the supervisory alliance, supervision contract, ethical and legal aspects, risk factors, the supervisee's integration of professional and personal ethics, multiple relationships, diversity, and worldviews that may differentiate the supervisee from the client and how these may affect the supervisee's behavior.

Case Study #1

Jon went to Graduate School after traveling the world for several years after college. He described himself as "highly privileged" and considered graduate school in psychology the ideal way to give back from the advantages and privilege he enjoyed. His first practicum placement in the postmaster's program Jon was working with homeless individuals in a temporary shelter. Jon's client was a 52-year-old male who had a family and had been a teacher for many years. It was unclear whether his substance use induced a psychotic episode or the reverse, but he was only recently sober and was making good progress toward obtaining subsidized housing. He had lost his family and everything he owned. He had always had an interest in photography, a theme that was frequently discussed in therapy because Jon too was a photography buff. It was close to Christmas, and Jon wanted to give his client a camera to motivate him to follow through with the forward-moving development. Jon's question to you as his supervisor was whether he should simply give the client the camera as a gift or whether he should pretend it came from a "Make-a-Wish" type of organization.

Case Study #2

Vanessa has been a marriage and family therapist at an agency for six months. Gary, one of the other three therapists in the agency and the only other single therapist, is her clinical supervisor. It will take Vanessa 2 years under supervision to accrue the experience she needs to be eligible to sit for the state licensing examination for her LMFT. One evening Gary calls

Vanessa to inquire whether she would like to go to a day-long workshop with him. The speaker for the workshop specializes in a kind of therapy in which Vanessa has expressed interest. Vanessa accepts and the workshop turns out to be an excellent professional experience. On the way home, Vanessa and Gary stop for dinner. Vanessa picks up the tab to thank Gary for including her. The following day Vanessa is sharing some of the experiences of the workshop with Camille, another therapist at the agency. When Camille asks, "Isn't Gary your supervisor?" Vanessa feels defensive and misunderstood. Later that day, Vanessa decides to go to her agency director and ask his opinion of the situation. He tells her not to be concerned about it and that Camille "worries about everything." During her next supervision session, Vanessa chooses not to mention either conversation to Gary.

Case Study #3

Margaret is a school counselor who has been assigned a trainee from the local university for the academic year. As she observes Noah work with elementary school children, she is increasingly impressed with his skills. She asks him to work with Peter, a nine-year-old, who has not adjusted well to his parents' recent divorce. Again, she is impressed with Noah's skill, his warmth and understanding, and ultimately, with the success he has in working with Peter. Margaret is a single parent who is concerned about her nine-year-old son. She decides to ask Noah to see him. Noah is complimented by her confidence in him. Margaret's son attends a different school, but she arranges to have Noah see him after school hours.

Case Study #4

Ruth has been assigned to a local mental health hospital for her internship to work with patients who are preparing to be discharged. It is her first day at the site and she is meeting with her site supervisor. He gives her a form to fill out, which asks for information regarding her student malpractice insurance. When Ruth tells her supervisor that she does not carry

such insurance, he advises her that it is their policy not to accept any student who does not have insurance. The supervisor also expresses some surprise because this has always been the hospital's policy and Ruth is not the first student to be assigned to them from her training program.

Use this page to make notes after each step and to summarize your approach. Elect a spokesperson for your group to recap your discussion for the other participants.

Determine: Is the matter an ethical one?

Consult: What ethical guidelines apply as a possible mechanism for resolution?

Consider: What sources might influence the kind of decision you will make?

Locate & Consult: Who will you talk to (trusted colleague, your supervisor) about this supervisee scenario?

Evaluate: What the rights responsibilities, and vulnerability of all affected parties?

Generate: What are alternative decisions that can be made/offered in this situation?

Enumerate: What are the consequences of making each decision?

Make: What decision are you going to make regarding the action your supervisee should take/what to counsel him on?

Implement: How are you going to implement this decision?

Summary:

Potential Ethical Pitfalls



Multiple relationships



Legal and ethical considerations
regarding suicide risk



Issues with violent clients



Legal and ethical issues in the
Internet era



Regulatory issues for Teletherapy



Teletherapy supervision

Multiple Relationship Considerations (pp 90-91)



Enter the relationship (beneficial) or avoid it (negative impact)?



Can the additional relationship potentially cause harm to the supervisee?



Are there cultural factors to be considered?



If harm seems unlikely or avoidable with the additional relationship provide benefit?



Risk of secondary relationship disrupt? Impact Objectivity?

Legal and Ethical Considerations Regarding Suicide Risk

- ▶ 97% of clinicians fear losing a client to suicide and it is estimated that one in four therapists will lose a client to suicide during their career.
- ▶ An estimated 40% of supervisee's have had a patient commit suicide or make a serious attempt.
- ▶ Supervisee's who experience a client suicide or attempt, experience feelings of shock, disbelief, failure, sadness, self blame, guilt , shame, and depression with the possibility of long-term anxiety and helplessness.
- ▶ The stress of a suicidal client may be even greater for the supervisee than for the supervisor who holds the liability.

Let's look at a
series of
procedures to
prepare supervisee
for the eventuality
of suicidal clients



When your supervisee's client commits suicide

- ▶ Be aware that the intense emotional impact immediately following a client suicide might last from a week to a month.
- ▶ Support an acceptance of the reality, coupled with knowing the supervisee is not alone are indicated.
- ▶ Meeting with him receiving support from the supervisor is essential.
- ▶ The possibility of meeting with other staff who knew the client or had worked with him or her may also be important.
- ▶ Talking with other professionals who have experienced client suicide.
- ▶ It is important for supervisees to know that they are not alone in this experience and to be helped to deal with the shock they have experienced.
- ▶ Stress management, inoculation, and effective regulation are important supervisee skills.

What is the impact on the supervisor?

- Clinical supervisors support supervisees by discussing suicidal behaviors, sharing their own experiences treating suicidal behaviors/suicide client deaths, and providing a comfortable environment to talk about their feelings related to treatment.
- Overseeing such cases also impacts clinical supervisors.
- Quantitative research suggests that clinical supervisors experience negative emotions when their supervisees are treating suicidal behaviors.
- Pilot research on this topic also suggests that supervisors experience higher than normal stress levels related to supervision.
- No published quantitative research investigates the symptoms accompanying the stress and negative emotions that clinical supervisors experience while overseeing clinicians whose clients exhibit suicidal behaviors.

Let's discuss a case of suicide of a supervisee client

The case study is about your supervisee
“Michelle” whose client committed suicide and
you, as her supervisor, are the one to inform
her of the suicide. You can find the case study
after this page in your manual.



“Michelle” was a 30-year-old White female clinical psychology graduate student completing her predoctoral internship at a community mental health clinic when her client, “Jonah,” a 23-year-old male, committed suicide. Jonah suffered from major depressive disorder and possibly dysthymia, and Michelle described Jonah as “passively suicidal” (i.e., no clear intent, plan, or motivation, but Jonah had told Michelle that “if I was suicidal I wouldn't tell you anyway”). Jonah, whose mother had died a few years ago, was receiving antidepressants from his psychiatrist.

Michelle and Jonah met weekly for 50-min individual therapy sessions, for a total of 6 weeks. Michelle reported that Jonah came to treatment at the urging of his father, was basically compliant with treatment but very difficult to connect with (e.g., Jonah had a hard time talking at all in sessions), and Michelle perceived anger in Jonah's apparent resistance. Near the end of each session, however, Jonah would become more emotional and cry, and then would feel ashamed. Michelle never felt that the therapy helped Jonah nor that Jonah was able to internalize any of Michelle's empathy.

Michelle learned of Jonah's suicide when her supervisor (Dr. S, a 60-year-old White female who was psychodynamically oriented, had more than 25 years of clinical experience and almost 10 years of supervision experience, with whom Michelle had worked 7 months at the time of the suicide, and with whom she had a “very positive” relationship) called Michelle at home when she was on spring break. Michelle indicated that learning of her client's death in this way (i.e., away from the site) allowed her to grieve on her own before she returned to the agency, where she anticipated people would want to interact with her regarding the suicide. In response to the suicide, Michelle stated that she not only felt anxious about returning to work with clients but also feared that another of her clients might commit suicide as well.

Michelle had fantasies of giving up therapy; indicated that she was shocked, depressed, and sad; and stated that she “just shut down” and was “consumed by” the suicide. In addition, she reported that she felt angry at Jonah for killing himself and “sticking me” with this. Michelle stated that she began to read about client suicide and its effects on therapists, and

she created an outreach presentation on suicide. Michelle also acknowledged feeling some reassurance that Jonah was not a client she had seen for a long time, though she admitted that the suicide stimulated her insecurities regarding being a therapist and that her “buttons and vulnerabilities [were] primed.”

Michelle reported that her supervisor was very supportive and concerned about her after Jonah's death, and that it was helpful to talk about the suicide in supervision (and was also beneficial to talk with her training director, other therapists, and her partner). It was helpful, as well, to acknowledge that when therapy enables clients to get in touch with how they feel, they sometimes feel worse. Michelle noted that it was most helpful when Dr. S shared her own experience of a client's suicide, which made Michelle feel “less stigmatized and separate,” as did Dr. S's sharing of her respect for Michelle's clinical work.

Unhelpful, however, was the way in which Dr. S handled the staff debriefing after the suicide: Michelle felt put on the spot, felt that the debriefing was focused on addressing suicide administratively, and experienced the staff as voyeuristic in expecting her to talk about her client's death and share intense feelings. She would have preferred that the debriefing be delayed a bit and that her supervisor let Michelle choose how and with whom to discuss the suicide. In addition, she wished that Dr. S had followed up more with her over time regarding the suicide. Immediately after Jonah's death, Michelle reported that her clinical work was affected in that she was more attentive and vigilant when clients talked about being suicidal; relatedly, she reported being more anxious and protective of her clients. She also reported that she felt more disengaged from clients and had to work hard to stay emotionally connected with them.

With regard to current effects of the event, Michelle indicated that she still feels “really sad” and becomes anxious when she works with a client who reminds her of Jonah, but she is less affected than she was immediately after his death. Finally, she reported that she has become more open to the idea of involving family members when working with depressed clients.

Issues with Violent Clients



Supervisee's and early career clinicians are at risk of experiencing violent client behavior because they are less alert to escalating cues of violence and have less knowledge of how to deescalate these situations.



Other high-risk situations that supervisors must competently address are sexual harassment by the client and the potential for the client commit violence.



Research suggests that many clinicians are misinformed about their state laws regarding the duty to warn, even though most were confident they understood these laws.



Research also found no correspondence between continuing education and legal and ethical issues, graduate education, or experience with violent clients and competence with duty to warn.

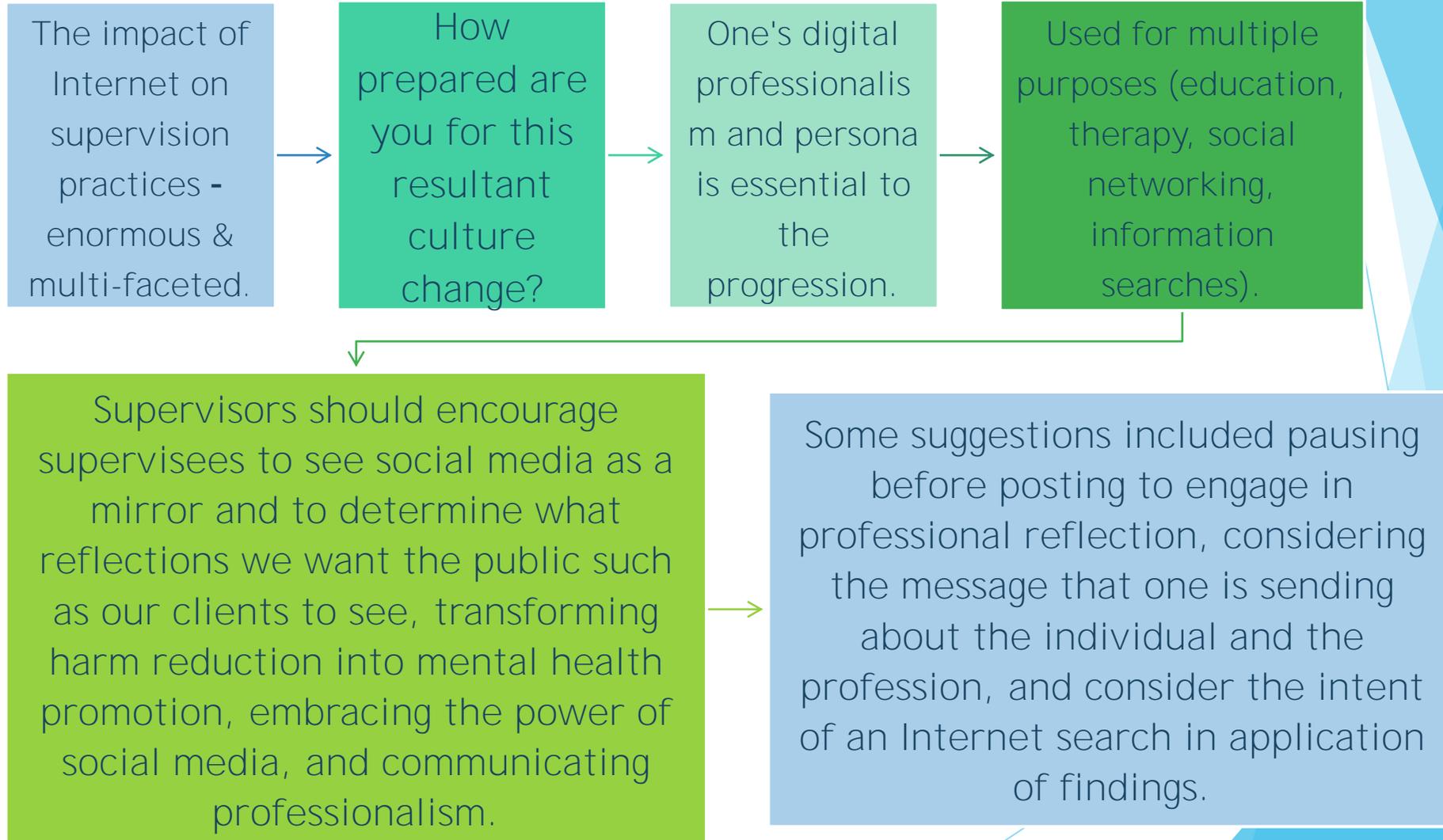


Issues with Violent Clients

Ensuring safety is a critical component of clinical supervision.

Assessing the ability to identify escalating or dangerous behaviors and the skills to manage these along with attitudes such as fear, submission regarding clients who are potentially dangerous are essential aspects of supervision.

Legal & Ethical Issues in the Internet Era



Conducting Internet searches: Ask yourself these questions before doing so

Why do I want to conduct this search what is my motivation or rationale?

With my search advance or compromise treatment?

Would it potentially benefit the client?

Should I obtain informed consent from the client? If not, why not?

Should I share the results of the search with the client?

How will I use the information?

How will I deal with undisclosed duty to warn if it arises?

Should I document the findings of the search in the clinical medical record?

How do I monitor my motivations in the ongoing risk or benefit profile regarding searching?

Important Legal Considerations When Conducting Searches on Supervisees

Legal peril exists with heightened scrutiny under the 14th Amendment Equal Protection clause in the Anti-Discrimination laws. There is strict **scrutiny for “suspect classifications”** such as race, national origin, religion. If it were determined that an Internet search identified a suspect classification, it could be argued that there was the reason for not accepting the training for the position.

Regulatory Issues for Teletherapy

The supervisor bears responsibility for knowledge of regulations regarding supervision for that jurisdiction and for referring the supervisee for guidance regarding regulations and requirements for licensure in jurisdictions in which they plan to practice.



Guidelines balance the competence of the clinician who provides or oversees Telepsychology technologies with the need to ensure the client is fully aware of the risks, limitations, and challenges of security and confidentiality.



Guidelines address the competence of clinicians, standards of care in the delivery of telepsychology services, informed consent, confidentiality of data in information, security of data and information, disposal of data and information in technologies, testing and assessment, and interjurisdictional practice.

Let's Discuss The Ethics of “Telesupervision”



Recent regulations changes (pre-COVID19) allow for up to 50% of face to face interactions for supervisory purposes to be conducted via and Internet or web-based platform such as Skype, zoom, or other live interactive platform.

Although studies of supervision via videoconferencing have been conducted and the practice is increasing, providing access to individuals in training and practice in remote areas, which reduces isolation and provide specialized input in consultation, is still necessary for supervision to have an in-person component.

Some barriers to the effectiveness of Telesupervision include inability to respond to emotional reactivity of the supervisee, level of supervisee disclosure, potential for more formulaic format, and lack of access for the supervisor or contextual emerging issues in the distant site where the client contact is occurring.

Guidelines for the practice of Telepsychology encourage supervisors to consult with those who are knowledgeable about the unique issues posed, strive to be familiar with the professional literature, have competence with provision of technology, and ensure the adequate face to face supervision is included to confirm the supervisee's reached the requisite competence.

We recommend you check with your board to determine current regulation expansions/requirements for conducting online supervision as the result of COVID19.



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Time for Lunch!

You can either log out and log back in or you can keep the zoom open with your audio and video off (recommended).

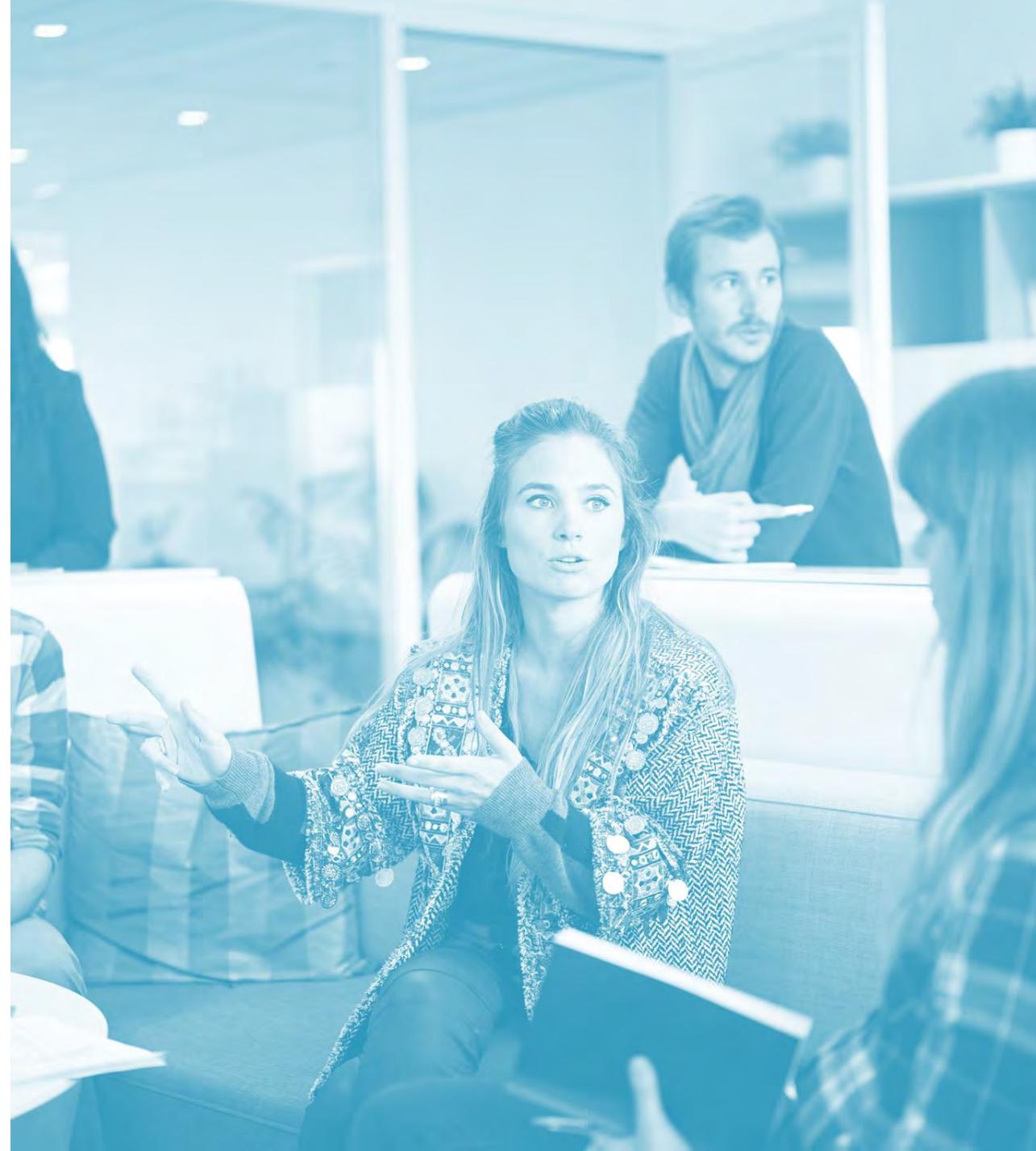
Please return in one hour.
Enjoy!



Ethics & Boundaries in Supervision

Ethical Challenges

Let's look at some examples of ethical dilemmas and questions faced by supervisors and consultants to discuss the presenting ethical issues (and corresponding ethical codes) to determine how to best address.



I am supervising a doctoral intern in providing outpatient psychotherapy. He has previous training in hypnosis, an area in which I have no background. He has a new client for whom he believes hypnosis would be helpful. Should I allow this?



I recently received an e-mail from a former supervisee notifying me that she just received her license to practice. I would like to take her out for dinner to celebrate. What should I consider before extending this invitation?



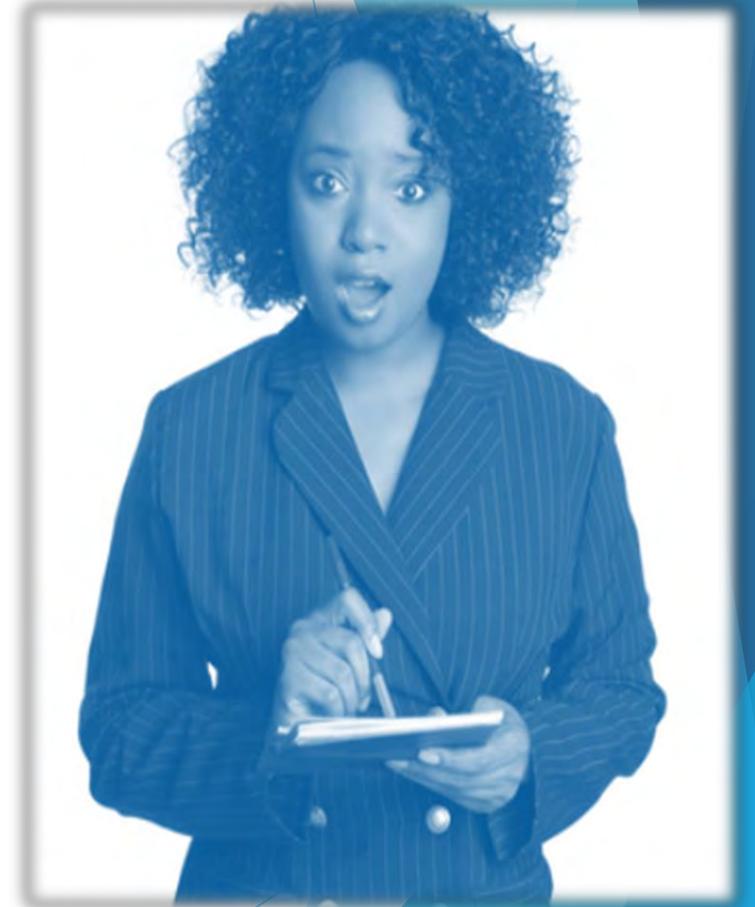
I have found that self-understanding is a fundamental component of being able to provide effective psychotherapy. To that end, I require students in my supervision groups to participate in experiential exercises designed to help them explore **their personal histories.** I've had a couple of student complaints and so am wondering how to proceed.



A colleague who works at a local hospital recently called me to ask about one of my former supervisees who applied for a **position in her department. He didn't list me as a reference.** Can I share my assessment of his capabilities?



My supervisee spoke favorably about some of her **own psychotherapist's behavior with her. I was** shocked at what seemed to me to be inappropriate boundaries, and I am worried about the role models she is being exposed to and apparently admires. I know this guy and am considering reporting him to the licensing board. But I am sure my supervisee **would be furious with me, and I'm afraid that would** destroy our relationship. Should I report him? Am I required to do so?



Most Prevalent Disciplinary Incidents Reported to State Board

A review of disciplinary actions by state boards over a 15-year period revealed that the most frequent reason for ethical complaints filed with the state board was sexual violations or dual relationship issues. These accounted for almost 35% of all ethics complaints, followed by unprofessional, unethical, negligent practice (28.6%), fraud (9.5%), and convictions of crimes (8.6%). *The fifth most frequent reason for complaint being filed with the state licensing board was for improper or inadequate supervision (4.9%).*

Ethics in Supervision

When considering ethical issues regarding supervision, a distinction must be made between supervising ethically and supervising legally. If a supervisor is supervising in a legal fashion, complying with all state, federal, and local statutes and regulations, she still may not be supervising in an ethical fashion given the ethics codes of her profession.

Ethics codes often demand more from professionals than simple adherence to statutes and regulations. For example, if supervision meets all the statutory and regulatory responsibilities, but there is not a written supervisory agreement, the supervisor may be in violation of their code of ethics.

Major Ethical Issues Related to Supervision

- Competence
- Due Process
- Informed Consent
- Multiple/Dual Relationships

Competence

The definition of competency to supervise varies from discipline to discipline, but most have three common components:

- Formal Education
- Professional Training
- Carefully Supervised Experience

Ethics codes that specifically address the issue of competence

“Psychologists provide services, teach and conduct research...within the boundaries of their competence based on their education, training, supervised experience, consultation, study, or professional experience.” APA (2002), 2.01

“Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience.... Counselors accept employment only for positions which they are qualified by education, training, supervised experience, state and national professional credentials, and appropriate professional experience.” ACA (2005), C.2.a and C.2.c’s

COE's that address competence

- ▶ "Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence." NASW (2008) 3.01
- ▶ **"Psychologists who delegate work to supervisees take reasonable steps to authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided and see that such persons perform these services competently."** APA (2002), 2.05
- ▶ **"Supervisors should teach courses and supervise clinical work only in areas where they are fully competent and experienced."** ACES (1995) 3.02

4 Elements of Supervisory Competence

Having been trained in supervision and having appropriate supervisory experience

Acquiring an appropriate level of academic and professional credentials in the area which they are supervising

Demonstrating clinical experience in the area being supervised

Competence in dealing with multicultural issues.

Intellectual vs Emotional Competence

Intellectual competence, i.e., education, knowledge, critical thinking, and conceptualization versus emotional competence, i.e., knowledge of self, self-monitoring, areas relevant to self-care. Simply because a supervisor has the intellectual competence to supervise, i.e. appropriate degrees and experience, doesn't guarantee being a competent supervisor.



A competent supervisor has **emotional competence** in addition to intellectual requirements of supervision. A supervisor may have the right degrees, previous experience, training in supervision, and ability to develop strategies, but may not be able to communicate these skills to a supervisee. The inability to interact effectively or connect on an interpersonal level with supervisees may seriously limit the effectiveness of a supervisor.

In addition to developing our intellectual competence, supervisors also need to be working on developing emotional competence. This can be achieved by focusing on things like knowledge of self, awareness of your own stimulus value, your impact on other people, and the **supervisor's level of burnout or compassion fatigue. A supervisor who is a "burnout" and is just going through the motions of supervision may be incompetent to supervise.**

Intellectual Competence vs Emotional Competence

Let's look at Emotional Competence



- ▶ Self-awareness of the status of one's functioning - the impact of personal events on one's ability to remain empathically engaged.
- ▶ Being aware of your abilities, competencies, and limitations and the factors, situations, and presentations that evoke emotional responses.
- ▶ Social, cultural, and political factors weigh in significantly.
- ▶ Remaining mindful that the same essential empathic **engagement, including feeling the client's pain and trauma,** increases the risk of vicarious traumatization.

Let's discuss....

- ▶ How can what has happened in your personal life impact your ability to be empathic with clients and supervisees?
- ▶ How do you identify and implement your skills/knowledge while being aware of your limitations in order to maximize the evoking of emotional responses from your supervisees?
- ▶ From your perspective, what social, cultural, and political factors can have significant impact on the alliance of the supervision relationship?
- ▶ How would you remain mindful that the same essential empathic **engagement, including feeling the client's pain and trauma, increases** the risk of vicarious traumatization and, when it occurs, manage this?

Let's look at legal terminology as it relates to the supervisory relationship



Due Process

An area for potential ethical issues in supervision would involve those supervisors who, as a result of the power differential, take advantage and exploit supervisees.

Supervisees need to be informed of their rights and the appeal process available if they disagree with an aspect of supervision or feel they are being treated unfairly. Supervisees need to know in advance what might constitute disciplinary action or termination and the proper notice that is required on the part of the supervisor.

A competent supervisor communicates the opportunity for a formal hearing, defense, and/or appeal to their supervisor. Generally, supervisees have a right to a clear understanding of the requirements and expectations of supervision.

Power Differential

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- A competent supervisor communicates the opportunity for a formal hearing, defense, and/or appeal to their supervisor. Generally, supervisees have a right to a clear understanding of the requirements and expectations of supervision.

Professional Ethics Codes supervisee's due process rights

"Supervisors inform supervisees of the policies and procedures which they are to adhere and the mechanisms for due process appeal of individual **supervisory actions.**" **ACA (2005) F.4.a**

"Social workers who provide supervision should evaluate a supervisee's performance in a manner that is fair and respectful..... Social workers who function as educators or field instructors for students should evaluate student's performance in a manner that is fair and respectful..... Social workers should accept employment or arrange to field placements only in organizations that exercise fair personal practices."
NASW (2008) 3.01d; 3.02b; and 3.09f

Professional Ethical Codes for Informed Consent in Supervision

“In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided the student or supervisee at the beginning of supervision.” APA (2002)

7.06



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Professional Ethical Codes for Informed Consent in Supervision

"Supervisors are responsible for incorporating tutor supervision the informed consent and participation. Supervisors inform supervisees of the policies and procedures to which they are to adhere in the mechanisms for due process appeal of individual supervisory actions." ACA (2005) F.4. a.



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Professional Ethical Codes for Informed Consent in Supervision

“A written understanding should be signed by both the supervisor and supervisee (and the agency administrator) at the beginning of supervision and amended or renegotiated to reflect changes.” NASW (1994) p.6



Informed Consent

Informed consent is a concept that has been largely developed in the context of providing medical, psychological, and therapeutic services. As a general concept, informed consent allows for:

1) Elucidating expectations, 2) Identifying mutually agreed upon goals, 3) Anticipating likely difficulties, and 4) Identifying the problem-solving processes in advance.

The concept of informed consent has recently been applied to supervisor/supervisee relationships and requires providing potential supervisees with information about the supervision that might reasonably influence their ability to make sound decisions about participation in supervision

INFORMED CONSENT



Please refer
to your
manual for a
sample of
supervision
informed
consent

Informed Consent Template

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 and 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, countertransference)

Statement of agreement

Signed acknowledgement by all parties that they understand and agree to comply with the contract

Informed Consent takes place on multiple levels:

Client's consent to
treatment by a
supervisee under a
supervisor's direction

Supervisor and
supervisee consent to
the supervisory
responsibility

The institution or
agency consents to
comply with clinical,
legal, and ethical
requirements

The client consents
to supervision of
their case by a
named individual

Client's consent that
confidential
information will be
shared with the
supervisor.

Possible Elements to be included in an Informed Consent Document



While the supervisor is certainly supervising in a legal fashion they may not be supervising in an ethical fashion and are clearly acting unethically. If a supervisor is supervising in an ethical fashion, adhering to all the mandates and criteria spelled out in the ethics code of their profession, that does not necessarily mean that they are supervising in a legal fashion.

This situation is less likely to occur, as some ethics codes require compliance with all federal state and local rules and regulations. It is assumed that all supervisors want to conduct themselves in an ethical fashion; however, the requirements for ethical supervision are much less specific and open to a variety of interpretations.

Ethics in Supervision

Ten Activities Required for Ethical Supervision

- Be trained; be competent
- Orient supervisees
- Informed Consent Agreement
- Know current ethical codes
- Have goals for supervision
- Create plans and structure for supervision
- Plan for evaluation criteria and methods
- Dialogue about dual relationships and multicultural issues
- Document, document, document, document!
- Regular supervision of supervision, not crisis consultation

What do you do if the answer is Not Clear?

One of the significant issues with attempting to be an ethical supervisor is that, in many instances, ethical codes do not provide a clear answer or direction as to how supervisory activities are to be conducted.

The nature of ethics prohibits or prevents an ethics code from being developed that is so detailed that it will cover every situation and every circumstance. There are some situations that no one could ever foresee or imagine, let alone develop a specific ethical standard to address.

What do you do if the answer is Not Clear?

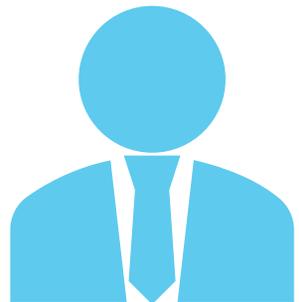
- At best, ethical codes almost universally start with the premise of some basic core principles that the profession aspires to and then attempts to develop a structure and guidelines based on those core principles.
- Ethics codes may make some direct statements regarding commonly observed situations, but these core principles must then be applied specifically to each supervisory relationship and situation.
- Each profession's code of ethics is a statement of beliefs and general principles that fellow professionals have developed as a consensus and have agreed upon.

Multiple/Dual Relationships

A major ethical concern in the supervisory relationships is multiple/dual relationships. Sexual or dual relationships were the primary reasons for board complaints and disciplinary actions. Historically it has also been a major area of ethical concern for professional organizations. APA Ethics Committee (2008) reported that over 60% of all ethics cases opened included multiple relationships as one factor.

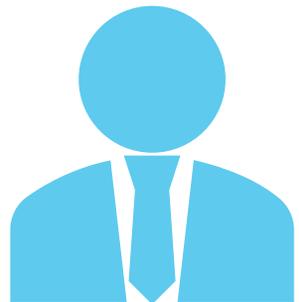
Almost all were in supervisory situations.

Professional Ethical Codes Multiple/Dual Relationships



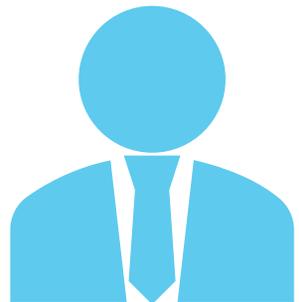
“Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority, such as clients/patients, students, supervisees, research participants, and employees.” APA (2002) 3.08

Professional Ethical Codes Multiple/Dual Relationships



“Supervisors who have multiple roles with supervisees should minimize potential conflicts. Where possible, the roles should be divided among several supervisors. Where this is not possible, careful explanation should be conveyed to the supervisee as to the expectations and responsibilities associated with each supervisory role.” **ACES (1995) 2.09**

Professional Ethical Codes Multiple/Dual Relationships

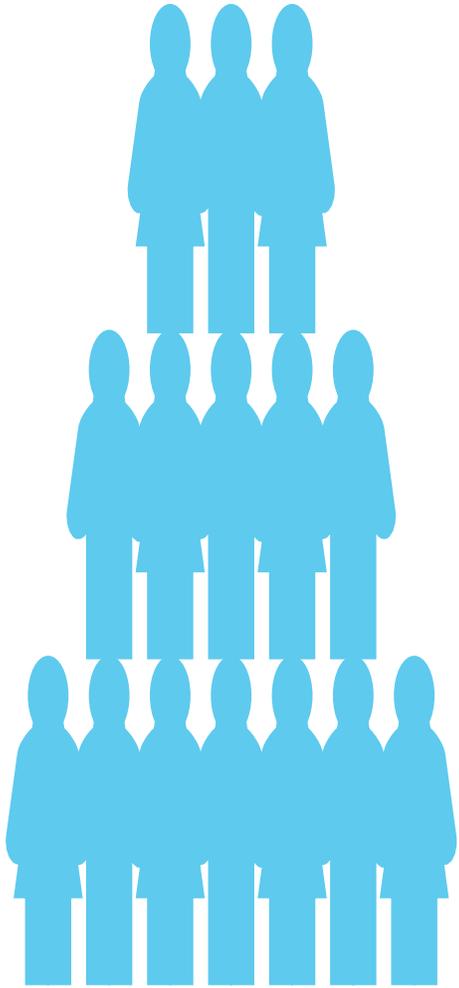


“Counseling supervisors avoid nonprofessional relationships with **current supervisees.....they do not** engage in any form of nonprofessional interaction that may compromise the **supervisory relationship.” ACA (2005)**

F.3.a.

Professional Ethical Codes

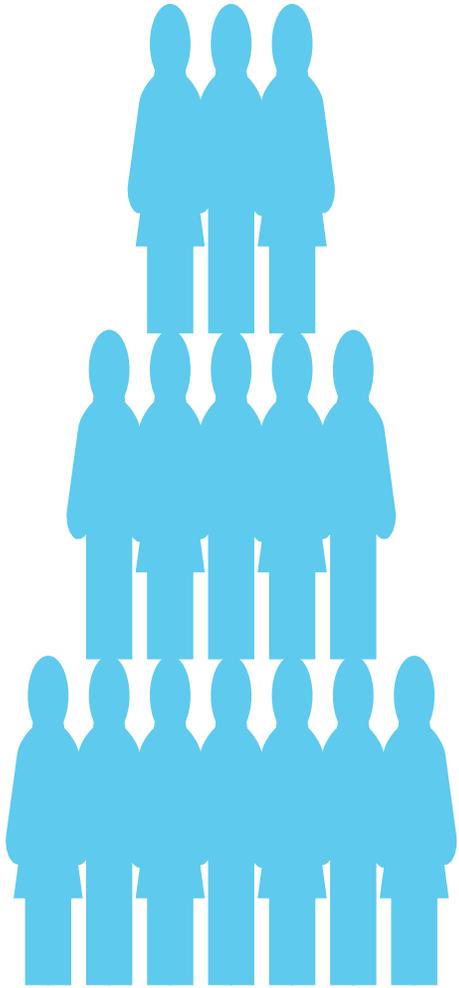
Multiple/Dual Relationships



“Members must not accept as supervisees those individuals with whom a prior or existing relationship could compromise the supervisor’s objectivity.....examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship. ” AAMFT (2001) 4.3 and 4.6

Professional Ethical Codes

Multiple/Dual Relationships



“Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student.” NASW (2008) 2.07

Boundary Crossing VS Boundary Violation

A boundary crossing is a non-pejorative term that describes departures from commonly accepted clinical practice that may or may not benefit the supervisee. Boundary crossings may be harmless, non-exploitative, or even supportive. Boundary crossings should be viewed as potentially high-risk behaviors and may include issues of money, place and space, gifts, services, clothing, language, self-disclosure, and physical contact.

A boundary violation is a clear departure from acceptable practice that places the supervisee or the supervisory process at serious risk.

7 Deadly Boundary Crossing - Examples?



TIME



PLACE



MONEY



GIFTS/FAVORS



CLOTHING



LANGUAGE

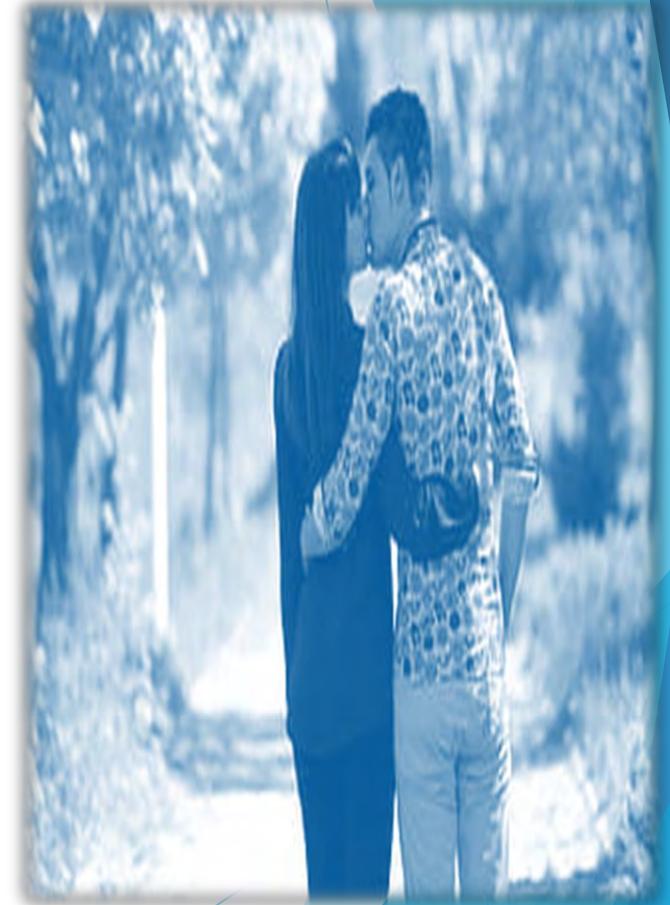


PHYSICAL
CONTACT

Supervisor - Supervisee Sexual Relationships

The simple answer is - **what part of “no” don’t you** understand. It is very difficult to imagine any set of circumstances where being involved with a supervisee in a romantic or sexual relationship could be justified. Ethics codes have specific prohibitions regarding sexual contact with supervisees and students (AAPC, ACA, APA, ASPPB, CPA, AAMFT, and NASW) and do not allow for exceptions.

The American Psychiatric Association (2009) is the one professional organization allowing for exceptions and states that **“sexual contact between a supervisor and a trainee or student may be unethical.”**



Supervisor - Supervisee Sexual Relationships

- Many supervisors and supervisees would prefer to minimize the issue of sexual intimacy between supervisors and supervisees, almost to the point of denial.
- A survey of female clinicians indicated that 17% of respondents reported having had sexual contact with educators/supervisors as graduate students and 31% reported having experienced seductive behavior with educators/supervisors while they were in professional training.

How do you interpret this statement?

“Because of the power differential and the supervisee's vulnerability implicit in supervisee/supervisor sexual relationships, completely voluntary consent may be impossible in supervisee/supervisor sexual relationships. Thus, to argue that such a relationship is consensual may be **fallacious.**”

Important takeaway #1

Multiple/dual relationships are a particularly difficult and **problematic issue within the helping professions.** “A multiple/dual relationship exists when a therapist or supervisor has a concurrent or consecutive personal, social, business, or professional relationship with a client or supervisee in addition to the therapist-client or supervisor-supervisee relationship, and these roles conflict or **compete**”.

Important takeaway #2

Supervisors have the responsibility for closely scrutinizing and monitoring the relationship that exists between themselves and their supervisees to prevent harm or exploitation. The question that must be asked repeatedly during a supervisory relationship is to what extent, if any, is my judgment as a supervisor impaired by a multiple or dual relationship. Duality cannot be avoided completely, but it can be managed thoughtfully and judiciously.



Supervisees who
do not Meet
Professional
Competence
Standards

Our responsibilities

- Supervisors give precedence to protecting the well-being of clients/patients above the training of the supervisee.
- When supervisees display problems of professional competence decisions made and actions taken by supervisors in response to supervisees' competence problems should be completed in a timely manner.

Key Expectations

Supervisors understand and adhere both to the supervisory contract and to program, institutional, and legal policies and procedures related to performance evaluations.

Supervisors strive to address performance problems directly. Effective management of professional competence problems begins with the supervision contract.

Key Expectations

Supervisors strive to identify potential performance problems promptly, communicate these to the supervisee, and take steps to address these in a timely manner allowing for opportunities to effect change.

Supervisors evaluate on an ongoing basis the supervisee's functioning with respect to a broad range of foundational and functional competencies, including professional attitudes and behaviors that are relevant to professional practice.

Key Expectations

Supervisors are competent in developing and implementing plans to remediate performance problems. In conjunction with the supervisee and relevant training colleagues, the supervisor develops written documentation of areas in which the supervisee has competence deficits, performance expectations, steps to be taken to address deficits, responsibilities for each party, performance monitoring processes, and the timelines that will be followed.

Key Expectations

Supervisors are mindful of their role as gatekeeper and take appropriate and ethical action in response to supervisee performance problems. In most situations, supervisees are ethically and legally entitled to a fair opportunity to remediate the competence problems and continue in their program of study.



What does Professional Competence Deficiency look like?

Supervisors who do not meet professional competence standards have been described in multiple ways such as supervisors with performance problems or trainees with problems of professional competence who demonstrate behaviors, attitudes, and/or skills that are not consistent with the expected ethical or professional standard given their stage of training.

Professional competence deficient supervisees exhibit interference in professional functioning that is reflected in one or more of the following ways:

An ability and or unwillingness to acquire an integrate professional standards into one's repertoire of bit professional behavior

An inability to acquire professional skills in order to reach an acceptable level of competency, and

An inability to control personal stress, psychological dysfunction, and or excessive emotional reactions that interfere with professional functioning

Furthermore.....

- The supervisee does not acknowledge, understand, or address the problem when it is identified.
- The problem is not merely a reflection of skill deficit that can be rectified by academic or didactic training.
- The quality of services delivered is consistently negatively affected.
- The problem is not restricted to one area of professional functioning.
- A disproportionate amount of attention by training personnel is required.
- The behavior does not change as a function of feedback, remediation efforts, and or time.

Let's take
a quick
break!!!



Please refer to the sample competency remediation plan in your manual



Supervisory Contract Elements

- a. Content, method, and context of supervision— logistics, roles, and processes
- b. Highest duties of the supervisor: protection of the client(s) and gatekeeping for the profession
- c. Roles and expectations of the supervisee and the supervisor, and supervisee goals and tasks
- d. Criteria for successful completion and processes of evaluation with sample evaluation instruments and competency documents (APA, 2010, 2.06)
- e. Processes and procedures when the supervisee does not meet performance criteria or reference to such if they exist in other documents
- f. Expectations for supervisee preparation for supervision sessions (e.g., video review, case notes, agenda preparation) and informing supervisor of clinical work and risk situations

A woman with dark hair, wearing a plaid shirt, is sitting on a light-colored couch. She has a thoughtful expression. To her left, a hand is visible holding a pen, as if writing on a notepad. The background is a plain wall. The entire image is overlaid with a semi-transparent blue filter.

BREAKOUT SESSION

There are 4 case studies. There will be four groups. Each group will determine what competency deficiency is being displayed by the supervisee and determine using contract elements and the Competence Remediation Plan to guide your approach/discussion with the supervisee. You can also refer to the supervision models and theory-based models discussed earlier. Select one representative of your group to be the supervisee and one to be the **supervisor to “role play” the discussion when we return to the main room.** You will have 15 minutes.

Competency Remediation Plan

Date of Competency Remediation Plan Meeting:

Name of Trainee:

Primary Supervisor/Advisor:

Names of All Persons Present at the Meeting:

All Additional Pertinent Supervisors/Faculty:

Date for Follow-up Meeting(s):

Circle all competency domains in which the trainee's performance does not meet the benchmark:

Foundational Competencies: Professionalism, Reflective Practice/Self-Assessment/Self-care, Scientific Knowledge and Methods, Relationships, Individual and Cultural Diversity, Ethical Legal Standards and Policy, Interdisciplinary Systems

Functional Competencies: Assessment, Intervention, Consultation, Research/evaluation, Supervision, Teaching, Management-Administration, Advocacy

Description of the problem(s) in each competency domain circled above:

Date(s) the problem(s) was brought to the trainee's attention and by whom:

Steps already taken by the trainee to rectify the problem(s) that was identified:

Steps already taken by the supervisor(s)/faculty to address the problem(s):

I, _____, have reviewed the above competency remediation plan with my primary supervisor/advisor, any additional supervisors/faculty, and the director of training. My signature below indicates that I fully understand the above. I agree/disagree with the above decision (please circle one). My comments, if any, are below (*PLEASE NOTE: If trainee disagrees, comments, including a detailed description of the trainee's rationale for disagreement, are REQUIRED*).

_____	_____	_____	_____
Trainee Name	Date	Training Director	Date

Trainee's comments (Feel free to use additional pages):

All supervisors/ faculty with responsibilities or actions described in the above competency remediation plan agree to participate in the plan as outlined above. Please sign and date below to indicate your agreement with the plan.

Competency Remediation Plan Continued

SUMMATIVE EVALUATION OF COMPETENCY REMEDIATION PLAN

Follow-up Meeting(s):

Date (s):

In Attendance:

<u>Competency Domain/ Essential Components</u>	<u>Expectations for Acceptable Performance</u>	<u>Outcomes Related to Expected Benchmarks (met, partially met, not met)</u>	<u>Next Steps (e.g., remediation concluded, remediation continued and plan modified, next stage in Due Process Procedures)</u>	<u>Next Evaluation Date (if needed)</u>

I, _____, have reviewed the above summative evaluation of my competency remediation plan with my primary supervisor(s)/faculty, any additional supervisors/faculty, and the director of training. My signature below indicates that I fully understand the above. I agree/disagree with the above outcome assessments and next steps (please circle one). My comments, if any, are below. *(PLEASE NOTE: If trainee disagrees with the outcomes and next steps, comments, including a detailed description of the trainee's rationale for disagreement, are REQUIRED).*

Trainee

Date

Training Director

Date

Trainee's comments (Feel free to use additional pages):

Competence Deficiency Case Studies – Refer to the Competence Remediation Plan and Elements of the Supervisory Contract slide # 242 for information to guide your answers to these questions:

- 1. What is the competence deficiency you would be discussing with the supervisee?**
- 2. What information did you indicate in the Competence Remediation Plan?**
- 3. What elements of the supervision contract did you reflect on?**
- 4. What would the discussion sound like? (Role Play)**

Case Study #1

Kelly is working on her master's degree in professional counseling at a university in Atlanta. She is a 31-year-old Caucasian who is in her first semester of internship at the university counseling center. Her first client was Amalia, a Puerto Rican second-semester freshman from New York City who is considering declaring a college major in chemical engineering or pre-dentistry. Amalia presents with feelings of homesickness. She misses her family greatly and is considering a transfer to a university in New York where she would be closer to home. Kelly is surprised to learn that Amalia is a third-generation college student and that her parents are both professionals: her father is a bank president, and her mother is a pediatrician. Kelly comments to Amalia that her English is "very good" and that she is surprised that Amalia is studying engineering and on the dean's list. She continues to provide 'supportive comments' to the client by stating things like 'you should be proud of how far you have come considering your cultural barriers' and 'I'll bet you are the only Puerto Rican female engineer in the class' followed by 'how does that feel'?

Case Study # 2

A new practicum counselor, Alice, was in her early twenties and, prior to entering practicum, had discussed her history of physical abuse, mentioning she never wanted to have to file an abuse report. During her practicum experience, she received individual supervision from a

Licensed Professional Counselor adjunct faculty member who had worked in the child welfare system. Alice was assigned a client through the clinic. In this instance the client was a 14-year-old female who lived with her father and stepmother due to prior neglect by her mother. During treatment, the 14-year-old client disclosed that she smoked marijuana with her mother and cousins during a weekend visit.

Clinic procedure requires student counselors to obtain immediate supervision if a client makes an allegation of abuse or neglect. Alice did not come out of the session to report the incident and said nothing after the session concluded. Later, during her one-hour individual supervision session, the supervisor watching the tape realized that the child's statement required a protective services report. Her supervisor walked Alice through the procedures of writing and filing the report, which Alice did without complaint.

Several days later, Alice came into my office and stated, "I feel like crap, I've ruined her life". Alice expressed fear that the client would never return for counseling, and fear that the client would hate her. She reported imagining all sorts of consequences including that the child's father would no longer allow the child to see her mother and that the child would no longer disclose information if she returned to counseling. She questioned her decision to make an abuse or neglect report and reported feeling angry at her supervisor "vowing that she would not tell her supervisor *anything* about her clients going forward."

Case Study #3

Maggie is a school counselor at a kindergarten through middle school, receiving group supervision to complete her licensed professional counselor requirements for state licensure. It was brought to her attention that a nine-year-old male was caught in the bathroom engaging in oral sex with another male student. Maggie met with the child to explore the reasons for this behavior and his understanding of his actions. During her meeting, the child stated he does this with his uncle. His uncle (maternal sibling) is an adult male, residing with the child and the child's single mother.

During group supervision, Maggie shared the case and explained that she contacted the mother, requesting her presence at the school immediately to discuss this serious situation. During the meeting with the mother, Maggie recommended that the mother request her brother, the uncle, move out of the home. Maggie had not reported the incident to child protective services (CPS). Maggie was directed by her supervisor to contact CPS immediately after group supervision. Approximately two hours later, the supervisor contacted Maggie to review her progress in reporting the abuse. Maggie was not available, but later sent me a text stating she would contact the supervisor in the morning.

Maggie did not report the abuse after group supervision. She planned to wait until the next day when she had the child's school file in front of her, but due to a snow day and school closures, Maggie believed she did not have to report the abuse. After following up again and upon finding out Maggie again failed to report, the supervisor ordered Maggie to file a report. The supervisor also reminded Maggie that her actions were unethical and illegal, were jeopardizing the safety of the child, and risking the supervisor's license and Maggie's own school and limited licenses. Maggie failed to be truthful about the case and the extent of her knowledge. She had known about the alleged sexual abuse for a least a week.

Random Discussion Point: Private VS Agency

Do you believe there are
different nuances and
expectations regarding the
different environments?





Becoming A Supervisor & Enhancing Supervisor Expertise

Role invocation from the perspective of the supervisee

Think back to one's own experience as a supervisee and consider the following:

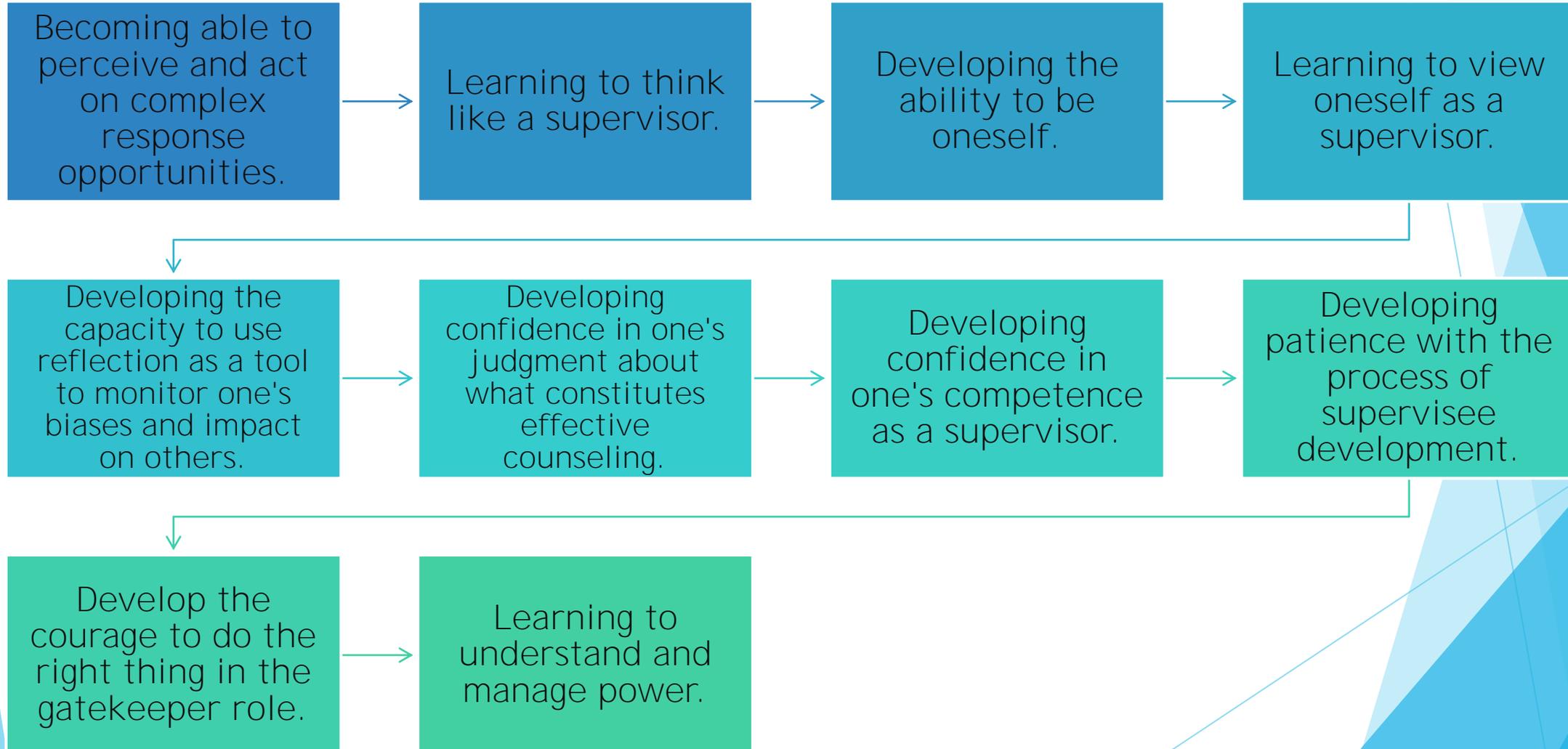
- Your attitudes, preparation, willingness to grow
- Your view of the supervision process
- Your ability to admit to difficulties or to discuss errors
- Your skill at discussing issues or problems with the supervisory relationship and self critique
- Your openness to feedback, accepting it non-defensively, and giving feedback to the supervisor
- Your understanding of how personal dynamics relate to psychotherapy and supervision as evidenced by speaking openly about personal emotional responses to clients your openness to multiple perspectives, client ratings of outcomes, and ethical and legal perspectives

Role Invocation as a Supervisor

It is important for the supervisor in training to engage in role invocation with the supervisee and to include the expectations and ground rules of the supervisor **role, essentially adopting the “supervisor” stance and** roll invocation, starting with such basics as the format for supervision; what the supervisor-in-training should prepare and have available in terms of written, audio or video materials; two way feedback expectations; multi cultural and diversity competence and infusion in the supervision process, ethical, legal, inside regulations; and general expectation such as being interactive in coming to supervision prepared.

Stages of Supervisor Development:

10 changes clinicians undergo as they become supervisors



Thank you and please remember to complete the evaluation that you should have received to your inbox in order to receive your certificate - because the board says we are required to do so plus we always want to improve!!



Training for Professional Excellence

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