CLINICAL SUPERVISION TRAINING

April 17-18, 2021
Phoenix, Arizona

ARIZONA COUNSELORS ASSOCIATION

PRESENTED BY LEE A. UNDERWOOD. PSYD

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I AM A DECISIVE ELEMENT

I Have Come To The Frightening Conclusion
That I Am The Decisive Element
In A [Supervisee's] Life.
It's My Personal Approach
That Creates The Climate,
Its My Mood
That Makes The Weather.
I Possess A Tremendous Power To Make
A [Supervisee's] Life
Miserable Or Joyous.
I Can Be A Tool
Of Torture Or An Instrument Of
Inspiration, I Can Humiliate Or Humor,
Hurt Or Heal, In All Situations, Its My Response That Decides Whether
A Crisis Will Be
Escalated Or De-Escalated
And A [Supervisee] Humanized Or De-Humanize

Haim Ginnot

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SATURDAY April 17, 2021		SUNDAY April 18, 2021	
9:00-10:30	• Introductions • Defining Supervision • Roles and Responsibilities of Clinical Supervisors • Case Scenario • Skills in Providing Supervision of Diagnosis, Creating Treatment Plans and Providing Treatment	9:00-10:30	• Models of Supervision • Supervision Methods and Techniques continued
10:30-10:45	BREAK	10:30-10:45	BREAK
10:45-12:00	• Models of Supervision • Supervision Methods and Techniques • Case Scenarios	10:45-12:00	• Observing and Assessing Supervision Skills • Providing Feedback

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DEFINING CLINICAL SUPERVISION

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INTRODUCTION TO CLINICAL SUPERVISION

- Defining supervision
- Roles and responsibilities of clinical supervisors
- Skills in providing supervision of diagnosis, treatment plans and providing treatment

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INTRODUCTIONS

- Professional identity, education and license
- What is your work setting as a counselor?
- Whom do/will you supervise?
- What is your experience with providing supervision?
- What are hoping to do with this training?

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WHEN YOU WERE A SUPERVISEE

- What is a positive experience that happened in your supervision?
- What is a negative experience that happened in your supervision?

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WHAT SUPERVISEES FAILED TO DISCLOSE

- 90% failed to disclose negative feelings toward a supervisor
- 60% failed to disclose their own personal issues
- 44% failed to disclose clinical mistakes
- 44% failed to disclose uneasiness or concerns about the supervisor's evaluations of them.
- 43% failed to disclose general observations of the client

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WHAT THEY HAD FAILED TO DISCLOSE

- 36% failed to disclose negative reactions to the client
- 25% failed to disclose thoughts or feelings of attraction toward the client.
- 23% failed to disclose positive feelings toward the supervisor
- 22% failed to disclose countertransference reactions to the client.

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REASONS FOR NOT DISCLOSING

- 73% perceived to be too personal
- 62% perceived to be unimportant
- 51% negative feelings such as shame, embarrassment, or discomfort
- 55% feelings of deference
- 50% poor alliance with supervisor
- 46% to avoid being perceived negatively

Ladany, Hill, Corbett & Nutt (1996)

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ADMINISTRATION AND LOGISTICS OF SUPERVISION

- The necessities of supervision process
- Knowledge of the supervisee's site
- Future planning of supervision goals

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SUPER VISION

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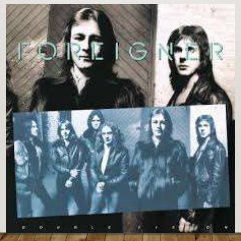
DOUBLE VISION



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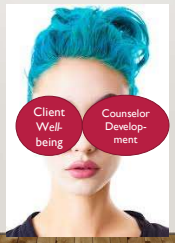
BEING BIFOCAL



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X-RAY VISION

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DEFINING CLINICAL SUPERVISION

- The relationship between a more experienced professional (supervisor) and less experienced professional (supervisee)
  - (Bernard & Goodyear, 2014)

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LEARNING TO THINK LIKE A SUPERVISOR

BORDERS, (1992)

- The shift from counselor to supervisor
- Different foci, thoughts, behaviors, skills
- "How can I intervene so this counselor will be more effective with this client and future clients?"

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SUPERVISOR IN COUNSELOR MODE

- Focus entirely on client
- Tell the counselor what to do with the client
- May neglect supervisee's reactions, skill level
- View supervisee as client

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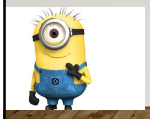
SUPERVISOR IN ADMINISTRATOR MODE

- Focus on counselor performance
- Professional behavior in the agency
- Focus on tangibles, e.g. client files
- Neglect client needs



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LEARNING TO THINK LIKE A SUPERVISOR

BORDERS, (1992)

- Counselors as learners
- Supervisor as educator
- Creating appropriate learning environments and strategies to help the counselor be more effective

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DEFINING CLINICAL SUPERVISION

- Supervision is an ***educational*** process
- Supervisors think of their supervisees as ***learners*** and they focus on creating an appropriate learning environment to help supervisees be more effective with clients and develop and mature into the profession of counseling

(Borders & Brown, 2005)

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ROLES & RESPONSIBILITIES OF CLINICAL SUPERVISORS

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SUPERVISOR ROLES

- Educator
- Consultant
- Mentor
- Counselor
- Evaluator
- Gatekeeper
- Fellow professional

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Comparing Supervision with Other Roles

	Teacher	Counselor	Administrator	Consultant	Case Manager
Similarities	Evaluative in nature	Use facilitative skills and gives attention to developing self-awareness	Monitor client case notes to be sure they are timely and appropriate	Brainstorm options for interventions	Review number and intensity of case load
Differences	Goals are more flexible than a teaching syllabus	Goal is to help supervisee manage emotions, identifications, cognitive distortions, values, and beliefs affecting work with clients	Is a focus only in terms of making sure supervisee is adhering to professional guidelines and policies	A hierarchy of authority exists with more responsibility on the supervisor	Is a focus only as needed in terms of supervisee self-care

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ADDITIONAL EXTRA-CLINICAL SUPERVISORY ROLES

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ADDITIONAL EXTRA-CLINICAL SUPERVISORY ROLES

- Coworker
- Fellow employee
- Friend

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To Whom are Supervisors Responsible?

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CLINICAL SUPERVISOR RESPONSIBILITIES

- Supervisee
- Supervisee's clients
- Agency/workplace
- The Board of Behavioral Health
- The Counseling profession
- The public

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What are Some Supervisor Skills?

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SUPERVISOR SKILLS

- Teaching
- Assessing supervisee needs
- Assessing supervisee learning style
- Creating a productive environment matching the learning needs of the supervisee
- Balance challenge and support
- Assessing/ensuring client safety and well-being
- Balance innovation and integration
- Attending to specific skills and immediate needs
- Teaching general principles about client dynamics and counseling process
- Skills in providing supervision of diagnosis, creating treatment plans and providing treatment

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SUPERVISOR AS EDUCATOR

- Supervision is "an intentional educational intervention"
- Creating a learning environment that matches the needs of the supervisee
  - Purposeful and intentional
  - Goal-directed
  - Proactive
  - Flexible

(Borders & Brown, 2005)

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SUPERVISOR AS EDUCATOR

Focus is on the professional development of the supervisee

Based on the supervisee needs, the focus could include

- Counseling skills and techniques
- Case conceptualization skills
- Assessment and diagnosis skills
- Creating treatment plans
- Application of counseling theory
- Multicultural counseling skills
- Supervisee self-awareness
- Supervisee self-care
- Supervisee self assessment skills
- Ethical decision making skills
- Professional behavior in the agency and with other professionals
- Professional advocacy skills

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CASE SCENARIO

- A client arrived for her appointment wearing a distinctive coat. The counselor remarked on its bright and beautiful colors. At the end of the day, the counselor returned home to find a box with an identical coat on her doorstep. The note said the client had made a big effort to find the identical coat as a way to say thank you for all the help she had received.

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CASE SCENARIO

- The counselor is your supervisee. She states that when trying to return the gift to the client, the client became distraught and said it felt like a rejection of her. The client asked the counselor to keep the coat at least until the next session and if the counselor still wanted to give it back, she would take it. The client stated that she could not return the coat because it was on sale.

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CASE SCENARIO

- What are the main issues in this scenario?
- What supervisory roles will be most useful to you in addressing these issues?
- To what parties are you responsible in this situation?
- What skills do you use to fulfill your responsibilities?
- Do any emotions or personal concerns come up for you as you consider handling your supervisory role in this situation?

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SKILLS IN PROVIDING SUPERVISION OF DIAGNOSES, CREATING TREATMENT PLANS AND PROVIDING TREATMENT

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GENERAL ASPECTS OF TREATMENT PLANNING

- Starts at client's entrance into the cottage and counseling room
- Ends at client's last session before program discharge
- Dichotomy between assessment & treatment and serves as bridge
- From assessment emerges the treatment plan
- Rapport & relationship building
- Serves as the contract between agency and the client and referral agent

~ Morrison, 2003

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UTILITY OF TREATMENT PLANNING

- Develop a specific plan at beginning of therapeutic relationship
  - Aims and benefits:
    - Preliminary strategy,
    - Adjustments or increases in service provision,
    - Meeting governing or certification requirements
    - Implications for managed health care organizations and funding sources
    - Review and standardization purposes

~Maruish, 2002

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GENERAL ASPECTS OF TREATMENT PLANNING

- Treatment planning defines parameters of counseling—the center piece
- Defines content and goals and strategies of relationship
- Benefits of planning benefit both client and professional include:
  - Keeps both on course
  - Provides points of discussion
  - Serves as a roadmap
  - Allows goal identification, development, planning, monitoring, progress, and measuring of outcomes

~Maruish, 2002

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IMPLICATIONS FOR TREATMENT TERMINATION

- Symptom management improved or reduction in negative symptomatology
- Use of pre and post test measures
- Effective medication use
- Relapse prevention worksheet are good indicators
- Harm reduction should be discussed
- Increase level of functioning or otherwise improved psychosocial circumstances
- Appropriate organizational setting involvement

~Marush (2002)

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OBJECTIVE MEASURES OF TREATMENT

- Brief Symptom Inventory (BSI)
- Trauma Symptom Checklist for Children (TSC-C)
- Beck Youth Inventory (BYI)
- Behavioral Assessment for Children Scales II (BASC-2)
- Positive Oriented Screening Inventory for Teenagers (POSIT)
- Youth Level of Services/Casemanagement Inventory (YLS/CMI)
- Millon Adolescent Clinical Inventory (MACI)
- Child Behavior Checklist (CBCL)
- Outcome Rating Scale (ORS)

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SUBJECTIVE MEASURES OF TREATMENT

- Behavioral self-reports of progress—client and guardian
- Provide rated reports or use of scaling reports
- Syndrome specific instruments that measure depression, anxiety, trauma, resiliency, substance use, suicidality, cognitive issues, aggression, sexual aggression, academic issues)
- The treatment plan acts as a compass and providers use it as a roadmap to judge expected changes and progress. Otherwise termination of counseling relationship, a change in service modality, or referral to another professional may be necessary

~Duncan, 2010; Maurish, 2002

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SUPERVISOR & SUPERVISEE RELATIONSHIP

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SUPERVISOR-SUPERVISEE RELATIONSHIP

- When supervision participants are asked to identify critical incidents in supervision, the most frequently cited incidents cluster around the supervisory relationship (Nelson & Friedlander, 2001; Ellis, 1991)

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THE SUPERVISORY RELATIONSHIP

- It's complicated
- Variety of roles, some of which seem contradictory: professional colleague, evaluator, gate keeper, counselor, support
- Variety of focus areas: personal growth and self-awareness, professional skill development and behaviors
- Changes over time – flexibility, renegotiation, back and forth

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THE SUPERVISORY RELATIONSHIP AND THE THERAPEUTIC RELATIONSHIP

- Parallel dynamics – vulnerability and trust, risk of disclosure and responsibility to create a safe environment
- Parallel processes – the need for flexibility over time and across situations, the balance of support and challenge, the possibility of resistance
- A good working alliance is essential: clear communication of expectations and boundaries
- Unlike counseling, supervision is evaluative

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CREATING A FACILITATIVE SUPERVISION ENVIRONMENT

- Create a safe, trusting environment to:
  - Support vulnerability
  - Allow risk-taking
  - Contain anxiety
- Give and receive feedback that encourages growth and change
- Acknowledge power and evaluation responsibilities of supervisor
- Recognize personal factors that may affect the relationship: trust, gender, race/ethnicity, personality, counseling setting, clientele

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ANXIETY AND RESISTANCE

- Anxiety is a part of the counselor development process
- Supervisee is being pushed to new and uncomfortable territory
- Sensitivity, support, containment
- Resistance as response to a perceived threat vs. resistance to learning or to supervisor
- Resistance can take many forms: passive, aloof, forgetful, tardiness, canceling, coming unprepared, overly compliant, argumentative

Supervisors have anxiety too: performance, authority issues, likeability, fear of resistance, countertransference, etc.

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CIRCUMSTANCES THAT ELICIT SUPERVISEE RESISTANCE

- Supervisee trust issues
- Client issues transmitted by parallel processes
- Disagreement about tasks and goals
- Supervisor level of directiveness
  - *Can* interventions
  - *Must* interventions
- Supervisee trait reactance
- Developmental level

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ADDRESSING SUPERVISEE RESISTANCE

- Supervision focus
  - *Least resistance when focus is on client*
- Supervisor style
  - *More directive increases resistance*
  - *Less directive reduces resistance*
- Supervisee counter transference
  - *Regarding their issues with a client*

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MANAGING SUPERVISEE ANXIETY

- Assess the anxiety as productive and valuable or obstructive
- Balancing supervisor challenge vs. support
- Supervision Structure
- Clear expectations

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THE SUPERVISORY RELATIONSHIP

- *"The supervisor relationship is a relationship between unequals, the objective of which is equalization. This would seem to be an inherent contradiction, a paradox, and is the challenge of supervision."* (Ackers, 1992)

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CRITICAL ISSUES IN SUPERVISION
(LOGANBILL, HARDY & DELWORTH, 1982)

- Competence – skills, techniques, mastery
- Emotional awareness – knowing self, awareness of feelings
- Autonomy – sense of self, independence and self-directedness
- Identity – theoretical consistency, conceptual integration
- Respect for individual differences – affirming difference, non-judgment, checking our biases

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CRITICAL ISSUES IN SUPERVISION
(LOGANBILL, HARDY & DELWORTH, 1982)

- Purpose and direction – goal setting, direction in counseling
- Personal motivation – meaning in their work, reward, satisfaction
- Professional ethics – professional behaviors, standards of practice, shared values

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ISSUES AND DILEMMAS

- Supervisee anxiety – can be contagious
- Supervisor countertransference
- Supervisor-supervisee conflict
- Relationship parameters: interpersonal power
- Potentially harmful consequences of supervision – supervisor's lack of awareness, incompetence, impairment

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DOCUMENTATION & RECORD KEEPING

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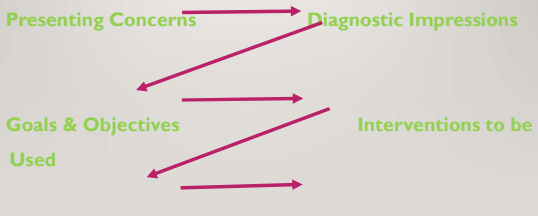
DOCUMENTATION OF SERVICES

- Flow tends to be as follows:



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SOAP NOTES

- Great for work settings that do not require formal treatment plans
- S – Subjective
- O – Objective
- A – Assessment
- P – Progress of Treatment

These operate as Treatment Planning

~Cameron & Turtle- Song (2002)

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MEASURING TREATMENT GOAL PROGRESS

On a monthly basis during the CFT, the therapist shall extract the three treatment goals from the Treatment Plan and enter/place on the Monthly Progress Report;

Based upon the treatment objectives, the therapist shall determine the percentage completion of each of the three goals;

- The percentage achieved towards the treatment goal will be inputted in Claim Track in required fields;
- Client treatment goal progress shall be determined by program length of stay---for example:
- 50% treatment goal progress is expected for clients in program 30 days or less;
- 65% treatment goal progress is expected for clients in program 31-60 days in program;
- 80% treatment goal progress is expected for clients in program 61 plus days in the program.

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MEASURING TREATMENT GOAL PROGRESS

- For AOC/DAP funded clients, the clients will need to achieve 80% of their treatment goals within 30 days; treatment goals and objectives will be written in such a way to support this level of progress.
- On a monthly basis, casemangers shall compile aggregate data on treatment goal progress based on length of stay and forward to the Clinical Director for review and training with therapists.
- On a quarterly basis, the Clinical Director shall prepare a report for the COO and CEO.

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PURPOSE OF DAILY NOTES

- Legal Document
- Written summary of services provided
- Documentation of client's response to services
- Documents progress toward treatment plan goals
- Billing

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CORE ELEMENTS OF A NOTE

- Identifying Info on each page
  - Name
  - ID Number
  - Date
- Documentation Supports Service
  - Summary of services and interventions provided
  - Client's response

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CORE ELEMENTS OF A NOTE

- Progress toward treatment plan goals
- Who provided the service:
  - Printed name
  - Signature
  - Education
  - Credentials
  - Date signed

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DOCUMENTATION DO'S AND DON'TS

- Do use black ink, only
- Do write legibly
- Do summarize pertinent information
- Do be descriptive
- Do report on "Just the facts"
- Do state observations, not assumptions or judgments
- Avoid errors in grammar, spelling and punctuation
- Keep client data strictly confidential and keep the names of other clients out of your notes
- Remember: If it's not documented, it didn't happen

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DOCUMENTATION DO'S AND DON'TS

- Don't document unnecessary information
- Don't enter derogatory or negative statements about a client
- Don't exclude information critical to explaining treatment decisions
- Don't use shorthand or abbreviations that aren't widely accepted
- Don't name or quote anyone who is not essential to the record. If the information is critical, use quotations and attribute the remarks appropriately

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DOCUMENTATION DO'S AND DON'TS

- Don't erase an entry, write an entry in erasable ink or pencil or use correction fluid;
- Don't sign your name unless you performed the care or saw it done
- Don't chart ahead of time-something may have happened and you may be unable to provide the care you charted;
- Don't leave blank lines that would allow insertions or raise the question whether information had been omitted;
- Don't amend someone else's documentation; and
- Don't suggest that another practitioner was negligent or describe staffing problems

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CONTINUATIONS

- Continuations are used when the front portion of the note is exhausted and more space is required.
- Continuations are added information that pertains to that shift and documented at the end of the shift.
- Circle "Continuation" on the back page of the note when your documentation requires the use of the back page.

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LATE ENTRIES

- Late Entries are used when used when information is added to the progress note on a different day.
- Late Entries are used when staff are asked to correct or add information that was not previously documented.
- Example:
  - ***3/22/12 10:00 a.m.*** *Late entry for* ***3/21/12*** *at 11:30 p.m., the client was found on the floor of her room beside the bed. Client reports that she slid off the side of the bed when attempting to sit down.*

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WHEN YOU MAKE AN ERROR

- Draw a single line through the error
  - ~~Prgress~~
- Enter correct word
- Write
  - Your Initials
  - Date
- Example Error Correction:

  "~~prgress~~ DW 4/2/12 progress"

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MODELS OF SUPERVISION

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WHAT IS THE VALUE OF A MODEL?

- A framework for a complex set of ideas, concepts, behaviors
- Assists in planning, conducting and evaluating your work as a supervisor
- Provides a common language for supervisor and supervisee that can aid in understanding expectations, responsibilities and goals

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MAJOR MODELS OF SUPERVISION

- Developmental Models
- Bernard's Discrimination Model
- Adaptive Supervision in Counselor Training

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DEVELOPMENTAL MODELS

- Based on stages of counselor professional development
- Typically 3-5 stages/levels of development
- Counselor professional development occurs across the lifespan of the counselor's profession and different types of supervision are needed at each level/stage
- Developmental level is not always equal to years of experience in the field

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COUNSELOR DEVELOPMENT

- Knowledge
- Skills
- Awareness/attitudes
- Professional identity

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INTEGRATED DEVELOPMENTAL MODEL

STOLTENBERG, MCNEIL, DELWORTH

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INTEGRATED DEVELOPMENTAL MODEL
(STOLTENBERG, MCNEIL, & DELWORTH, 1998)

Four Stages of Development
- Dependent
- Dependent-autonomous
- Conditional dependency
- Integrated

Three Structures in Assessing Professional Growth
- Motivation – interest, investment, effort
- Autonomy – degree of independence
- Awareness – self-preoccupation, awareness of client's world, enlightened self-awareness: cognitive and affective components

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LEVEL 1 - DEPENDENT

- Supervisees have limited training, limited experience in the specific area in which they're being supervised
  - **Motivation:** motivation and anxiety are high; focused on acquiring skills, want to know the "correct" or "best" approach with clients
  - **Autonomy:** dependent on supervisor. Needs structure, positive feedback, and little direct confrontation
  - **Awareness:** High self-focus, but with limited self-awareness; apprehensive about evaluation.

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LEVEL 2 – DEPENDENT-AUTONOMOUS

- Making transition from being "highly dependent, imitative and unaware in responding to a highly structured, supportive, and largely instructional supervisory environment" (usually end of internship)
  - **Motivation:** Fluctuating, as the supervisee goes back and forth between very confident to unconfident and confused in new settings and situations
  - **Autonomy:** functioning more independently, but still goes back and forth between dependency and autonomy – can produce resistance to the supervisor
  - **Awareness:** greater ability to focus on and empathize with client. Balance is still an issue, can result in confusion and enmeshment with the client.

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LEVEL 3 – CONDITIONAL DEPENDENCY

- Supervisees are focusing more on a personalized approach to practice and on using and understanding of "self" in therapy
  - **Motivation:** consistent; occasional doubts about one's effectiveness, but not immobilizing
  - **Autonomy:** solid belief in one's own professional judgment, supervision tends to be more collegial as differences between supervisor and supervisee expertise diminish
  - **Awareness:** Supervisees become more self-aware, but with a different quality than in Level 1. Ability to remain focused on the client while stepping back and attending to their own personal reactions and keeping them separate in their decision making and interventions.

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LEVEL 3I - INTEGRATED

- Supervisee reaches level three across multiple domains (assessment, case conceptualization, treatment plans and goals, ethics, theoretical orientation, multicultural/diversity, intervention). The task remains to integrate across domains, personalize their approach to professional practice. Strong awareness of strengths and weaknesses.

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BEGINNING STAGE COUNSELORS

- Black and white thinking
- Broad, somewhat simplistic, categorical understanding of clients
- More focused on self than client
- Wants to know the "rules" and the "right" thing to do
- Little awareness of strengths, weaknesses, and motivations
- Lack of confidence, often anxious

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MIDDLE STAGE COUNSELORS

- More differentiated perceptions of clients with the same presenting issue
- More flexible
- More individualized
- Greater confidence and fairly consistent awareness of strengths and limitations
- Can lose confidence when they face new clinical issue

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LATER STAGE COUNSELORS

- More comprehensive case conceptualizations
- More individualized case conceptualizations
- Comfortable with paradoxes
- Consider more sophisticated dynamics in human relationships

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DISCRIMINATION MODEL

JANINE BERNARD

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DISCRIMINATION MODEL
(BERNARD, 1979, 1997 AND LANNING, 1986))

- Understands the supervisor is functioning in different roles at different times throughout supervision
- Understands the supervisor has different focus areas at different times during supervision
- Uses a matrix to combine roles and focus areas for specific supervisor situations and specific supervisee learning needs
- Supervisees can create their own learning goals based on the focus areas

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FOCUS AREAS

- Counseling performance skills
- Cognitive counseling skills
- Self-awareness
- Professional behaviors

Roles

Teacher – Supervisee needs structure, instruction, modeling and giving direct feedback

Counselor – facilitates supervisee reflection and awareness of internal processes

Consultant – more collegial role when supervisor wants supervisee to trust his/her own insights and feelings about their work, or when supervisor challenges supervisee to think/act on their own

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FOCUS AREAS

- Counseling performance skills – what a counselor does in session, basic and advanced skills, theory-based techniques, procedural skills e.g. opening and closing a session, and issue-specific skills
- Cognitive counseling skills – how a counselor thinks before, during and after session, case conceptualization, moment-to-moment thought process in session, motivation for intervention choices, how a counselor perceives client movement toward goals
- Self-awareness – supervisee's recognition of personal issues, beliefs, motivations that influence in-session behavior, client assessment and conceptualization, goal choice, distance or over-identification with client
- Professional behaviors – adherence to ethical, legal and professional guidelines and appropriate on-site behaviors

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SUPERVISOR ROLES

- **Teacher** – What are some things a supervisor might teach a supervisee? What are some ways those things might be taught?
- **Counselor** – When would a supervisor use his/her counseling skills with a supervisee? How might attention to content and process be important in supervision? Is it ok to go into a supervisees personal issues in supervision?
- **Consultant** – If you're a senior professional facilitating the growth of a junior professional, how can the consultant role help the supervisee? What are some behaviors a supervisor might use in the consultant role?

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ADAPTIVE SUPERVISION

ROBERT RANDO

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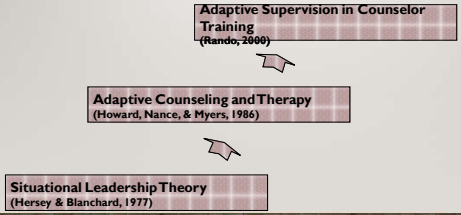
Adaptive Supervision in Counselor Training



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Adaptive Supervision in Counselor Training

Adaptive Counseling and Therapy - ACT / **Adaptive Supervision in Counselor Training - ASiCT**

- Readiness
- Intervention Style
- Match & Move

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Readiness

Task Relevant:

- **Willingness**
  - ✓ *Attitude*
  - ✓ *Motivation*
  - ✓ *Fear*
- **Ability**
  - ✓ *Knowledge*
  - ✓ *Skills*
- **Self-Confidence**
  - ✓ *Personal Empowerment*
  - ✓ *Self-Respect*
  - ✓ *Self-Regard*

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Intervention Styles

Two Dimensions

- Direction
  - ✓ ***Goal Directed***
  - ✓ ***Who? What? When? and Where?***
  - ✓ ***Sequencing? Techniques/Methods?***
  - ✓ ***Who's responsible for what?***
- Support
  - ✓ ***Concern***
  - ✓ ***Empathy***
  - ✓ ***Regard***
  - ✓ ***Relational***

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Match & Move

Match Intervention Style (of Therapist – ACT or of Supervisor – ASiCT) to Client (ACT) or Trainee (ASiCT) Readiness

GOAL: Move target (i.e., to higher level of readiness)

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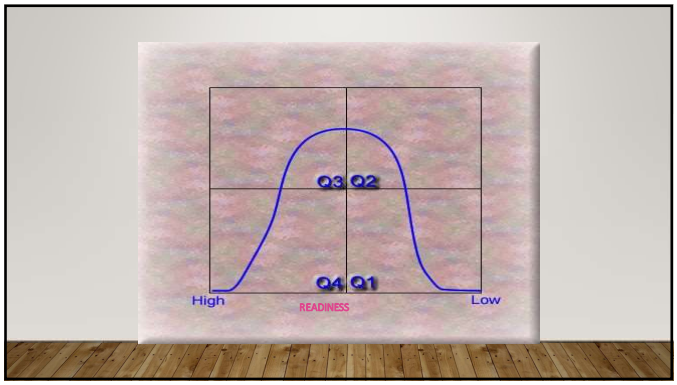

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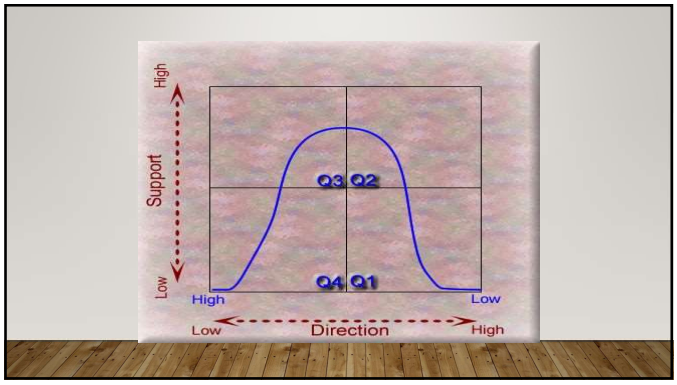

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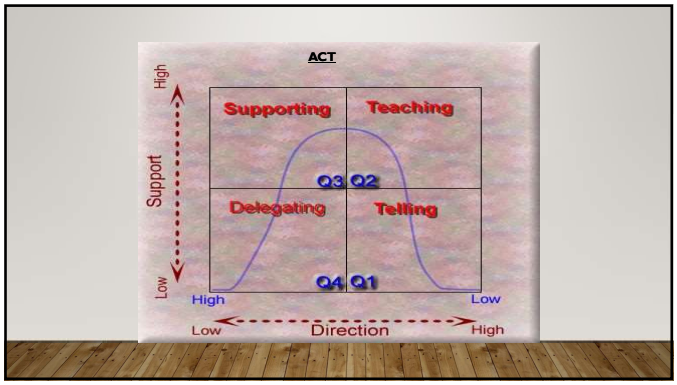
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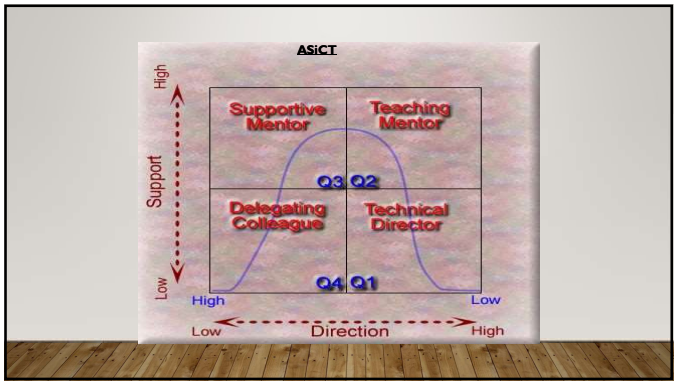
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Delegating Colleague
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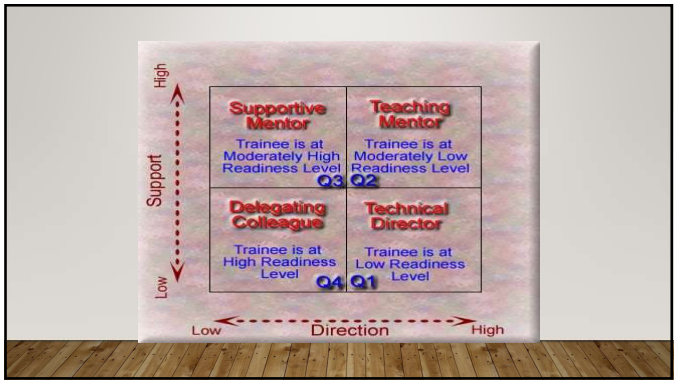
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Support
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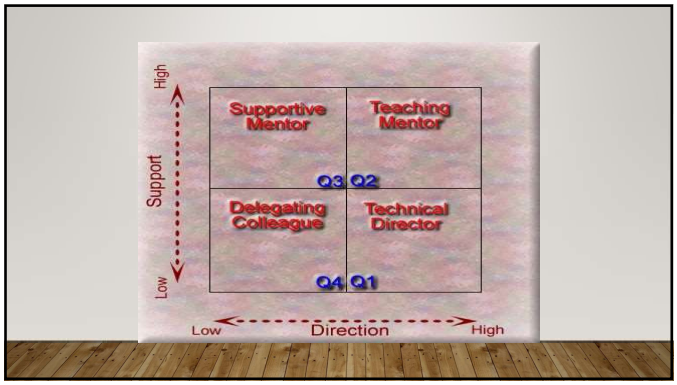
Supportive Mentor
Trainee is at Moderately High Readiness Level
Teaching Mentor
Trainee is at Moderately Low Readiness Level
Q3 Q2
Delegating Colleague
Trainee is at High Readiness Level
Technical Director
Trainee is at Low Readiness Level
Q4 Q1
Low
Direction
High

99



100

CASE SCENARIOS

101

In viewing a videotape of Alberto's session with his client you notice that he is not reflecting the client's emotional content. Alberto is an advanced intern with strong therapeutic skills. In discussing his interaction with the client, you learn that this client represents Alberto's first time working with a physically violent client. Alberto states, "I just don't know what to do. I find myself distracted during the session, thinking about how I don't want to make the client angry. Do you think it would be o.k. for me to refer him?"

102

CASE SCENARIOS

103

In viewing a videotape of Alberto's session with his client you notice that he is not reflecting the client's emotional content. Alberto is an advanced intern with strong therapeutic skills. In discussing his interaction with the client, you learn that this client represents Alberto's first time working with a physically violent client. Alberto states, "I just don't know what to do. I find myself distracted during the session, thinking about how I don't want to make the client angry. Do you think it would be o.k. for me to refer him?"

104

You have been supervising Jerry, a fairly new LAC at your agency. You are informed by a co-worker that Jerry has been expressing to other trainees and your colleagues, that he has misgivings about the quality of the supervision that you are providing. Your co-worker informs you that she told Jerry that he should express his concerns directly to you and that she may inform you of the situation as well. Jerry proceeds through the next supervision session without making a comment. You notice that he is providing minimal information and seems rather distracted. This pattern continues into the next supervisory meeting. How would you handle this situation with Jerry?

105

INTERVENTIONS - QUESTIONS

- What was going on for you when you asked that question?
- What were you hoping to learn from that question?
- How do you think the client reacted to that question?
- If you could say something different there, what might you say?

106

SUPERVISION TECHNIQUES

107

THINKING ALOUD TECHNIQUE

- Supervisor plays counselor role and thinks aloud while recalling the session
- Offer your thinking process tentatively – supervisee may or may not share your process
- Adds to supervisee perspective
- Models empathy in difficult situations
- Nonjudgmental tone is critical

Encourage supervisee's clinical judgment

108

THINKING ALOUD TECHNIQUE

- Modeling counselor cognitive skills for supervisee by thinking aloud about:
  - Client's words and nonverbal behaviors
  - Comparing client today versus previous sessions
  - Acceptance of contradictions in client's behavior, which are framed as meaningful rather than wrong
  - One way to put the information together
  - Openness to checking out hypothesis about client's experience without having to "figure it all out" before doing/saying anything

109

USE OF METAPHOR

- Listen for supervisee generated metaphor of self, client, and counseling relationship
- Play out supervisee generated metaphor
  - "This client is acting like a child." "What might this child need?"
  - "I feel like she's just going in circles." "And you're walking in circles with her?"
  - "I feel like I'm stuck." "What do you do when you're not stuck?"
- Elicit metaphors from supervisees for self, client, counseling relationship, supervisory relationship
- Supervisors can also generate metaphors for processing
- Demonstration of using a metaphor in the counseling session

110

ROLE PLAY

- Useful for practicing skills and exploring client dynamics
- Typically, supervisee plays counselor and supervisor plays client, with focus on specific skill/technique or have a new interaction/conversation
- Allows for immediate feedback and repeated practice sessions
- Can focus role play on a particular type of difficult client (e.g., angry, dependent, seductive)
- Reverse roles (supervisee as client) can improve understanding, empathy, compassion for client

111

MODELING

- Demonstration of skills for supervisee
  - Specific micro-skill
  - Procedural tasks: Opening/closing session
  - Processing of experiential exercise
- Be cautious not to overwhelm beginning level supervisee with your skill level
- Modeling is always happening from supervisor to supervisee:
  - Attitude about clients
  - Confidentiality
  - Openness to feedback
  - Congruence

112

PROCESS QUESTIONS

- Check out Unstated Agendas
  - What would you have liked to have said to her or him at this point?
  - What's happening here?
  - What did you feel like doing?
  - How were you feeling about your role as counselor at this point?
  - What did that mean to you?
  - If you had more time, where would you have liked to have gone?

113

PROCESS QUESTIONS

- Encourage Cognitive Examination
  - What were you thinking at that time?
  - What thoughts were you having about the client at that time?
  - What's going on in your mind right here?
  - Did you have any ideas about what you wanted to do with that?
  - Were you able to say it the way you wanted to?
  - Did you want to say anything else?
  - Did you have a plan of where you wanted the session to go next?
  - What kind of image were you projecting to the client?
  - Is that the image you wanted to project?

114

PROCESS QUESTIONS

- How do you think he/she was seeing you at this point?
- Do you think he/she is aware of your feelings? Your thoughts?
- What messages do you think he/she was trying to give you?
- Did you feel he/she had any expectations of you at this point?
- Do you think your description of the interaction would coincide with his/her description
- How do you think the client feels about talking with you about this problem?

115

PROCESS QUESTIONS

- What did you want him or her to tell you?
- What did you want to hear?
- What would you have liked from him/her?
- Did you want her or him to see you in a particular way? How?
- What message did you want to give him or her?
- What did you really want to tell him/her at this moment? What got in the way from doing so?

116

NATURE, EXTENT AND IMPORTANCE OF WHAT PSYCHOTHERAPY TRAINEES DO NOT DISCLOSE TO THEIR SUPERVISORS

LADANY, HILL, CORBETT & NUTT (1996)

117

WHAT SUPERVISEES FAILED TO DISCLOSE

- 90% failed to disclose negative feelings toward a supervisor
- 60% failed to disclose their own personal issues
- 44% failed to disclose clinical mistakes
- 44% failed to disclose uneasiness or concerns about the supervisor's evaluations of them.
- 43% failed to disclose general observations of the client

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WHAT THEY HAD FAILED TO DISCLOSE

- 36% failed to disclose negative reactions to the client
- 25% failed to disclose thoughts or feelings of attraction toward the client.
- 23% failed to disclose positive feelings toward the supervisor
- 22% failed to disclose countertransference reactions to the client.

119

REASONS FOR NOT DISCLOSING

- 73% perceived to be too personal
- 62% perceived to be unimportant
- 51% negative feelings such as shame, embarrassment, or discomfort
- 55% feelings of deference
- 50% poor alliance with supervisor
- 46% to avoid being perceived negatively

120

OBSERVING AND ASSESSING SUPERVISEE SKILLS

121

WHAT MAKES A GOOD ASSESSMENT?

- How will you be able to observe and evaluate your supervisee's assessment skills?

122

WHAT MAKES A GOOD CASE CONCEPTUALIZATION?

- How will you be able to observe and evaluate your supervisee's case conceptualization skills?

123

WHAT MAKES A GOOD TREATMENT PLAN?

- How will you be able to observe and evaluate your supervisee's treatment planning skills?

124

WHAT IS CASE CONCEPTUALIZATION?

- Anticipating challenges and roadblocks:
  - The test of an effective case conceptualization is its viability in predicting the obstacles and challenges most likely throughout stages of intervention.
  - These obstacles include those involving active engagement in and commitments to the intervention process, adherence, resistance, ambivalence, alliance ruptures, transference, enactments, relapse and termination.

125

WHAT IS CASE CONCEPTUALIZATION?

- Case Conceptualization is defined as….

  We all case conceptualize and don't know it.

  Making the this unknown to the known.

  For a professional, we take this to a more stringent and responsible approach. This differentiates between the professional and nonprofessional.

  Essentially, we are talking about the thinking behind the thinking – case conceptualization.

126

WHAT IS CASE CONCEPTUALIZATION?

Levels of Conceptualization

- **High level** case conceptualization answers all of the above questions: what happened, why did it happen, what roles does culture play, how can it change, and what are potential obstacles from preventing change.
- **Moderate level** case conceptualization like the high level conceptualization addresses diagnostic, clinical, cultural, and treatment formulation.
  - It misses elements related to treatment focus and strategy. Additionally, treatment will not be tailored to the client and no inclusion of obstacles to treatment goals and strategies.
- **Low level** case conceptualization are likely to be an extended description of info rather than explanation, b/c they fail to address the diagnostic, clinical, and treatment formulation questions.
  - Thus treatment goals may not be clearly defined and/or focused. No explanatory or predictive power.

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Case Conceptualization Components	Low Level Case Conceptualization	Moderate Level Case Conceptualization	High Level Case Conceptualization
Presentation (presenting problem)	X	X	X
Precipitant (triggers related to presenting problem)		X	X
Maladaptive pattern (inflexible/ineffective manner of thinking or acting)		X	X
Predisposition (factors fostering adaptive or maladaptive pattern)		X	X
Cultural identity (sense of belonging to a particular ethnic group)			X
Culture acculturation/stress (level of adaption to dominant culture)			X
Cultural explanation (beliefs regarding cause of distress, condition or impairment)			X
Culture vs. personality (operative mix of culture and personality dynamics)			X
Treatment goals (stated short and long term to outcomes)		X	X
Treatment focus (central therapeutic emphasis related to adaption pattern)	X		X
Treatment strategy (action plan)		X	X
Obstacles (predictable challenges to treatment process)	X		X
Prognosis (prediction of the likely course, duration, and outcome of a mental health condition with or without tx)		X	X

128

"IT IS THE MARK OF AN EDUCATED MIND TO BE ABLE TO ENTERTAIN A THOUGHT WITHOUT ACCEPTING IT."

-Aristotle

129

GIVING FEEDBACK TO SUPERVISEES

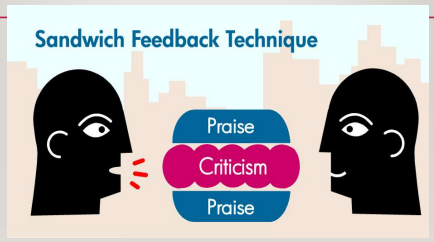
130

HOW DO WE GIVE GOOD FEEDBACK TO SUPERVISEES?

"That was the most offensive thing I've seen in twenty years of teaching. And that includes an elementary school production of *Hair*."

131

FEEDBACK SANDWICH



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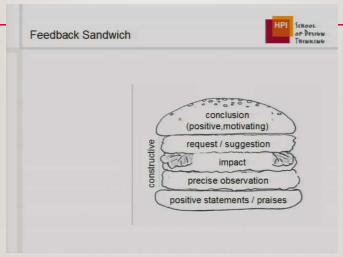
FEEDBACK SANDWICH



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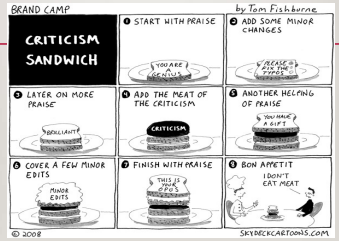
FEEDBACK SANDWICH



134

135 CORBS

- CLEAR – be clear about what feedback you want to give
- OWNED – feedback is your own perception and not an "ultimate truth"
- REGULAR – give feedback as soon after the event as possible, early enough for the person to respond to it, and often
- BALANCED – balance negative and positive feedback on the whole
- SPECIFIC – focus on particular interactions or behaviors you have witnessed

Materials adapted from: Hawkins, P & Shohet, R. (1989). *Supervision in the helping professions*. Milton-Keynes: Open University Press.

135

136 GUIDELINES FOR FEEDBACK

- Feedback provides information to help the receiver recognize the impact of his or her words or behaviors
- To be effective, feedback must be kindly delivered by the sender and graciously accepted by the receiver
- It is conveyed in such a way that the relationship remains intact.

136

137 GUIDELINES FOR FEEDBACK

It is DESCRIPTIVE rather than EVALUATIVE. Avoid "good" "bad" or other evaluative language.

Be SPECIFIC when you describe the behavior of interest. What exactly has happened? What did the receiver do that elicited the feedback?

Deliver the feedback as quickly as possible following the behavior

Deliver the feedback directly to the receiver

Uses "I" messages to indicate that you assume full ownership and responsibility for what is being said. "I heard you saying…." "I saw you doing……"

Addresses behaviors that can be changed, not traits or characteristics of which the receiver has no control

137

138 PENDLETON MODEL

Pendleton D, Scofield T, Tate P, Havelock P. 1984.

1. Check the learner wants and is ready for feedback.
2. Let the learner give comments/background to the material that is being assessed.
3. The learner states what was done well.
4. The observer states what was done well.
5. The learner states what could be improved.
6. The observer states **how** it could be improved.
7. An action plan for improvement is made.

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139

GUIDELINES FOR RECEIVING FEEDBACK

- Be open and listen first, without interrupting or immediately objecting to what is being said.
- Listen without turning the focus of the discussion back on the sender.
- Accept the feedback, rather than immediately refuting it.
- Recognize that the speaker has a right to his or her perceptions and to say what he or she is sharing.
- Be open and attentive to the sender and ask for clarification, if needed.
- Actively *hear* what is being said and try to understand what the sender means.
- Reflect upon what is being said about the behavior that prompted the feedback and accept responsibility for that behavior.
- Convey a genuine interest in receiving the feedback and in making the appropriate personal changes.

139

CASE SCENARIOS

140

Thomas is a seasoned alcohol and drug counselor who recently joined the staff at the center. Thomas is very familiar with the diagnosis and treatment of substance-related and mood disorders. He has limited experience and knowledge in the diagnosis of most other mental disorders. Thomas is certified as a chemical dependency counselor and is currently under supervision as he pursues licensure as a clinical counselor. Thomas is open to the supervisory process and readily seeks feedback.

During the course of the supervisory meeting, Thomas presented two cases. Case one detailed an individual who was referred to counseling for an assessment of alcohol use with the question of possible substance dependence. In the presentation of this case, Thomas provided a review of the client's referral information, substance use history, family structure, and other relevant mental status data. In his presentation and conceptualization of this case it was evident that Thomas was at a high level of readiness. He was able to accurately identify information in support of his diagnosis (i.e., Alcohol Abuse), identify relevant client factors in the assessment process (e.g., minimal defensiveness, no history of family substance dependence, a significant history of substance abuse resulting in legal problems, emotional immaturity, ignorance regarding substance effects, minimization). He has a clearly defined treatment plan and the requisite skills for the application of the treatment plan. Thomas evidenced confidence in his case conceptualization and was open to feedback; however, he presented no specific questions.

141

Tyler is trainee in the early phases of her training. She is working with her second client. You view a session in which Tyler defends her view to the client after the client challenges her intervention. When you ask Tyler about her choice to defend her view to the client, she states, "I'm not sure. Did I do something wrong? I guess that I wanted her to understand where I'm coming from. She doesn't seem to buy into the treatment plan."

142

Gemma is your supervisee and she has been working in your agency as a LAC for over a year. She has performed well with a wide variety of cases. The case presented by Gemma in this supervision session referred to a female client with a history of self-abuse (i.e. cutting arms and legs), suicidal gestures (overdosing on non-prescription pain medication - hospitalization required), relational conflicts with mother, sister, and roommate, history of sexual abuse (child molestation by paternal uncle) and physical abuse (perpetrated by father), non-significant history of substance use, academic problems (failing two of four classes this term), and significant resistance during the counseling process. When presenting this information Gemma appeared frustrated noting that she has had a great deal of difficulty obtaining the data over the course of three sessions. She reported that she was unsure as to how she should address the client's history of abuse, relational conflicts, and resistance. Gemma reported that she has primarily focused on continual assessment of suicidal ideation, mental status, and psychosocial history and noted "I feel like I'm spinning my wheels."

143

INTERVENTIONS - QUESTIONS

- What was going on for you when you asked that question?
- What were you hoping to learn from that question?
- How do you think the client reacted to that question?
- If you could say something different there, what might you say?

144