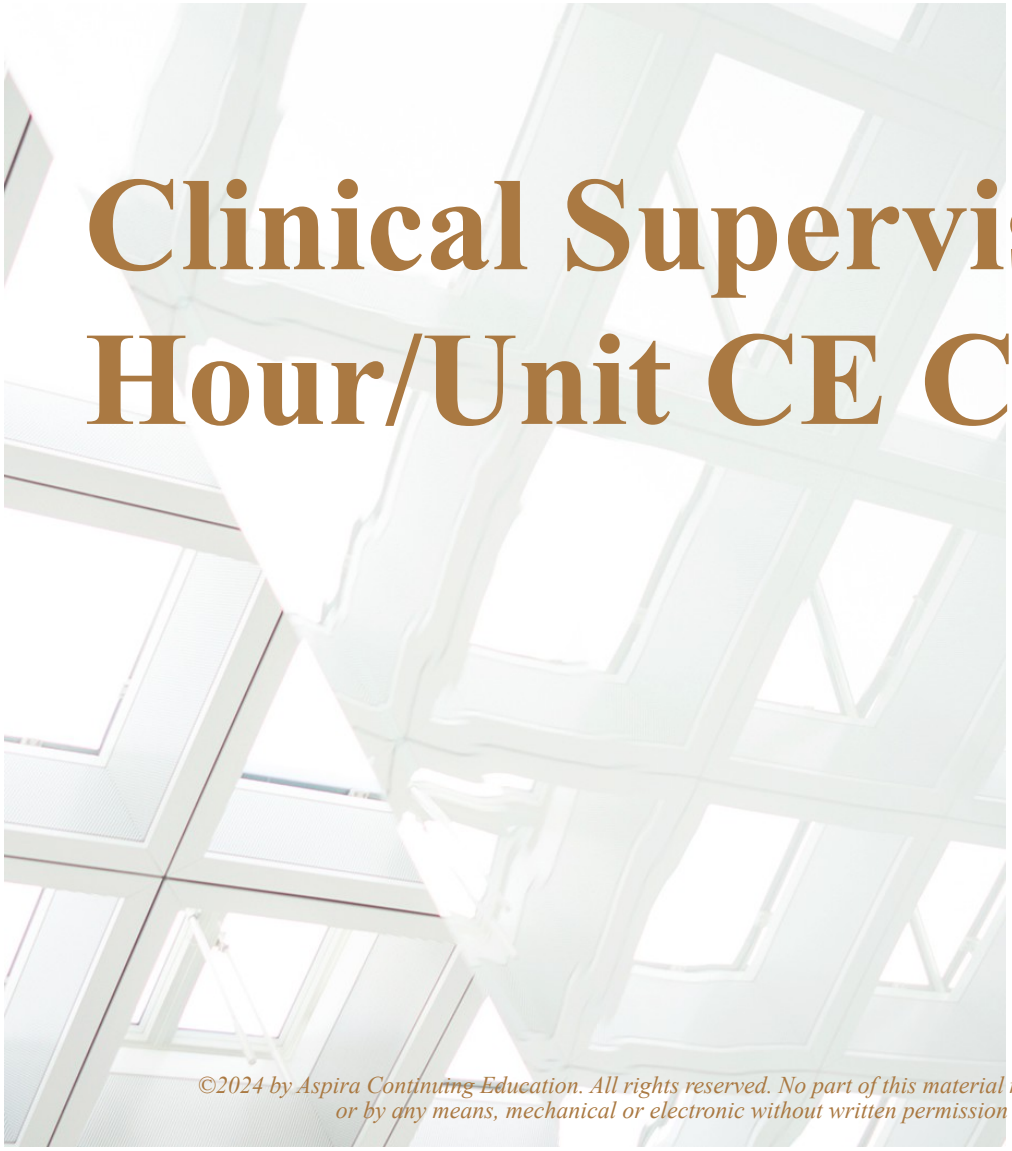

Clinical Supervision 15 Hour/Unit CE Course

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Learning Objectives

This course is designed to help you:

1. Describe at least two empirically and methodologically sound approaches to effective supervision.
2. Identify and discuss at least two specific supervisory roles within the context of the supervisory relationship.
3. Explain at least two specific multi-culturally competent supervision strategies, and comparative perspectives on supervision cross-culturally.
4. Identify at least two cultural and contextual factors related to clinical supervision.
5. Discuss at least one defining characteristic of clinical supervision that makes it a distinct professional practice.
6. Describe at least two functions of clinical supervision.
7. Describe at least one competency-based supervision model which focuses primarily on the skills and learning needs of the supervisee.
8. Describe at least one treatment based supervision model.
9. Identify at least two legal issues in clinical supervision.
10. Identify at least one ethical issue in clinical supervision.
11. Discuss at least two advantages regarding the use of technology in clinical supervision.
12. Explain at least one supervision practice associated with formative and restorative outcomes.
13. Describe at least one ethical consideration in relationship to online supervision of couples therapy.
14. Identify at least two methods in monitoring supervised performance.
15. Explain at least two characteristics of cultural humility.

Table of Contents

Course Disclaimer

The purpose of The Clinical Supervision 15 Hour/Unit CE Course is to provide a compendium of material that offers a general overview of information pertaining to clinical supervision for mental health professionals. The materials contained herein are intended to compile an overview of research and provide a comprehensive knowledge base for clinicians who wish to expand their knowledge in clinical supervision. This course is NOT all-inclusive or in sufficient detail to ensure success in certification/licensure exams but can be used as a resource to enhance overall understanding of clinical supervision. As an adjunct to previously received didactic and experiential training in clinical supervision, this course is also intended to assist the aspiring clinical supervisor in exploring concepts, theories, techniques and principles of this complex and dynamic undertaking. Care has been taken to confirm the accuracy of the information presented and to describe generally accepted science. However, the author, Aspira Continuing Education, editors and publishers are not responsible for errors or omissions or for any consequences from the application of the information presented in this course and make no warranty, express or implied, with respect to the contents of this publication.

1. Introduction to Clinical Supervision

Definitions of Clinical Supervision

The most prominent definitions of clinical supervision have many common elements, although their emphases may be somewhat different.

- Supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive (Powell & Brodsky).
- Supervision is an intervention provided by a senior member of a profession to a more junior member or members. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper of those who are to enter the particular professional (Bernard & Goodyear).
- Supervision is a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices(CSAT).
- Clinical supervision is an interpersonal tutorial relationship centered on the goals of skill development and professional growth via learning and practicing. Through observation, evaluation, and feedback, supervision enables the counselor to acquire the competence needed to deliver effective patient care while fulfilling professional responsibilities (Durham).
- Supervision is a process whereby a counselor with less experience learns how to better

provide services with the guidance of a counselor with more experience and skill. It is distinct from teaching in that the "curriculum" is individually determined by the supervisees and their clients (Bernard and Goodyear). Although there is some variation in the literature about the therapeutic nature of the supervisory relationship, based on the supervisor's theoretical orientation in the substance abuse field, it is generally agreed that supervision is not therapy for the counselor. In fact, a clear boundary must exist between supervision and counseling. Although the supervisee's behavior is under scrutiny, therapeutic interventions are provided for the purpose of improving the supervisee's ability to provide services, not for any broader reason (Bernard and Goodyear).

- ➡ According to the NASW, "…professional supervision is defined as the relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place. The supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency, and applicable ethical content in the practice setting. The supervisor and the supervisee both share responsibility for carrying out their role in this collaborative process. Supervision encompasses several interrelated functions and responsibilities…"
- ➡ According to the APA, "Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science- informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. Henceforth, supervision refers to clinical supervision and subsumes supervision conducted by all health service psychologists across the specialties of clinical, counseling, and school psychology." and furthermore, " Competency-based supervision is a metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/cultural clinical setting (adapted from Falender & Shafranske). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision."

(Source: American Psychological Association. Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from http://apa.org/about/policy/guidelines-supervision.pdf).

Advantages of Clinical Supervision

✓Clinical supervision is an essential part of professional practice and clinical programs.
✓Clinical supervision enhances staff retention and morale. Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision.
✓Clinical supervision needs the full support of agency administrators.
✓The supervisory relationship is the crucible in which ethical practice is developed and reinforced.
✓Clinical supervision is a skill that has to be developed.
✓Clinical supervision most often requires balancing administrative and clinical supervision tasks.
✓ Culture and other contextual variables influence the supervision process; supervisors

need to continually strive for cultural competence.
✓Successful implementation of evidence-based practices requires ongoing supervision.
✓Supervisors have the responsibility to be gatekeepers for the profession.
✓Clinical supervision is effective when it involves direct observation methods.

Clinical supervision is emerging as the crucible in which clinicians acquire knowledge and skills for the profession, providing a bridge between the classroom and practice. Supervision is to improve client care, develop the professionalism of clinical personnel, and impart and maintain ethical standards in the field. In recent years, clinical supervision has become the cornerstone of quality improvement and assurance.

Your role and skill set as a clinical supervisor are distinct from those of clinician and/or administrator. Quality clinical supervision is founded on a positive supervisor–supervisee relationship that promotes client welfare and the professional development of the supervisee. You are a teacher, coach, consultant, mentor, evaluator, and administrator; you provide support, encouragement, and education to clinicians while addressing an array of psychological, interpersonal, physical, and spiritual issues of clients. Ultimately, effective clinical supervision ensures that clients are competently served. Supervision ensures that counselors continue to increase their skills, which in turn increases treatment effectiveness, client retention, and staff satisfaction. The clinical supervisor may sometimes also serve as liaison between administrative and clinical staff.

The following focuses primarily on the teaching, coaching, consulting, and mentoring functions of clinical supervisors. Supervision is a profession in its own right, with its own theories, practices, and standards. The profession requires knowledgeable, competent, and skillful individuals who are appropriately credentialed both as counselors and supervisors.

According to the APA, "Although supervisor competency is assumed, little attention has been focused on the definition, assessment, or evaluation of supervisor competence (Bernard & Goodyear). This has diminished the perceived necessity for training in supervision. As Kitchener concluded, it has been much easier to identify the absence of competence than to define it. Articulating practices consistent with competent supervision ultimately facilitates the provision of quality services by supervisees and minimizes potential harm to supervisees and clients (Ellis et al.)".

(Source: American Psychological Association. Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from http://apa.org/about/policy/guidelines-supervision.pdf).

According to the APA, The *Guidelines on Supervision* are organized around seven domains including:

- Domain A: Supervisor Competence
- Domain B: Diversity

- Domain C: Supervisory Relationship
- Domain D: Professionalism
- Domain E: Assessment/ Evaluation/ Feedback
- Domain F: Problems of Professional Competence
- Domain G: Ethical, Legal, and Regulatory Considerations

Central Principles of Clinical Supervision

- **Clinical supervision is an essential part of all clinical programs.** Clinical supervision is a central organizing activity that integrates the program mission, goals, and treatment philosophy with clinical theory and evidence-based practices (EBPs). The primary reasons for clinical supervision are to ensure (1) quality client care, and (2) clinical staff continues professional development in a systematic and planned manner.

- **Clinical supervision enhances staff retention and morale.** Staff turnover and workforce development are major concerns in the substance abuse treatment field. Clinical supervision is a primary means of improving workforce retention and job satisfaction.

- **Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision.** Supervision needs to be tailored to the knowledge base, skills, experience, and assignment of each counselor. All staff needs supervision, but the frequency and intensity of the oversight and training will depend on the role, skill level, and competence of the individual. The benefits that come with years of experience are enhanced by quality clinical supervision.

- **Clinical supervision needs the full support of agency administrators.** Just as treatment programs want clients to be in an atmosphere of growth and openness to new ideas, counselors should be in an environment where learning and professional development and opportunities are valued and provided for all staff.

- **The supervisory relationship is the crucible in which ethical practice is developed and reinforced.** The supervisor needs to model sound ethical and legal practice in the supervisory relationship. This is where issues of ethical practice arise and can be addressed. This is where ethical practice is translated from a concept to a set of behaviors. Through supervision, clinicians can develop a process of ethical decision-making and use this process as they encounter new situations.

- **Clinical supervision is a skill in and of itself that has to be developed.** Good counselors tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors

need a different role orientation toward both program and client goals and a knowledge base to complement a new set of skills. Programs need to increase their capacity to develop good supervisors.

- **Clinical supervision most often requires balancing administrative and clinical supervision tasks.** Sometimes these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the roles to promote the efficacy of the clinical supervisor.

- **Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence.** Supervisors require cultural competence at several levels. Cultural competence involves the counselor's response to clients, the supervisor's response to counselors, and the program's response to the cultural needs of the diverse community it serves. Since supervisors are in a position to serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.
- **Successful implementation of EBPs requires ongoing supervision.** Supervisors have a role in determining which specific EBPs are relevant for an organization's clients (*Lindbloom, Ten Eyck, & Gallon*). Supervisors ensure that EBPs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring counselors. Excellence in clinical supervision should provide greater adherence to the EBP model. Because State funding agencies now often require substance abuse treatment organizations to provide EBPs, supervision becomes even more important.

- **Supervisors have the responsibility to be gatekeepers for the profession.** Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of clients. More than anyone else in an agency, supervisors can observe counselor behavior and respond promptly to potential problems, including counseling some individuals out of the field because they are ill-suited to the profession. This "gatekeeping" function is especially important for supervisors who act as field evaluators for practicum students prior to their entering the profession. Finally, supervisors also fulfill a gatekeeper role in performance evaluation and in providing formal recommendations to training institutions and credentialing bodies.

- **Clinical supervision effectively involves direct observation methods.** Direct observation should be the standard in the field because it is one of the most effective ways of building skills, monitoring counselor performance, and ensuring quality care. Supervisors require training in methods of direct observation, and administrators need to provide resources for implementing direct observation. Although small agencies might not have the resources for one-way mirrors or videotaping equipment, other direct observation methods can be employed (see the section on methods of observation).

Practical Issues in Clinical Supervision

Distinguishing Between Supervision and Therapy

Differences Between Supervision and Counseling

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

The boundary between counseling and clinical supervision may not always be clearly marked, for it is necessary, at times, to explore supervisees' limitations as they deliver services to their clients. Address clinicians' personal issues only in so far as they create barriers or affect their performance. When personal issues emerge, the key question you should ask the supervisee is,

	Clinical Supervision	Administrative Supervision	Counseling
Purpose	• Improved client care • Improved job performance	• Ensure compliance with agency and regulatory body's policies and procedures	• Personal growth • Behavior changes • Better self-understanding
Outcome	• Enhanced proficiency in knowledge, skills, and attitudes essential to effective job performance	• Consistent use of approved formats, policies, and procedures	• Open-ended, based on client needs
Timeframe	• Short-term and ongoing	• Short-term and ongoing	• Based on client needs
Agenda	• Based on agency mission and counselor needs	• Based on agency needs	• Based on client needs
Basic Process	• Teaching/learning specific skills, evaluating job performance, negotiating learning objectives	• Clarifying agency expectations, policies and procedures, ensuring compliance	• Behavioral, cognitive, and affective process including listening, exploring, teaching

Source: Adapted from Dixon, 2004

how does this affect the delivery of quality client care? What is the impact of this issue on the client? What resources are you using to resolve this issue outside of the counseling dyad? When personal issues emerge that might interfere with quality care, your role may be to transfer the case to a different clinician. Most importantly, you should make a strong case that the supervisee should seek outside counseling or therapy.

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

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

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

How is this client affecting you? What feelings does this client bring out in you? What is your behavior toward the client in response to these feelings? What is it about the substance abuse behavior of this client that brings out a response in you?

- ‣ What is happening now in your life, but more particularly between you and the client that might be contributing to these feelings, and how does this affect your counseling?
- ‣ In what ways can you address these issues in your counseling?
- ‣ What strategies and coping skills can assist you in your work with this client?

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

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

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

- ✓ The need for approval and acceptance as a knowledgeable and competent supervisor.
- ✓ Unresolved personal conflicts of the supervisor activated by the supervisory relationship.
- ✓ Reactions to individual supervisees, such as dislike or even disdain, whether the negative response is "legitimate" or not. In a similar vein, aggrandizing and idealizing some supervisees (again, whether or not warranted) in comparison to other supervisees.
- ✓ Sexual or romantic attraction to certain supervisees.

- ✓ Cultural countertransference, such as catering to or withdrawing from individuals of a specific cultural background in a way that hinders the professional development of the counselor.

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

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

Clinical Supervision Definitions Across Disciplines

Significant agreement exists across disciplines defining the components of clinical supervision (Bernard & Goodyear). The American Psychological Association Taskforce on Supervision Guidelines for Health Service Psychology studied the best practices and guidelines of multiple disciplines.

American Psychological Association
Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. (APA, p. 5)

NASW
Professional supervision is defined as the relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place. The supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency, and applicable ethical content in the practice setting. The supervisor and the supervisee both share responsibility for carrying out their role in this collaborative process. (NASW, Best Practice Standards in Social Work Supervision, p. 63. Functions, Methods and Techniques of a Clinical Supervisor)

- (b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries. • NASW Code of Ethics, 2021 • Analysis of Supervision for Social Work licensure (2019/2021) • Comprehensive set of competencies: knowledge, skills, and attitudes, for social work supervision towards licensure

AAMFT

MFT supervision is the process of evaluating, training, and providing oversight to trainees using relational or systemic approaches for the purpose of helping them attain systemic clinical skills. Supervision is provided to an MFT or MFT trainee …through live observation, face-to face contact, or visual/audio technology-assisted means as allowed in this handbook. When a supervisor candidate intends on receiving credit for supervisory experience toward the AS designation, he or she must be actively involved in the supervision; simply observing other supervision, although valuable, does not qualify toward requirements. Supervisors, supervisor mentors, and supervisor candidates must ensure that supervision using technology complies with the AAMFT Code of Ethics and applicable laws for ensuring privacy and security of confidential information. (AAMFT)

SAMSHA

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

2. Functions, Methods, and Techniques of a Clinical Supervisor

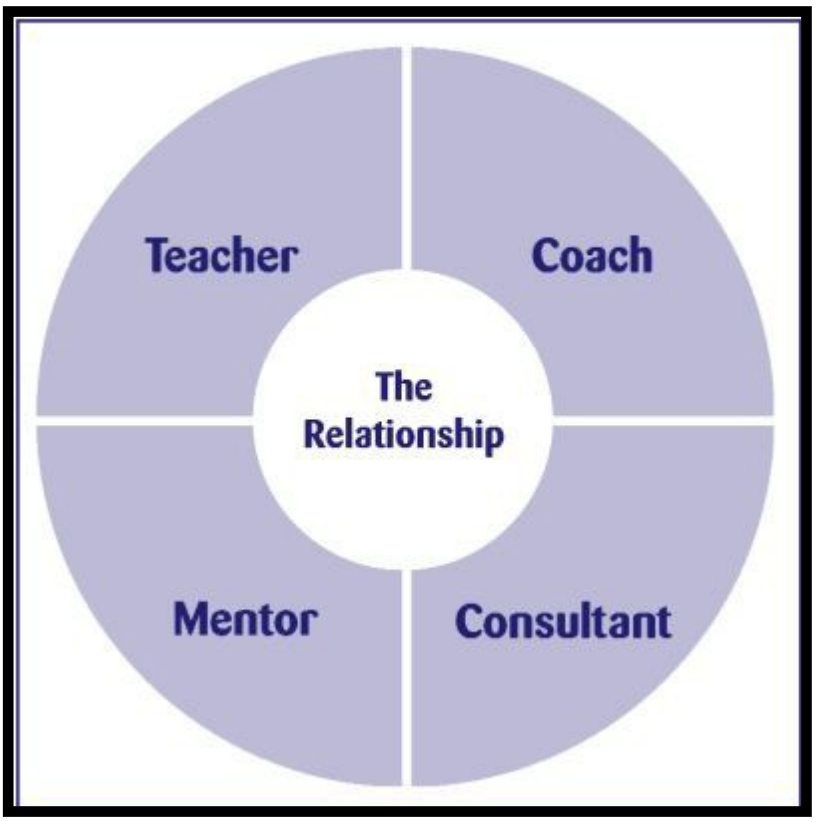
Quality clinical supervision is founded on a positive supervisor–supervisee relationship that promotes client welfare and the professional development of the supervisee. You are a teacher, coach, consultant, mentor, evaluator, and administrator; you provide support, encouragement, and education to staff while addressing an array of psychological, interpersonal, physical, and spiritual issues of clients. Ultimately, effective clinical supervision ensures that clients are competently served. Supervision ensures that supervisees continue to increase their skills, which in turn increases treatment effectiveness, client retention, and staff satisfaction. The clinical supervisor may also serve as liaison between administrative and clinical staff.

This section focuses primarily on the teaching, coaching, consulting, and mentoring functions of clinical supervisors. Supervision, like counseling, is a profession in its own right, with its own theories, practices, and standards. The profession requires knowledgeable, competent, and skillful

individuals who are appropriately credentialed both as clinicians and supervisors.

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

Roles of the Clinical Supervisor Figure 1



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

- ✓ **Teacher:** Assist in the development of counseling knowledge and skills by identifying learning needs, determining counselor strengths, promoting self-awareness, and transmitting knowledge for practical use and professional growth.

Supervisors are teachers, trainers, and professional role models.

- ✓ **Consultant: I**ncorporate the supervisory consulting role of case consultation and review, monitoring performance, counseling the counselor regarding job performance, and assessing counselors. In this role, supervisors also provide alternative case conceptualizations, oversight of counselor work to achieve mutually agreed upon goals, and professional gatekeeping for the organization and discipline (e.g., recognizing and addressing counselor impairment).
- ✓ **Coach:** In this supportive role, supervisors provide morale building, assess strengths and needs, suggest varying clinical approaches, model, cheerlead, and prevent burnout. For entry-level counselors, the supportive function is critical.
- ✓ **Mentor/Role Model:** The experienced supervisor mentors and teaches the supervisee through role modeling, facilitates the counselor's overall professional development and sense of professional identity, and trains the next generation of supervisors.

Central Principles of Clinical Supervision

This section highlights several principles of clinical supervision. Clinical supervision enhances the quality of client care; improves efficiency of clinicians in direct and indirect services; increases workforce satisfaction, professionalization, and retention; and ensures that services provided to the public uphold legal mandates and ethical standards of the profession.

The central principles discussed in this section are:

- **Clinical supervision is an essential part of all clinical programs.** Clinical supervision is a central organizing activity that integrates the program mission, goals, and treatment philosophy with clinical theory and evidence based practices (EBPs). The primary reasons for clinical supervision are to ensure (1) quality client care, and (2) clinical staff continue professional development in a systematic and planned manner.
- **Clinical supervision enhances staff retention and morale.** Staff turnover and workforce development can be significant factors in the mental health and social work fields. Clinical supervision is a primary means of improving workforce retention and job satisfaction.
- **Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision.** Supervision needs to be tailored to the knowledge base, skills, experience, and assignment of each counselor. All staff need supervision, but the frequency and intensity of the oversight and training will depend on the status, role, skill level, and competence of the individual. The benefits that come with years of experience are enhanced by quality clinical supervision.
- **Clinical supervision needs the full support of agency administrators.** Just as treatment programs want clients to be in an atmosphere of growth and openness to new ideas, clinicians should be in an environment where learning and professional development and opportunities are valued and provided for all staff.
- **The supervisory relationship is the crucible in which ethical practice is developed and reinforced.** The supervisor needs to model sound ethical and legal practice in the supervisory relationship. This is where issues of ethical practice arise and can be addressed. This is where

ethical practice is translated from a concept to a set of behaviors. Through supervision, clinicians can develop a process of ethical decision-making and use this process as they encounter new situations.

- **Clinical supervision is a skill in and of itself that has to be developed.** Good clinicians tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client goals and a knowledge base to complement a new set of skills. Programs need to increase their capacity to develop good supervisors.
- **Clinical supervision in mental health treatment most often requires balancing administrative and clinical supervision tasks.** Sometimes these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the roles to promote the efficacy of the clinical supervisor.
- **Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence.** Supervisors require cultural competence at several levels. Cultural competence involves the counselor's response to clients, the supervisor's response to counselors, and the program's response to the cultural needs of the diverse community it serves. Since supervisors are in a position to serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.
- **Successful implementation of EBPs requires ongoing supervision.** Supervisors have a role in determining which specific EBPs are relevant for an organization's clients (Lindbloom, Ten Eyck, & Gallon). Supervisors ensure that EBPs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring clinicians. Excellence in clinical supervision should provide greater adherence to the EBP model.
- **Supervisors have the responsibility to be gatekeepers for the profession.** Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of clients. More than anyone else in any organization, supervisors can observe clinician behavior and respond promptly to potential problems. This "gatekeeping" function is especially important for supervisors who act as field evaluators for practicum students prior to their entering the profession. Finally, supervisors also fulfill a gatekeeper role in performance evaluation and in providing formal recommendations to training institutions.
- **Clinical supervision should involve direct observation methods.** Direct observation is important in the field because it is one of the most effective ways of building skills, monitoring clinical performance, and ensuring quality care. Supervisors require training in methods of direct observation, and administrators need to provide resources for implementing direct observation.

Guidelines for New Supervisors

Congratulations on your appointment as a supervisor! By now you might be asking yourself a few questions: What have I done? Was this a good career decision? There are many changes ahead. If you have been promoted from within, you'll encounter even more hurdles and issues. First, it is important to face that your life has changed. You might experience the loss of friendship of peers. You might feel that you knew what to do as a clinician, but feel totally lost with your new responsibilities. You might feel less effective in your new role. Supervision can be an emotionally

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

Suggestions for new supervisors:

- Quickly learn the organization's policies and procedures and human resources procedures (e.g., hiring and firing, affirmative action requirements, format for conducting meetings, giving feedback, and making evaluations). Seek out this information as soon as possible through the human resources department or other resources within the organization.
- Ask for a period of 3 months to allow you to learn about your new role. Use this time to find your managerial voice and decisionmaking style.
- Take time to learn about your supervisees, their career goals, interests, developmental objectives, and perceived strengths.
- Work to establish a contractual relationship with supervisees, with clear goals and methods of supervision.
- Learn methods to help staff reduce stress, address competing priorities, resolve staff conflict, and other issues in the workplace.
- Obtain training in supervisory procedures and methods.
- Find a mentor, either internal or external to the organization.
- Shadow a supervisor you respect who can help you learn the ropes of your new job.
- Ask for regular, weekly meetings with your administrator for training and instruction.
- Seek supervision of your supervision.

Problems and Resources

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

Working With Staff Who Are Resistant to Supervision

Some of your supervisees may have been in the field longer than you have and see no need for supervision. Other clinicians, having completed their graduate training, do not believe they need

further supervision, especially not from a supervisor who might have less formal academic education than they have. Other resistance might come from ageism, sexism, racism, or classism.

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

When clinicians respond defensively or reject directions from you, try to understand the origins of their defensiveness and to address their resistance. Self-disclosure by the supervisor about experiences as a supervisee, when appropriately used, may be helpful in dealing with defensive, anxious, fearful, or resistant staff. Work to establish a healthy, positive supervisory alliance with staff. Because clinicians have not been exposed to clinical supervision, you may need to train and orient the staff to the concept and why it is important for your organization.

Things a New Supervisor Should Know

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

1. The reason for supervision is to ensure quality client care. As stated throughout this section, the primary goal of clinical supervision is to protect the welfare of the client and ensure the integrity of clinical services.

2. Supervision is all about the relationship. As in counseling, developing the alliance between the clinician and the supervisor is the key to good supervision.

3. Culture and ethics influence all supervisory interactions. Contextual factors, culture, race, and ethnicity all affect the nature of the supervisory relationship. Some models of supervision (e.g., Holloway) have been built primarily around the role of context and culture in shaping supervision.

4. Be human and have a sense of humor. As role models, you need to show that everyone makes mistakes and can admit to and learn from these mistakes.

5. Rely on direct observation of your supervisees and give specific feedback. One of the best ways to determine a clinician's skills is to observe him or her.

6. Have and practice a model of supervision; have a sense of purpose. Before you can teach a supervisee knowledge and skills, you must first know the philosophical and theoretical foundations on which you, as a supervisor, stand. Supervises need to know what they are going to learn from you, based on your model of counseling and supervision.

7. Make time to take care of yourself spiritually, emotionally, mentally, and physically. Again, as role models, superviseess are watching your behavior. Do you "walk the talk" of self-care?

8. You have a unique position as an advocate for the organization, the supervised, and the client. As a supervisor, you have a wonderful opportunity to assist in the skill and professional development of your staff, advocating for the best interests of the supervisee, the client, and your organization.

Models of Clinical Supervision

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

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

Competency-based models (e.g., micro-training, the Discrimination Model, and the Task-Oriented Model) focus primarily on the skills and learning needs of the supervisee and on setting goals that are **s**pecific, **m**easurable, **a**ttainable, **r**ealistic, and **t**imely (SMART). They construct and implement strategies to accomplish these goals. The key strategies of competency-based models include applying social learning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using various supervisory functions (teaching, consulting, and counseling).

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

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

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

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

➡ Explicitly addressing diversity of supervisees (e.g., race, ethnicity, gender, age, sexual orientation) and the specific factors associated with these types of diversity;

➡ Explicitly involving supervisees' concerns related to particular client diversity (e.g., those whose culture, gender, sexual orientation, and other attributes differ from those of the supervisee) and addressing specific factors associated with these types of diversity; and

➡ Explicitly addressing supervisees' issues related to effectively navigating services in intercultural communities and effectively networking with agencies and institutions.

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

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

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

✓ Rooted in the individual, beginning with the supervisor's self, style, and approach to leadership.

✓ Precise, clear, and consistent.

✓ Comprehensive, using current scientific and evidence-based practices.

✓ Operational and practical, providing specific concepts and practices in clear, useful, and measurable terms.

✓ Outcome-oriented to improve counselor competence; make work manageable; create a sense of mastery and growth for the counselor; and address the needs of the organization, the supervisor, the supervisee, and the client.

Finally, it is imperative to recognize that, whatever model you adopt, it needs to be rooted in the learning and developmental needs of the supervisee, the specific needs of the clients they serve, the goals of the agency in which you work, and in the ethical and legal boundaries of practice.

These four variables define the context in which effective supervision can take place.

Developmental Stages of Clinicians

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

This schema uses a three-stage approach. The three stages of development have different characteristics and appropriate supervisory methods. Further application of the IDM to the substance abuse field is needed.

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

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

Dev·elopm:enta,l bevel	Characte,riistics	Jo Inerease 'Supervision Competence
Level 1	• Is anxious regarding role • Is na'i\Je about a uming the role ofupervisor • Is focused on doing the "rrigh "thing • May overly rre-:spond as anexpert" • Is uncomfortable providing direct feedback	• Follow structure and formats • Design system,s to increa-se organi:zatiori o"f supervision • Assign Level I rnun!.elors
Level 2:	• Shows confu fon and conflict • Sees supervision as complex and multidimen• im,al • Needs support to maintain motivation • Overfocused on wunselo:r's deficits and per-c;eiv@d n11sistanc@ • May fall back to being a the.rapist with the counsellor	• Provide e.upervis.ion of the supervi-activ si,on • Assign Level 1 counselors
Level, 3	• Is highly mo ivated • Can prnvid@an honest self-appraisal of t!l'engths and weakne"Scses au. pervisor • Is comfortable with evaluation process • Provides thorough, obj€!rtivl1!fo@db11dc	• Comfortable with all levels

Source: Stoltenberg, Delworth, & Mr::11/eil, 1998

Developmental Level	Characteristics	Supervision Skills Development Needs	Techniques
Level 1	• Focuses on self • Anxious, uncertain • Preoccupied with performing the right way • Overconfident of skills • Overgeneralizes • Overuses a skill • Gap between conceptualization, goals, and interventions • Ethics underdeveloped	• Provide structure and minimize anxiety • Supportive, address strengths first, then weaknesses • Suggest approaches • Start connecting theory to treatment	• Observation • Skills training • Role playing • Readings • Group supervision • Closely monitor clients
Level 2	• Focuses less on self and more on client • Confused, frustrated with complexity of counseling • Overidentifies with client • Challenges authority • Lacks integration with theoretical base • Overburdened • Ethics better understood	• Less structure provided, more autonomy encouraged • Supportive • Periodic suggestion of approaches • Confront discrepancies • Introduce more alternative views • Process comments, highlight countertransference • Affective reactions to client and/or supervisor	• Observation • Role playing • Interpret dynamics • Group supervision • Reading
Level 3	• Focuses intently on client • High degree of empathic skill • Objective third person perspective • Integrative thinking and approach • Highly responsible and ethical counselor	• Supervisee directed • Focus on personal-professional integration and career • Supportive • Change agent	• Peer supervision • Group supervision • Reading

Source: Stoltenberg, Delworth, & McNeil, 1998

	Description	Advantages	Disadvantages
Case Consultation/ Case Management	Discussion of cases Brief case reviews	• Helps organize information, conceptualize problems, and decide on clinical interventions • Examines issues (e.g., cross-cultural issues), integrates theory and technique, and promotes greater self-awareness • An essential component of treatment planning	• The validity of self-report is dependent on counselor developmental level and the supervisor's insightfulness • Does not reflect broad range of clinical skills of the counselor
Direct Observation	The supervisor watches the session and may provide periodic but limited comments and/or suggestions to the clinician	• Allows teaching of basic skills while protecting quality of care • Counselor can see and experience positive change in session direction in the moment • Allows supervisor to intervene when needed to protect the welfare of the client, if the session is not effective or is destructive to the client	• May create anxiety • Requires supervisor caution in intervening so as to not take over the session or to create undue dependence for the counselor or client • Can be seen as intrusive to the clinical process • Time consuming
Audiotaping	Audiotaping and review of a counseling session	• Technically easy and inexpensive • Can explore general rapport, pace, and interventions • Examines important relationship issues • Unobtrusive medium • Can be listened to in clinical or team meetings	• Counselor may feel anxious • Misses nonverbal cues • Poor sound quality often occurs due to limits of technology
Videotaping	Videotaping and review of a counseling session	• A rich medium to review verbal and nonverbal information • Provides documentation of clinical skills • Can be viewed by the treatment team during group clinical supervision session • Uses time efficiently • Can be used in conjunction with direct observation • Can be used to suggest different interventions • Allows for review of content, affective and cognitive aspects, process relationship issues in the present	• Can be seen as intrusive to the clinical process • Counselor may feel anxious and self-conscious, although this subsides with experience • Technically more complicated • Requires training before using • Can become part of the clinical record and can be subpoenaed (should be destroyed after review)

	Description	Advantages	Disadvantages
Webcam	Internet supervision, synchronistic and asynchronistic Teleconferencing	• Can be accessed from any computer • Especially useful for remote and satellite facilities and locations • Uses time efficiently • Modest installation and operation costs • Can be stored or downloaded on a variety of media, watched in any office, then erased	• Concerns about anonymity and confidentiality • Can be viewed as invasive to the clinical process • May increase client or counselor anxiety or self-consciousness • Technically more complicated • Requires assurance that downloads will be erased and unavailable to unauthorized staff
Cofacilitation and Modeling	Supervisor and counselor jointly run a counseling session Supervisor demonstrates a specific technique while the counselor observes This may be followed by roleplay with the counselor practicing the skill with time to process learning and application	• Allows the supervisor to model techniques while observing the counselor • Can be useful to the client ("two counselors for the price of one") • Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning • Counselor sees how the supervisor might respond • Supervisor incrementally shapes the counselor's skill acquisition and monitors skill mastery • Allows supervisor to aid counselor with difficult clients	• Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning • The client may perceive counselor as less skilled than the supervisor • Time consuming
Role Playing	Role play a clinical situation	• Enlivens the learning process • Provides the supervisor with direct observation of skills • Helps counselor gain a different perspective • Creates a safe environment for the counselor to try new skills	• Counselor can be anxious • Supervisor must be mindful of not overwhelming the counselor with information

Source: Adapted from Mattel, 2007.

Clinicians at an advanced developmental level have different learning needs and require different supervisory approaches from those at Level 1;

✦The developmental level can be applied for different aspects of a clinicians overall competence (e.g., Level 2 mastery for individual counseling and Level 1 for couples counseling).

Developmental Stages of Supervisors

Supervisor Developmental Model

A number of methods and techniques are available for clinical supervision, regardless of the modality used. Methods include (as discussed previously) case consultation, written activities such as verbatims and process recordings, audio and videotaping, and live observation. Techniques include modeling, skill demonstrations, and role playing. (See descriptions of these and other methods and techniques in *Bernard & Goodyear,; Borders & Brown,; Campbell,; and Powell & Brodsky.*) outlines some of the methods and techniques of supervision, as well as the advantages and disadvantages of each method. The context in which supervision is provided affects how it is carried out. A critical issue is how to manage your supervisory workload and make a reasonable effort to supervise. The contextual issues that shape the techniques and methods of supervision include:

➡ The allocation of time for supervision. If the 20:1 rule of client hours to supervision time is followed, you will want to allocate sufficient time for supervision each week so that it is a high priority, regularly scheduled activity.

➡ The unique conditions, limitations, and requirements of the agency. Some organizations may lack the physical facilities or hardware to use videotaping or to observe sessions. Some organizations may be limited by confidentiality requirements, such as working within a criminal justice system where taping may be prohibited.

➡ The number of supervisees reporting to a supervisor. It is difficult to provide the scope of supervision discussed in this document if a supervisor has more than ten supervisees. In such a case, another supervisor could be named or peer supervision could be used for advanced staff.

➡Clinical and management responsibilities of a supervisor. Supervisors have varied responsibilities, including administrative tasks, limiting the amount of time available for clinical supervision.

The following are resources for supervision:

✳ Code of Ethics from the Association of Addictions Professionals (NAADAC; http://naadac.org).

✳ International Certification & Reciprocity Consortium's Code of Ethics (http://www.icrcaoda.org).

✳ Codes of ethics from professional groups such as the AmericanAssociation for Marriage and Family Therapy (http://www.aamft.org), the American Counseling Association (http://www.counseling.org), the Association for Counselor Education and Supervision (http://www.acesonline.net), the

✳ American PsychologicalAssociation (http://www.apa.org), the National Association of Social Workers (http://www.socialworkers.org), and the National Board for Certified Counselors (NBCC; http://www.nbcc.org).

✳ ACES Standards for Counseling Supervisors; ACES Ethical Guidelines for Counseling Supervisors (http://www.acesonline.net/ethical_guidelines.asp); and NBCC Standards for the

Ethical Practice of Clinical Supervision.

Barriers to Implementing Clinical Supervision

- Managers place a low priority on supervision or lack the time and energy to develop a program.
- Counselors place a low priority on supervision or lack the time to participate in developing a program.
- Supervisors lack adequate training to perform this job well.
- Too few individuals are adequately qualified and available.
- The roles of clinical and administrative staff are blurred, creating conflict.
- A common language and conceptual framework is lacking among supervisors, supervisees, and administrators.
- Funding is scarce; resources need to be used directly for client care.
- The belief that when the supervisor and supervisee are of different cultures, the practical benefits of clinical supervision may be limited.
- The belief that to express a need for clinical supervision indicates an inability to do the job. (Source: Roche, Todd, & O'Connor, p. 244; Powell & Brodsky)

Research on these issues is extremely complex, which has prevented many from undertaking it. Efficacy studies are now accepted as the standard of evidence-based practices, but clinical supervision does not easily lend itself to this type of study. For the most part, it is not prescriptive, standardized, or manualized. Differences among supervisors are enormous. Criteria for effectiveness and client outcomes are elusive, and comparisons are difficult, if not impossible to make (*Bernard & Goodyear)*.

Models and Developmental Stages of Clinical Supervision

It makes intuitive sense that supervisors and clinicians progress through what could be described as stages as they become more expert in their fields. Developmental clinical models are not new. The Integrated Developmental Model (IDM) was developed by *Stoltenberg, McNeil, and Delworth* and is perhaps the best known approach of several developmental models, which assume that a clinician matures and becomes more self-confident and skilled over time. With experience, the clinician undergoes a shift in awareness from self ("how am I doing?") to client ("how is the client feeling?") and from dependence ("what should I do in this case?") to autonomy ("how is the therapeutic relationship progressing?"). Effective supervision should be matched to the counselor's developmental level and therefore use different techniques at different times.

Level 1 clinicians are new to the field, highly motivated, and highly anxious. Supervision for these people should include direct observation, skills training, and support. According to *Stoltenberg, McNeill, and Delworth*, a clinician with 1–5 years of experience in the field might be expected to be in Level 1. Level 2 clinicians have 6–9 years' experience and are able to show empathy toward their clients, but have uneven success in practicing their skills (they are usually

aware of this. In supervision, they need support, empathy, and constructive feedback but are ready to begin processing personal issues, such as self-awareness and defensiveness. At Level 3, clinicians are fairly autonomous and have gained professional identity. They typically have been in the field for more than 10 years and have a high level of insight into their functioning. They benefit from supervision that is more collegial and can discuss the supervisor—supervisee relationship and countertransference. Stoltenberg et al. also indicates that supervisors go through similar stages of development, from Levels 1–3, over the course of their career.

In their review, Falender and Shafranske conclude that while developmental models are appealing, there is no empirical support for them. However, it makes sense to conclude that individuals can learn to become better supervisors and that in the process, they become increasingly confident and less dependent on more experienced supervisors.

To reiterate the above statement, *Watkins*, among others, has proposed that supervisors similarly progress through stages as they become more competent, autonomous, identified with their role as supervisors, and self-aware. They begin in "role shock" and progress through role recovery/ transition and role consolidation to role mastery. As their experience grows, they come to have greater confidence in their supervisory skills; more insight about their effect on supervisees; a clearer, more integrated theoretical basis for their supervisory style, and a consolidated, well-elaborated sense of professional identity *(Bernard & Goodyear, Campbell, Watkins).*

Psychotherapy-based or philosophically based models provide an excellent opportunity for supervisors to model the behaviors they wish to teach. They have been developed for the major theoretical orientations of therapists, including cognitive–behavioral, psychodynamic, psychoanalytic, and client-centered approaches. Most models begin with a specific psychotherapeutic model or philosophy of treatment, especially in the marriage and family therapy field. It has been estimated that 90 percent of the literature on clinical supervision grows out of a specific psychotherapeutic model.

Discrimination models or social role models attempt to identify the variety of roles the supervisor assumes and the supervisory foci that are addressed under each role (*Bernard & Goodyear*). The roles used most frequently by theorists are teacher, counselor, and consultant. They also include monitor, evaluator, therapist, facilitator, and administrator. The foci in Bernard and Goodyear's **Discrimination Model** are intervention, conceptualization, and personalization. Others foci include counseling skill, professional role, emotional awareness, supervisory relationship, and therapist's process. Although social role models may provide a useful tool for supervisors, empirical evidence does not support their "adequacy," according to Falender and Shafranske. However, the Discrimination Model is especially valuable to supervisors to differentiate what role they are adopting at a particular time in supervision, and with individual supervisees. Variations on the Discrimination Model are the **Competency-Based Approach** (*Falender & Shafransky*), the **Contextual Model** (*Holloway*), the **Task-Oriented Model** (*Mead*) and the **Interactional Model** (*Shulman)*.

The Blended Model (*Powell & Brodsky*) is the only model specific to substance abuse counseling supervisors. The model has a number of essential elements:

- Self. Each supervisor develops an idiosyncratic style of supervision, largely based upon his or her personality profile and model of counseling.
- Philosophy of counseling. Supervisors articulate their philosophy or model of

counseling, describing what they do in counseling, what models and techniques they use, and at what times and/or circumstances.

- Descriptive dimension. The blended model uses a version of Bascue and Yalof's Descriptive Dimensions.
- Stages of clinician development. This model adapts the IDM model of Stoltenberg et al. and other developmental approaches to clinical supervision.
- Contextual factors. The blended model uses the work of Holloway and other contextual models of clinical supervision, addressing factors affecting supervision, such as age, race, gender, ethnicity, recovery–non-recovery, disciplines, academic background, and the like.
- Affective–behavioral axis. The model views supervision along a continuum, blending affective and behavioral changes for the counselor in supervision.
- Spiritual dimensions. In addition to addressing cognitive, skills, affective, and latent issues in supervision, a supervisor may address "spiritual" issues. The first four components aid a counselor in understanding "how" to counsel. The spiritual dimension focuses on "why" issues: why a counselor does what he or she does.

Modalities of Supervision

Individual supervision is, historically, the typical modality of supervision most clinicians receive. It provides the supervisor the opportunity to develop a closer relationship with the supervisee and to tailor the process to the unique needs of that person. Several formats are possible in individual supervision. Live supervision includes bug-in-the-ear (where the supervisor provides feedback via an earphone in the supervisee's ear), phone-ins, and consultation breaks. Each method is distracting to one degree or another (*Bernard & Goodyear*). Co-facilitation, where the supervisor sits in on the individual or group session led by the supervisee, allows the supervisor to share the experience of the group. In this format, the supervisor can intervene directly if the session become counter-therapeutic (*Powell & Brodsky*). For many counselors, possession debriefing is common. The supervisee brings a case or a problem that arose during a session to the supervisory session for discussion. This type of self-report, although convenient, is problematic, particularly for inexperienced counselors who may miss important details and nuances in a clinical situation (*Bernard & Goodyear, Powell & Brodsky*).

The advantages of individual supervision are that confidentiality can be better preserved, counselors may feel more safe and comfortable in a one-on-one experience, individual needs can be better addressed, and greater depth and honesty may be established. The disadvantages of individual supervision are that it is time consuming and therefore expensive, particularly if a supervisor has several supervisees. It also increases opportunities for miscommunication among staff, and does not provide counselors with opportunities to learn from each other.

Distance supervision (individual and group), by telephone or email has also been used. A current, and largely unmonitored and regulated system is cyber supervision, where the supervisor observes a counseling session through the Internet. A number of States have cyber supervision programs in place. Key issues about this medium remain to be addressed: confidentiality of information, scrutiny and oversight by regulatory bodies, credentialing of cyber supervisors, and other legal and ethical concerns (*Derrig-Palumbo & Seine, Powell, Kraus, Zack, & Stricker*).

Group, dyadic, and triadic supervision, in which two or more supervisees meet with a supervisor, is widely used with counselors. The advantages of group supervision are similar to those of group therapy. The primary advantage is that it saves time and money; more counselors can receive supervision with less time spent. The group can provide feedback to supervisees from a variety of perspectives and the team can learn from each other. Dependence on the supervisor is lessened in group supervision, while supervisees enjoy mutual support and have greater opportunities for learning (*Bernard & Goodyear*). These modalities furnish more opportunities for team-building, role-playing, and simulations (*Powell & Brodsky*). On the other hand, individual supervisees may not get what they need in a group, and shame and embarrassment can result from self-disclosure to peers. Supervisors have to be attuned to group process and dynamics. Competitive, challenging behavior can occur between peers. However, for substance abuse supervision, group seems to be an ideal medium to maximize the limited time available for clinical supervision (*Powell & Brodsky*).

Research has generally supported the effectiveness of group supervision (e.g., *Wilbur, Wilbur-Roberts, Hart, Morris, & Betz)*. In tracking a six-person group, interviews by Christiansen and Kline indicate that group processes operate in this modality. "Participation anxiety" related to group members' perceptions of risk changed qualitatively as the group matured. Over time, group members came to recognize the anxiety as a helpful motivator to their learning. Trust increased, and feedback was perceived as less evaluative and more informative.

Several surveys show a limited preference among supervisees for individual supervision. No studies of counselors' preferences for one modality were found in *Eby et al.'s* research. Ray and Altekruse compared four modalities of supervision used with master's level counseling students. Eighty-one percent ranked individual supervision the most or second most helpful experience, while 45 percent ranked group supervision equally highly. Newgent, Davis, and Farley compared group, individual, and triadic (supervisor and two supervisees) modalities of supervision for doctoral-level counselor education students (n = 15). These students preferred individual supervision in terms of their satisfaction, their perception of its effectiveness, and their belief that it better met their needs. Again, the data are sparse, with relatively small sample sizes not specific to the substance abuse field.

Supervisory Styles and Contributing Factors

Supervisory styles have been categorized into three main types (*Friedlander & Ward*), as shown below. The categories have little research to support the differentiation and/or effectiveness of supervisory styles.

Fernando and Hulse-Killacky's survey of master's level counseling students indicated that both attractive and interpersonally sensitive styles contribute to supervisees' satisfaction with supervision, and the task-oriented style contributes to their self-efficacy.

Supervisors' self-disclosure is often used in clinical supervision, but differently with different supervision styles (*Ladany & Lehrman-Waterman*). Supervisors who use the attractive style are more likely to self-disclose in general and specifically to relate neutral counseling experiences. Those who use the interpersonally sensitive style disclose fewer neutral counseling experiences. Supervisors' perception of their style is related to the perception of their supervisory working alliance (*Ladany, Walker, & Melincoff*). The supervisors who saw themselves as more self-

disclosing were more likely to use attractive and interpersonally sensitive styles and have a stronger emotional bond in supervision. Those who used a task-oriented style were likely to have a mutual agreement on the tasks of supervision with their supervisees.

The appropriate supervisory style may be based on the counselor's level of experience (*Stoltenberg et al.)*. Level 1 clinicians may likely need more practical information and work on clinical skills (task-oriented style). Level 2 and 3 clinicians, who may be dealing with complex counter-transferential issues, for example, might benefit from an interpersonally sensitive style (*Powell & Brodsky*). Supervisory styles are also related to the supervisor's theoretical orientation, with interpersonal sensitivity more characteristic of supervisors with a psychodynamic orientation and task orientation being related to cognitive–behavioral orientation (*Friedlander & Ward*).

Category	Role	Description
Attractive	Consult	• Open • Warm • Friendly • Flexible • Supportive
Interpersonally sensitive	Clinician	• Invested • Therapeutic • Committed • Perceptive
Task oriented	Teacher	• Goal oriented • Practical • Focused • Structured

(Source: Friedlander & Ward)

Categories of Supervisory Style

Finally, in a survey of supervisors of clinicians, no gender differences were found for how supervisors report working with male and female supervisees (*Reeves, Culbreth, & Greene*). Supervisors under age 50 were less likely than those over 50 to decide on the topics discussed in supervision, less likely to require adherence by supervisees to directives, and more comfortable in self-disclosure. Certified clinical supervisors were more likely to use the attractive and interpersonally sensitive styles than the task-oriented style. Younger supervisors and those with

more education appeared to be more flexible in supervision (*Reeves et al*).

Cross-Cultural Supervision

One's culture is generally viewed as a strength that, during treatment or supervision, should be validated (*Garcia*). Clinical supervision must address gender, racial, ethnic, and cultural concerns. Particularly when the client and counselor (or counselor and supervisor) are of different cultures, this disparity can have a significant impact on the therapeutic alliance and the effects of treatment (*Holloway*). Supervisors can have a positive effect on their supervisees by providing a climate in which discussion of these issues is encouraged and by modeling appropriate behaviors. Some of the skills included in cultural competence include "awareness, openness, and sincere attention to cultural and racial factors, guidance and explicit discussion of culture-specific issues, being vulnerable and sharing [supervisors'] own struggles, and providing opportunities for multicultural activities" (*Inman, Borders and Brown*). Supervisors have a responsibility to initiate discussions on:

- Their own cultural background and that of the supervisee.
- The ways the values and traditions of the culture can affect counseling and supervision expectations and goals.
- Their own multicultural strengths and weaknesses and those of the supervisee.
- Racial identity models described in the literature.
- The ways their level of racial or cultural identity influence their counseling or supervising (*Daniels, D'Andrea, Kim, & So*).

Racial, ethnic, and cultural issues will arise when supervisor and supervisee are of different cultures. Whether the supervisor is responsive to these concerns or not can make a difference in the quality of the supervisory relationship. One group of researchers defined cultural responsiveness in supervision as: "Responses that acknowledge the existence of, show interest in, demonstrate knowledge of, and express appreciation for the client's and supervisee's ethnicity and culture and that place the client's and supervisee's problem in a cultural context" (*Burkard, Johnson, Madson, Pruitt, Contreras-Tadych, et al*.).

Using consensual qualitative research, Burkard et al. examined culturally responsive and unresponsive events that occurred in supervision with culturally mismatched dyads. European American supervisees and supervisees of color had generally positive reactions to the supervisors' culturally responsive events and felt their supervisory relationship improved afterward. In events that left negative feelings, supervisors of color avoided discussing cultural concerns with their European American supervisees. Supervisees of color, in contrast, reported that their European American supervisors actively dismissed their cultural concerns. Both groups expressed negative feelings as a result of these events, including anger, frustration, and disappointment (*Burkard et al.)*.

Legal and Ethical Issues in Supervision

In today's environment, legal and ethical issues in supervision, as in counseling, have become more numerous and complex. Clinical supervisors have an obligation to know the relevant State laws that apply to their practice and to ensure that their supervisees also have this knowledge.

Malpractice and liability claims related to clinical supervision include cases involving situations where supervisors failed in their duty to properly supervise counselors and oversee cases. Legal issues include vicarious liability, by which a supervisor is responsible for the supervisee's behavior; duty to warn and to protect, which for substance abuse counselors involves supervisory guidance; and malpractice. A good defense against malpractice is consultation with colleagues and documentation of when supervisory sessions took place and what was discussed (*Powell & Brodsky)*. Thorough discussions of legal issues are in most supervision texts (*Falvey, Reamer*).

Supervisors of clinicians need to be familiar with their respective code of ethics. ACA's Code of Ethics, Section F, Supervision, Training and Teaching, and for Supervisor's of Substance Abuse Counselors, the Codes of Ethics of National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the codes of ethics of the applicable certification boards for the counselors they supervise is one example.

Ethical issues for supervisors, as for clinicians, vary. Supervisors are responsible for adherence to their own discipline's code of ethics and for ensuring that their supervisees adhere to theirs.

Dual relationships occur when a supervisor has a second relationship with a supervisee, such as a social, financial, business, or workplace relationship. "Sexual or romantic interactions or relationships with current supervisees are prohibited" according to the ACA Code of Ethics *(see also Falvey*).

Boundary violations are a type of dual relationship. They can occur in the structure of the supervisory relationship (e.g., having a supervisory session in one's living room or during dinner in a restaurant) or in its process (e.g., giving gifts, physical contact). A number of studies of the frequency of sexual misconduct in supervision have been conducted. Between 1.4 and 4.0 percent of supervisors have had sexual relationships with their supervisees (*Falender & Shafranske*). Some boundary issues are clear; others are difficult to resolve.

The client must give **informed consent** for the clinician to discuss his or her case with the supervisor. Bernard and Goodyear suggested that informed consent should occur at three levels: client consent to treatment, client consent to supervision of their case, and supervisee consent to supervision. (For a detailed explanation of these three levels, see Falvey.)

Supervisor confidentiality is analogous to counselor confidentiality, which must be maintained unless clearly defined circumstances demand disclosure to protect the welfare of the client or the public at large. Supervisors must know the limits of confidentiality, at both State and Federal levels.

Over half the psychotherapy interns in one study reported at least one ethical violation by their supervisor (*Ladany, Lehrman-Waterman, Molinaro, & Wolgast*). The most common were inadequate performance evaluation, breach of confidentiality, and inability to work with alternative perspectives. The existence of these perceived violations was associated with a weaker supervisory relationship and lower satisfaction.

Several models for resolving ethical dilemmas are suggested by Falender and Shafranske. (See also Falvey, *Clinical Supervision: Ethical Practice and Legal Risk Management,* and Reamer, *Tangled Relationships: Managing Boundary Issues in the Human Services).*

Supervision contracts or agreements are generally recommended. Besides listing the basics, including the frequency, length of sessions, and length of the course of supervision, the agreement should specify the modality and approaches to be used, along with the duties and responsibilities of all parties (*Bernard & Goodyear, Campbell, Northwest Frontier ATTC*).

Supervisor Training and Supervision

Training of supervisors has become a significant concern at the State and Federal level, with increasing attention given, especially with the advent of credentialing requirements for certified clinical supervisors. A number of training models are available. An Internet search will indicate resources in addition to the following:

- Northwest Frontier ATTC, Clinical Supervision: Building Chemical Dependency Counselor Skills.
- New England ATTC, Evidence-Based Practices and Clinical Supervision.
- Mid-Atlantic ATTC, Motivational Interviewing and Clinical Supervision.

What makes a good course in supervision? When seeking training in supervision, look for the course that:

- Fulfills the training hours for credentialing as a certified clinical supervisor.
- Is approved by the State credentialing body.
- Is specific to clinical supervision
- Provides formal training in supervisory theory and techniques as well as a period of supervised supervision of others.
- Is both didactic and experiential, with ample opportunities for skill building and practice.
- Addresses specific, job-related concerns and issues of the trainees.

Administrative Issues in Supervision

Organizational support for supervision is essential to instilling the belief that clinical supervision is key to staff retention and workforce development. Strategies for reducing the costs involved in a supervision program include agreements with other agencies, using retired supervisors interested in part-time employment, and group supervision (Roche, Todd, & O'Connor).

Other key organizational issues include how certain organizational models and styles of management influence the process of clinical supervision and how organizational receptivity to supervision affects the outcome and effectiveness of clinical supervision. Although little research has been conducted on these issues, they remain key factors that influence the adoption of clinical supervision within an organization.

Elements in a Supervision Policy

Element	Description	Example
Why supervision?	An explanation of the importance of supervision in this workplace	Supervision improves clinical practice, supports treatment staff, and can help improve client outcomes
Policy	What the organization is committed to delivering	All staff who have direct contact with clients will have access to individual or group supervision
Purpose	An overall purpose describing the supervision program's direction	Clinical supervision promotes high quality clinical practice, professional standards, and competencies
Outcomes	The standards the organization would like to achieve in supervision	All supervision is provided by qualified and experienced practitioners; the quality of clinical practice and the professional needs of staff are identified and monitored
Evaluation	The program's evaluation protocol	An annual survey of supervisors and supervisees will be conducted to evaluate the process
Key players	Identification of key players and their roles	Supervisees, supervisors, administrators; supervisees negotiate the model of supervision that best meets their needs.
Specific clinical arrangements	The arrangements under which supervision will take place in the organization	Group supervision by an experienced facilitator

(Source: Roche, Todd, & O'Connor)

Although some similarities exist between clinical work and supervising, there are many important differences. Clinical supervision has its own knowledge base, and supervisors must understand different theoretical perspectives. They also must understand the roles clinical supervisors are expected to fill and the various modalities, or ways of implementing supervision, that are available.

The Competencies

- Understand the role of clinical supervision as the principal method for monitoring and ensuring the quality of clinical services.
- Appreciate the systemic role of the clinical supervisor as a primary link between management and direct services.
- Understand the multiple roles of the clinical supervisor, including consultant, mentor, teacher, team member, evaluator, and administrator.
- Be able to define the purpose of clinical supervision specific to the organization's clinical and administrative contexts, including supervisory goals and methods.
- Be familiar with a variety of theoretical models of clinical supervision, including (but not limited to) psychotherapy-based, developmental, multicultural, integrative, and blended models.
- Be able to articulate one's model of supervision.
- Be familiar with modalities of clinical supervision, including individual, group, direct observation, and consultation.
- Be familiar with the current research literature related to recommended practices in clinical supervision.
- Be familiar with the literature regarding multiple learning strategies (e.g., instructions, demonstrations, role plays, critiques).
- Recognize the importance of establishing with the supervisee a productive, healthy learning alliance focused on improving client services and job performance.
- Understand and reinforce the complementary roles of members on a multidisciplinary team.
- Understand the importance of assessing needs and carefully planning and systematically implementing individual and group supervisory activities that promote clinical and program service improvement.

Tools and Approaches in Clinical Supervision

Clinical supervision plays a pivotal role in the development and enhancement of skills for mental health and social work professionals. This section explores empirically supported techniques in clinical supervision, focusing on evidence-based strategies that contribute to the professional growth and competence of mental health and social work professionals. Drawing on current research and literature, this section highlights key elements such as the supervisory alliance, reflective practice, and ongoing professional development.

Introduction

Clinical supervision is a critical component of the training and ongoing professional development of mental health and social work professionals. Supervisors are tasked with guiding and supporting their supervisees in the application of theoretical knowledge, clinical skills, and ethical decision-making. This section reviews empirically supported techniques in clinical supervision that have demonstrated effectiveness in enhancing the competency and confidence of MFTs and social workers.

1. The Supervisory Alliance:

One of the foundational aspects of effective clinical supervision is the establishment and maintenance of a strong supervisory alliance. The supervisory alliance refers to the collaborative and trusting relationship between the supervisor and supervisee. Research indicates that a positive supervisory alliance is associated with increased satisfaction, openness to feedback, and improved clinical outcomes (Bernard & Goodyear). Empirical studies emphasize the importance of clear communication, mutual respect, and a supportive environment within the supervisory relationship. Techniques such as regular check-ins, goal setting, and fostering a culture of openness contribute to the development of a robust supervisory alliance.

2. Reflective Practice:

Reflection is a key component of professional development and clinical competence. Supervisors can encourage reflective practice by incorporating techniques such as case conceptualization, self-assessment, and critical incident analysis. Research suggests that engaging in reflective supervision enhances the ability of mental health and social work professionals to critically evaluate their interventions, understand their clients' perspectives, and refine their therapeutic skills (Watkins). Supervisors can integrate reflective techniques into supervision sessions by encouraging supervisees to explore their thoughts and emotions related to clinical cases. Additionally, incorporating tools such as video recording and case presentations can facilitate a more in-depth analysis of therapeutic interactions.

3. Ongoing Professional Development:

Empirical evidence supports the integration of ongoing professional development as a central component of clinical supervision. Continuous learning ensures that mental health and social work professionals stay informed about the latest research, ethical standards, and evidence-based practices. Supervisors can facilitate professional growth by encouraging attendance at workshops, conferences, and relevant training opportunities (Borders et al). Furthermore, incorporating peer consultation and group supervision sessions can provide a collaborative platform for sharing experiences, seeking feedback, and expanding knowledge. The literature suggests that a commitment to ongoing professional development contributes to increased confidence, competence, and adaptability in the rapidly evolving field of mental health.

By incorporating these evidence-based strategies, supervisors can create an enriching and supportive environment that fosters the growth and competence of their supervisees. As the field continues to evolve, it is imperative for clinical supervisors to stay informed about current research and integrate effective techniques to ensure the ongoing success of the next generation of mental health professionals.

4. Use of Technology in Clinical Supervision:

In recent years, technological advancements have provided new avenues for enhancing clinical supervision. Research has shown that the integration of technology into supervision can improve accessibility, increase flexibility, and facilitate continuous communication between supervisors and supervisees (Gutierrez Dizon, 2020). Videoconferencing, online forums, and virtual platforms have become valuable tools in overcoming geographical barriers and promoting collaborative learning. Supervisors can utilize video recordings of therapy sessions, allowing for more comprehensive feedback on therapeutic techniques, interventions, and non-verbal communication. Virtual platforms also offer opportunities for group supervision, fostering a sense of community among supervisees and promoting diverse perspectives on case presentations.

5. Cultural Competence and Diversity:

Empirical research underscores the significance of integrating cultural competence and diversity considerations into clinical supervision. MFTs and social workers need to be equipped with the skills to work effectively with individuals from diverse backgrounds. Supervisors should incorporate discussions on cultural humility, awareness of biases, and the impact of cultural factors on the therapeutic process.

Evidence suggests that a culturally sensitive approach to supervision contributes to improved client outcomes, increased cultural competence among supervisees, and a more inclusive and supportive professional environment (Hays, Chang, & Havice). Supervisors can employ techniques such as case vignettes, role-playing, and multicultural competence assessments to enhance the cultural responsiveness of their supervisees.

6. Feedback and Assessment:

Providing constructive feedback is a fundamental aspect of clinical supervision. Research indicates that feedback should be specific, timely, and tailored to the individual needs of the supervisee (Ladany et al.). Regular performance assessments, self-evaluations, and goal-setting can contribute to a structured and goal-oriented supervision process. Supervisors can utilize standardized tools for evaluating clinical competencies, ethical decision-making, and interpersonal skills. Incorporating feedback from clients and utilizing outcome measures can further enhance the effectiveness of clinical supervision by focusing on evidence-based practices and client outcomes.

7. Ethical Considerations in Clinical Supervision:

Ethical guidelines and considerations are paramount in clinical supervision. Supervisors must be well-versed in ethical codes and standards, ensuring that their supervisees adhere to ethical principles in their practice. Empirical studies emphasize the importance of addressing ethical dilemmas, promoting ethical decision-making, and creating a safe space for supervisees to discuss ethical concerns (Corey, Corey, & Callanan). Supervisors can incorporate ethical case discussions, role-playing scenarios, and ethical decision-making models into supervision sessions. Additionally, creating a supportive environment where supervisees feel comfortable discussing their ethical concerns without fear of judgment is crucial for fostering ethical competence.

8. Trauma-Informed Supervision:

With the growing recognition of the prevalence of trauma in clients' lives, trauma-informed supervision has emerged as an important area of focus. Empirical evidence suggests that integrating trauma-informed principles into supervision enhances the ability of mental health and social work professionals to recognize and respond to trauma in their clients (Pearlman & Saakvitne). Supervisors can incorporate trauma-focused training, case discussions involving trauma-informed interventions, and self-care strategies into supervision. This approach not only supports the well-being of clients but also contributes to the resilience and professional longevity of the supervisee.

9. Interdisciplinary Collaboration:

Research has shown that interdisciplinary collaboration enhances the quality of mental health care. Supervisors can facilitate collaboration by encouraging communication and consultation between MFTs, social workers, and professionals from other disciplines (Regehr, Bogo, Regehr, & Patton). Interdisciplinary collaboration promotes a holistic understanding of clients' needs and encourages the integration of diverse perspectives into the therapeutic process. Supervisors can organize joint supervision sessions, case conferences, or collaborative projects that involve professionals from different disciplines. This approach broadens the knowledge base of supervisees, promotes effective teamwork, and enhances the overall quality of mental health services.

Conclusion:

Clinical supervision for mental health and social work professionals is a dynamic and evolving field that benefits from the integration of empirically supported techniques. As the mental health landscape continues to change, supervisors must adapt their approaches to ensure the ongoing professional development and well-being of their supervisees. By embracing a comprehensive and evidence-based framework, clinical supervisors can play a crucial role in shaping competent, ethical, and culturally responsive mental health professionals.

More on Interdisciplinary Collaboration

Interdisciplinary collaboration is a dynamic and essential component of effective clinical supervision for Marriage and Family Therapists (MFT) and social workers. This collaborative approach involves integrating professionals from various disciplines, such as psychology, counseling, psychiatry, nursing, and other related fields, to enhance the overall quality of mental health care.

- **Promoting Holistic Understanding:**

Interdisciplinary collaboration fosters a holistic understanding of clients and their complex needs. In mental health settings, clients often present with multifaceted challenges that may require diverse perspectives for comprehensive assessment and intervention. By bringing together professionals from different disciplines, supervisors facilitate a more nuanced understanding of clients' experiences, contributing to more effective and tailored treatment plans.

- **Knowledge Exchange:**

One of the key benefits of interdisciplinary collaboration is the exchange of knowledge and expertise. MFTs and social workers can learn from professionals in other fields, gaining insights into alternative therapeutic approaches, assessment methods, and intervention strategies. This knowledge exchange promotes a culture of continuous learning, expanding the skill set of supervisees and encouraging a broader perspective on mental health issues.

- **Team-Based Case Consultations:**

Interdisciplinary collaboration can be facilitated through team-based case consultations. Supervisors can organize sessions where professionals from different disciplines come together to discuss challenging cases, share their expertise, and collaboratively develop intervention plans. These team-based consultations create a rich learning environment, encouraging open dialogue and fostering a sense of shared responsibility for client care.

- **Enhanced Treatment Planning:**

Collaborating with professionals from diverse backgrounds can lead to more comprehensive and effective treatment planning. For example, an MFT may collaborate with a psychiatric nurse to address both the relational dynamics within a family and the mental health concerns of an individual. This holistic approach contributes to a more integrated and client-centered treatment strategy that considers both psychological and biological factors.

- **Effective Referral Processes:**

Interdisciplinary collaboration strengthens the referral process, allowing professionals to connect clients with the most appropriate services. For instance, a social worker may collaborate with a substance abuse counselor to provide comprehensive support for a client dealing with both mental health and addiction issues. Supervisors can guide supervisees in developing effective referral networks and communication strategies with professionals in other disciplines.

- **Cultural Competence through Diversity of Perspectives:**

Working with professionals from different disciplines enhances cultural competence by exposing supervisees to a diversity of perspectives. Cultural nuances may be better understood when professionals with varied backgrounds collaborate, fostering an environment that values and respects different cultural norms, beliefs, and practices.

- **Enhanced Problem-Solving:**

The interdisciplinary approach encourages creative problem-solving. Different disciplines bring unique insights and strategies to the table, contributing to a more dynamic and innovative problem-solving process. Supervisors can guide supervisees in developing the skills necessary for effective collaboration, including effective communication, negotiation, and conflict resolution within interdisciplinary teams.

In conclusion, integrating interdisciplinary collaboration into clinical supervision enriches the professional development of MFTs and social workers. By fostering a collaborative culture, supervisors contribute to the creation of well-rounded mental health professionals who can navigate the complexities of client care with a broader perspective and a more diverse skill set. As the field continues to recognize the interconnectedness of various aspects of mental health, interdisciplinary collaboration remains a crucial element in preparing supervisees for the challenges of contemporary mental health practice.

- **Interdisciplinary Training Opportunities:**

Clinical supervisors can facilitate interdisciplinary collaboration by providing training opportunities that involve professionals from different disciplines. Workshops, seminars, and conferences that bring together experts from diverse fields create spaces for shared learning and networking. These training events can expose supervisees to innovative practices, emerging research, and collaborative models of care.

- **Case-Based Learning Across Disciplines:**

Incorporating case-based learning activities into supervision sessions can further promote interdisciplinary collaboration. Supervisors can present complex cases that require input from professionals with diverse expertise. This approach encourages supervisees to think critically, seek consultation from colleagues in other disciplines, and develop a more holistic understanding of the clients they serve.

- **Integration of Technology for Collaboration:**

The use of technology can facilitate interdisciplinary collaboration, especially in settings where physical proximity may be a challenge. Video conferencing, collaborative document sharing, and virtual platforms can enable professionals from different disciplines to connect, share insights, and collectively contribute to the development of comprehensive care plans. Supervisors can guide supervisees in leveraging technology for effective interdisciplinary communication.

- **Promoting Interprofessional Communication Skills:**

Effective communication is a cornerstone of successful interdisciplinary collaboration. Supervisors can emphasize the development of interprofessional communication skills, such as active listening, clear and concise expression of ideas, and the ability to translate discipline-specific language for a broader audience. These skills are crucial for fostering understanding and cooperation among professionals with varied backgrounds.

- **Addressing Power Dynamics:**

Recognizing and addressing power dynamics within interdisciplinary teams is essential for successful collaboration. Supervisors can guide supervisees in navigating professional hierarchies, promoting a culture of mutual respect, and fostering an environment where all team

members feel valued. Open discussions about power differentials and their impact on collaboration can contribute to a more egalitarian and supportive team dynamic.

- **Research Collaboration Opportunities:**

Interdisciplinary collaboration extends to the realm of research. Supervisors can encourage supervisees to engage in collaborative research projects with professionals from other disciplines. This not only enhances the research skills of MFTs and social workers but also contributes to the development of evidence-based practices that draw on a diverse range of perspectives.

- **Supervision of Interdisciplinary Teams:**

In some settings, supervisors may have the opportunity to provide supervision to interdisciplinary teams directly. This involves overseeing the collaboration between professionals from different disciplines, ensuring effective communication, and promoting a cohesive approach to client care. Supervisors can model collaborative leadership and guide their supervisees in managing interdisciplinary teams.

As the field of clinical supervision continues to evolve, it is crucial for supervisors to remain attuned to the latest empirical research and evidence-based practices. This section has highlighted additional approaches, such as the use of technology, cultural competence, and feedback mechanisms, which contribute to the effectiveness of clinical supervision for MFTs and social workers. By embracing these empirically supported strategies, supervisors can foster an environment that promotes professional growth, cultural responsiveness, and the delivery of high-quality mental health services.

The integration of interdisciplinary collaboration into clinical supervision goes beyond theoretical discussions and training. It involves creating a culture that values diverse perspectives, fosters effective communication, and actively seeks collaboration across disciplines. By incorporating these strategies, supervisors can equip MFTs and social workers with the skills and mindset necessary for successful interdisciplinary engagement, ultimately enhancing the quality of mental health care.

Clinical Supervision Modalities

Clinical supervision modalities vary, and different approaches may be suitable for mental health professionals based on their training, theoretical orientation, and the specific context of their work. Here are several widely accepted clinical supervision modalities for mental health professionals, along with brief definitions and current references:

✶ **Psychodynamic Supervision**: Psychodynamic supervision focuses on exploring unconscious processes, transference, and countertransference dynamics in the therapeutic relationship. It often involves understanding the impact of early experiences on the therapist-client relationship (Watkins, C. E. Jr., & Milne, D. L. The Wiley International Handbook of Clinical Supervision).

- **Cognitive-Behavioral Therapy (CBT) Supervision:** CBT supervision emphasizes the application of cognitive and behavioral techniques in therapy. It involves case conceptualization, skill development, and the use of structured interventions to address clients' cognitions and behaviors (Bennett-Levy, J., Thwaites, R., & Haarhoff, B. Supervision: A Vital Ingredient in Cognitive Behavioural Therapy Training and Practice).

- **Integrative or Eclectic Supervision:** Integrative supervision draws from various therapeutic modalities, allowing supervisors to tailor their approach based on the needs of the supervisee and the client. It involves integrating techniques and theories from different therapeutic orientations (Bernard, J. M., & Goodyear, R. K.Fundamentals of Clinical Supervision).

- **Solution-Focused Supervision:** Solution-focused supervision emphasizes exploring and building on clients' strengths, resources, and solutions rather than focusing solely on problems. It encourages goal-setting and collaborative problem-solving (Franklin, C., & Biever, J. L. Solution).

- **Person-Centered Supervision:** Person-centered supervision, rooted in the work of Carl Rogers, emphasizes creating a supportive and nonjudgmental space for supervisees to explore their thoughts and feelings. It focuses on empathy, unconditional positive regard, and congruence.

These definitions provide a broad overview of each modality, and it's essential to recognize that there is often overlap between modalities. Mental health professionals and their supervisors may choose or integrate various modalities based on the specific needs of the supervisee, the therapeutic context, and the theoretical orientation of the supervisor.

CBT as a Supervision Modality

Empirical Support for Cognitive Behavioral Therapy (CBT) as a Clinical Supervision Modality for Mental Health Professionals

1. Introduction:

Clinical supervision plays a pivotal role in the professional development of mental health professionals, and the choice of supervision modality significantly influences the outcomes of therapeutic interventions. This paper focuses on the empirical support for CBT as a supervision modality, emphasizing its impact on therapists' clinical competence, adherence to evidence-based practices, and the improvement of client outcomes.

2. Empirical Support for Enhanced Clinical Competence:

Numerous studies have demonstrated the positive impact of CBT-based supervision on therapists' clinical competencies. A meta-analysis by Milne et al. (2008) found that therapists receiving CBT

supervision exhibited significant improvements in their ability to conceptualize cases, apply therapeutic techniques, and manage challenging clinical situations. The structured nature of CBT lends itself well to supervision, allowing for targeted skill development and fostering therapists' confidence in their clinical decision-making.

3. Promoting Adherence to Evidence-Based Practices:

CBT is inherently rooted in evidence-based practices, and its integration into supervision promotes a commitment to empirical support in therapy. The work of Rakovshik and McManus highlights that therapists who receive CBT supervision show a greater adherence to evidence-based interventions, leading to more consistent and effective treatment outcomes. The emphasis on empirical support in CBT supervision aligns with the broader movement toward evidence-based practice in the mental health field.

4. Improvement in Client Outcomes:

Research consistently indicates that therapists who undergo CBT-based supervision contribute to better client outcomes. A study by Muse and McManus (2013) found that clients treated by therapists who received CBT supervision exhibited greater improvement in symptom reduction and overall well-being. This suggests that the skills acquired through CBT supervision positively impact the quality and effectiveness of therapeutic interventions, ultimately benefiting clients.

5. Evaluation of CBT-Based Supervision Models:

Various models of CBT supervision have been empirically evaluated to determine their effectiveness. A review by Bennett-Levy et al. examined different CBT supervision approaches, including group supervision, live supervision, and self-practice/self-reflection. The findings revealed that each model had unique strengths, with all models contributing to therapists' skill development and the enhancement of therapeutic outcomes.

6. Supervision and Therapist Burnout:

CBT-based supervision has also been linked to lower levels of therapist burnout. A study by Bond and Dryden found that therapists who participated in CBT supervision reported reduced levels of emotional exhaustion and increased job satisfaction. The structured and goal-oriented nature of CBT supervision may contribute to therapists feeling more supported and competent in managing the demands of their profession.

7. Challenges and Future Directions:

While the empirical support for CBT as a clinical supervision modality is substantial, challenges exist, including the need for ongoing research on specific components of CBT supervision and its applicability to diverse therapeutic orientations. Additionally, exploring the impact of CBT supervision on long-term therapist development and the sustainability of improved outcomes remains an avenue for future investigation.

8. Conclusion:

In conclusion, the empirical evidence strongly supports the use of CBT as a clinical supervision modality for mental health professionals. From enhancing clinical competence to promoting evidence-based practices and improving client outcomes, CBT-based supervision stands out as an effective and evidence-driven approach. Mental health professionals and supervisors alike can benefit from embracing CBT as a foundational modality for clinical supervision, contributing to the ongoing advancement of the field. Continued research and exploration of the nuanced aspects of CBT supervision will further solidify its role in shaping the next generation of proficient and effective mental health practitioners.

CBT-based supervision techniques

Cognitive Behavioral Therapy (CBT)-based supervision techniques provide a structured framework for guiding supervisees in their clinical practice. These techniques focus on enhancing specific CBT skills, fostering reflective practice, and promoting the application of evidence-based interventions. Here are five CBT-based supervision techniques:

➡ **Case Formulation and Conceptualization:**

- *Technique:* Begin supervision sessions by collaboratively developing case formulations and conceptualizations with supervisees. Encourage them to identify and analyze key cognitive and behavioral patterns contributing to clients' presenting issues.
- *Rationale:* This technique emphasizes the importance of individualized case conceptualization in CBT, ensuring that interventions are tailored to the specific needs and cognitive-behavioral processes of each client. It enhances supervisees' ability to apply CBT principles systematically.

➡ **Role-Playing and Behavioral Rehearsal:**

- *Technique:* Utilize role-playing and behavioral rehearsal exercises to simulate therapeutic interactions. Ask supervisees to take on the role of both therapist and client, allowing them to practice and refine CBT techniques, such as cognitive restructuring or behavioral experiments.
- *Rationale:* Role-playing provides a safe and structured environment for supervisees to experiment with CBT interventions, receive feedback, and build confidence in their application. It promotes experiential learning and enhances the transfer of skills to real-world clinical scenarios.

➡ **Socratic Questioning and Guided Discovery:**

- *Technique:* Emphasize the use of Socratic questioning during supervision. Encourage supervisees to employ open-ended questions that facilitate guided discovery and help clients explore and challenge their cognitive distortions.
- *Rationale:* Socratic questioning is a core CBT technique. Integrating it into supervision helps develop the skill of facilitating client insight and self-discovery, fostering a collaborative therapeutic relationship grounded in exploration and understanding.

➡ **Cognitive and Behavioral Case Analysis:**

- *Technique:* Review specific cases brought by supervisees through a cognitive and behavioral lens. Discuss the identification of automatic thoughts, core beliefs, and behavioral patterns. Collaboratively explore how these elements contribute to clients' difficulties and inform treatment planning.
- *Rationale:* This technique enhances supervisees' ability to apply CBT principles to real cases, fostering a deeper understanding of the interplay between thoughts, emotions, and behaviors. It supports the development of individualized and evidence-based treatment strategies.

➡ **Parallel Process and Self-Reflection:**

- *Technique:* Integrate parallel process observations into supervision, drawing parallels between the supervisory relationship and the therapeutic relationship. Encourage supervisees to reflect on their own cognitive and emotional responses during sessions with clients and in supervision.
- *Rationale:* Parallel process observations promote self-awareness and self-reflection, essential components of effective CBT practice. Supervisees can gain insights into their own cognitive processes and emotional reactions, fostering personal and professional growth.

These CBT-based supervision techniques are designed to be adaptable to various clinical contexts and can be tailored to meet the specific needs and developmental levels of supervisees. By incorporating these techniques, supervisors contribute to the ongoing development of therapists who are skilled in applying CBT principles in their clinical work

More on Solution Focused Supervision

Drawing upon existing research literature and empirical studies, this section highlights specific SFS techniques that have demonstrated effectiveness in enhancing supervisees' clinical skills, fostering a solution-focused mindset, and contributing to positive outcomes in mental health practice. The empirical support for these techniques reflects the growing recognition of the value of solution-focused approaches in the supervision context.

1. Introduction:

Solution-Focused Supervision (SFS) is an approach that aligns with the principles of solution-focused brief therapy, emphasizing strengths, resources, and solutions rather than problems. This section reviews empirically validated SFS techniques and their impact on the professional development of mental health professionals.

2. Empirically Validated SFS Techniques:

a. **Scaling Questions:**

- *Technique:* Scaling questions involve asking supervisees to rate their confidence, progress, or other relevant aspects on a numerical scale. For example, "On a scale of 1 to 10, how confident do you feel about your intervention strategies with the client?"
- *Empirical Support:* A study by Franklin, Moore, and Hopson (2017) found that the use of scaling questions in supervision was associated with increased supervisee self-efficacy and a more solution-focused orientation.

b. **Exception-Seeking Questions:**

- *Technique:* Exception-seeking questions guide supervisees in identifying instances when the client's problems were less intense or absent. For example, "Can you recall a time when the client's symptoms were less severe or not present at all?"
- *Empirical Support:* A meta-analysis by Guterman and Rudes indicated that exception-seeking questions in supervision were associated with improved client outcomes and increased supervisee confidence.

c. **Goal Setting and Miracle Question:**

- *Technique:* Supervisees are encouraged to collaboratively set specific, achievable goals with clients and explore the "Miracle Question," asking, "If a miracle happened and the problem was solved, how would things be different?"
- *Empirical Support:* Studies by Trepper et al. and Kim et al. demonstrated that goal setting and the Miracle Question positively influenced clients' engagement and outcomes.

d. **Feedback on What Works:**

- *Technique:* Supervisors focus on providing feedback to supervisees about what is working well in their interventions. This emphasizes strengths and reinforces effective strategies.
- *Empirical Support:* A study by Kim et al. (2019) found that emphasizing what works during supervision contributed to a more positive supervisee mindset and improved therapeutic alliance with clients.

e. **Future-Oriented Reflection:**

- *Technique:* Encouraging supervisees to reflect on future possibilities and how they envision progress in client cases. This technique helps shift the focus from current challenges to potential solutions.
- *Empirical Support:* Research by Lee and Kim suggested that future-oriented reflection in supervision was associated with increased supervisee optimism and a more solution-focused approach in therapy.

3. Integration of SFS Techniques into Supervision Practices:

a. **Supervisor Training:**

- *Technique:* Provide supervisor training in Solution-Focused Supervision techniques to enhance the competence of those overseeing mental health professionals. This includes workshops, ongoing education, and opportunities for supervisors to practice SFS techniques.
- *Empirical Support:* A study by Gingerich and Peterson emphasized the importance of supervisor training in the effective implementation of solution-focused approaches in supervision.

b. **Utilization of Technology:**

- *Technique:* Integrate technology to enhance the accessibility and implementation of SFS techniques. Virtual platforms, video conferencing, and electronic resources can facilitate remote supervision and the application of SFS principles.
- *Empirical Support:* Research by Halinski and Brack suggested that technology-enhanced supervision approaches were positively received by mental health professionals, contributing to increased engagement and effectiveness.

4. Future Directions:

Future research should explore the long-term impact of Solution-Focused Supervision techniques on supervisee and client outcomes, investigate cultural adaptations of SFS, and examine potential combinations with other supervision modalities for optimal effectiveness. Continued exploration of innovative approaches and the integration of technology will further enhance the application of SFS in mental health supervision

5. Challenges and Considerations:

Despite the growing empirical support for Solution-Focused Supervision techniques, challenges and considerations exist. These include the need for ongoing research to explore the cultural competence of SFS, its applicability across diverse populations, and the potential integration with other therapeutic modalities.

6. Conclusion:

Empirical evidence supports the effectiveness of Solution-Focused Supervision techniques in enhancing the professional development of mental health professionals. The integration of these techniques into supervision practices contributes to a positive, strengths-focused orientation, ultimately benefiting both supervisees and their clients. As the field continues to evolve, ongoing research and exploration of innovative ways to integrate and adapt SFS techniques will contribute to the advancement of solution-focused approaches in mental health supervision.

3. Clinical Supervision Implementation

This section provides a practical guide for clinical supervisors to support their local clinical practice and includes topics addressing clinical supervision implementation within community-based behavioral health. The first part of this section reflects government policy oriented issues. Otherwise, the balance of the materials are gleaned from local practice and/or national research.

Clinical Supervision and Clinical Practice Guidelines, Behavioral Health Services Division, Human Services Department A. Overview:

Clinical supervision instructs, models, and encourages self-reflection of the supervisee's acquisition of clinical and administrative skills through observation, evaluation, feedback, and mutual problem-solving. However, it should be understood that there might be opportunities in which the clinical supervisor chooses to give professional direction based on experience, expertise, and/or for ethical or safety concerns. Clinical supervision is delivered within the supervisor's professional practice license and ethical standards. Clinical supervision is provided to all treatment/clinical staff who are either employed or under contract by a provider organization such as group practices or behavioral health specialty organization or an individual provider.

- Clinical supervisors need to meet the standards for clinical supervision as defined by their professional practice board.
- Clinical supervisor responsibilities: provide support, consultation, and oversight of clients' treatment to include: assessment of needs; diagnoses/differential diagnoses (MH,SA,andCOD); clinical reasoning and case formulation which addresses documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions. All of the above should be:
  - ✓ Continuously reviewed and adjusted according to an individual's status, success and challenges.
  - ✓ Teaching the importance of retaining continuity throughout all documentation.
  - ✓ Ensuring plans, interventions, goals, and supports are appropriate to diagnosis.
- Clinical Supervision assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.
- Clinical Supervision assures that an appropriate safety and crisis management plans are in place at the onset of service delivery.
- Clinical Supervision addresses ethics and ethical dilemmas as aligned with the appropriate professional practice board.
- Clinical Supervisors will document date, duration, and the content of supervision session for their supervisee(s), which includes a professional development plan. All documents pertaining to clinical supervision will be readily available to the supervisee. B.
- A clinical supervisor has been approved by their respective professional licensing board as having met board requirements for providing clinical supervision.

Guidelines for Clinical Practice and Clinical Supervision

Why Have Implementation Guidelines?

Within the performance domains discussed throughout this course, responsibilities are clearly laid out for supervisee development, maintaining professional and ethical standards, program development and quality assurance, performance evaluation, and administrative functions. When supervisors have an opportunity to observe and evaluate the work of clinicians, they become aware of both the strengths and the deficits of the services being delivered. They can identify issues that need resolution and services or supervisee skills that need to be enhanced.

Such comprehensive practice, in reality, is relatively rare in clinical settings today. Most treatment agencies have clinical supervisors. However, their work typically is limited to administrative and case management duties such as reviewing case records, facilitating case staffing conferences, and collaborating on difficult cases.

Actual observation of clinical services, performance feedback, coaching, teaching, and negotiating professional development plans occur relatively infrequently. For most agencies, adopting clinical supervision practices consistent with the performance domains identified in this course will require a significant change in operations. In return for their investment in time and resources, agencies will find themselves engaged in an improvement-oriented approach to the monitoring and development of clinical services that likely will lead to improved staff retention, enhanced counselor skills, and better clinical outcomes.

If agencies are to improve their supervisory practices by adding activities identified as clinical supervision competencies, a set of guidelines is needed to support the development of an implementation plan and to ensure a smooth transition from existing practice to a different way of supervising clinical staff. Some necessary tasks include—

- Defining or clarifying the rationale, purpose, and methods for delivering clinical supervision;
- Ensuring that agency management fully understands and supports the changes that need to be made;
- Providing training and support in supervisory knowledge and skill development; and
- Orienting clinicians to the new supervision rationale and procedures.

Research indicates that successful change requires a comprehensive plan, management support, effective leadership, and a period of effort sufficient for the change to become a normative practice (Bradley et al.). Agencies should introduce and enact changes in supervisory practice over a defined period that allows for procedures to be developed, supervisors to test the new operations, and clinicians to provide feedback and adjust to a more collaborative, observational supervisory process. The broad goal is to create a continuous learning culture in the agency that encourages professional development, service improvement, and a quality of care that maximizes benefits to the agency's clients.

What Needs to be Implemented?

Agency management needs to study the five performance domains in the Supervisor Competencies and compare them with existing agency practice to determine the type and extent of change needed. At a minimum, management needs to examine its current—

- Organizational culture;
- Policies and procedures;
- Position descriptions;
- Direct service expectations; and
- Time allocated to the delivery of clinical supervision.

Time is a significant issue. The type of clinical supervision described in this document takes considerably more time than is typically allotted in community agencies. Nonetheless, that time should be considered an investment that will return benefits of improved service delivery, fewer direct service performance problems, improved risk management, and better treatment outcomes.

If agency management clarifies expectations for both the delivery and the outcome of clinical supervision before its implementation, staff is likely to be more receptive to the time investment necessary to implement an effective clinical supervision model. Supervisors need to be trained in the roles and processes of clinical supervision that are consistent with management expectations. Such training is best delivered over a period that allows supervisors to apply new knowledge and practices during the learning process. Making available a consultant or coach, who can meet regularly with supervisory staff to guide implementation, enhances the likelihood of a smooth and effective transition.

While supervisors are being trained, staff clinicians need to be introduced to the new supervisory paradigm. As clinicians begin to experience being observed, receiving feedback, and negotiating individual development plans, it is important that they discuss their experiences with supervisors and managers. Such discussion likely will yield suggestions for process improvement and provide opportunities to clarify misunderstandings and improve communication.

Most agencies can expect to complete the initial change process within 6 months. However, learning and adjustments to the model will continue as agencies assess the performance and needs of both supervisors and clinical staff. Agencies may need to be encouraged to “hang in there” when faced with implementation difficulties. In addition, when a new practice is introduced and adopted, the ability to monitor, provide feedback, and coach facilitates continuous quality improvement and increases fidelity to a new protocol. Without the opportunity to directly monitor clinical processes, it is unlikely that fidelity to any treatment intervention or protocol will be maintained.

Effective clinical supervisors are skilled, experienced clinicians. They are knowledgeable about generally accepted, research-based assessment, intervention, treatment, and recovery strategies. It is important that supervisees believe that their supervisors have substantial knowledge and skill to pass

along. However, knowledge and skill as a clinician are not enough to ensure success as a clinical supervisor.

The specific tasks, responsibilities, and roles of supervisors vary depending on agency mission, target population, theoretical model, treatment modality, and general structure. However, some basic competencies are common to a variety of settings and professional disciplines. These basic concepts are reflected in the foundation area competencies in this document. They are common across the variety of disciplines and interest groups that provide care for clients. The competencies identified as *foundation areas* complement those found in the transdisciplinary foundations section. The framework used here identifies five foundation areas in clinical supervision:

- Theories, Roles, and Modalities of Clinical Supervision;
- Leadership;
- Supervisory Alliance;
- Critical Thinking; and
- Organizational Management and Administration.

Each contains several competencies that, taken together, define the work of the clinical supervisor.

Leadership

Introduction

Leadership is an important element of clinical supervision. Leadership may be defined as a bidirectional social influence process in which supervisors seek voluntary participation of supervisees to achieve organizational goals, while providing leadership in the management structure of the agency. Leaders mentor, coach, inspire, and motivate. They build teams, provide structure, create cohesion, and resolve conflict. In addition, leaders build organizational culture, facilitate individual and organizational growth and change, and foster a culturally sensitive service delivery system by consistently advocating, at all levels of the organization, the need for high-quality clinical care for all patients or clients of the agency.

The Competencies

- ✓ Use a leadership style that creates and maintains an environment based on mutual respect, trust, and teamwork.
- ✓ Be a role model by taking full responsibility for one's decisions, supervisory practices, and personal wellness.
- ✓ Seek job performance feedback from supervisees, peers, and managers to improve supervisory practices.
- ✓ Create, regularly assess, and revise a personal leadership plan to provide direction for one's continuing professional development.
- ✓ Seek out and use leadership mentors to assist with one's personal development, knowledge acquisition, and skill development.

- ✓ Understand the historical context of treatment and use that understanding to participate in developing the agency's guiding vision and its related mission, principles, and sense of purpose.
- ✓ Clarify agency vision, mission, and service goals and objectives for the supervisee.
- ✓ Interpret agency mission, policies, procedures, and critical events. Effectively communicate those interpretations to supervisees and foster an organizational climate that promotes continuous improvement and excellence in client care.
- ✓ Understand, monitor, and ensure compliance with State and Federal regulations and accrediting body.
- ✓ Recognize the safety and security issues facing the organization and participate in enforcing and enhancing organizational policies that ensure the safety and security of clients, personnel, and facilities.
- ✓ Understand and acknowledge the power differential inherent in the supervisor– supervisee relationship, using power fairly and purposefully avoiding the abuse of power.
- ✓ Proactively structure and schedule clinical supervision activities.
- ✓ Teach, mentor, and coach in the context of the organization's core values.
- ✓ Provide honest feedback—positive, constructive, and corrective.
- ✓ Guide through motivational empowerment rather than control. Facilitate work through team building, training, coaching, and support.
- ✓ Plan and organize for orderly workflow, controlling details without being overbearing.
- ✓ Empower and delegate key duties to others while maintaining goal clarity and commitment. Delegate mindfully, considering both the supervisee's professional development and the agency's needs.
- ✓ Encourage supervisee participation in communicating observations, ideas, and suggestions to agency management.

Supervisory Alliance

Introduction

Clinical supervision takes place in the context of the supervisor–supervisee relationship. A positive supervisory alliance includes mutual understanding of the goals and tasks of supervision and a strong professional bond between supervisor and supervisee. To be effective, a supervisor must have a clear understanding of the nature and dynamics of this relationship.

The Competencies

- ✓ Be familiar with the literature about supervisory alliance, including key factors that strengthen or compromise the supervisory alliance, supervisory contracting, and relational issues (e.g., transference and countertransference).

- ✓ Understand the complex, multilevel, and bidirectional nature of the supervisory triad of client, clinician, and supervisor. Maintain an awareness of potential dual relationships and boundary violations within the triad.
- ✓ Recognize that the supervisor–supervisee relationship develops over time and that the stage of relationship development influences the rules, roles, and expectations of the alliance.
- ✓ Conceptualize the supervisor–supervisee relationship as a learning alliance that provides for role induction, includes agreement on goals and tasks, and recognizes the bond that develops between the supervisor and the supervisee.
- ✓ Understand the value of mentoring as a dynamic way of forming an alliance, teaching counseling skills through encouragement, and giving suggestions for accomplishing goals.
- ✓ Create an explicit supervisory contract that clarifies expectations and goals, the relationship's structure and evaluative criteria, and the limits of supervisor–supervisee confidentiality.
- ✓ Present as a credible professional who possesses knowledge and expertise relevant to the setting and the population being served.
- ✓ Model ethical behavior vis-à-vis the supervisee and reinforce ethical standards in the relationship between the supervisee and the supervisee's clients.
- ✓ Be continually alert to the effects of one's interpersonal style on the supervisee.
- ✓ Maintain appropriate boundaries in forming and maintaining a safe and trusting professional relationship.
- ✓ Attend to cultural, racial, gender, age, and other diversity variables essential to a productive supervisor–supervisee relationship.
- ✓ Understand, recognize, and know how to ameliorate the effects of personal counter-transference triggered by the supervisee's interpersonal style, the supervisee's developmental issues, or the supervisee's unresolved personal issues.
- ✓ Recognize interpersonal conflict and supervisory impasses, accept appropriate responsibility, and actively participate in resolving difficulties.

Critical Thinking

Introduction

Critical thinking refers to the cognitive processes of conceptualizing, analyzing, applying information, synthesizing, and evaluating. Supervisors are expected to use critical thinking to make sound decisions and solve problems on a regular basis; they also must help supervisees hone critical thinking skills.

The Competencies

- ✓ Understand the various contexts (e.g., organizational, political, societal, cultural) in which supervision is conducted**.**

- ✓ Analyze and evaluate agency issues and policies to better understand, clarify, and participate in the continuous improvement of agency and staff performance and service outcomes.
- ✓ Evaluate and select written and oral communication strategies appropriate to the audience and purpose.
- ✓ Select, adapt, implement, and evaluate appropriate problem-solving, decision-making, and conflict resolution techniques.
- ✓ Apply experience, insight, and lessons learned to new situations.
- ✓ Apply critical thinking to information gathering by evaluating the content of the information and the credibility of its source.
- ✓ Ask supervisees relevant and clarifying questions and listen critically for content and underlying issues in their self-disclosure.
- ✓ Help supervisees develop skills in case conceptualization and analysis of client– counselor interactions.
- ✓ Negotiate, communicate, and document the resolution of conflicts or disagreements and strategies for resolving performance problems. Document outcomes.
- ✓ Develop sound criteria for self-evaluation and clarify personal beliefs, values, and biases.
- ✓ Help supervisees develop sound criteria for self-evaluation and clarify their beliefs, values, and biases.

Organizational Management and Administration

Introduction

Management can be defined as the process of working with and through others to achieve organizational objectives in an efficient, legal, and ethical manner. Administration, in the context of this section, is the day-to-day implementation of the organization's policies and procedures.

Although clinical supervision is distinguished from administrative supervision in some models of supervisory practice, the two significantly overlap in the real world. Virtually all clinical supervisors have responsibility for some management and administrative activities, but the scope of these activities can vary widely depending on the organization.

The Competencies

- ✓ Recognize that organizational and managerial skills and tasks enhance clinical supervision.
- ✓ Understand and consistently apply agency policies, procedures, organizational structure, and communication protocols.
- ✓ Understand the legal demands and liabilities inherent in supervisory and clinical services, including the vicarious liabilities incurred in supervising interns and students.
- ✓ Be familiar with and abide by current principles, laws, ethical guidelines, and agency policies regarding personnel management.

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- ✓ Learn to implement effective disciplinary and administrative management techniques that enhance clinical supervision and accomplishment of the organization's mission.
- ✓ Understand and ensure supervisee compliance with State program licensing requirements and with other State and Federal laws and statutes.
- ✓ Understand and ensure supervisee compliance with the substance use disorder treatment standards of the organization's healthcare accrediting body (e.g., Commission on Accreditation of Rehabilitation Facilities, Joint Commission on Accreditation of Healthcare Organizations).
- ✓ Monitor and maintain the human and technical resources needed to meet organizational and program objectives.
- ✓ Evaluate and contribute to improving the organization's cultural proficiency.
- ✓ Possess and continually improve organizational and time management skills.
- ✓ Understand and work within the organization's budgetary constraints.
- ✓ Effectively apply technology, within agency and regulatory limits, for communication, program monitoring, report writing, problemsolving, recordkeeping, case management, and other activities.
- ✓ Ensure the maintenance, storage, and security of employee records and protected health information consistent with the organization's policies and procedures, government regulations, and ethical principles.

Performance Domains

Performance domains identify specific areas of clinical supervision practice that are essential to protecting client welfare, achieving agency goals, and improving clinical services. To ensure high-quality service delivery, supervisors work to develop and maintain competence among direct service staff while adhering to high professional and ethical standards. Supervisors provide supervisees with appropriate feedback while facilitating knowledge and skill development. To accomplish these tasks, supervisors must gather objective information on which to base an evaluation of their supervisees' performance. Supervisors also perform administrative tasks that preserve and build the organizational culture. The framework used here identifies five performance domains:

- ➡ Clinician Development;
- ➡ Professional and Ethical Standards;
- ➡ Program Development and Quality Assurance;
- ➡ Performance Evaluation; and
- ➡ Administration.

The competencies listed within each performance domain identify the specific abilities and responsibilities that clinical supervisors must master to be effective in the essential roles they play in the service delivery system.

Clinician development and performance evaluation are discussed here as two separate performance domains because each requires a distinct set of competencies. It is important to note, however, that each is integral to the other. Performance evaluation without a clinician development process would not necessarily lead to improved clinician proficiency. Similarly, clinician development activities in the absence of performance evaluation would likely be untargeted, general, and of less value to the clinician.

Clinician Development

Introduction

The continuous development of staff clinical skills is key to the delivery of high-quality client care. Clinician development is a complex process that involves teaching, facilitating, collaborating, and supporting clinician self-efficacy. Supervisors must facilitate this process in the context of a collaborative supervisor–supervisee relationship and within professional, ethical, and legal guidelines. Supervisors also must consistently maintain a multicultural perspective.

The Competencies

- ✓ Teach supervisees the purpose of clinical supervision and how to use it effectively.
- ✓ Ensure that comprehensive orientation is provided to new employees, including in areas such as the organization's client population, mission, vision, policies, and procedures.
- ✓ Build a supportive and individualized supervisory alliance that respects professional boundaries.
- ✓ Maintain a constructive supervisory learning environment that fosters awareness of oneself and others, motivation, self-efficacy, enthusiasm, and two-way feedback.
- ✓ Conceptualize and plan individual and group supervision activities, incorporating supervisees' preferred learning styles, cultures, genders, ages, and other appropriate variables.
- ✓ Encourage supervisees to examine their views regarding culture, race, values, religion, gender, sexual orientation, and potential biases.
- ✓ Help supervisees develop skills of empathy and acceptance specific to working with culturally diverse clients.
- ✓ Provide timely and specific feedback to supervisees on their conceptualizations of client needs, attitudes toward clients, clinical skills, and overall performance of assigned responsibilities.
- ✓ Create a professional development plan with supervisees that includes mutually approved goals and objectives for improving job performance, how goals and objectives will be met (including the respective responsibilities of the supervisor and the supervisee), a timeline for expected accomplishments, and measurements of progress and goal attainment.
- ✓ Implement a variety of direct supervisory activities (e.g., role play, live supervision/observation, review of audiotaped and videotaped sessions, presentation/discussion of case studies) to teach

and strengthen supervisees' theoretical orientation, professional ethics, clinical skills, and personal wellness.

- ✓ Help supervisees recognize, understand, and cope with unique problems of transference and countertransference when working with clients with substance use disorders.
- ✓ Acknowledge supervisees' development and celebrate accomplishments through frequent rewards and recognition.
- ✓ Encourage and help supervisees develop a personal wellness plan to manage their stress and avoid compassion fatigue and burnout.

Professional and Ethical Standards

Introduction

Supervisors work in a complex environment subject to professional, statutory, and regulatory guidelines. This domain identifies competencies related to protecting the public, clients, and staff members. It also describes the development of supervisors' professional identity and integrity in the context of professional supervisory practice.

The Competencies

- ✓ Be familiar with relevant professional codes of ethics (see Appendix B), client's rights documents, and laws and regulations that govern both counseling and clinical supervision practices.
- ✓ Ensure that supervisees are familiar with generally accepted professional codes of ethics, State and Federal statutes regarding duty to report (e.g., child abuse) and duty to warn (e.g., threat of physical violence against a reasonably identifiable victim or victims), Federal confidentiality (e.g., 42 Code of Federal Regulations, Part 2) and privacy (e.g., Health Insurance Portability and Accountability Act) rules and regulations, and other legal constraints on the counseling relationship.
- ✓ Follow due process guidelines when responding to grievances and ensure that supervisees know their rights as employees and understand the organization's employee grievance procedures.
- ✓ Ensure that supervisees are familiar with client's rights and understand client grievance procedures.
- ✓ Ensure that supervisees inform clients about the limits of confidentiality (e.g., child abuse reporting, specific threats of violence).
- ✓ Ensure that supervisees inform clients about supervision practices (e.g., direct observation, session transcripts) and obtain documented informed consent from clients as appropriate (e.g., signed releases for audio or video recording of sessions).
- ✓ Learn about supervisees' cultures, lifestyles, beliefs, and other key factors that may influence their job performance.
- ✓ Use and teach supervisees an ethical decisionmaking model, such as that described by Corey and colleagues, as a guide for supervisory and clinical practice.

- ✓ Understand the risks of dual relationships and potential conflicts of interest in the supervisor–supervisee relationship and maintain appropriate relationships at all times.
- ✓ Help supervisees develop awareness of possible dual relationships in the client– counselor relationship.
- ✓ Monitor supervisees' clinical practice to enhance their competence and ensure their ethical treatment of clients.
- ✓ Provide timely consultation and guidance to supervisees in situations that present moral, legal, and/or ethical dilemmas.
- ✓ Ensure that supervisees maintain complete, accurate, and necessary documentation at all times, including detailed descriptions of actions taken in critical situations.
- ✓ Intervene immediately and take action as necessary when a supervisee's job performance appears to present problems.
- ✓ Report supervisees' ethical violations to the appropriate professional organizations and State bodies as required.
- ✓ Maintain familiarity with consensus- and evidence-based best practices in treatment.
- ✓ Build supervisory competence by actively participating in professional organizations and in a variety of relevant professional and educational activities.
- ✓ Seek supervision and consultation to evaluate one's personal needs for training and education, receive and discuss feedback on supervisory job performance, and implement a professional development plan.
- ✓ Practice only within one's areas of clinical and supervisory competence.
- ✓ Develop and maintain a personal wellness plan for physical and mental health and encourage supervisees to develop and maintain personal wellness plans.

Program Development and Quality Assurance

Introduction

Program development is the process of guiding the natural evolution of a service delivery organization to maximize the potential of its staff and resources to meet the needs of the population it serves. Quality assurance (QA) is the process of designing, implementing, monitoring, and improving a program's activities to ensure maximum effectiveness and efficiency of services within the limitations of the agency and its operating environment.

The extent to which clinical supervisors are responsible for program development and QA activities varies, depending on the size, structure, and mission of the organization. However, all clinical supervisors have *some* responsibility for these activities.

The Competencies

- ✓ Structure and facilitate staff learning about specific consensus- and evidence-based treatment interventions, program service design, and recovery models relevant to the organization and the population it serves.
- ✓ Understand the limitations of addiction treatment in general; its relationship to sustained, long-term recovery; and the specific limitations of the models or design in use by supervisees.
- ✓ Understand and be able to apply principles of technology transfer to assist in the adoption and implementation of new clinical practices.
- ✓ Identify, develop, and obtain appropriate learning and treatment resource materials that meet the needs of the agency, its clients, and supervisees.
- ✓ Plan and facilitate inservice training and other organizational activities that support application of empirically based clinical interventions that are responsive to needs of the agency, clients, and supervisees.
- ✓ Understand the balance between fidelity and adaptability when implementing new clinical practices.
- ✓ Be familiar with the methods used to analyze the organization's developmental needs and clinical outcomes, including regular needs assessments.
- ✓ Advocate within the agency for ongoing quality improvement, including strategies for enhancing client access, engagement, and retention in treatment.
- ✓ Understand the organization's QA plan and comply with all monitoring, documenting, and reporting requirements.
- ✓ Develop program goals and objectives and counselor development plans that are consistent with the organization's QA plan.
- ✓ Solicit, document, and use client feedback to improve service delivery.
- ✓ Provide diversity training and other experiences that empower one to become an advocate for the organization's target population and an agent of organizational change.
- ✓ Build and maintain relationships with referral sources and other community programs to expand, enhance, and expedite service delivery.
- ✓ Develop skills to advocate for clients throughout the entire continuum of care.

Performance Evaluation

Introduction

Clinician evaluation is central to the assurance of high-quality client care. It is a professional and ethical responsibility of clinical supervisors to regularly monitor the quality of supervisees' performance, to facilitate improvement in supervisees' clinical competence, and to assess supervisees' readiness to practice with increasing autonomy. As such, this domain is closely related to Clinician Development. The competencies in each are distinct yet highly complementary and interactive.

The Competencies

- ✓ Communicate agency expectations about the job duties and competencies, performance indicators, and criteria used to evaluate job performance.
- ✓ Understand the concept of supervision as a two-way evaluative process with each party providing feedback to the other, including constructive sharing and resolution of disagreements. Actively encourage supervisees to provide feedback to the supervisor regarding the supervisor's performance.
- ✓ Assess supervisees' professional development, cultural competence, and proficiency.
- ✓ Differentiate between clinician developmental issues and those requiring corrective action (e.g., ethical violations, incompetence).
- ✓ Assess supervisees' preferred learning style, motivation, and suitability for the work setting.
- ✓ Use multiple sources of quantitative and qualitative data, direct and indirect observations, and formal and informal methods of assessment to ensure substantiated and accurate evaluation.
- ✓ Institute an ongoing formalized, proactive process that identifies supervisees' training needs, actively involves supervisees in conjointly reviewing goals and objectives, and reinforces performance improvement with positive feedback.
- ✓ Communicate feedback clearly, including feedback regarding performance deficits, weak competencies, or harmful activities. Provide timely written notification of all performance problems and ensure that supervisees understand the feedback.
- ✓ Evaluate the competency, including the fidelity, with which supervisees implement research-based treatment protocols.
- ✓ Address and manage relational issues common to evaluation, including anxiety, disagreements, and full discussion of performance problems.
- ✓ Guide and evaluate supervisees' ability to use a range of evaluative tools (e.g., process recordings, memory work, audiotapes and videotapes, direct observation) and encourage them to use the most effective techniques available in the setting.
- ✓ Skillfully use state and agency evaluation tools and procedures.
- ✓ Self-assess for evaluator bias (e.g., leniency, overemphasis on one area of performance, favoritism, stereotyping) and conflict with other supervisory roles.
- ✓ Adhere to professional standards of ongoing supervisory documentation, including written individual development plans, supervision session notes, written documentation of corrective actions, and written recognition of good performance.

Administration

Introduction

Clinical supervisors' administrative responsibilities are the executive functions of the position, those duties that help the organization run smoothly and efficiently. Administrative responsibilities include following the organization's policies and procedures (including those related to human resource

management), ensuring the maintenance of case records, monitoring case documentation, assisting in financial resource development (e.g., grant proposal writing), and developing relationships with referral sources in the community. Administrative responsibilities also include program development and quality assurance, which are addressed separately in PD3. Although the competencies described below are administrative in nature, many overlap significantly with clinical functions and serve to ensure the quality of services being delivered within the agency. As noted previously, the range of administrative functions clinical supervisors are responsible for will vary from agency to agency.

The Competencies

- ✓ Participate in developing, maintaining, applying, and revising the organization's policies, procedures, and forms.
- ✓ Monitor, evaluate, and provide feedback regarding supervisees' compliance with administrative policies and procedures.
- ✓ Understand and ensure that supervisees understand the organization's chain-of command and communication protocols.
- ✓ Monitor, evaluate, and provide guidance regarding the supervisees' case recordings, including session notes, treatment plans, correspondence, and behavioral contracts.
- ✓ Establish and maintain an efficient and comprehensive record keeping system that provides clear, chronological documentation of supervisory activities.
- ✓ Recommend personnel actions to maintain high standards of clinical care (e.g., hiring, performance recognition, disciplinary action, suspension, termination of clinical staff).
- ✓ Maintain and regularly update clinical staff job descriptions according to agency policies and procedures.
- ✓ Understand and help supervisees understand and manage the relationships among clinical services, fee assessment and collection, and overall fiscal responsibility.
- ✓ Understand and comply with procedures necessary for processing third-party payment claims, if applicable.
- ✓ Participate actively in the organization's resource development activities (e.g., grant application or proposal writing).
- ✓ Develop and rely on schedules, deadlines, and reminders to meet service needs and ensure completion of assigned projects and tasks.
- ✓ Ensure that supervisees have proper training for using information technology systems and have access to technical assistance and other resources.
- ✓ Obtain regularly scheduled diversity, crisis management, and safety training for oneself and supervisees.
- ✓ Develop and comply with intraorganizational and interorganizational agreements that expand, enhance, and expedite service delivery.
- ✓ Maintain security of all supervisory notes, assessments, and other pertinent documents.

✓ Structure and facilitate effective staff meetings.

Informed Clinical Supervision Implementation (Including Social Work Supervisory Elements)

High Quality Practice

The term practice refers to the collective set of actions used to plan and deliver interventions and supports. The purpose of practice is to help a person or family to achieve an adequate level of:

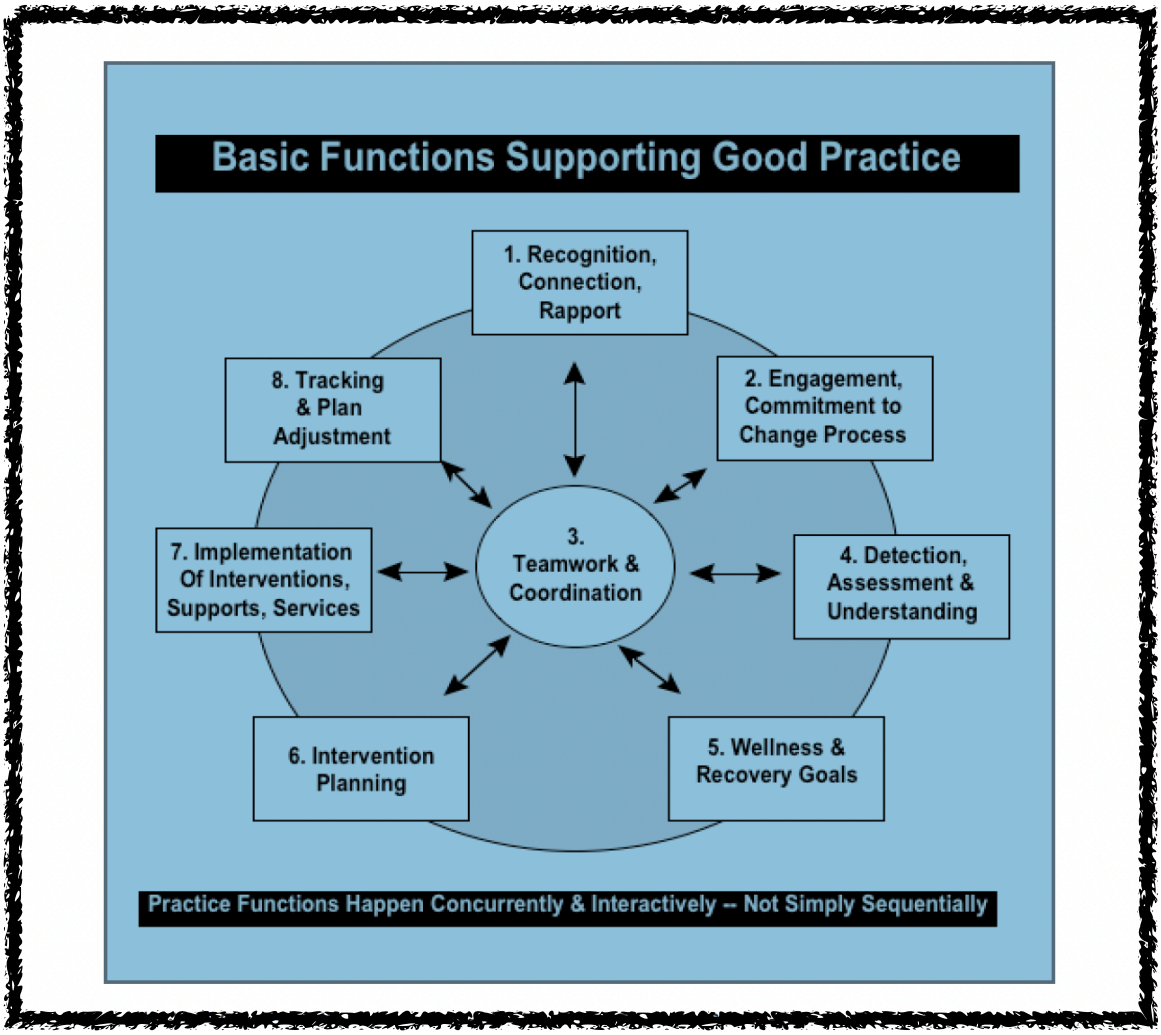
- Well-being (e.g., safety, stability, permanency for dependent children, physical and emotional health),
- Daily functioning (e.g., basic tasks involved in daily living, as appropriate to a person's life stage and ability),
- Basic supports for daily living (e.g., housing, food, income, health care, child care), and
- Fulfillment of key life roles (e.g., a child being a successful student or an adult being a successful parent or employee).

Basic Expectations of High Quality Practice

This practice framework sets forth the actions/functions used by frontline practitioners to partner with a person receiving services to bring about positive life changes that assist the person by maintaining successes and managing challenges as they occur.Typical activities in practice include engaging the client and other key stakeholders in a connected, unifying effort through teamwork and fully understanding the person, their needs and environment. It also includes collaboratively defining results to be achieved, selecting and using intervention strategies and supports, resourcing and delivering planned interventions and supports, and tracking and adjusting intervention strategies until desired outcomes are achieved. The basic functions of quality practice are:

✓ Engaging Service Partners
✓ Assessing and Understanding the Situation
✓ Planning Positive Life-Change Interventions
✓ Implementing Services
✓ Getting and Using Results

The Practice Wheel: A Practice Model Defines the Principles and Organizing Functions Used by Practitioners The practice framework also encompasses the core values and expectations for providing services. The framework functions to organize casework and service delivery, to guide the training and supervision of staff, and clarifies quality measures and accountability. Basic practice functions are illustrated in the “practice wheel” diagram below.



The practice wheel can be utilized to guide supervision by providing a framework and expectations for working with persons receiving services. For example, supervision and training could progress along the practice wheel with each function as a topic of focus to strengthen and operationalize expectations.

Clinical Supervision as a Foundation For Strong Clinical Practice: Clinical Supervision is the foundation for assuring consistent, high quality practice. It provides a mechanism for clinical practice improvement at both an individual staff level as well as at the organizational level.

Individual Practitioner Level Supervision: The Clinical Supervision for individual frontline practitioners should consistently:

- ✓ Provide support, consultation, and oversight of clients' treatment to include assessment of needs; diagnoses/differential diagnoses (MH,SA, and COD);clinical reasoning and case formulation, to include documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions. All of which should be continuously reviewed and adjusted according to an individual's status, success and challenges.
- ✓ Teach the importance of retaining continuity throughout all documentation.

- ✓ Ensure plans, interventions, goals, and supports are appropriate to diagnosis; and, aligned with the supervisee's theoretical orientations
- ✓ Use parallel process where the supervisee's development is being addressed alongside the emerging clinical issues.
- ✓ Address the supervisee's steps to insure an individual's active involvement at all levels and that the individual voice and choice are clearly represented and documented.
- ✓ Assure that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the individual's continued recovery and success.
- ✓ Assure that an appropriate safety and crisis management plans are in place at the onset of service delivery.
- ✓ Address ethics and ethical dilemmas as aligned with the appropriate professional practice board.

Group Level Supervision: In addition to reinforcing multi-disciplinary teaming, group supervision can serve as a good teaching/training venue in which provider trends are highlighted (e.g. engagement, population profiles, and the presenting severity/types of disorders, theoretical orientation and case conceptualization.) The Clinical Supervisor's experiences in group supervision can also inform and strengthen the work of the entire team through the use of a recognized Clinical Practice Improvement model.

Organizational Level Benefits of Clinical Supervision:

- ✓ Assures high quality treatment for individuals.
- ✓ Creates clearly defined treatment goals which are measurable and time limited
- ✓ Assures the treatment plan is a living, working document with the individual.
- ✓ Ensures proper documentation of care and can help with program integrity issues
- ✓ Ensures staff are trained and properly implementing Evidenced-based Practices.
- ✓ Ensures fidelity to evidenced based practice models (e.g. Multisystem Therapy, Integrated Dual Diagnosis Treatment, Substance Abuse Matrix model)
- ✓ Improve staff development and employee retention
- ✓ Provides a risk management tool (e.g. Reduction of critical incidence)

Organizational Expectations: Agencies are expected to have policies and procedures that assure that:

- ✓ Clinical Supervision is conducted in a manner that ensures adequate attention to each supervisee and quality oversight for the cases;
- ✓ Clinical Supervision occurs frequently and follows a structured process that includes individual & group, clinical oversight, and regular access to supervisors;
- ✓ Both individual and group clinical supervision occurs multiple times during any month with documentation to evidence that clinical supervision has occurred accordingly.

All individual practitioner's, group practices' and facilities' Quality Improvement Program should have a Clinical Practice Improvement program that:

- ✓ Utilizes the findings from its Clinical Supervision to the improve the provider performance;
- ✓ Addresses care planning consistent with: wraparound planning approaches; system of care principles; and, a recovery philosophy. o Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring.

- ✓ Has a review protocol should examine strengths and improvements in the following areas: - Engagement - Teamwork - Assessment&understanding - Outcomes & goals - Intervention planning - Resources - Adequacy of interventions - Tracking and adjustment

Guiding Values and Principles of Practice: The following values and principles for practice in the provision of services to all individuals, youth and families served within the public behavioral health system:

- ✓ Individual/family-driven, individualized and needs-based
- ✓ Developmentally appropriate
- ✓ Inclusive of family or natural supports
- ✓ Offers an array of services & supports
- ✓ High quality
- ✓ Community-based.
- ✓ Culturally and linguistically aware and accepting
- ✓ Use of early identification and intervention
- ✓ Integrative approach
- ✓ Trauma responsive
- ✓ Strength-based
- ✓ Outcome based
- ✓ Least restrictive
- ✓ Recognize perseverance and resiliency/ trauma informed

Monitoring of Clinical Practice and Clinical Supervision.

The organization's documentation should include (but is not limited to):

- ✓ Policies that describe the provider's clinical supervision of all treatment staff including their Human Resources requirements for the clinical supervisor (credentials, job description, skill sets, training requirements and schedules).
- ✓ Procedures that include:
  - ◉ A template that documents when and how clinical supervision is provided to individuals and multidisciplinary teams in individual and group settings;
  - ◉ Annual training plan for all staff that provide treatment services.
  - ◉ Backup contingency plans for periods of clinical supervisor staff turnover.

Clinical Practice Improvement: The organization's Quality Improvement Program must have a Clinical Practice Improvement component that:

- ✓ Addresses care planning consistent with holistic and comprehensive care planning and system of care principles
- ✓ Examines the provider’s strength and weaknesses in the clinical care functions of: engagement, teamwork, assessment & understanding, outcomes&goals, intervention planning, resources, adequacy of intervention, and tracking & adjustment;
- ✓ Includes process improvement approaches, relevant data collection, fidelity measures and data for outcome monitoring;
- ✓ Evaluates the outcomes of its clinical interventions and develops improved strategies.

Technical Assistance: Regulatory state staff should monitor agencies for compliance with this clinical supervision requirement should the need arise.

- ✓ Dedicate resources and personnel (i.e.,state employees or contracted clinicians) to provide technical assistance in identifying acceptable and appropriate policies and procedure through the Supervisory Certification process.
- ✓ Explore use of telehealth video conferencing as a tool in clinical supervision.
- ✓ Provide Clinical Reasoning and Case Formulation training and consultation to Clinical Supervisors.
- ✓ Provide training and supports for supervising specific to those working in integrated settings and teams.

The Clinical Supervision Experience

Introduction

Supervision is part of one's professional practice, education and training in which the supervisor and supervisee collaborate to develop the supervisee's skills in evidence-based and effective promising practices as well as to protect the welfare of clients served. The provider organization of both the supervisor and supervisee will benefit from having formal agreements (or contracts), expectations, and policies related to the provision of supervision. Modifications may be necessary in the event that an organization is not able to provide a supervisor from within (internal to the provider). In these situations, the organization will benefit from having specific policies and contracts with external supervisors to ensure that all parties are familiar with the expectations, legal responsibilities, and roles. Furthermore, organizations as well as all supervisors and supervisees will benefit from a comprehensive understanding of the provider policies, state licensing board regulations, and documentation that may differ depending upon disciplines. For example, many boards stipulate specific requirements to become an eligible supervisor, documentation, and required hours. Please consult all these resources prior to initiation of the clinical supervision experience.

Best Practice Guidelines Discipline: Specific best practice guidelines related to supervision promote high standards to guide clinicians. Please consult each of these as relevant:

- ✓ American PsychologicalAssociation Guidelines for Clinical Supervision in Health Service Psychology
- ✓ Association for Counselor Education and Supervision of the American Counseling Association Best Practices in Clinical Supervision
- ✓ National Association of Social Workers Best Practice Standards in Social Work Supervision

The Clinical Supervision Relationship: Both supervisor and supervisee will benefit from understanding their roles and the professional responsibilities that each person has in order to uphold their responsibilities and understand the expectations that come along with such an important relationship. The Clinical Supervision Relationship addresses critical responsibilities of both parties. The Rights and Responsibilities of Supervisor and Supervisee: In order to promote a healthy and collaborative supervisory relationship, both the supervisor and supervisee benefit from having clear rights and responsibilities.

Additional Information on Various Models of Clinical Supervision

Psychotherapy-based models of supervision often feel like a natural extension of the therapy itself. "Theoretical orientation informs the observation and selection of clinical data for discussion in supervision as well as the meanings and relevance of those data (Falender & Shafaanske, p. 9). Thus, there is an uninterrupted flow of terminology, focus, and technique from the counseling session to the supervision session, and back again.

- ✓ **Psychodynamic Approach to Supervision:** Psychodynamic supervision draws on the clinical data inherent to that theoretical orientation (e.g., affective reactions, defense mechanisms, transference and countertransferece, etc.). Frawley-O'Dea and Sarnat classify psychodynamic supervision into three categories: patient-centered, supervisee-centered, and supervisory matrix centered. Patient-centered began with Freud and, as the name implies, focuses the supervision session on the patient's presentation and behaviors. The supervisor's role is didactic, with the goal of helping the supervisee understand and treat the patient's material. The supervisor is seen as the uninvolved expert who has the knowledge and skills to assist the supervisee, thus giving the supervisor considerable authority (Frawley-O'Dea & Sarnat). a. Supervisee-centered psychodynamic supervision came into popularity in the 1950s, focusing on the content and process of the supervisee's experience as a counselor (Frawley-O'Dea & Sarnat; Falender & Shafranske). Process focuses on the supervisee's resistances, anxieties, and learning problems (Falender & Shafranske). The supervisor's role in this approach is still that of the authoritative, uninvolved expert (Frawley-O'Dea & Sarnat), but because the attention is shifted to the psychology of the supervisee, supervision utilizing this approach is more experiential than didactic (Falender & Shafranske). b. The supervisory-matrix-centered approach opens up more material in supervision as it not only attends to material of the client and the supervisee, but also introduces examination of the relationship between supervisor and supervisee. The supervisor's role is no longer one of uninvolved expert. Supervision within this approach is relational and the supervisor's role is to "participate in, reflect upon, and process enactments, and to interpret relational themes that arise within either the therapeutic or supervisory dyads" (FrawleyO'Dea & Sarnat, p. 41). This includes an examination of parallel process, which is defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Haynes, Corey, & Moulton).
- ✓ **Cognitive-Behavioral Supervision:** As with other psychotherapy-based approaches to supervision, an important task for the cognitive-behavioral supervisor is to teach the techniques of the theoretical orientation. Cognitive-behavioral supervision makes use of observable cognitions and behaviors—particularly of the supervisee's professional identity and his/her reaction to the client (Hayes, Corey, & Moulton). Cognitive-behavioral techniques used in supervision include setting an agenda for supervision sessions, bridging from previous sessions, assigning homework to the supervisee, and capsule summaries by the supervisor (Liese & Beck).
- ✓ **Person-Centered Supervision:** Carl Rogers developed person-centered therapy around the belief that the client has the capacity to effectively resolve life problems without interpretation and direction from the counselor (Haynes, Corey, & Moulton). In the same vein, person-centered supervision assumes that the supervisee has the resources to effectively develop as a clinician. The supervisor is not seen as an expert in this model, but rather serves as a "collaborator" with the

supervisee. The supervisor's role is to provide an environment in which the supervisee can be open to his/her experience and fully engaged with the client (Lambers). In person-centered therapy, "the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship are the prime determinants of the outcomes of therapy" (Haynes, Corey, & Moulton, p. 118). Person-centered supervision adopts this tenet as well, relying heavily on the supervisor-supervisee relationship to facilitate effective learning and growth in supervision.

- ✓ **Developmental Models of Supervision:** In general, developmental models of supervision define progressive stages of supervisee development from novice to expert, each stage consisting of discrete characteristics and skills. For example, supervisees at the beginning or novice stage would be expected to have limited skills and lack confidence as counselors, while middle stage supervisees might have more skill and confidence and have conflicting feelings about perceived independence/dependence on the supervisor. A supervisee at the expert end of the developmental spectrum is likely to utilize good problem-solving skills and be reflective about the counseling and supervisory process (Haynes, Corey, & Moulton). For supervisors employing a development approach to supervision, the key is to accurately identify the supervisee's current stage and provide feedback and support appropriate to that developmental stage, while at the same time facilitating the supervisee's progression to the next stage (Littrell, Lee-Borden, & Lorenz; Loganbill, Hardy, & Delworth; Stoltenberg & Delworth). To this end, a supervisor uses an interactive process, often referred to as "scaffolding" (Zimmerman & Schunk), which encourages the supervisee to use prior knowledge and skills to produce new learning. Throughout this process, not only is the supervisee exposed to new information and skills, but the interaction between supervisor and supervisee also fosters the development of advanced critical thinking skills. While the process, as described, appears linear, it is not. A supervisee may be in different stages simultaneously; that is, the supervisee may be at mid-level development overall, but experience high anxiety when faced with a new client situation.
  - ◉ Integrated Development Model: One of the most researched developmental models of supervision is the Integrated Developmental Model (IDM) developed by Stoltenberg, Stoltenberg and Delworth and, finally, by Stoltenberg, McNeill, and Delworth (Falender & Shafranske, Haynes, Corey, & Moulton). The IDM describes three levels of counselor development:
    - ➡ Level 1 supervisees are generally entry-level students who are high in motivation, yet high in anxiety and fearful of evaluation;
    - ➡ Level 2 supervisees are at mid-level and experience fluctuating confidence and motivation, often linking their own mood to success with clients; and
    - ➡ Level 3 supervisees are essentially secure, stable in motivation, have accurate empathy tempered by objectivity, and use therapeutic self in intervention. (Falender & Shafranske)

  As noted earlier, the IDM stresses the need for the supervisor to utilize skills and approaches that correspond to the level of the supervisee. So, for example, when working with a level-1 supervisee, the supervisor needs to balance the supervisee's high anxiety and dependence by being supportive and prescriptive. The same supervisor when supervising a level-3 supervisee would emphasize supervisee autonomy and engage in collegial challenging. If a supervisor was to consistently mismatch his/her responses to the developmental level of the supervisee, it would likely result in significant difficulty for the supervisee to satisfactorily master the current developmental stage. For example, a supervisor who demands autonomous behavior from a level-1 supervisee is likely to intensify the supervisee's anxiety.
- ✓ **Integrative Models of Supervision:** Haynes, Corey, and Moulton describe two approaches to integration: technical eclecticism and theoretical integration.

- Technical eclecticism tends to focus on differences, chooses from many approaches, and is a collection of techniques. This path calls for using techniques from different schools without necessarily subscribing to the theoretical positions that spawned them. In contrast, theoretical integration refers to a conceptual or theoretical creation beyond a mere blending of techniques. This path has the goal of producing a conceptual framework that synthesizes the best of two or more theoretical approaches to produce an outcome richer than that of a single theory. (Haynes, Corey, & Moulton, p. 124).
- Bernard's Discrimination Model: Today, one of the most commonly used and researched integrative models of supervision is the Discrimination Model, originally published by Janine Bernard in 1979. This model is comprised of three separate foci for supervision (i.e., intervention, conceptualization, and personalization) and three 22 possible supervisor roles (i.e., educator, counselor, and consultant) (Bernard & Goodyear). The supervisor could, in any given moment, respond from one of nine ways (three roles x three foci). For example, the supervisor may take on the role of educator while focusing on a specific intervention used by the supervisee in the client session, or the role of counselor while focusing on the supervisee's conceptualization of the work. Because the response is always specific to the supervisee's needs, it changes within and across sessions.

✓ **Systems Approach:** In the systems approach to supervision, the heart of supervision is the relationship between supervisor and supervisee, which is mutually involving and aimed at bestowing power to both members (Holloway). Holloway describes seven dimensions of supervision, all connected by the central supervisory relationship. These dimensions are: the functions of supervision, the tasks of supervision, the client, the trainee, the supervisor, and the institution (Holloway). The function and tasks of supervision are at the foreground of interaction, while the latter four dimensions represent unique contextual factors that are, according to Holloway, covert influences in the supervisory process. Supervision in any particular instance is seen to be reflective of a unique combination of these seven dimensions.

✓ **Reflective Supervision:** The three building blocks of reflective supervision—reflection, collaboration, and regularity—are outlined below. {The author 's description reflects a child/family context.}

- **1. Reflection**: Reflection means stepping back from the immediate, intense experience of handson work and taking the time to wonder what the experience really means. What does it tell us about the family? About ourselves? Through reflection, we can examine our thoughts and feelings about the experience and identify the interventions that best meet the family's goals for self-sufficiency, growth and development. Reflection in a supervisory relationship requires a foundation of honesty and trust. The goal is to create an environment in which people do their best thinking— one characterized by safety, calmness and support. Generally, supervisees meet with supervisors on a regular basis, providing material (like notes from visits with families, videos, verbal reports, etc.) that will help stimulate a dialogue about the work. As a team, supervisor and supervisee explore the range of emotions (positive and negative) related to the families and issues the supervisee is managing. As a team, they work to understand and identify appropriate next steps. Reflective supervision is not therapy. It is focused on experiences, thoughts and feelings directly connected with the work. Reflective supervision is characterized by active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee to answer her own questions, and to provide the support and knowledge necessary to guide decision-making. In addition, the supervisor provides an empathetic, nonjudgmental ear

to the supervisee. Working through complex emotions in a "safe place" allows the supervisee to manage the stress she experiences on the job. It also allows the staff person to experience the very sort of relationship that she is expected to provide for clients and families.

- 2**. Collaboration:** The concept of collaboration (or teamwork) emphasizes sharing the responsibility and control of power. Power in an infant/family program is derived from many sources, among them position in the organization, ability to lead and inspire, sphere of influence and network of colleagues. But most of all, power is derived from knowledge—about children and families, the field, and oneself in the work. While sharing power is the goal of collaboration, it does not exempt supervisors from setting limits or exercising authority. These responsibilities remain firmly within the supervisor's domain. Collaboration does, however, allow for a dialogue to occur on issues affecting the staff person and the program.
- 3. **Regularity:** Neither reflection nor collaboration will occur without regularity of interactions. Supervision should take place on a reliable schedule, and sufficient time must be allocated to its practice. This time, while precious and hard to come by, should be protected from cancellation, rescheduling, or procrastination. That said, everyone working in infant/family programs knows that there are times when scheduling conflicts or emergencies arise, making it necessary to reschedule supervision meetings. When this happens, set another time to meet as soon as possible. If the need to reschedule arises frequently, it makes sense to consider why this is happening. Is the selected time an inconvenient one? Is the supervisor or the staff member overburdened, or is either having difficulty with time management skills? Is there some tension in the staff/supervisory relationship prompting either party to postpone their meeting? It takes time to build a trusting relationship, to collaborate, and to share ideas, thoughts, and emotions. Supervisory meetings are an investment in the professional development of staff and in the future of the infant/family program. Staff will take their cues from leaders: do program directors make time for supervision? Do the program's leaders "walk the talk"? Excerpted from Parlakian, R. Look, listen, and learn: Reflective supervision and relationship-based work. Washington, D.C: ZERO TO THREE. E. Reflective Supervision Infant Mental Health Professionals who provide services to infants and young children and their families involved in child protective services face multiple daily challenges. Working with stressed and traumatized infants/young children and their families, as well as the systems charged with providing services and oversight, affects professionals on many levels. These early professionals (mental health providers, developmental specialists, early interventionists, home visitors, family educators, Head Start teachers, public health nurses, child welfare workers and others) in turn require support and ongoing professional development to provide perspective, increase their skills, and avoid burn-out. Reflective supervision, a practice that has evolved from the multi-disciplinary field of infant mental health, provides the support needed by practitioners who are exposed to the intense emotional content and life experiences related to their work with families. An ongoing professional development process, reflective supervision provides a way for professionals working with very young children to reach greater understanding of their own responses, as well as the babies and adults they work with, and as a result, facilitating quality practice and intervention.

In person clinical supervision is defined as the supervisee and supervisor face-to-face in same physical setting. Tele supervision is defined as utilization of HIPPA compliant teleconferencing technology such as ZOOM platform that provides face-to-face supervision with a supervisee and supervisor. This can be either individual or group. Utilization of telephone or email can complement this type of supervision.

Although this type of supervision was initially employed in rural and frontier settings, where the supervisee and supervisor may be physically located some distance from each other, this has obviously more recently been applied in urban settings as well. Encryption should be utilized at all times with attention to licensure and interstate boundaries regarding location of the supervisor and supervisee. It is important to check with your state professional board regarding rules allowing tele supervision.

Behavioral Health Integration

Integration and collaborative care are often used when discussing health care innovation and delivery. Three levels of collaborative care can be described as coordinated care, co-located care, and integrated care (Hunter, Goodie, Oordt, & Dobmeyer). In coordinated care the providers will share information at a distance and as needed. In co-located care the providers are in close proximity and collaboration is more common, but each provides services in traditional roles. Truly integrated care has providers working in seamless service delivery models with high level collaboration between disciplines, shared information systems, and common work spaces. Hunter, Goodie, Oordt, and Dobmeyer use an example of the primary care behavioral health model to provide examples of integrated behavioral health services. This model is a truly integrated behavioral health provider working alongside of primary care providers. The model allows for quick screening and interventions and is specifically designed to not impede the fast pace of primary care. Other models include integration of primary care providers into traditional specialty behavioral health services. Behavioral health providers that have only worked in specialty behavioral health will face new challenges as integration becomes more of a reality (Robinson &Reiter,). Understanding levels of integration, collaboration, co-location, and team-based care will certainly be important tools for clinical supervision. The ability to provide clinical supervision in multiple environments, populations, and varying levels of integrated behavioral health services are crucial as innovation in health care continues. Tools include:

- Five Levels of Integration Self-Assessment Tool: Five Levels of Behavioral Health Integration
- A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers C. References Hunter, C. L., Goodie, J. L., Oordt, M.S.,& Dobmeyer, A. C. Integrated behavioral health in primary care; Step-by-step guidance for assessment and intervention (2nd ed.). Washington, DC: American Psychological Association. Robinson, P. J., & Reiter, J. T. Behavioral consultation and primary care (2nd ed.). Switzerland: Springer International Publishing. 31 VIII.

Evaluation Tools include:

- Therapist Evaluation Checklist
- Supervisor Evaluation Form
- Supervisor Competency Assessment
- Key Areas for Evaluation of Clinical Supervision

4. Cultural and Contextual Factors

Competency Based Supervision and Cultural Humility

In a comprehensive examination, competency-based supervision emerges as a metatheoretical approach that explicitly delineates the constituent components of clinical competencies—comprising knowledge, skills, and attitudes. This approach guides learning strategies, evaluation procedures, and aligns with criterion-referenced competence standards in line with evidence-based practices (EBPs) and the specific local or cultural clinical context (*adapted from Falender & Shafranske*). It's crucial to note that while competency-based supervision is a valuable approach, it does not negate the relevance of other supervision models (*APA, 2014*).

Key aspects of this metatheoretical approach involve ensuring that supervisee goals stem from self-assessment and incorporate supervisor input garnered from observations in both sessions and supervision. The approach emphasizes a strength-based perspective, building upon the supervisee's existing strengths and aligning with the terms outlined in the supervision contract. Additionally, it promotes experiential learning through methods such as modeling, role-play, reflective practice, and ethical problem-solving (*Falender, 2023)*.

Cultural humility is integral to effective supervision, recognizing the supervisory process as a cultural encounter *(Falicov)*. This involves accurate self-perception of one's cultural values, adopting an other-oriented perspective, and incorporating respect into the supervisory process. Descriptors of this cultural humility include being open, non-defensive, thoughtful, and reflective in responding to culturally loaded queries. It also involves considering one's own cultural identities in relation to power, privilege, prejudice, discrimination, and oppression (*Falicov; Hook et al*.).

Relational safety is emphasized in supervision, with a focus on establishing, modeling, empowering, and supporting it within the supervisory relationship or group context. The supervisor's critical examination of assumptions plays a vital role in building relational safety, addressing emotional, cognitive, and cultural factors influencing the client and the relationships within supervision (*Adapted from Ramirez-Stege et al*.).

Harmful supervision has the potential to cause psychological, emotional, and physical harm or trauma to both the supervisee and the client. For example, trainee experiences of racism, sexism, heterosexism, and ableism in a Veterans Affairs setting have been documented. It is important for supervisors to recognize and respond to various forms of discrimination and microaggressions, thereby fostering a safe and supportive learning environment.

The need for affirmative clinical supervision is highlighted, particularly in addressing the unique challenges faced by LGBTQ clients. The supervisor's role in respecting diverse identities, supporting clients' experiences, and enhancing supervisee competence should be emphasized. Supervisors need to be attuned to competence, bias, and the unique needs of diverse clients. Supervisors should also be responsive to linguistic minorities, especially Asian American supervisees facing challenges such as a deficit lens, overbearing assumptions, and acts of disrespect. Supervisors should engage in open dialogue, validate experiences, and explore the intersectionality of identities in the supervisory relationship *(Falender, 2023; Cencirulo et al., 2021)*.

Drawing from meta-analyses, valuable insights have been revealed into helpful and unhelpful supervisor behaviors as reported by supervisees. Establishing a secure learning environment, facilitating learning, and acknowledging and negotiating differences are identified as helpful, while behaviors lacking sensitivity, accountability, and ethical consideration, failure to create a safe and supportive environment, and limitations in sharing knowledge and skills are considered unhelpful *(Coleiro, Creaner, & Timulak, 2022).* The narrative extends its focus to post-degree supervision, revealing concerning statistics about supervisees receiving inadequate and harmful supervision during their licensure process. It highlights the challenges of supervisees identifying such inadequacies and harmful aspects, emphasizing the importance of supervision contracts in mitigating these issues *(Cook & Ellis, 2022).*

Addressing the competence of therapists in Substance Use Disorders (SUD) treatment, the narrative recognizes the need for therapists to assess their own competence. It points out the gap in training trajectories, where many mental health disciplines lack coursework on substance abuse treatment despite a significant percentage of social workers reporting interactions with clients dealing with substance use issues *(SAMHSA).*

The text also touches upon the challenging aspect of self-assessment, citing studies that reveal mental health professionals' bias towards overly optimistic self-perceptions of their skills and treatment outcomes. It underscores the importance of seeking feedback and remaining aware of potential biases when evaluating one's own performance. Supervisor self-assessment is highlighted as a crucial component, referring to guidelines for clinical supervision in health service psychology. The text encourages supervisors to engage in ongoing self-reflection, seeking evidence-based strategies to enhance their supervisory practices *(Falender et al.).*

Finally, the text addresses the accommodation of disabilities, emphasizing the necessity of formal accommodations and acknowledging the barriers faced by supervisees with disabilities. It underscores the importance of mentorship, peer support, and disability-affirmative training to create an inclusive and supportive learning environment *(Lund et al.).*

Affirmative clinical supervision emphasizes the need for supervisors to attend to both competence and biases. It underscores the role of supervisors in teaching and modeling affirming behaviors towards the diversity of each client. Specific attention is given to LGBTQ clients, who may present with feelings of shame, confusion, and anger due to societal pressures. The supervisor's responsibility is outlined to enhance the supervisee's competence, focusing on knowledge, skills, and attitudes in alignment with APA guidelines for sexual minority persons and professional ethics codes *(Falender, 2023)*.

Addressing the accommodation of disabilities, the narrative acknowledges the formal necessity of accommodations for supervisees with disabilities. However, it sheds light on the existing barriers, including stigma, lack of institutional support, and limited access to materials. The importance of mentorship, peer support, and disability-affirmative training is underscored, emphasizing the need for a comprehensive and inclusive approach *(Lund et al.)*.

The text delves into supervisee experiences and the impact of post-degree supervision on licensure. It reveals alarming statistics of supervisees experiencing inadequate and harmful supervision, emphasizing the importance of supervision contracts in mitigating these challenges. The narrative urges a critical examination of supervisory practices to ensure the well-being of both supervisees and clients *(Cook & Ellis)*.

The narrative concludes with a reflection on the challenges of self-assessment, both for therapists and supervisors. It stresses the importance of seeking feedback, remaining aware of biases, and adopting evidence-based strategies to enhance supervisory practices. The call for a continuous commitment to self-reflection and improvement resonates throughout, underlining the dynamic nature of effective supervision in the field of mental health *(Falender et al; Walfish et al.; Hannan et al.)*.

In summary, the narrative provides a comprehensive exploration of competency-based supervision, cultural humility, and the multifaceted challenges within supervisory relationships. It calls for continuous self-assessment, a commitment to diversity and inclusivity, and a proactive approach in addressing issues to ensure ethical and effective supervision.

Cultural Humility

Cultural humility is a concept that originated in the field of healthcare and is particularly relevant in contexts where individuals from diverse cultural backgrounds interact. It emphasizes a lifelong commitment to self-evaluation and self-critique, as well as the acknowledgment of and respect for cultural differences. Cultural humility goes beyond cultural competence, which often implies acquiring a set of skills and knowledge about other cultures, by focusing on the ongoing process of self-reflection and the willingness to learn from others.

Key components of cultural humility include:

- **Openness and Self-Reflection:** Practitioners actively engage in self-reflection, critically examining their own cultural biases and assumptions.
- **Other-Oriented Perspective:** This involves seeing individuals from other cultures as experts on their own experiences and recognizing the importance of learning from them.
- **Respect and Lack of Superiority:** Cultural humility promotes an attitude of respect towards others' cultural backgrounds and a recognition that no one culture is superior to another.
- **Continuous Learning:** It involves a commitment to lifelong learning about different cultures, including staying informed about cultural dynamics and changes.
- **Adaptable Communication:** Practitioners strive to communicate effectively across cultural differences, understanding that communication styles can vary significantly.

Cultural Humility in Clinical Supervision:

Cultural humility in clinical supervision involves fostering an attitude of openness, self-awareness, and continuous learning regarding cultural factors. It acknowledges the dynamic nature of cultural interactions and recognizes the importance of supervisors approaching the supervision process with humility and respect for the diverse cultural backgrounds of their supervisees and clients.

Key Components:

- **Self-Reflection:** Clinical supervisors practicing cultural humility engage in ongoing self-reflection to become aware of their own cultural biases and assumptions. This self-awareness forms the foundation for effective supervision across diverse cultural contexts.
- **Open Dialogue:** Cultural humility encourages open and honest dialogue between supervisors and supervisees about cultural issues. Supervisors should create a safe space for supervisees to express their cultural identities and challenges they may encounter in their work.
- **Addressing Power Dynamics:** Supervisors practicing cultural humility recognize and address power dynamics inherent in the supervisory relationship. This involves acknowledging the influence of cultural backgrounds on power differentials and promoting a collaborative and empowering supervisory environment.
- **Cultural Responsiveness:** Cultural humility emphasizes the importance of tailoring supervisory approaches to be culturally responsive. This includes adapting communication styles, interventions, and assessments to align with the cultural needs of both supervisees and clients.

Cultural Humility in Supervisory Relationships:

Supervisors should approach the supervisory relationship with cultural humility, recognizing and respecting the unique cultural perspectives of each supervisee. This involves acknowledging the power dynamics inherent in supervision and creating a space where supervisees feel empowered to discuss cultural issues. The following includes characteristics of cultural humility in supervision:

1. Intersectionality and Cultural Competence:

- Cultural humility recognizes the importance of intersectionality, acknowledging that individuals possess multiple intersecting identities that influence their experiences. In clinical supervision, supervisors need to be attentive to how various aspects of identity, such as race, gender, sexual orientation, and socioeconomic status, intersect and impact the supervisory process.

2. Emphasizing Lifelong Learning:

- Cultural humility promotes the idea of lifelong learning, encouraging supervisors to continuously educate themselves about diverse cultures, traditions, and belief systems. This commitment to ongoing learning ensures that supervisors stay attuned to the evolving needs of their supervisees and clients.

3. Adapting Supervision Approaches:

- Supervisors practicing cultural humility adapt their supervision approaches to be inclusive and culturally responsive. This may involve tailoring feedback, interventions, and assessment methods to align with the cultural backgrounds of supervisees and the populations they serve.

4. Addressing Bias and Stereotypes:

- Cultural humility requires supervisors to address and challenge their own biases and stereotypes. In the supervisory relationship, open discussions about biases, cultural assumptions, and their potential impact on clinical work contribute to a more inclusive and culturally sensitive supervisory environment.

5. Empowering Supervisees:

- A key aspect of cultural humility is empowering supervisees to become advocates for culturally competent and ethical mental health practices. Supervisors can foster this empowerment by supporting supervisees in developing their cultural competence, advocating for clients from diverse backgrounds, and engaging in social justice initiatives.

6. Integrating Cultural Humility in Supervision Models:

- Explore how cultural humility can be integrated into existing supervision models. This involves adapting traditional models to include cultural humility components, ensuring that they address the unique needs of a diverse range of supervisees and clients.

7. Evaluating the Impact of Cultural Humility Training:

- Examine studies that assess the effectiveness of training programs designed to enhance cultural humility among mental health and social work supervisors. Investigate how these training initiatives impact the quality of supervision and the cultural competence of supervisees.

8. Cultural Humility in Crisis Intervention:

- Explore how cultural humility principles are applied in crisis intervention situations. Supervisors should be prepared to guide their supervisees in providing culturally sensitive mental health support during crises, considering the unique cultural aspects that may influence individuals' responses and coping mechanisms.

9. Technology and Telehealth Considerations:

- Investigate how cultural humility is maintained in the context of technology-mediated supervision, especially in the era of increased telehealth services. Consider the challenges and opportunities presented by virtual platforms in maintaining cultural sensitivity.

10. Client and Community Involvement in Supervision:

- Explore the role of clients and community members in the supervision process. Cultural humility extends beyond the individual supervisory relationship to include community

perspectives. Examine how involving clients and communities in supervision contributes to culturally competent mental health practices.

11. Cultural Humility and Burnout Prevention:

- Investigate the potential link between cultural humility in supervision and burnout prevention. Explore how a culturally humble approach may enhance resilience, self-care, and overall well-being among mental health and social work professionals.

12. Supervision Across Diverse Settings:

- Examine how cultural humility is practiced in various settings, such as schools, community mental health centers, private practices, or hospitals. Consider how cultural humility is adapted to the unique contexts of these settings, where the demographics and needs of the populations served may differ.

13. Cultural Humility in Ethical Decision-Making:

- Explore how cultural humility influences ethical decision-making within the supervisory context. This includes discussions on confidentiality, informed consent, and the ethical considerations related to culturally sensitive interventions.

14. Trauma-Informed Cultural Humility:

- Investigate how cultural humility is integrated into trauma-informed supervision. This approach recognizes the prevalence of trauma and the importance of understanding cultural nuances in trauma interventions.

15. Cultural Humility in Supervision of Diverse Modalities:

- Explore how cultural humility is applied in the supervision of various therapeutic modalities, such as cognitive-behavioral therapy, psychodynamic therapy, or narrative therapy. Consider how cultural humility enhances the effectiveness of different therapeutic approaches.

16. Cultural Humility and Collaborative Supervision:

- Examine the role of collaborative supervision in promoting cultural humility. Collaborative supervision involves a mutual learning process between supervisors and supervisees, fostering an environment where diverse perspectives are valued.

17. Cultural Humility and Professional Development:

- Investigate how cultural humility contributes to the ongoing professional development of mental health and social work professionals. Consider its impact on career longevity, job satisfaction, and the ability to adapt to evolving cultural landscapes.

18. Cultural Humility and Evaluative Feedback:

- Explore how evaluative feedback incorporates cultural humility principles. This includes discussions on how supervisors provide constructive feedback that is culturally sensitive, encouraging continuous learning and growth.

19. Culturally Inclusive Supervision Assessment Tools:

- Look into the development and utilization of assessment tools that specifically measure cultural humility within the context of clinical supervision. Investigate how these tools contribute to the ongoing improvement of supervisory practices.

20. Cultural Humility and Reflective Practice:

- Investigate how supervisors integrate reflective practice into the supervisory process, emphasizing the importance of self-reflection on cultural biases and assumptions. Reflective practice contributes to the ongoing development of cultural humility.

21. Culturally Responsive Assessment:

- Examine how supervisors guide supervisees in conducting culturally responsive assessments. This includes understanding the influence of culture on diagnostic processes, assessment tools, and treatment planning.

22. Cultural Humility and Group Supervision:

- Explore the dynamics of cultural humility within group supervision. Consider how supervisors foster a culture of inclusivity and cultural sensitivity when supervising teams of mental health and social work professionals.

23. Cultural Humility and Social Justice Advocacy:

- Investigate the role of cultural humility in preparing supervisees to be advocates for social justice within the mental health and social work fields. Examine how supervisors foster a commitment to addressing systemic inequalities.

24. Cultural Humility and International Perspectives:

- Explore how cultural humility is applied in supervision when working with international or culturally diverse populations. Consider the unique challenges and opportunities presented when providing mental health services across borders.

25. Cultural Humility and Client Feedback:

- Investigate the integration of client feedback within the cultural humility framework. Examine how supervisors encourage supervisees to seek and incorporate client perspectives, particularly those related to cultural dynamics.

26. Cultural Humility in Crisis and Trauma Supervision:

- Examine how cultural humility principles are applied when supervising mental health professionals working in crisis and trauma settings. Consider the cultural aspects of trauma responses and interventions.

27. Cultural Humility and Implicit Bias Training:

- Investigate how supervisors address implicit biases within the supervisory relationship. Explore training methods and interventions aimed at raising awareness and mitigating the impact of implicit biases.

28. Cultural Humility in Supervision of New Technologies:

- Explore the implications of cultural humility in supervising mental health professionals using new technologies, such as virtual reality or online therapy platforms. Consider how supervisors ensure cultural competence in digital mental health services.

29. Cultural Humility and Community Engagement:

- Investigate how cultural humility extends beyond the clinical setting into community engagement. Explore how supervisors encourage supervisees to actively engage with diverse communities to better understand their needs and preferences.

30. Cultural Humility and Ethical Dilemmas:

- Investigate how supervisors guide supervisees in navigating ethical dilemmas with a culturally humble approach. Consider the complexities of ethical decision-making in diverse cultural contexts.

31. Cultural Humility and Self-Care Practices:

- Explore how cultural humility informs discussions on self-care within the supervisory relationship. Consider how supervisors address the unique self-care needs of mental health and social work professionals working with diverse populations.

32. Cultural Humility in Group Supervision:

- Examine how cultural humility principles are applied in group supervision settings. Consider the dynamics of diversity within the group and how supervisors foster an inclusive and culturally sensitive group supervision environment.

33. Cultural Humility and Interdisciplinary Supervision:

- Explore how cultural humility is incorporated into supervision models that involve collaboration between mental health professionals and professionals from other disciplines. Consider the interdisciplinary aspects of providing holistic and culturally competent care.

34. Cultural Humility and Social Media Ethics:

- Examine the role of cultural humility in guiding supervisees' ethical use of social media platforms in the context of mental health practices. Consider the implications of online interactions on cultural sensitivity and professionalism.

35. Cultural Humility and Language Access:

- Explore how supervisors address language barriers and ensure language access in the provision of mental health services. Consider strategies for promoting effective communication and cultural understanding in multilingual settings.

36. Cultural Humility and Trauma-Informed Supervision:

- Investigate how cultural humility intersects with trauma-informed supervision. Explore how supervisors integrate trauma-informed approaches with cultural competence to support supervisees in working with trauma survivors from diverse backgrounds.

37. Cultural Humility and Supervision Feedback Models:

- Examine how cultural humility influences the feedback models used in clinical supervision. Consider approaches that encourage open dialogue, self-reflection, and growth, while also addressing cultural considerations.

Cultural Humility Assessment Tools in Clinical Supervision

The development of assessment tools that specifically measure cultural humility within the context of clinical supervision has emerged from a growing recognition of the importance of cultural competence in mental health and social work. These tools are designed to evaluate the attitudes, skills, and behaviors associated with cultural humility, aiming to foster an environment where supervisors and supervisees can engage in continuous learning and improvement. The formation of such tools often involves:

- **Literature Review:** Researchers review existing literature on cultural competence, humility, and effective supervision to inform the development of assessment tools. This involves understanding the key components of cultural humility and how they manifest within the supervisory relationship.
- **Expert Input:** Collaboration with experts in multicultural counseling, psychology, and supervision ensures that the tools are grounded in theoretical frameworks and practical insights. Input from professionals with diverse cultural backgrounds and experiences helps capture a comprehensive understanding of cultural humility.
- **Pilot Testing:** Assessment tools undergo pilot testing to assess their reliability and validity. This involves administering the tools to a diverse group of mental health clinicians and social workers in supervised settings to identify any potential issues, refine language, and ensure clarity.
- **Cultural Sensitivity Review:** Cultural sensitivity reviews involve assessing whether the language and content of the tools are inclusive and relevant across diverse cultural contexts. This step ensures that the assessment tools are applicable to a broad range of cultural backgrounds.

Advantages of Assessment Tools for Cultural Humility in Clinical Supervision:

- **Promoting Self-Reflection:** Assessment tools encourage both supervisors and supervisees to engage in critical self-reflection regarding their cultural awareness, knowledge, and skills. This introspection lays the foundation for ongoing growth and improvement.
- **Identifying Areas for Development:** These tools provide a structured mechanism for pinpointing specific areas where individuals may need further development in terms of cultural humility. This targeted feedback allows for more focused training and supervision plans.
- **Strengthening Supervisory Relationships:** The use of assessment tools emphasizes the importance of a strong working alliance that addresses cultural dynamics. This focus on the supervisory relationship fosters trust, open communication, and collaboration between supervisors and supervisees**.**
- **Tailoring Supervision Plans:** By identifying individual strengths and weaknesses in cultural humility, assessment tools contribute to the creation of tailored supervision plans. Supervisors can adapt their approaches to better support the unique needs of each supervisee.
- **Supporting Ongoing Professional Development:** Continuous improvement is a hallmark of cultural humility. Assessment tools contribute to ongoing professional development by providing a baseline for measuring progress over time. Supervisees can track their growth in cultural competence through regular assessments.
- **Enhancing Cultural Competence in Client Care:** Ultimately, the advantages of these assessment tools extend beyond the supervisory relationship. As supervisors and supervisees enhance their cultural humility, the quality of client care improves, leading to more effective and culturally sensitive mental health interventions.
- **Institutional and Organizational Impact:** The use of these tools can contribute to broader cultural competence initiatives within institutions and organizations. Supervisors who model cultural humility set a precedent for a culturally competent organizational culture.

In summary, assessment tools for cultural humility in clinical supervision are valuable instruments that contribute to ongoing improvement by fostering self-reflection, identifying areas for development, strengthening supervisory relationships, and supporting a continuous journey toward enhanced cultural competence in mental health and social work practices. When utilizing these tools, it's essential to consider the cultural context and the specific needs of the individuals involved. Additionally, ongoing dialogue and feedback between supervisors and supervisees about cultural competence are crucial for effective implementation. Always ensure that the chosen assessment tools align with the goals and values of the supervisory relationship.

Relational Safety

Relational Safety In the context of clinical supervision refers to the establishment and maintenance of a secure, supportive, and trusting relationship between the supervisor and the supervisee. This concept is essential for creating an environment where supervisees feel comfortable, respected, and able to openly discuss and explore their clinical work, challenges, and personal reactions. The term encompasses emotional, psychological, and professional safety within the supervisory relationship.

Key components of relational safety in clinical supervision include:

- **Open Communication:**Encouraging an atmosphere where supervisees feel free to express their thoughts, concerns, and questions without fear of judgment or reprisal.
- **Non-Defensive Atmosphere:** Fostering an environment in which both supervisor and supervisee can engage in constructive feedback and dialogue without becoming defensive, allowing for genuine exploration and learning.
- **Respectful and Supportive Interactions:** Demonstrating respect for the supervisee's perspectives, experiences, and cultural background, and providing emotional support as they navigate their professional development.
- **Attention to Emotional Well-Being:** Acknowledging and addressing emotional and psychological factors that may impact the supervisee's well-being and clinical work, promoting a holistic approach to supervision.
- **Cultural Sensitivity:** Incorporating cultural humility and sensitivity to create a safe space for supervisees from diverse backgrounds, ensuring that cultural differences are understood and respected**.**
- **Exploration of Personal Reactions:** Facilitating discussions about the supervisee's emotional responses to clinical cases, allowing for reflection on how personal experiences may influence the therapeutic process.
- **Supervisory Examination of Assumptions:** Encourages supervisors to critically examine their assumptions and biases, creating an environment where personal biases can be acknowledged and addressed in the interest of the supervisee's professional growth (Falender, 2023).
- **Promotion of Reflective Practice:** Reflective practice, involving the examination of one's thoughts and actions, is integral to relational safety. Supervisors should foster an environment where supervisees feel comfortable engaging in reflective discussions about their clinical work (Ramirez-Stege et al.).

- **Attention to Emotional, Cognitive, and Cultural Factors:** Relational safety involves the supervisor's critical examination of factors influencing the client, as well as the therapist-client and supervisor-supervisee relationships. This includes emotional, cognitive, and cultural factors that impact the clinical process (Adapted from Ramirez-Stege et al.).
- **Incorporation of Multicultural Humility:** Cultivating a supervisory environment that embraces multicultural humility, as outlined by Falicov, involves accurate perception of one's own cultural values, a respectful and open attitude, and the ability to question assumptions in a cultural frame.
- **Consideration of Power Dynamics:** Relational safety also requires supervisors to consider power dynamics within the supervisory relationship, including exploring the impact of cultural identities associated with power, privilege, prejudice, discrimination, and oppression (Falender, 2023).
- **Dialogues on Microaggressions and Inaction:** The supervisory relationship should provide a platform for discussing instances of microaggressions or inaction observed by supervisees, fostering open dialogues that acknowledge and address these issues (Cencirulo et al., 2021; Falender, 2023).
- **Supervisor's Role in Creating Psychological Safety:** Supervisors play a crucial role in creating psychological safety within the supervisory dyad. This involves initiating dialogues with validation, curiosity, and ongoing reflection, ultimately instilling multicultural humility in the supervisory relationship (Cencirulo et al., 2021; Falender, 2023).
- **Initiation of Dialogues on “Isms":** A culturally safe supervisory space allows for the initiation of dialogues regarding various "isms" (racism, heterosexism, gender, ableism), exploring the contextual responses and creating an environment where these discussions can occur openly (Cencirulo et al., 2021; Falender, 2023)**.**
- **Supervisory Response to Trainee Experiences: Supervisors need to recognize and respond to trainees' experiences of racism, sexism, heterosexism, and ableism.** This involves acknowledging the high frequency of such experiences and initiating dialogues with validation, curiosity, and support (Cencirulo et al., 2021; Falender, 2023).
- **Promoting Affirmative Clinical Supervision:** Affirmative clinical supervision involves supervisors teaching their supervisees to affirm the diversity of each client, validating their experiences, and enhancing competence in working with diverse populations (Rose et al.).

Relational safety is a dynamic and ongoing process that involves continuous communication, reflection, and adaptation within the supervisory relationship. Relational safety is foundational for effective supervision as it promotes a culture of learning, openness, and collaboration. It allows supervisees to take risks, explore challenges, and engage in self-reflection without fear of judgment, ultimately contributing to their professional development and the quality of client care.It is fundamental to creating an environment where supervisees can thrive, explore their professional identities, and engage in meaningful learning experiences.

Relational Safety Techniques

➡ **Supervisory Alliance Building:** Building a strong supervisory alliance involves creating a positive, collaborative, and respectful relationship between the supervisor and the supervisee. This

includes establishing clear expectations, promoting open communication, and demonstrating a commitment to the supervisee's professional development.

- **Reflective Practice:** Reflective practice involves encouraging supervisees to critically examine and reflect on their thoughts, feelings, and actions in the therapeutic process. It fosters self-awareness and helps integrate learning from clinical experiences.
- **Empirical Support:** Research supports the positive impact of reflective practice on clinical skill development and professional growth (Sawyer & Hardy).
- **Feedback and Feedforward:** Providing both feedback (information about past performance) and feedforward (suggestions for future improvement) is crucial for creating a supportive learning environment. Constructive feedback should be specific, timely, and framed in a way that promotes growth.
- **Cultural Humility Training:** Incorporating cultural humility training into supervision involves raising awareness of cultural biases, promoting cultural sensitivity, and fostering an open dialogue about cultural dynamics within the therapeutic relationship.
- **Multicultural Supervision Models:** Utilizing supervision models that explicitly address multicultural competence can enhance the relational safety of the supervisory relationship. These models provide a framework for discussing cultural factors and promoting diversity awareness.
- **Attachment-Informed Supervision:** Incorporating attachment theory principles into supervision involves recognizing and addressing attachment dynamics within the supervisory relationship. This can enhance the emotional safety and security of the supervisee.
- **Trauma-Informed Supervision:** Trauma-informed supervision recognizes the impact of trauma on both clients and supervisees. Creating a safe and supportive space that acknowledges the potential impact of trauma fosters a sense of safety.
- **Strengths-Based Supervision:** Strengths-based supervision focuses on identifying and building upon the strengths of the supervisee. It emphasizes positive aspects of performance and encourages a mindset of continuous improvement.
- **Person-Centered Communication:** Description: Emphasizing person-centered communication involves active listening, empathy, and understanding. This technique creates a supportive space for supervisees to express themselves openly and feel heard.
- **Role Modeling:** Supervisors who model ethical behavior, cultural competence, and reflective practice set a standard for supervisees. Observing positive role models contributes to a safe and supportive learning environment.
- **Collaborative Goal Setting:** Involving supervisees in the goal-setting process fosters a collaborative approach to supervision. Establishing clear goals and expectations enhances mutual understanding and promotes a shared vision for professional development.
- **Supervisory Feedback Models:** Using structured feedback models, such as the Pendleton model or the SBI (Situation-Behavior-Impact) model, provides a systematic approach to giving and receiving feedback. This promotes clarity and effectiveness in communication**.**
- **Culturally Informed Assessment Tools:** Integrating culturally informed assessment tools, such as the Multicultural Counseling Inventory (MCI) or the Cross-Cultural Supervision Checklist, aids in assessing and addressing cultural dynamics within the supervisory relationship.
- **Supervision Contracts:** Establishing clear and explicit supervision contracts that outline roles, responsibilities, and expectations enhances the transparency of the supervisory relationship. This reduces ambiguity and contributes to a sense of safety.

- **Strengths-Based Assessment:** Incorporating strengths-based assessment approaches involves recognizing and leveraging the supervisee's existing strengths. This positive approach contributes to a supportive supervisory climate.
- **Ongoing Evaluation and Adaptation:** Regularly evaluating the effectiveness of the supervisory relationship and adapting strategies based on feedback promotes a dynamic and responsive supervisory approach. This ongoing process contributes to relational safety.

Empirically supported relational safety techniques contribute to the effectiveness of clinical supervision by promoting a secure and supportive learning environment. Integrating a combination of these techniques, tailored to the unique needs of supervisees, enhances the overall quality of the supervisory relationship.

Culture

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

- Identify the competencies necessary for supervisees to work with diverse individuals and navigate intercultural communities.
- Identify methods for supervisors to assist supervisees in developing these competencies.
- Provide evaluation criteria for supervisors to determine whether their supervisees have met minimal competency standards for effective and relevant practice.

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

The competencies listed in this document reflect the importance of culture in supervision. The Counselor Development domain encourages self-examination of attitudes toward culture and other contextual variables. The Supervisory Alliance domain promotes attention to these variables in the supervisory relationship

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

There are three levels of cultural consideration for the supervisory process: the issue of the culture of the client being served and the culture of the counselor in supervision. Holloway emphasizes the cultural issues of the organization, the geographic environment of the organization, and many other contextual factors. Specifically, there are three important areas in which cultural and contextual factors play a key role in supervision: in building the supervisory

relationship or working alliance, in addressing the specific needs of the client, and in building supervisee competence and ability. It is your responsibility to address your supervisees' beliefs, attitudes, and biases about cultural and contextual variables to advance their professional development and promote quality client care.

Continuum of Cultural Competence

Becoming culturally competent and able to integrate other contextual variables into supervision is a complex, long-term process. There are several stages on a continuum of becoming culturally competent.

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

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

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

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

✓ What demographic variables do you use to identify yourself?

✓ What world views (e.g., values, assumptions, and biases) do you bring to supervision based on your cultural identities?

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

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

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

Qualities of Effective Cultural Competence Training

The qualifications of the trainer, the selection of training strategies, and the use of reputable training curricula are extremely important in developing culturally competent staff and responsive services. The following concepts should be considered in the development and implementation of cultural training:

- Cultural training should begin with educating new staff members about the organization's vision, values, and mission as related to culturally responsive services. Orientation should address the demographic composition of clientele, policies and procedures for cultural and linguistic services, counseling and performance expectations for assessment, treatment planning, and delivery of culturally responsive services.
- Before developing and initiating a training plan for culturally responsive services, ask staff members about their training needs specific to the cultural groups that they serve. Receptivity will likely increase if managers and administrators involve clinical staff in the planning process rather than assuming that they know exactly what staff members need regarding cultural training.
- Training should occur across time, and a training plan should detail how to provide training for new employees. Too often, trainings occur at one time, ignoring the complexity of cultural groups and suggesting that one training session is sufficient to achieve cultural competence. Cultural competence evolves from ongoing professional development.
- Training should incorporate diverse learning strategies, including experiential learning and cultural immersion when appropriate (e.g., participation in community activities, role-plays, case presentations). Training should be experientially based and process oriented, allowing selfreflection as part of the training and assigning self-reflection activities between training sessions (see the how-to box on self-reflection on the next page).
- Training should provide information that is practice- or research-based to ensure that participants see it as reputable and clinically sound.
- Training should create a welcoming, nonjudgmental, and professional atmosphere in which staff members, regardless of race, ethnicity, or cultural group, have the freedom and safety to explore their own beliefs and to learn about other cultural groups. Training efforts should not scapegoat mainstream cultural groups or make general statements about specific racial or ethnic groups without noting that there are many cultural subgroups within a given racial or ethnic group—often

characterized by, but not limited to, geographic location, socioeconomic status, or educational levels. Participation guidelines should be clarified for each training.

- ➡ Training should be conducted by an interdisciplinary, multicultural training team that is experienced in training and well versed in cultural competence.
- ➡ Trainers should allow time for staff members to ask questions and process the presented materials and experiential exercises, and they should use staff questions and exercises to explore and correct misperceptions in a nonjudgmental manner.

How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision

Ask participants to preselect three clients whom they are currently counseling and will likely continue to counsel prior to the next training or supervision session. Selection should be based on clients' diversity in age, race, gender, ethnicity, socioeconomic status, education, and/or geographic location. After each participant has selected three clients (remind participants not to disclose actual client identity if this is an external training outside of the agency), ask them to keep a self-reflection journal wherein the number of entries coincide with each client session until the next training. Participants should write about their internal process, including reactions such as feelings, thoughts, or behaviors during the session that relate to the influence of culture. For example:

- ✓ Identify racial, ethnic, and cultural similarities and differences between you and your client.
- ✓ Explain how your cultural and clinical worldviews influence your dialog, treatment planning, and expectations of yourself and your client in the session.
- ✓ Describe assumptions that you have learned to make about your client's specific race, ethnicity, or culture(s).
- ✓ Even if you think these assumptions, beliefs, or biases do not play a role in your current counseling relationship and approach, discuss how they could influence your counseling. Provide a specific example.
- ✓ Describe the feelings that you have about your client. How do these feelings relate to your client's racial, ethnic, or cultural identity?
- ✓ Explain the differences and similarities in worldviews between you and your client.
- ✓ Discuss how your and your client's beliefs about health, healing, disease, and addiction differ.
- ✓ Describe how your client's experience with discrimination, oppression, and prejudice could influence his/her current level of distress, psychological functioning, and response to treatment. • Explore how you attend to your client's worldview in each session.
- ✓ Describe a misunderstanding or erroneous counseling response during a counseling session that appears related to differences in cultural identification, values, or behavior.
- ✓ Identify cultural knowledge that you must obtain to gain a better understanding of your client.
- ✓ Discuss the most important lessons that you have learned from your client.

Task: Provide Culturally Congruent Clinical Supervision

Although educational institutions have developed curricula and standards to reinforce the need for a multicultural perspective in training, many clinical supervisors lack sufficient training in this area (e.g., avoid cultural topics in supervision, have difficulty giving culturally appropriate consultations or direction, fail to guide/reinforce timely implementation of policies or procedures that support culturally responsive services with their supervisees). This can significantly impede organizations attempting to introduce or improve culturally responsive clinical services. It is essential for

organizations to provide supervisees with clinical supervisors who are culturally aware, have engaged in multicultural training, and model culturally competent behaviors in clinical supervision sessions (e.g., allowing or engaging in discussions centered on race, ethnicity, and cultural groups in the session). Clinical supervision is the glue that reinforces culturally competent behavior, and it is often the only avenue of ongoing clinical training and follow-up after specific workshops or trainings are offered by the organization. Clinical supervisors should adopt a multicultural framework to guide the supervision process (e.g., Sue's multidimensional model for developing cultural competence). Endorsement of a model for developing and enhancing cultural competence helps both supervisors and supervisees understand how to address cultural issues in supervision and pursue personal and professional development that supports culturally responsive clinical services. (For a specific example, see Field and colleagues' Latina–Latino multicultural developmental supervisory model.) The model guides supervision and reinforces the premise that cultural variables influence each aspect of supervision: the relationship between supervisors and supervisees, the supervisors' and supervisees' perceptions and assessments of clients' presenting issues, the interactions between supervisees and their clients, and the treatment recommendations and directions that evolve from supervision.

Task: Evaluate Staff Performance on Culturally Congruent and Complementary Attitudes, Knowledge, and Skills

Organizations committed to endorsing and implementing culturally responsive services need policies and procedures that reflect this commitment in job descriptions and staff evaluations across all levels of the organization. By incorporating specific goals, expectations, and tasks into performance evaluations, staff members will receive an important and consistent message from the organization that culturally competent behavior and responsive services are valued and rewarded.

Staff Education and Training Guidelines

OMH recommends tailoring curriculum topics to the roles and responsibilities of trainees and the specific needs of populations served over time but suggests that training should at least address:

- The effects of cultural differences between counselors and clients/consumers on clinical and other workforce encounters, such as the therapeutic alliance.
- The elements of effective communication among staff members and clients/consumers from diverse cultural groups who use different languages, including how to work with interpreters and telephone language services.
- Strategies for resolving racial, ethnic, or cultural conflicts between staff members and clients. • The organization's policies and procedures for written language access, including how to gain access to interpreters and translated written materials.
- Parts of the Civil Rights Act of 1964 that address services for clients with limited English proficiency.
- The organization's complaint or grievance procedures.
- The effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive care.

- The impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service use, quality of care, and health outcomes.
- Differences in the clinical management of diseases and conditions indicated by differences in the race or ethnicity of clients.
- The effects of cultural differences among clients/consumers and staff members on health outcomes, client satisfaction, and treatment planning. (Source: OMH Adapted from material in the public domain.)

How To Discuss Professional Development in Multicultural Counseling

This tool facilitates supervisee–supervisor discussions surrounding professional development activities that promote cultural competence. Supervisors can ask supervisees to review the list and check off activities that they have engaged in recently or in the past several months. Supervisors can then use the completed exercise as a starting point for gaining more specific information on activities endorsed by supervisees. Even if supervisees check off no items, reviewing the list reinforces activities that build cultural competence. Materials needed: A printed copy of the checklist and a pen or pencil.

Instructions: Mark off the activities you have engaged in during the past month and/or 6 months.

Past 6 months
____ I recognized a prejudice I have about certain people.
____ I talked to a colleague about a cultural issue.
____ I sought guidance about a cultural issue that arose in therapy.
____ I attended a multicultural training seminar.
____ I attended a cultural event.
____ I attended an event in which most other people weren't of my race.
____ I reflected on my racial identity and how it affects my work with clients.
____ I read a chapter or an article about multicultural issues.
____ I read a book about a racial group other than my own.
____ I sought consultation or supervision about multicultural issues.
____ I talked to a friend/associate about how our racial differences affect our relationship.
____ I challenged a racist remark—my own or someone else's.

Source: Pack-Brown and Williams, p. 136. Used with permission.

Culturally Responsive Performance Evaluation Criteria

Cultural competence is measured by the degree to which counselors, administrators, and other staff members engage in observable actions and attitudes that reflect cultural responsiveness. Following are examples of descriptive evaluation criteria that address a few aspects of culturally responsive behavior:

- Engages in ongoing self-analysis to identify and address personal and cultural biases.
- Actively seeks to view life through the eyes of others and, through doing so, develops a greater level of sensitivity for the values and life challenges of other groups.

- Participates in hands-on training opportunities and seeks practice and feedback that build toward mastery of responsive needs assessment techniques.
- Seeks opportunities to engage in cross-cultural activities and interactions

5. Trauma Informed Clinical Supervision

Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care. One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated in 2009 (*Bernard & Goodyear, 2009*). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Clinician competencies*:*

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.

- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (*Falender & Shafranske*). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical supervision in a TIC supervision should focus on the following priorities:

✓ General case consultation
✓ Specialized consultation in specific and unusual cases
✓ Opportunities to process clients' traumatic material
✓ Boundaries in the therapeutic and supervisory relationship
✓ Assessment of secondary traumatization
✓ Counselor self-care and stress management
✓ Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific

counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback.

Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (*Martino et al.*). Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the clinician may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize clinicians.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the clinician–client relationship and in which exploring the nature of boundaries in both client– clinician and clinician–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field. Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address. To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members.

Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.
When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. The term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (*Newall & MacNeil*). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (*Von Rueden et al.*). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience

intrusive trauma symptoms.

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma *(Newall & MacNeil*). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma related disorders reported higher levels of traumatic stress symptoms (*Bober & Regehr)*. Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and non-trauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience, having specialized training in trauma informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (*Sprang, Clark, & WhittWoosley,*). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multi-method study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (*McGarrigle & Walsh*). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices. One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma related disorders and reduces the sense of hopelessness that is often a part of the work. One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (*Sprang et al.*). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (*Bober & Regehr*).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (*Shoptaw, Stein, & Rawson*). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (*Sprang et al*.). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (*Bober & Regehr*).

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Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors. Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to

participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report post-traumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma". To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- ➡Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- ➡Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and non trauma related counselor caseloads.
- ➡Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- ➡ Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to reduce the risk for secondary traumatization and promote counselor resilience.
- ➡ Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Assessment of Secondary Traumatization

Clinicians with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately. *Stamm* has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout" *(Newall & MacNeil*).
Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (*Adams, Figley, & Boscarino; Newall & MacNeil*).
This tool can be used in individual and group clinical supervision, trainings on self-care, andteam meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization. The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction sub-scale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives.

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group. Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not re-experiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group.

In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

Recognizing SecondaryTraumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

Recognizing STS in Clinicians Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor". So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

Addressing Secondary Traumatization

If a clinician is experiencing STS, the supervisor and organization should address it immediately. Clinical supervisors can collaborate with clinicians to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the clinician is experiencing, providing specific self-care strategies to counteract the stress.

Decisions about strategies for addressing secondary traumatization should be based on the

personal preferences of the clinician, the opportunity for an immediate intervention following a critical incident, and the clinician's level of awareness regarding his or her experience of STS. Clinicians may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (*Myers & Wee*).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual individual sessions); if possible, these services should be offered continuously instead of just one time.

Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

- Psychological distress
- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation
- Cognitive shifts
- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client re-experiences trauma or reenacts trauma in counseling
- Feeling victimized by client
- Relational disturbances
- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Over-identification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life
- Frame of reference
- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world

- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

(Sources: Figley, Newall & MacNeil, Saakvitne et al.)

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased. Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before. Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

Addressing Secondary Traumatization

If a clinician is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with clinicians to devise an individualized plan that is accessible, acceptable, and appropriate for each c clinician and that addresses the secondary stress reactions the clinician is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the clinician, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Clinicians may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (*Myers & Wee)*.

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be

voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent longterm aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For non-crisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors:

Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances. If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a non-judgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.

- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the clinician and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work. When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the supervisee and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on supervisee issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, supervisee should be encouraged to address them in their own counseling or psychotherapy.

Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage clinicians in regular screening/self-assessment of clinicians' experience of STS.
2. Address signs of STS with clinicians in clinical supervision.
3. Work collaboratively with clinicians to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide clinicians a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide clinicians with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with clinicians to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Clinician Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (*Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy*). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (*Burke et al.,)*. A comprehensive self-care plan should include activities that nourish the physical, psychological/ mental, emotional/relational, and spiritual aspects of clinicians' lives.
The literature on clinician self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have substance use and trauma-related disorders.

Clinicians are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Clinician self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues suggest that when administrators support clinician self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on clinicians (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain. Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

A Comprehensive Self-Care Plan

A self-care plan should include a self assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

- Physical self-care
- Psychological self-care (includes cognitive/mental aspects)
- Emotional self-care (includes relational aspects)
- Spiritual self-care

Activities that may help clinicians find balance and cope with the stress of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives. In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16 to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the

families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem." —Member of a Disaster Response Team at the Pentagon after September 11 (*Source: Walser*)

Essential Components of Self-Care

Saakvitne and colleagues describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

- Awareness of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
- Balance of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
- Connection to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

Comprehensive Self-Care Plan Worksheet Instructions

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

<u>Physical</u>
- What are non-chemical things that help my body relax?
- What supports my body to be healthy?
- Psychological/Mental
- What helps my mind relax?
- What helps me see a bigger perspective?
- What helps me break down big tasks into smaller steps?
- What helps me counteract negative self-talk?
- What helps me challenge negative beliefs?
- What helps me build my theoretical understanding of trauma and addictions?
- What helps me enhance my counseling/helping skills in working with traumatized clients?
- What helps me become more self-reflective?

Emotional/Relational

- What helps me feel grounded and able to tolerate strong feelings?
- What helps me express my feelings in a healthy way?
- Who helps me cope in positive ways and how do they help?
- What helps me feel connected to others?
- Who are at least three people I feel safe talking with about my reactions/feelings about clients?
- How can I connect with those people on a regular basis?

Spiritual

- What helps me find meaning in life?
- What helps me feel hopeful?
- What sustains me during difficult times?
- What connects me to something greater?

Clinical supervisors can help clinicianss review their self-care plans through the ABCs by reflecting on these questions:

➡ Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?

➡ Has the clinician described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?

➡ Has the clinician identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (*Saakvitne et al.*). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care.

Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives. Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators

can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma informed organization.

The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the Oklahoma City bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care. Ethical Principles of Self-Care in Practice These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines

- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.
- Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from
- work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in
- and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.
- Commitment to self-care: Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care. Source: Green Cross Academy of Traumatology, 2010.

PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the past 30 days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I [help].
___ 3. I get satisfaction from being able to [help] people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I [help].
___ 7. I find it difficult to separate my personal life from my life as a [helper].
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
___ 9. I think that I might have been affected by the traumatic stress of those I [help].
___ 10. I feel trapped by my job as a [helper].
___ 11. Because of my [helping], I have felt "on edge" about various things.
___ 12. I like my work as a [helper].
___ 13. I feel depressed because of the traumatic experiences of the people I [help].
___ 14. I feel as though I am experiencing the trauma of someone I have [helped].
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a [helper].
___ 20. I have happy thoughts and feelings about those I [help] and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
___ 24. I am proud of what I can do to [help].
___ 25. As a result of my [helping], I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a [helper].
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

Your Scores on the ProQOL: Professional Quality of Life Screening
Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

What Is My Score and What Does It Mean?
In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale
Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table below.

Burnout Scale
On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are not happy so you reverse the score.

Secondary Traumatic Stress Scale
Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table below.

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the

greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout. The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

6. Legal and Ethical Considerations in Clinical Supervision

Legal and Ethical Issues in Supervision

In today's environment, legal and ethical issues in supervision, as in counseling, have become more numerous and complex. Clinical supervisors have an obligation to know the relevant state and federal laws that apply to their practice and to ensure that their supervisees also have this knowledge. Malpractice and liability claims related to clinical supervision include cases involving situations where supervisors failed in their duty to properly supervise and oversee cases. Legal issues include vicarious liability, by which a supervisor is responsible for the supervisees behavior; duty to warn and to protect, which for clinicians involves supervisory guidance; and malpractice. A good defense against malpractice is consultation with colleagues and documentation of when supervisory sessions took place and what was discussed (Powell &Brodsky). Thorough discussions of legal issues are in most supervision texts (Falvey, Reamer). Ethical issues for supervisors vary. Supervisors are responsible for adherence to their own discipline's code of ethics and for ensuring that their supervisees adhere to theirs.

Dual relationships occur when a supervisor has a second relationship with a supervisee, such as a social, financial, business, or workplace relationship. "Sexual or romantic interactions or relationships with current supervisees are prohibited" according to the ACA Code of Ethics (ACA, p. 14; see also Falvey). Boundary violations are a type of dual relationship. They can occur in the structure of the supervisory relationship (e.g., having a supervisory session in one's living room or during dinner in a restaurant) or in its process (e.g., giving gifts, physical contact). A number of studies of the frequency of sexual misconduct in supervision have been conducted. Between 1.4 and 4.0 percent of supervisors have had sexual relationships with their supervisees (Falender & Shafranske).

Some boundary issues are clear; others are difficult to resolve. The client must give informed consent for the counselor to discuss his or her case with the supervisor. Bernard and Goodyear suggested that informed consent should occur at three levels: client consent to treatment, client consent to supervision of their case, and supervisee consent to supervision. (For a detailed explanation of these three levels, see Falvey.) Supervisor confidentiality is analogous to counselor confidentiality, which must be maintained unless clearly defined circumstances demand disclosure to protect the welfare of the client or the public at large. Supervisors must know the limits of confidentiality, at both State and Federal levels.

Over half the psychotherapy interns in one study reported at least one ethical violation by their supervisor (Ladany, Lehrman-Waterman, Molinaro, & 253 Wolgast). The most common were inadequate performance evaluation, breach of confidentiality, and inability to work with alternative perspectives. The existence of these perceived violations was associated with a weaker supervisory relationship and lower satisfaction. Several models for resolving ethical dilemmas are suggested by Falender and Shafranske. (See also Falvey, Clinical Supervision: Ethical Practice and Legal Risk Management, and Reamer, Tangled Relationships: Managing Boundary Issues in the Human Services).

Supervision contracts or agreements are recommended. Besides listing the basics, including the frequency, length of sessions, and length of the course of supervision, the agreement should specify the modality and approaches to be used, along with the duties and responsibilities of all parties (Bernard & Goodyear, Campbell, Northwest Frontier ATTC). Dual Relationships and Boundary Issues Dual relationships can occur at two levels: between supervisors and supervisees and between counselors and clients. You have a mandate to help your supervisees recognize and manage boundary issues.

A dual relationship occurs in supervision when a supervisor has a primary professional role with a supervisee and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship. Examples of dual relationships in supervision include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an Alcoholics Anonymous sponsor for a former supervisee. Obviously, there are varying degrees of harm or potential harm that might occur as a result of dual relationships, and some negative effects of dual relationships might not be apparent until later. Therefore, firm, always-or-never rules aren't applicable. You have the responsibility of weighing with the supervisee the anticipated and unanticipated effects of dual relationships, helping the supervisee's self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship.

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

The most common basis for legal action against clinicians (20 percent of claims) and the most frequently heard complaint by certification boards against counselors (35 percent) is some form of boundary violation or sexual impropriety. Codes of ethics for most professions clearly advise that dual relationships between clinicians and clients should be avoided. Dual relationships between supervisee and supervisors are also a concern and are addressed in the ethical codes of various related professions.

Problematic dual relationships between supervisees and supervisors might include intimate relationships (sexual and non-sexual) and therapeutic relationships, wherein the supervisor becomes the counselor's therapist. Sexual involvement between the supervisor and supervisee can include sexual attraction, harassment, consensual (but hidden) sexual relationships, or intimate romantic relationships. Other common boundary issues include asking the supervisee to do favors, providing preferential treatment, socializing outside the work setting, and using emotional abuse to enforce power. It is imperative that all parties understand what constitutes a dual relationship between supervisor and supervisee and avoid these dual relationships.

Sexual relationships between supervisors and supervisees and supervisees clients occur far more frequently than one might realize (Falvey). In many States, they constitute a legal transgression as well as an ethical violation.

Informed Consent

Informed consent is key to protecting the clinician and/or supervisor from legal concerns, requiring the recipient of any service or intervention to be sufficiently aware of what is to happen, and of the potential risks and alternative approaches, so that the person can make an informed and intelligent decision about participating in that service. The supervisor must inform the supervisee about the process of supervision, the feedback and evaluation criteria, and other expectations of supervision. The supervision contract should clearly spell out these issues. Supervisors must ensure that the supervisee has informed the client about the parameters of counseling and supervision (such as the use of live observation, video- or audio taping).

Confidentiality

In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor's vicarious liability. Informed consent and concerns for confidentiality should occur at three levels: client consent to treatment, client consent to supervision of the case, and supervisee consent to supervision (Bernard & Goodyear). In addition, there is an implied consent and commitment to confidentiality by supervisors to assume their supervisory responsibilities and institutional consent to comply with legal and ethical parameters of supervision. (See also the Code of Ethics of the Association for Counselor Education and Supervision [ACES], available online at http://www.acesonline.net/ethical_guidelines.asp). With informed consent and confidentiality comes a duty not to disclose certain relational communication. Limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies. Criteria for waiving client and supervisee privilege should be stated in institutional policies and discipline specific codes of ethics and clarified by advice of legal counsel and the courts. Because standards of confidentiality are determined by State legal and legislative systems, it is prudent for supervisors to consult with an attorney to determine the State codes of confidentiality and clinical privileging. In the substance abuse treatment field, confidentiality for clients is clearly defined by Federal law: 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA). Key information is available at http:// www.hipaa.samhsa.gov. Supervisors need to train counselors in confidentiality regulations and to adequately document their supervision, including discussions and directives, especially relating to duty-to-warn situations. Supervisors need to ensure that clinicians provide clients with appropriate duty- to-warn information early in the counseling process and inform clients of the limits of confidentiality as part of the agency's informed consent procedures. Under duty- to-warn requirements (e.g., child abuse, suicidal or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may need to be waived.

Organizations should have a policy stating how clinical crises will be handled (Falvey). What mechanisms are in place for responding to crises? In what timeframe will a supervisor be notified of a

crisis situation? Supervisors must document all discussions with supervisees concerning duty-to-warn and crises. At the onset of supervision, supervisors should ask supervisees if there are any duty-to-warn issues of which the supervisor should be informed.

New technology brings new confidentiality concerns. Websites now dispense information about treatment and provide counseling services. With the growth in online counseling and supervision, the following concerns emerge: (a) how to maintain confidentiality of information, (b) how to ensure the competence and qualifications of counselors providing online services, and (c) how to establish reporting requirements and duty to warn when services are conducted across State and international boundaries. New standards will need to be written to address these issues. (The National Board for Certified Counselors has guidelines for counseling by Internet at http://www.nbcc.org/AssetManagerFiles/ethics/internetcounseling.pdf.)

Supervisor Ethics

The standards and ethics regard to dual relationship and other boundary violations include that supervisors will:

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

Supervisor Training and Supervision (Please also see updated requirements for supervisors)

Training of supervisors has become a significant concern at the State and Federal level, with increasing attention given, especially with the advent of credentialing requirements for certified clinical supervisors. A number of training models are available. An Internet search will indicate resources in addition to the following:

- Northwest Frontier ATTC, Clinical Supervision: Building Chemical Dependency Counselor Skills.
- New England ATTC, Evidence-Based Practices and Clinical Supervision.
- Mid-Atlantic ATTC, Motivational Interviewing and Clinical Supervision.

Administrative Issues in Supervision

Organizational support for supervision is essential to instilling the belief that clinical supervision is key to staff retention and workforce development. Strategies for reducing the costs involved in a supervision program include agreements with other agencies, using retired supervisors interested in part-time employment, and group supervision (Roche, Todd, & O'Connor). Other key organizational issues include how certain organizational models and styles of management influence the process of clinical supervision and how organizational receptivity to supervision affects the outcome and

effectiveness of clinical supervision. Although little research has been conducted on these issues, they remain key factors that influence the adoption of clinical supervision within an organization.

Supervision and Training Using New Technologies

Many clinician training and education activities are already conducted using computers and the Internet, and research generally indicates that these technologies are effective for this purpose (Ferreira, Liebowitz, Murdock, Williams, Becker, Bruce, & Young). Computer technologies also offer a number of potential benefits for the training of clinicians, such as the ability to provide real-time feedback to trainees who are conducting practice sessions. Trepal, Haberstroh, Duffey, and Evans discussed some of the issues involved in teaching counseling skills via the Internet, especially in terms of establishing a relationship. A review by Hayes discussed the use of computers in training and supervising clinicians, including such factors as use of computer based simulations, student attitudes toward new technology, and ethical issues. Individual and group instruction can be conducted using Web-based technology; at least one study has found the latter to be an effective training platform for teaching CBT to counselors (Weingardt, Cucciare, Bellotti, & Lai). Vaccaro and Lambie reviewed options for conducting computer-based training and supervision, as well as advantages and disadvantages and ethical concerns for this type of supervision/training. Smith, Carpenter, et al., randomly assigned 97 substance use disorder treatment counselors who were enrolled in a 2-day motivational interviewing workshop to receive live supervision conducted using video conferencing technology, supervision using videotaped practice sessions, or the workshop alone without an additional supervision component. Participants' sessions with clients were rated 1, 8, and 20 weeks after the workshop using the Motivation Interviewing Treatment Integrity Coding System. Participants who used teleconferencing for supervision had significantly better compliance compared with those who used the workshop alone, and they did a significantly better job in maintaining a proper ratio between questions and reflections than did those in either of the other groups.

Clinical supervision can also be conducted using phone and Internet technologies. Abbass et al., reviewed literature on the use of Web conferencing technology to supervise psychotherapists. They noted its benefits in terms of reducing costs, enabling long-distance supervision, and integrating supervision with training and educational materials. They also reviewed some potential problems, such as technical difficulties, the absence of local support during times of crisis, and possible difficulties/anxieties relating to the supervisory alliance.

Standards of Best Practice

According to the NASW, "The use of technology for supervision purposes is increasing. Video-conferencing is a growing technological tool used to provide supervision, especially in remote areas. Some jurisdictions allow electronic means for supervision; others may limit the amount of supervision that can be provided from a distance. When using technology to provide distance supervision, one must be aware of standards of best practice for providing this tool and be knowledgeable of the statutes and regulations governing the provision of such services." According to the ASWB, "When using or providing supervision and consultation by technological means, social work supervisors and supervisees shall follow the standards that would be applied to a face-to-face

supervisory relationship and shall be competent in the technologies used.", The ASWB further clarifies it's interpretation of this by stating, "Social workers should follow applicable laws regarding direct services, case, or clinical supervision requirements and the use of technology for the purposes of licensure. Supervision for purposes of licensure is governed by regulatory boards that may have specific definitions and requirements pertaining to the use of technology in supervision. Social workers receiving supervision for the purposes of licensure have a responsibility to become familiar with these definitions and meet the requirements. Third-party payers and professional entities may have additional requirements that need to be followed. Social workers should retain a qualified supervisor or consultant for technology concerns that may arise. When using technology for client services, proper training should be obtained to become familiar with the technologies being used. As with all supervisor–supervisee relationships, the supervisor may share the responsibility for services provided and may be held liable for negligent or inadequate practice by a supervisee."

Supervisory Problems and Resources

Supervisors may encounter a broad array of issues and concerns. The following are resources for supervision:

- Code of Ethics from the Association of Addictions Professionals (NAADAC; http://naadac.org).
- International Certification & Reciprocity Consortium's Code of Ethics (http:// www.icrcaoda.org).
- Codes of ethics from professional groups such as the American Association for Marriage and Family Therapy (http://www.aamft.org), the American Counseling Association (http:// www.counseling.org), the Association for Counselor Education and Supervision (http:// www.acesonline.net), the American Psychological Association (http:// www.apa.org), the National Association of Social Workers (http:// www.socialworkers.org), and the National Board for Certified Counselors (NBCC; http://www.nbcc.org).
- ACES Standards for Counseling Supervisors; ACES Ethical Guidelines for Counseling Supervisors (http://www.acesonline.net/ ethical_guidelines.asp); and NBCC Standards for the Ethical Practice of Clinical Supervision. Barriers to Implementing Clinical Supervision, Source: Roche, Todd, & O'Connor, p. 244; Powell & Brodsky.

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

- ➢ Ethical decision-making is a continuous, active process.
- ➢ Ethical standards are not a cookbook. They tell you what to do, not always how.
- ➢ Each situation is unique. Therefore, it is imperative that all personnel learn how to think ethically and how to make sound legal and ethical decisions.
- ➢ The most complex ethical issues arise in the context of two ethical behaviors that conflict; for instance, when a counselor wants to respect the privacy and confidentiality of a client, but it is in the client's best interest for the counselor to contact someone else about his or her care.
- ➢ Therapy is conducted by fallible beings; people make mistakes hopefully, minor ones.
- ➢ Sometimes the answers to ethical and legal questions are elusive. Ask a dozen people, and you'll likely get twelve different points of view.

Helpful resources on legal and ethical issues for supervisors include Beauchamp and Childress, Falvey, Gutheil and Brodsky, Pope, Sonne, and Greene, and Reamer.

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

(1) Vicarious liability (or respondent superior)

(2) Dual relationships and boundary concerns

(3) Informed consent

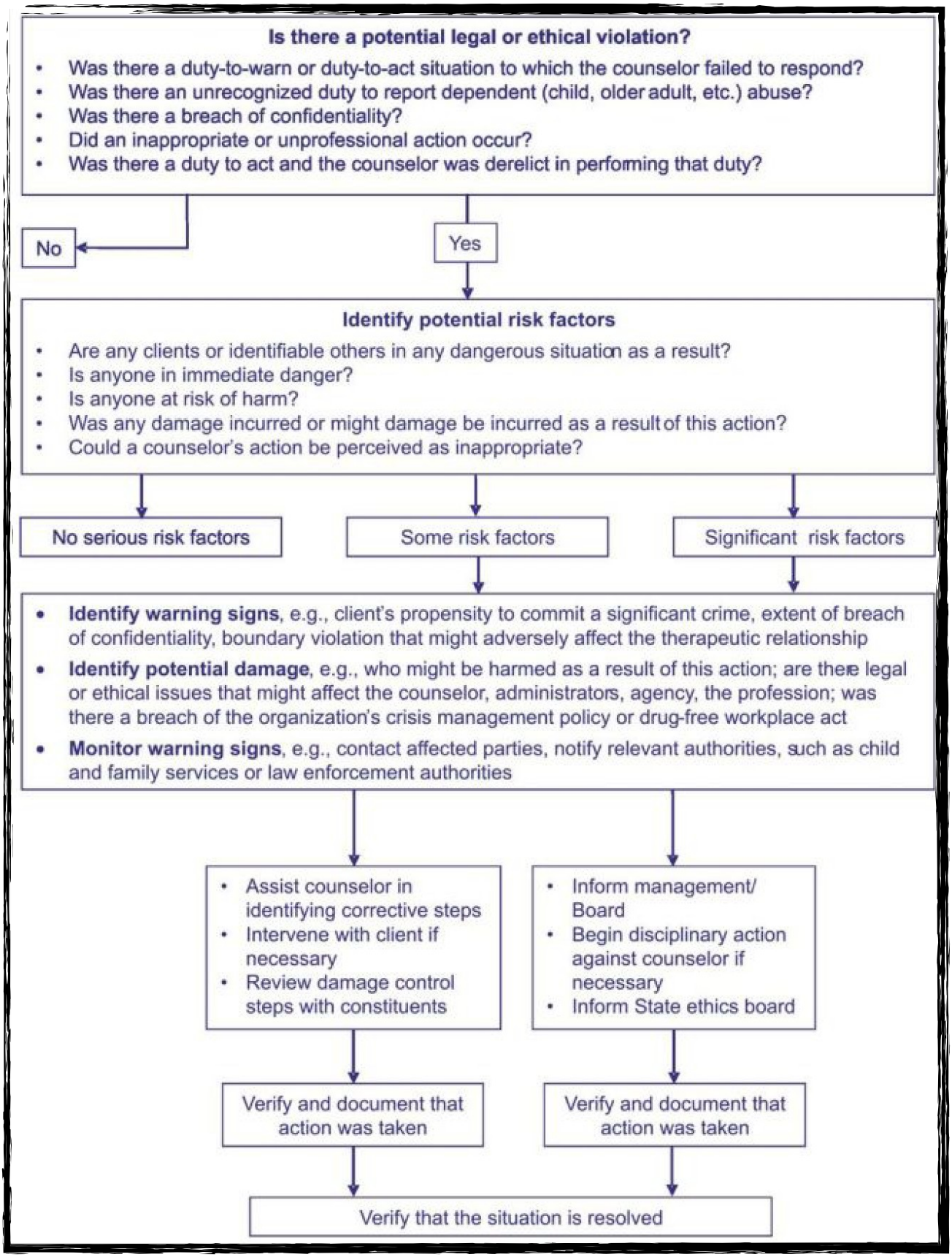
(4) Confidentiality

(5) Supervisor ethics

Direct Versus Vicarious Liability

An important distinction needs to be made between direct and vicarious liability. Direct liability of the supervisor might include dereliction of supervisory responsibility, such as "not making a reasonable effort to supervise" (defined below). In vicarious liability, a supervisor can be held liable for damages incurred as a result of negligence in the supervision process. Examples of negligence include providing inappropriate advice to a clinician about a client (for instance, discouraging a clinician from conducting a suicide screen on a depressed client), failure to listen carefully to a supervisee's comments about a client, and the assignment of clinical tasks to inadequately trained clinicians. The key legal question is: "Did the supervisor conduct him- or or herself in a way that would be reasonable for someone in his position?" or "Did the supervisor make a reasonable effort to supervise?" A generally accepted time standard for a "reasonable effort to supervise" in the behavioral health field is 1 hour of supervision for every 20–40 hours of clinical services. Of course, other variables (such as the quality and content of clinical supervision sessions) also play a role in a reasonable effort to supervise. State requirements vary and need to be adhered to.

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



The figure above indicates how a supervisor might manage a situation where he or she is concerned about a possible ethical or legal violation by a clinician.

CAMFT, NASW, and APA Ethical Standards

CAMFT Ethical Standards

SUPERVISOR, SUPERVISEE, EDUCATOR, AND STUDENT RESPONSIBILITIES

Marriage and family therapists, supervisees and students employ effective and respectful communication when fulfilling their professional responsibilities. Marriage and family therapists, when acting as supervisors and educators, are cognizant of their impact on the professional development of supervisees and students; they do not exploit the trust and dependence of students and supervisees and whenever possible they appropriately safeguard the best interests of the clients/ patients of supervisees.

7.1 MAINTAINING PROFESSIONAL BOUNDARIES WITH SUPERVISEES AND STUDENTS: Marriage and family therapists are aware of their influential position with respect to their students and supervisees, and they avoid exploiting the trust and dependency of such persons. Marriage and family therapists therefore avoid engaging in relationships with supervisees and students (over whom they exercise professional authority) that are reasonably likely to impair professional judgment or lead to exploitation. Provision of therapy to students or supervisees over whom the supervisor or educator exercise professional authority is unethical and provision of marriage and family therapy supervision to clients/patients is also unethical. Other acts which are likely to be unethical include, but are not limited to, borrowing money from a supervisee, engaging in a business venture with a supervisee, or engaging in a close personal relationship with a supervisee or student. Such acts with a supervisee's spouse, partner or immediate family member may also be considered unethical dual relationships.

7.2 SEXUAL CONTACT WITH SUPERVISEES AND STUDENTS: Marriage and family therapists do not engage in sexual contact with supervisees or students with whom they exercise professional authority. Sexual contact includes, but is not limited to, sexual intercourse, sexual intimacy, and sexually explicit communications without a sound clinical, supervisory, or educational basis. Such acts with the spouse, partner, or immediate family member of a supervisee or student are likely to be unethical and exploitive. (See also section 4.5 Sexual Contact.)

7.3 SEXUAL HARASSMENT OF SUPERVISEES OR STUDENTS: Marriage and family therapists do not engage in sexual harassment of supervisees or students.

7.4 COMPETENCE OF SUPERVISEES: Marriage and family therapists assure that the extent, quality and kind of supervision provided is consistent with the education, training, and experience level of the supervisee. Marriage and family therapists do not permit their students, employees, or supervisees to perform or to hold themselves out beyond their pre-licensed status or to perform professional services beyond their scope of competence.

7.5 MAINTAINING SUPERVISION SKILLS: Marriage and family therapists who act as supervisors are responsible for maintaining the quality of their supervision skills and for obtaining consultation or supervision for their work as supervisors whenever appropriate.

7.6 KNOWLEDGE OF LAWS AND REGULATIONS: Supervisors and supervisees have a responsibility to be knowledgeable about relevant laws and regulations pertaining to the practice of marriage and family therapy.

7.7 CHANGES IN LEGAL REQUIREMENTS AND ETHICAL STANDARDS: Supervisors maintain awareness of and stay current with changes in professional and ethical standards and legal requirements. Supervisors ensure that their supervisees are aware of professional and ethical standards and legal responsibilities.

7.8 CULTURE AND DIVERSITY: Supervisors and educators are aware of and address the role that culture and diversity issues play in their supervisory and educational relationships, including, but not limited to, evaluating, terminating, disciplining, or making decisions regarding supervisees or students.

7.9 POLICIES AND PROCEDURES: Supervisors and educators create and implement policies and procedures that are clear and that are disclosed to supervisees and students at the commencement of and throughout supervision or education.

7.10 PERFORMANCE APPRAISALS: Supervisors provide supervisees with periodic performance appraisals and evaluative feedback throughout the supervisory relationship and identify and address the limitations of supervisees that might impede performance.

7.11 BUSINESS PRACTICES: When acting as employers and/or supervisors, marriage and family therapists follow lawful business practices.

7.12 BARTERING WITH SUPERVISEES: Marriage and family therapists ordinarily refrain from accepting goods or services from supervisees in return for services rendered due to the potential for conflicts, exploitation, and/or distortion of the professional relationship. Bartering should only be considered and conducted if the supervisee requests it, the bartering is not otherwise exploitive or detrimental to the supervisory relationship, and it is negotiated without coercion. Marriage and family therapists are responsible to ensure that such arrangements are not exploitive and that a clear written agreement is created. Marriage and family therapists are encouraged to consider relevant social and/or cultural implications of bartering including whether it is an accepted practice among professionals within the community. (For bartering with clients/patients, see also section 12.5 Bartering.)

7.13 PERFORMANCE ASSISTANCE: Supervisors guide supervisees in securing assistance when needed for the supervisee to maintain or improve performance, such as personal psychotherapy, additional education, training, or consultation. Supervisees have the responsibility to seek information and to ask for supervisorial guidance when necessary.

7.14 DISMISSAL: Supervisors shall document their decisions to dismiss supervisees.

7.15 REVIEW OF TRAINEE AGREEMENTS: Supervisors are aware of and review any trainee agreements with qualified educational institutions.

7.16 CLIENTS/PATIENTS ARE PATIENTS OF EMPLOYER: Supervisees understand that the clients/patients seen by them are the clients/patients of their employers.

7.17 SUPERVISOR QUALIFICATIONS: Supervisors maintain licensure and meet/satisfy the qualifications, laws and regulations pertaining to supervision.

7.18 SUPERVISEE REGISTRATION AND LIMITED ROLE: Supervisees maintain registrations when required by law and/or regulation and function within this limited role as permitted by the licensing law and/or regulations.

NASW Best Practice Standards in Social Work Supervision

The NASW Best Practice Standards in Social Work Supervision states, "National Association of Social Workers (NASW) and the Association of Social Work Boards (ASWB) have developed Best Practice Standards in Social Work Supervision (hereafter "Supervision Standards") to support and strengthen supervision for professional social workers. The standards provide a general framework that promotes uniformity and serves as a resource for issues related to supervision in the social work supervisory community. The knowledge base of the social work profession has expanded, and the population it serves has become more complex. Therefore, it is important to the profession to have assurance that all social workers are equipped with the necessary skills to deliver competent and ethical social work services. Equally important to the profession is the responsibility to protect clients. The NASW and ASWB Task Force on Supervision Standards maintain that supervision is an essential and integral part of the training and continuing education required for the skillful development of professional social workers. Supervision protects clients, supports practitioners, and ensures that professional standards and quality services are delivered by competent social workers.

The NASW Code of Ethics and the ASWB Model Social Work Practice Act serve as foundation documents in the development of the supervision standards. These standards support the practice of social workers in various work settings and articulate the importance of a collective professional understanding of supervision within the social work community".

Click the following link to view the full NASW Code of Ethics

NBCC Code of Ethics

SUPERVISION AND CONSULTATION

- Counselors who provide clinical supervision shall obtain appropriate training, including continuing education concerning current clinical trends, in order to meet the needs of their supervisees and the clients they serve.
- Counselors who provide supervision services shall provide accurate written information to supervisees regarding the counselor's credentials, as well as information regarding the process of supervision. This information shall include the conditions of supervision, supervision goals, case management procedures, confidentiality and its limitations, appraisal methods, and timing of evaluations.
- Counselors who act as counselor educators, field placement supervisors, or clinical supervisors shall not engage in sexual or romantic intimacy with current and former students or supervisees for at least five (5) years from the date of the last academic and/or supervision contact, whichever is later. Prohibited intimate sexual or romantic engagements include in- person contact and electronic interactions.
- Counselors who provide clinical supervision services shall keep accurate records of supervision goals and the supervisee's progress. All supervision related information shall be treated as

confidential, except to prevent serious and foreseeable harm to a client or others, or when legally required to do so by a court or government agency order. When a supervisor receives a court or governmental agency order requiring the production of supervision records, the counselor shall make reasonable attempts to promptly notify the supervisee. In cases in which the supervisee is a student in a counselor education program, the supervisor counselor shall release supervision records consistent with the terms of the supervision arrangement with the counselor education program.

- Counselors who provide clinical supervision services shall intervene in situations where a supervisee is impaired or incompetent and potentially placing the client(s) at risk. The clinical supervisor will notify the supervisee of any concerns and provide recommended or required steps to seek assistance. The supervisor also may take steps to end the supervisee's services to protect the client, and may only resume services after the completion of any recommended or required remediation

APA Ethical Guidelines

The following is quoted directly from the APA Ethical Guidelines regarding supervision:

EXECUTIVE SUMMARY

"The purpose of the Guidelines for Clinical Supervision in Health Service Psychology (hereafter referred to as Guidelines on Supervision) is to delineate essential practices in the provision of clinical supervision. The overarching goal of these Guidelines on Supervision is to promote the provision of quality supervision in health service psychology using a competency framework to enhance the development of supervisee competence ensuring the protection of clients/ patients and the public. These Guidelines on Supervision are intended to be aspirational in nature to guide psychologists proactively towards enhancing supervision practice. The term Guidelines on Supervision, as used in this document, is consistent with the provisions of the American Psychological Association (APA) policy on Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology (Section I C[1]) (APA, 2004), as passed by the APA Council of Representatives. An assumption underlying all supervision is that the supervisor is competent—both as a professional psychologist and as a clinical supervisor (Fouad et al., 2009). Supervision is for assessment, treatment, and other activities of the health service psychologist; and it occurs across varied settings. Ironically, however, minimal attention has been given to defining, assessing, or evaluating supervisor competence (Bernard & Goodyear, 2014; Falender & Shafranske, 2013) or to determining requisite training for clinical supervision. The supervisor is responsible for ensuring the protection of the public, and this duty cannot be achieved without supervisor competence. This requires developing the knowledge, skills, and attitudes in the provision of supervision, and receiving training specific to clinical supervision (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Reiser & Milne, 2012). Further, education and training in health service psychology increasingly employs a competency-based approach to the definition, assessment, and evaluation of student learning outcomes. Both the competence of supervisors and the application of competency-based approach to supervision can be enhanced by developing guidelines that assist supervisors in the provision of high quality supervision. The Guidelines on Supervision are the product of a task force convened by the APA Board of Educational Affairs. Members of the task force were selected for their expertise in the area of supervision. The majority of their work was conducted through conference calls and electronic

mail with one face-to-face meeting; and the task force adhered to a tight timeline in recognition of the considerable need for such a document.

AMERICAN PSYCHOLOGICAL ASSOCIATION

This section outlines guidelines for supervision of students in health service psychology edu- cation and training programs. The goal was to capture optimal performance expectations for psychologists who supervise. It is based on the premises that supervisors a) strive to achieve competence in the provision of supervision and b) employ a competency-based, metatheoretical approach to the supervision process.

The Guidelines on Supervision were developed as a resource to inform education and training regarding the implementation of competency-based supervision. The Guidelines on Supervision build on the robust literatures on competency-based education and clinical supervision.
They are organized around seven domains: supervisor competence; diversity; relationships; professionalism; assessment/evaluation/feedback; problems of professional competence, and ethical, legal, and regulatory considerations. The Guidelines on Supervision represent the collective effort of a task force convened by the APA Board of Educational Affairs (BEA).

The Guidelines on Supervision are predicated on a number of common assumptions and agreed upon definitions. Although an extensive list of definitions appears in Appendix A to this document, three key definitions are provided below:

HEALTH SERVICE PSYCHOLOGIST.
“Psychologists are recognized as Health Service Providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic and therapeutic intervention services relative to the psychological and physical health of consumers based on:
1) having completed scientific and professional training resulting in a doctoral degree in psychology;
2) having completed an internship and supervised experience in health care settings; and
3) having been licensed as psychologists at the independent practice level” (APA, 1996). The

Guidelines on Supervision focus on supervision for health service psychologists. A health service psychologist was defined by APA policy in 1996 and reaffirmed in the 2011 revision of the APA Model Act for State Licensure of Psychologists (APA, 2011c). Members of the task force agreed that a clear and delimited scope for the Guidelines on Supervision was important to promote understanding and use of this document. The term health service psychology (HSP) is preferred as it is narrower than professional psychology, a designation that includes the specialty of industrial-organizational psychology, which was not addressed by the task force. Health service psychology is inclusive of the specialties of clinical, counseling, and school psychology.

SUPERVISION is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. Henceforth, supervision refers to clinical supervision and subsumes supervision

conducted by all health service psychologists across the specialties of clinical, counseling, and school psychology.

COMPETENCY-BASED SUPERVISION is a metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/ cultural clinical setting (adapted from Falender & Shafranske, 2007). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision. The Guidelines on Supervision are organized around seven domains: Domain A: Supervisor Competence Domain B: Diversity Domain C: Supervisory Relationship Domain D: Professionalism Domain E: Assessment/ Evaluation/ Feedback Domain F: Problems of Professional Competence Domain G: Ethical, Legal, and Regulatory Considerations Within each of these seven domains, guidelines for supervision are articulated with a supporting rationale informed by the empirical and theoretical literature. Although this framework is useful to present the Guidelines on Supervision, there is considerable conceptual and practical overlap among these domains. Consideration was given to the utility and implementation of the Guidelines on Supervision as well as to minimizing redundancy when making decisions about the best domain for a specific guideline.

GUIDELINES FOR CLINICAL SUPERVISION IN HEALTH SERVICE PSYCHOLOGY

INTRODUCTION

Statement of Need and Context for the Guidelines on Supervision A primary goal of education and training programs in health service psychology is to prepare psychologists who are competent to engage in provision of psychological services and professional practice. Supervision is thus a cornerstone in the preparation of health service psychologists (Falender et al., 2004). There is a tremendous amount of conceptual, theoretical, and research literature pertaining to supervision, but prior to the development of these Guidelines on Supervision, there has been no set of consensually agreed upon guidelines adopted as association policy to inform the practice of high quality supervision for health service psychology. Although supervisor competency is assumed, little attention has been focused on the definition, assessment, or evaluation of supervisor competence (Bernard & Goodyear, 2014; Falender & Shafranske, 2013). This has diminished the perceived necessity for training in supervision. As Kitchener (2000) concluded, it has been much easier to identify the absence of competence than to define it. Articulating practices consistent with competent supervision ultimately facilitates the provision of quality services by supervisees and minimizes potential harm to supervisees and clients (Ellis et al., 2014). Competence entails performing one's professional role within the standards of practice and includes the ability to identify when one is not performing adequately. An essential aspect of competence is metacompetence, or the ability to know what one does not know and to self-monitor reflectively one's ongoing performance (Falender & Shafranske, 2007; Hatcher & Lassiter, 2007; APA, 2010, 2.01). Professional negligence is the failure of competence and is legally actionable: a failure of competence is practicing below a reasonable standard of care for supervision (Falender & Shafranske, 2014; Saccuzzo, 2002). While clinical supervision has been recognized as a distinct activity in the literature, its recognition as a core competency domain for psychologists has been a long time coming (Bernard & Goodyear, 1992; Hess, 2011). Since the profession's adoption of supervision as a distinct professional competence

(Fouad et al., 2009; Kaslow et al., 2004), a definition of supervision has emerged and encompasses the knowledge, skills, and values/attitudes specific to the practice of supervision (Falender et al., 2004; Falender & Shafranske, 2004, 2007; Fouad et al., 2009). This recognition of supervision as a distinct competency has evolved in the context of an overall focus on competency-based education and training in health service psychology that has gained momentum over the past decade (Fouad & Grus, 2014). The movement is consistent with the national dialogue about the responsibility of education and training programs to be accountable for ensuring quality education and training that leads to expected student learning outcomes (New Leadership Alliance for Student Learning and Accountability, 2012). Supervisory competency includes valuing supervision as a distinct professional competency and valuing specific training in clinical supervision (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Reiser & Milne, 2012). However, the recognition that training in supervision is necessary has also been slow to occur (Rings, Genuchi, Hall, Angelo, & Cornish, 2009). A preliminary framework for supervisor competence was produced by the 2002 Competencies Conference (Falender et al., 2004), received confirmatory support from doctoral internship directors (Rings et al., 2009), and serves as a basis for this framework. To be a competent supervisor, an individual possesses and maintains knowledge, skills, and values/attitudes that comprise the distinct professional competency of clinical supervision as well as general competence in the areas of clinical practice supervised and in consideration of the cultural contexts.

Supervision that applies a competency-based approach entails the creation of an explicit framework and method to initiate, develop, implement, and evaluate the process and outcomes of supervision. A competency-based approach is predicated on supervisors having the knowledge, skills, and attitudes regarding the provision of quality supervision and professional psychology models, theories, practices. In addition, supervisors have knowledge, skills and values with respect to multiculturalism and diversity, legal and ethical parameters; and management of supervisees who do not meet criteria for performance. Supervisors also attain knowledge and skills in theories and processes for group, individual, and distance supervision. Implicit in the concept of competence is an awareness of and attention to one's interpersonal functioning and professionalism and valuing individual and cultural diversity (Kaslow et al., 2007). The competency-based approach is being adopted in multiple specialties (e.g., Stucky, Bush, & Donders, 2010), psychotherapy theoretical approaches (e.g., Farber, 2010; Farber & Kaslow, 2010; Sarnat, 2010), and internationally (e.g., Psychology Board of Australia, 2013). A logical next step to build upon the identified elements of competence in supervision is to develop and approve guidelines that promote the provision of competent supervision. Other organizations have published guidelines on supervision that have informed the development of these Guidelines on Supervision. Specifically, the following regulatory boards and psychological associations have promulgated guidelines related to supervision.

- The Association for Counselor Education and Supervision (ACES), a division of the American Counseling Association developed supervision guidelines for counselor education (Borders et al., 2011). The ACES guidelines on supervision are organized around 12 domains.
- The American Association of Marriage and Family Therapy developed a formal approval process for supervisors with nine learning objectives that candidates must demonstrate (American Association of Marriage and Family Therapy, 2007).
- The National Association for School Psychologists addresses supervision as part of a more comprehensive document on the provision of integrated and comprehensive school psychological services (National Association for School Psychologists, 2010).

- The Psychology Board of Australia's Guidelines for supervisors and supervisor training providers consists of a document that focuses on competency-based supervision (Psychology Board of Australia, 2013).
- The Australian Psychological Society Guidelines on Supervision specifically addresses the supervision contract, ACES categories are: initiating supervision, goal setting, giving feedback, conducting supervision, the supervisory relationship, diversity and advocacy considerations, ethical considerations, documentation, evaluation, supervision format, the supervisor, and supervisor preparation. AAMFT categories include: knowledge of supervision models, ability to delineate one's own model of supervision, ability to foster relationships with the supervisee and the client, assess relationship problems, conduct supervision using various modalities, able to act on considerations within the supervisory relationship, attentive to issues of diversity, knowledge of ethical and legal issues related to supervision, and AAMFT supervisor procedural knowledge. ethical issues, and supervision contexts (Australian Psychological Society, 2003).
- The New Zealand Psychologists Board's Best-practices guidelines for supervision provides recommendations about a variety of aspects of supervision including the process and functions of supervision, supervisor competencies, the supervision relationship, and cultural issues (New Zealand Psychologists Board, 2007).
- The British Psychological Society, Committee on Training in Clinical Psychology has guidelines for clinical supervision within their criteria for the accreditation of postgraduate training programs in clinical psychology (British Psychological Society, Committee on Training in Clinical Psychology, 2008).
- The Association of State and Provincial Psychology Boards (ASPPB) is currently revising their supervisions guidelines (Steve DeMers, personal communication, 2013a).
- The California Board of Psychology has published a document on supervision best practices (California Board of Psychology, 2010).
- The College of Psychologists of Ontario, Canada has a Supervision Resource Manual (2nd edition) (College of Psychologists of Ontario, Canada, 2009).
- The Canadian Psychological Association developed the Ethical guidelines for supervision in psychology: Teaching, research, practice, and administration (Canadian Psychological Association, 2009) and a Resource guide for psychologists: Ethical supervision in teaching, research, practice, and administration (Pettifor et al., 2010). Four principles frame the guidelines(from the CPA Code of Ethics, 2000): respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society.
- The Association of Social Work Boards has developed guidelines on supervision for both educators and regulators using a competency framework identifying six domains of competence (Association of Social Work Boards, 2009).
- The National Association of Social Workers and the Association of Social Work Boards recently released a document on best practices for supervision (National Association of Social Workers and the Association of Social Work Boards, 2013), articulating five standards: context in supervision, conduct of supervision, legal and regulatory issues, ethical issues, and technology.

Scope of Applicability

These Guidelines on Supervision are meant to inform the practice of clinical supervision with supervisees in areas of health service psychology and training. They apply to the full range of supervised service delivery including assessment, intervention, and consultation and across all aspects of professional functioning. The Guidelines on Supervision are predicated on a number of pre-existing policies, fundamental assumptions, and definitions: Supervision can occur in a variety of contexts: supervision of service delivery by supervisees, administrative supervision, supervision of research activities conducted by supervisees, and supervision of individuals mandated by regulatory entities related to disciplinary actions. This document addresses supervision of clinical services provided by individuals in health service psychology education and training programs and applies to supervision of practicum experiences, internships, and postdoctoral training. Interprofessional education is a valuable training activity and supervisees should have opportunities to learn from and with professionals other than a psychologist. Recent guidelines for Interprofessional Collaborative Practice (2011) were endorsed by APA (Interprofessional Education Collaborative, 2011). However, this supervision guidelines document refers exclusively to supervision provided by psychologists to supervisees in health service psychology. Supervisors are committed to upholding the APA Ethical Principles of Psychologists and Code of Conduct and adhering to state and federal statues regulating psychologist and psychological practice. Supervisors strive to adhere to relevant APA general practice guidelines including but not limited to the Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients, Guidelines for Assessment of and Intervention with Persons with Disabilities, Guidelines for Psychological Practice with Girls and Women, Guidelines for Psychological Practice with Older Adults, and the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2011a, 2011b, 2007a, 2004a, 2003). Supervisors are expected to comply with relevant education and training standards such as those promulgated through the APA Commission on Accreditation (APA, 2009) as well as other relevant guidelines, e.g., American Psychological Association Guidelines for the Practice of Telepsychology (APA, 2013a), Guidelines for Psychological Practice in Health Care Delivery Systems (APA, 2013b), and Record Keeping Guidelines (APA, 2007b). Supervision is distinguished from these other professional activities by 1) professional responsibility and liability, 2) the purpose of the activity, 3) the relative power of the parties involved, and 4) the presence or absence of evaluation. In consultation, the consultant does not evaluate the referring provider, does not bear case responsibility, and the consultee is not required to implement the input of consultation. Supervision is distinguished from personal psychotherapy of the supervisee by maintaining the focus of inquiry on the client/patient, supervisee reactions to the client/patient, and/or the supervision process related to the client/patient (Bernard & Goodyear, 2014; Falender & Shafranske, 2004).

Mentoring is distinguished from supervision by an absence of evaluation or power differential, and by the mentor’s advocacy for the protege’s professional development and welfare (Johnson & Huwe, 2002; Kaslow & Mascaro, 2007). Assumptions of the Guidelines on Supervision The development of these Guidelines on Supervision is predicated on a number of assumptions. These assumptions were agreed upon by the members of the task force as foundational to the provision of clinical supervision and are reflected in the guidelines delineated in this document. Specifically, supervision:

• is a distinct professional competency that requires formal education and training
• prioritizes the care of the client/patient 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
• is anchored in the current evidence base related to supervision and the competencies being supervised
• occurs within a respectful and collaborative supervisory relationship, that includes facilitative and evaluative components and which 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 personal factors including values, attitudes, beliefs, and interpersonal 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
• incorporates bi-directional feedback between the supervisor and supervisee
• includes evaluation of the acquisition of expected competencies by the supervisee
• serves a gatekeeping function for the profession
• is distinct from consultation, personal psychotherapy, and mentoring

Use of the Term Guidelines
The term guidelines generally refers to pronouncements, statements, or declarations that recommend or suggest specific professional behaviors, endeavors, or conduct for psychologists. In this spirit, they are aspirational in intent. They are not intended to be mandatory or exhaustive and may not be applicable to every situation, nor are they intended to take precedence over the judgment of supervisors or others who are responsible for education and training programs. Education and training guidelines may be written as an advisory set of procedures related to curriculum development, pedagogy, or assessment; as interpretive commentary or instruction on education policy or standards; as a set of guiding principles about teaching and learning or program development; or as suggested goals and objectives of learning. These Guidelines on Supervision are intended as suggestions or recommendations for psychologists providing supervision of students in education and training programs in health service psychology. As used in this document, the term guidelines is consistent with the provisions of the APA policy on Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology (Section I C[1]) (APA, 2004b), as passed by the APA Council of Representatives. Process of Developing the Guidelines on Supervision The Guidelines on Supervision were prepared by a task force convened by the APA Board of Educational Affairs in March of 2012. The task force was charged to: “develop education and training guidelines for promising practices in (1) supervision encompassing the range of requisite supervisor {supervision} competencies; (2) adoption of a competency-based approach to supervision mindful of the developmental trajectory of the supervisee {of the process}.” The task force met via conference call approximately once a month from late summer 2012 to early spring 2013. One faceto-face meeting of the task force occurred May 31-June 2, 2013 at which previously prepared drafts of the Guidelines on Supervision were discussed and revised. Following the meeting, the task force continued to refine the Guidelines on Supervision via electronic mail. Purpose of these Guidelines on

Supervision The Guidelines on Supervision have the potential for broad impact on the profession by delineating practices relevant to quality supervision. Specifically, the Guidelines on Supervision are intended to have the following impacts: • For supervisors, the Guidelines on Supervision provide a framework to inform the development of supervisors and to guide self-assessment regarding professional development needs. • For supervisees, the Guidelines on Supervision promote the delivery of competency-based supervision with the goal of supervisee competency development. • A goal of the Guidelines on Supervision is to provide assurance to regulators that supervision of students in education and training programs in health service psychology is provided with and places value on quality. Implementation Steps BEA will serve as the APA entity responsible for oversight of the implementation process. Implementation and dissemination of the Guidelines on Supervision will occur through: • Distribution to and possible endorsement by the member organizations represented on the Council of Chairs of Training Councils, including the doctoral training councils and the Association of Psychology Postdoctoral and Internship Centers
• Presentations at the annual meetings of the APA and training council meetings.
• Submission to a peer-reviewed psychology journal for publication of a manuscript describing the Guidelines on Supervision.
• Submission to the APA Commission on Accreditation for consideration as a resource document in program reviews for accreditation.
• Development of continuing education programs targeted to health service psychologists who may not have had formal training in supervision.

The Guidelines on Supervision is a "living document." Accordingly, APA has established a systematic plan for periodically reviewing and revising such documents to reflect developments in the discipline and the education and training process. Formal reviews will occur every ten years, which is consistent with APA Association Rule 30-8.3 requiring cyclical review of approved standards and guidelines within periods not to exceed 10 years.

The Guidelines on Supervision are organized around seven domains:
Domain A: Supervisor Competence
Domain B: Diversity
Domain C: Supervisory Relationship
Domain D: Professionalism
Domain E: Assessment/ Evaluation/ Feedback
Domain F: Problems of Professional Competence
Domain G: Ethical, Legal, and Regulatory Considerations

These domains are drawn from a review of the literature on supervision as well as competency-based education and training. The domains and their associated Guidelines are interdependent and while some overlap exists among them it is important that they are considered in their entirety.

SUPERVISOR COMPETENCE
Supervision is a distinct professional practice with knowledge, skills, and attitudes, that supervisors require specific training to attain (Falender, Burnes, & Ellis; Falender, Ellis, & Burnes; Bernard & Goodyear, Reiser & Milne). The supervisor serves as role model for the supervisee, fulfills the highest duty of protecting the public, and is a gatekeeper for the profession ensuring that supervisees

meet competence standards in order to advance to the next level or to licensure. 1. Supervisors strive to be competent in the psychological services provided to clients/ patients by supervisees under their supervision and when supervising in areas in which they are less familiar they take reasonable steps to ensure the competence of their work and to protect others from harm. Supervisors possess up-to-date knowledge and skills regarding the areas being supervised (e.g., psychotherapy, research, assessment), psychological theories, diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and individual differences and intersections of these with diversity dimensions. Supervisors also have knowledge of the clinical specialty areas in which supervision is being provided and of requirements and procedures to be taken when supervising in an area in which expertise has not been established (Barnett et al., Goodyear & Rodolfa, APA, 2.01, 2.03). Supervisors are knowledgeable of the context of supervision including its immediate system and expectations, and the sociopolitical context. Supervisors are knowledgeable too about emergent events in the setting or context that impact the client(s)/ patient(s) (Falender et al.). 2. Supervisors seek to attain and maintain competence in the practice of supervision through formal education and training. Competence entails demonstrated evidence-based practice as well as in the various modalities (e.g., family, group and individual), theories, and general knowledge, skills, and attitudes and research support of competency-based supervision. Supervisors obtain requisite training in knowledge, skills, and attitudes of clinical supervision (Newman,; Watkins). Supervisors are skilled and knowledgeable in competency-based models, in developing and managing the supervisory relationship/alliance (Bernard & Goodyear, Falender & Shafranske, Ladany, Mori, & Mehr), and in enhancing the supervisee's clinical skills (Milne). The formal education and training should include instruction in didactic seminars, continuing education, or supervised supervision. At a minimum, education and training in supervision should include: models and theories of supervision; modalities; relationship formation, maintenance, rupture and repair; diversity and multiculturalism; feedback, evaluation; management of supervisee's emotional reactivity and interpersonal behavior; reflective practice; application of ethical and legal standards; decision making regarding gatekeeping; and considerations of developmental level of the trainee (Bernard & Goodyear, Falender & Shafranske, Newman). The supervision reflects practices informed by competency- and evidence-based practice to enhance accountability (Milne & Reiser, Reese et al., Stoltenberg & Pace, Watkins, Watkins, Worthen & Lambert). Assessment entails use of outcome measures and ratings from multiple supervisors (e.g., Reese et al., Watkins, Worthen & Lambert). Assessment strategies include both formative and summative evaluation and procedures for competence assessment. 3. Supervisors endeavor to coordinate with other professionals responsible for the supervisee's education and training to ensure communication and coordination of goals and expectations. Coordination can assist supervisees in managing these multiple roles and responsibilities as well as supervisory expectations. Coordination is especially important to seek when a supervisee is exhibiting performance problems, when the supervisory relationship is under stress, or when the supervisor seeks another perspective (Thomas). 4. Supervisors strive for diversity competence across populations and settings (as defined in APA). Diversity competence is an inseparable and essential component of supervision competence that involves relevant knowledge, skills, and values/attitudes (for more information, see Domain B: Diversity). 5. Supervisors using technology in supervision (including distance supervision), or when supervising care that incorporates technology, strive to be competent regarding its use. Supervisors ensure that policies and procedures are in place for ethical practice of telepsychology, social media, and digital communications between any combination of client/patient, supervisee, and supervisor

(APA; Fitzgerald, Hunter, Hadjistavropoulos, & Koocher). Considerations should include services appropriate for distance supervision, confidentiality, and security. Supervisors are knowledgeable about relevant laws specific to technology and supervision, and technology and practice. Supervisors model ethical practice, ethical decision-making, and professionalism, and engage in thoughtful dialogues with supervisees regarding use of social networking and internet searches of clients/patients and supervisees (Clinton, Silverman, & Brendel, Myers, Endres, Ruddy, & Zelikovsky).

DIVERSITY

Diversity competence is an inseparable and essential component of supervision competence. It refers to developing competencies for working with diversity issues and diverse individuals, including those from one's own background. More commonly, these competencies refer to working with others from backgrounds different than one's own but includes the complexity of understanding and factoring in the multiple identities of each individual: client(s), supervisee, supervisor and differing worldviews. Competent supervision attends to a broad range of diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and includes sensitivity to diversity of supervisees, clients/patients, and the supervisor (APA, 2003, 2004a, 2007a, 2010 (2.03); 2011a, 2011b). Supervisors are encouraged to infuse diversity into all aspects of clinical practice and supervision, including attention to oppression and privilege and the impact of those on the supervisory power differential, relationship, and on client/patient and supervisee interactions and supervision interactions. 1. Supervisors strive to develop and maintain self-awareness regarding their diversity competence, which includes attitudes, knowledge, and skills. Supervisors understand that they serve as important role models regarding openness to self- exploration, understanding of one's own biases, and willingness to pursue education or consultation when indicated. Supervisors also are important role models regarding their diversity knowledge, skills and, attitudes. Supervisors' ability to self-reflect, revise and update knowledge and advance their skills in diversity serve as important lessons for supervisees. Modeling these competencies helps to establish a safe environment in which to address diversity dimensions within supervision as well as in the larger professional setting. 2. Supervisors planfully strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of their supervisees. Supervisors consider infusion of diversity competence in supervision as an ethical imperative and respect the human dignity of their supervisees and the clients/patients with whom the supervisee works (APA, Bernard & Goodyear, Falender, Shafranske, & Falicov). Supervisors play a significant role in developing the diversity competencies of their supervisees. Research finds that diversity competence among supervisors can lag behind that of their supervisees (Miville, Rosa, & Constantine). Fortunately, diversity competence can be directly and constructively addressed by supervisors, who in turn can facilitate the diversity competence of their supervisees. Moreover, all supervision can be viewed as multicultural in the same manner that all therapy is multicultural (Pederson). Adopting such a framework strengthens the supervisory relationship, enhances supervisor competence, and promotes the diversity competencies of both supervisors and supervisees (Andrews, Kuemmel, Williams, Pilarski, Dunn, & Lund, Dressel, Consoli, Kim,on, Snowman, McCown, & Biehler). Viewing diversity as normative, rather than as an exception, aids supervisors in being sensitive to important similarities and differences between themselves and their supervisees that may affect the supervisory relationship. Supervisors recognize the value of and pursue ongoing training in diversity competence as part of their professional development and life-long learning. In order to ensure diversity competence sufficient to provide

culturally sensitive supervision, supervisors seek to continue to develop their own knowledge, skills, and attitudes, particularly in diversity domains that are most commonly relevant to their clinical supervision. At a minimum, supervisors should have attained formal training in diversity through their own doctoral training program or continuing professional development workshops, programs, and independent study, should be familiar with APA guidelines addressing diversity (APA, 2003, 2004a, 2007a, 2011a, 2011b), and should pursue continuing education to maintain current competence and build knowledge in emerging areas (APA, 2010, 2.03). 4. Supervisors aim to be knowledgeable about the effects of bias, prejudice, and stereotyping. When possible, supervisors model client/patient advocacy and model promoting change in organizations and communities in the best interest of their clients/patients. Supervision occurs within the context of diversity and social and political systems. Of special importance is the impact of bias, prejudice and stereotyping, both positive and negative, on therapeutic and supervisory relationships within these systems. Supervisors promote the supervisee's competence by modeling advocacy for human rights and intervention with institutions and systems (Burnes & Singh). 5. Supervisors aspire to be familiar with the scholarly literature concerning diversity competence in supervision and training. Supervisors strive to be familiar with promising practices for navigating conflicts among personal and professional values in the interest of protecting the public. Considerable scholarship has been published on supervision and diversity (e.g., Bernard & Goodyear, Falender, Burns, & Ellis, Miville et al.). Resources include competency-based training models for integrating diversity dispositions of supervisors and supervisees (Miville et al.), and the duty of supervisors to assist supervisees in navigating inevitable tensions between personal and professional values in providing competent client/patient care (e.g., Behnke, Bienske & Mintz, Forrest, Mintz, Jackson, Neville, Illfelder-Kaye, Winterowd, & Loewy, Winterowd, Adams, Miville, & Mintz,).

DOMAIN C SUPERVISORY RELATIONSHIP

The quality of the supervisory relationship is essential to effective clinical supervision (e.g., Bernard & Goodyear, Falender & Shafranske, Holloway, O'Donovan, Halford, & Walters). Quality of the supervision relationship is associated with more effective evaluation (Lehrman-Waterman & Ladany), satisfaction with supervision (Ladany, Ellis, & Friedlander), and supervisee self-disclosure of personal and professional reactions including reactivity and counter transference (Falender & Shafranske, Ladany , LehrmanWaterman, Molinaro, & Wolgast). The power differential is a central factor in the supervisory relationship and the supervisor bears responsibility for managing, collaborating, and discussing power within the relationship (Porter & Vasquez). 1. Supervisors value and seek to create and maintain a collaborative relationship that promotes the supervisees' competence. Supervisors initiate collaborative discussion of the expectations, goals, and tasks of supervision. By initiating this discussion, they establish a working relationship that values the dignity of others, responsible caring, honesty, transparency, engagement, attentiveness, and responsiveness, as well as humility, flexibility, and professionalism (Ellis, Ring, Hanus, & Berger). In discussing the supervisory relationship, the supervisor should: (1) initiate discussions about differences, including diversity, values, beliefs, biases, and characteristic interpersonal styles that may affect the supervisory relationship and process; (2) discuss inherent power differences and supervisor responsibility to manage such differences wisely; and (3) take responsibility to establish relationship conditions that promote trust, reliability, predictability, competence, perceived expertise, and developmentally-appropriate challenge. 2. Supervisors seek to specify the responsibilities and expectations of both parties in the supervisory relationship. Supervisors identify expected program competencies and

performance standards, and assist the supervisee to formulate individual learning goals. The supervisor is encouraged to explicitly discuss with the supervisee aspects of the supervision process such as: program goals, individual learning goals, roles and responsibilities, description of structure of supervision, supervision activities, performance review and evaluation, and limits of supervision confidentiality. The supervisor also provides clarity about duties including that the primary duty of supervisor is to the client/ patient, and secondarily to competence development of the supervisee. (The supervision contract is discussed further in the Legal and Ethical Section.) 3. Supervisors aspire to review regularly the progress of the supervisee and the effectiveness of the supervisory relationship and address issues that arise. As the supervisory relationship and the supervisee's learning needs evolve over time, the supervisor should work collaboratively with the supervisee to revise the supervision goals and tasks. When disruptions occur in the supervisory relationship, supervisors seek to address and resolve the impasses and disruptions openly, honestly, and in the best interests of client/patient welfare and the supervisee's development (Safran, Muran, Stevens, & Rothman).

DOMAIN D PROFESSIONALISM

Professionalism goes hand in hand with a profession's social responsibility (see Hodges et al., Vasquez & Bingham). The "professionalism covenant" puts the needs and welfare of the people they serve at the forefront (Grus & Kaslow). Grus and Kaslow summarized these as: "behavior and comportment that reflect the values and attitudes of psychology (Fouad et al., Hatcher et al.). The essential components include:
(1) integrity – honesty, personal responsibility and adherence to professional values;
(2) deportment;
(3) accountability;
(4) concern for the welfare of others; and
(5) professional identity."

1. Supervisors strive to model professionalism in their own comportment and interactions with others, and teach knowledge, skills, and attitudes associated with professionalism. Supervisory modeling of professionalism occurs across professional settings. Supervisees' understanding of what is professional or ethical is still developing (Gottlieb, Robinson, & Younggren). Modeling is a powerful means to teach attitudes and behaviors (e.g., Tarvydas), including professionalism (Cruess, Cruess, & Steinert.) Supervisors, in vivo, can exemplify virtue, humanism, and honest communication (Grus & Kaslow, modified from Hatcher et al.). One important aspect of supervision is to socialize supervisees into a particular profession (e.g., Ekstein & Wallerstein); to help them learn to "think like" those in that profession. In interprofessional settings, supervisors model professionalism in cooperative, collaborative, and respectful interaction with team members.
2. Supervisors are encouraged to provide ongoing formative and summative evaluation of supervisees' progress toward meeting expectations for professionalism appropriate for each level of education and training. Modeling alone is insufficient to teach professionalism; it should be embedded in a larger training curriculum incorporating developmentally expected behaviors (Grus & Kaslow). Supervisees need clear criteria to judge the extent to which they are demonstrating developmentally appropriate professionalism (Fouad et al., Kaslow et al.) as well as feedback about the extent to which they are meeting those criteria. The knowledge, skills, and attitudes associated with professionalism have been addressed within and across disciplines with much congruence. These include, "altruism, accountability, benevolence, caring and compassion,

courage, ethical practice, excellence, honesty, honor, humanism, integrity, reflection/self-awareness, respect for others, responsibility and duty, service, social responsibility, team work, trustworthiness, and truthfulness" (Grus and Kaslow).

ASSESSMENT/EVALUATION/ FEEDBACK

Assessment, evaluation, and feedback are essential components of ethical supervision (Carroll, Falender et al.). However, supervisors have been found to provide it relatively infrequently (e.g., Ellis et al., 2014; Friedlander, Siegel, & Brenock, 1989; Hoffman, Hill, Holmes, & Freitas, 2005), which leads to failures in gatekeeping and failures of supervisors in informing supervisees about their competency development (Thomas, 2010), and creates potential for ethical complaints (Falvey & Cohen, 2004; Ladany et al., 1999). To be effective, assessment, evaluation, and feedback need to be directly linked to specific competencies, to observed behaviors, and be timely (APA, 2010, 7.06; Hattie & Timperley, 2007). 1. Ideally, assessment, evaluation, and feedback occur within a collaborative supervisory relationship. Supervisors promote openness and transparency in feedback and assessment, by anchoring such in the competency development of the supervisee. Establishment and maintenance of the supervisory relationship provide the basis for assessment, evaluation, and feedback. Supervisee disclosure of client data is enhanced by a strong relationship (See Domain C in this document on the Supervisory Relationship.) 2. A major supervisory responsibility is monitoring and providing feedback on supervisee performance. Live observation or review of recorded sessions is the preferred procedure. Supervisee self-report is the most frequently used source of data on supervisee performance and client/patient progress (e.g., Goodyear & Nelson, 1997; Noelle, 2002; Scott, Pachana, & Sofranoff, 2011). The accuracy of those reports, however, is constrained by human memory and information processing as well as by supervisees' self-protective distortion and biases, (Haggerty & Hilsenroth, 2011; Ladany, Hill, Corbett, & Nutt, 1996; Pope, Sonne, & Green, 2006; Yourman & Farber, 1996) that result in their not disclosing errors, resulting in the loss of potentially important clinical data. The more direct the access a supervisor has to a supervisee's professional work, the more accurate and helpful their feedback will likely be. Supervisors should use live observation or audio or video review techniques whenever possible, as these are associated with enhanced supervisee and client/patient outcomes (Haggerty & Hilsenroth, 2011; Huhra, Yamokoski-Maynhart, & Prieto, 2008). Supervisors should not limit work samples only to those identified by the supervisee; some work samples should be selected by supervisors. Review of work samples should be planful and focus on specific competency development and defined supervision goals (Breunlin, Karrer, McGuire, & Cimmarusti, 1988; Hatcher, Fouad, Grus, Campbell, McCutcheon, & Leahy, 2013). In addition, the developmental level of the supervisee should be considered when identifying methods to monitor and provide feedback to the trainee. An organization can reduce legal risk through direct observation of the supervisee's work (e.g., using live or video observation of sessions) thus satisfying the monitoring standard of care in supervision. Supervisors aspire to provide feedback that is direct, clear, and timely, behaviorally anchored, responsive to supervisees' reactions, and mindful of the impact on the supervisory relationship. In delivering feedback, supervisors are sensitive to: (a) the power differential as a function of the supervisory evaluative and gatekeeping roles; (b) culture, diversity dimensions (e.g., gender, race, sexual orientation, socio-economic status) and other sources of privilege and oppression (Ancis & Ladany, 2001; Ryde, 2000; Shen-Miller, Forrest, & Burt, 2012); (c) supervisee developmental level (Stoltenberg & McNeill, 2010); (d) the possibilities of the supervisee experiencing demoralization (Watkins, 1996) or shame (Bilodeau, Savard, & Lecomte, 2012) in response to the feedback; and (e) timing and the amount of feedback that a supervisee can

assimilate at any given moment (Westberg & Jason, 1993). Feedback should occur at frequent intervals, with some positive and corrective feedback in each supervision session so that evaluation is not a surprise (Bennett et al., 2006). In instances when a supervisee exhibits problems in professional competence, supervisors are expected to be courageous and provide this difficult feedback, doing so in a direct and supportive manner. Indirect delivery of difficult feedback to supervisees is not associated with good training outcomes (Hoffman et al., 2005). The difficulty of delivering difficult feedback is especially challenging in multicultural supervision (Burkard, Knox, Clarke, Phelps, & Inman, in press; Shen-Miller et al., 2012). Collaborative conversations among supervisors regarding diversity, consultation, and examination of biases were described as helpful in contextual understanding of individual supervisee development (Shen-Miller et al., 2012). 4. Supervisors recognize the value of and support supervisee skill in self-assessment of competence and incorporate supervisee self-assessment into the evaluation process. Incorporating the use of supervisee self-assessment into the evaluation of supervisees can enhance skill development, provide useful reflection on the delivery of services, and inculcate attitudes of self-assessment as a lifelong learning tool (Wise, Sturm, Nutt, Rodolfa, Schaffer, & Webb, 2010). Research has shown that there are limitations to the accuracy of self-assessments (Dunning, Heath, & Suls, 2004; Gruppen, White, Fitzgerald, Grum, & Woolliscroft, 2000) indicating that the provision of significant feedback to supervisees should be used to enhance supervisee assessment of self-efficacy (Eva & Regehr, 2011). 5. Supervisors seek feedback from their supervisees and others about the quality of the supervision they offer, and incorporate that feedback to improve their supervisory competence. It is important that supervisors obtain regular feedback about their work. Supervisors may not obtain regular feedback once they are licensed and as a result may tend to overestimate their competence (e.g., Walfish, McAlister, O'Donnell, & Lambert, 2012) and tend to grow in confidence about their abilities, even though that is not necessarily matched by corresponding increases in ability (see Dawes, 1994). Although studies on supervisee nondisclosures (e.g., Ladany et al, 1996; Mehr, Ladany & Caskie, 2010; Yourman & Farber, 1996) suggest difficulty in obtaining candid information from supervisees, it is important that supervisors routinely seek—and utilize—feedback about their own supervision (see e.g., Williams, 1994).

GUIDELINES FOR CLINICAL SUPERVISION IN HEALTH SERVICE PSYCHOLOGY DOMAIN PROFESSIONAL COMPETENCY PROBLEMS

Only a small proportion of supervisees in health service psychology programs demonstrate significant problems in professional competence, but most academic and internship programs report at least one supervisee with competence problems in the previous five years (Forrest et al., 1999). When this occurs it can be helpful to consider the multiple contexts in which problem behavior is embedded (e.g., cultural beliefs, licensure and accreditation, peers, faculty, supervisors) (Forrest et al., 2008). Supervisors must be prepared to protect the well-being of clients/patients and the general public, while simultaneously supporting the professional development of the supervisee. They also must be mindful of the effects on the training program itself, as peers typically are aware of trainees with problems of professional competence and often have concerns that those problems are not being addressed (Rosenberg, Getzelman, Arcinue, & Oren, 2005; Shen-Miller et al., 2011; Veilleux et al., 2012). 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 (Kaslow, Rubin, Forrest, & et al., 2007). They also are guided by the training program's intentional and well-prepared plans for addressing such problems (Forrest et al., 2013).

1. 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 (elements of that contract are presented in the Ethics section of these Guidelines on Supervision) (Goodyear & Rodolfa, 2012; Thomas, 2007). The contract provides prior written notice of the competencies required for satisfactory performance in the supervised experience (Gilfoyle, 2008) as well as the process of evaluation, the procedures that will be followed if the supervisee does not meet the criteria, and procedures available to the supervisee to clarify or contest the evaluation. This contract shall occur in the context of the program communicating clearly the Due Process Guidelines to the supervisees as required by the Commission on Accreditations Guidelines and Principles (Domains A and G). In the event a supervisee is exhibiting performance problems, supervisors seek consultation to ensure understanding of program, institutional, and legal policies and procedures related to performance evaluations.
2. 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 abroad range of foundational and functional competencies, including professional attitudes and behaviors that are relevant to professional practice. Their determinations about areas in which the supervisee does not meet competence expectations must (a) take into consideration distinctions between normative developmental challenges and significant competence problems (Fouad et al., 2009; Hatcher et al., 2013; Kaslow et al., 2004; Rodolfa et al., 2005) and (b) be attuned to the intersections between diversity issues and competence (Constantine & Sue, 2007; Kaslow, Rubin, Forrest, & et al., 2007; Shen-Miller et al., 2009). Supervisors also seek consultation from and work in concert with relevant program and institutional participants when addressing potential performance issues. Especially when potential performance problems are suspected, supervisors directly observe and monitor supervisees' work, and seek input about the supervisee's performance from multiple sources and from more than one supervisor. Supervisee's professional behaviors and attitudes should be carefully documented in writing with dates and specific behaviors included in the record. Documentation is essential throughout the training trajectory in establishing clarity regarding the performance expectations and the supervisee's attaining the requisite competencies and is important in remediation or in adversarial actions. Once supervisors have identified that a supervisee has professional competence problems, they have an ethical responsibility to discuss these with the supervisee and to develop a plan to remediate those problems (APA, 2010; 7.06). Supervisors do so in a manner that is clear, direct, and mindful of the barriers to assuring that such conversations are effective and likely to maintain the supervisory relationship (Hoffman et al., 2005; Jacobs et al., 2011). Conversations addressing competence problems shall occur with sensitivity to issues of individual and cultural differences (Constantine & Sue, 2007; Shen-Miller et al., 2012).
3. 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 (Kaslow, Rubin, Forrest, & et al., 2007). The supervisor will follow the steps outlined in this plan, including the development of timely written evaluations that are anchored in the stipulated performance criteria (Kaslow, Rubin, Forrest, & et al., 2007). Supervisors evaluate their role in the supervisory relationship and adjust their role as needed, providing more direction and oversight and assuring that client/ patient welfare is not threatened and appropriate care is provided. These responsibilities need to be balanced with both training and gatekeeping responsibilities.

4. 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 (McAdams & Foster). Supervisors strive to closely monitor and document the progress of supervisees who are taking steps to address problems of competence. Should the supervisee not meet the stipulated performance levels after completing the agreed-upon remediation steps, attending to supervisee due process, supervisors must consider dismissal from the training program. Supervisors must have a clear understanding of competence problems that reflect unethical and/or illegal behavior that is sufficiently serious to warrant immediate dismissal from the training program (Bodner et al.). Such considerations occur in the context of the training program's organization's explicit plans for addressing such problems

ETHICS AND REGULATORY CONSIDERATIONS

Valuing and modelling ethical behavior and adherence to relevant legal and regulatory parameters in supervision is essential to upholding the highest duty of the supervisor, protecting the public. Improper or inadequate supervision is the seventh most reported reason for disciplinary actions by licensing boards (ASPPB, 2013c). Supervisees may perceive their supervisors to engage in unethical behavior (Ladany, et al.), sometimes due to misunderstanding the structure of the supervisory relationship and/or a supervisor's failure to secure informed consent. Generally, though, there is some evidence that supervisors and supervisees agree on what comprises ethical behavior (Worthington, Tan, & Poulin). Supervisors model ethical practice and decision making and conduct themselves in accord with the APA ethical guidelines, guidelines of any other applicable professional organizations, and relevant federal, state, provincial, and other jurisdictional laws and regulations. Supervisors support the acculturation of the supervisee into the ethics of the profession, their professionalism, and the integration of ethics into their professional behavior (Handelsman, Gottlieb, & Knapp, Knapp, Handelsman, Gottlieb, & VandeCreek). Supervisors ensure that supervisees develop the knowledge, skills, and attitudes necessary for ethical and legal adherence. The supervisor is a role model for ethical and legal responsibility. Supervisors discuss values that bear on professional practice, applications of ethical guidelines to specific cases, and the use of ethical decision-making models (Koocher & Keith-Spiegel, Pope & Vasquez). The supervisor is responsible for understanding the jurisdictional laws and regulations and their application to the clinical setting for the supervisee (e.g., duty to warn and protect; Werth, Welfel, & Benjamin). Supervisors are knowledgeable of legal standards and their applicability to both clinical practice and to supervision. Supervisors uphold their primary ethical and legal obligation to protect the welfare of the client/patient. The highest duty of the supervisor is protection of the client/patient (Bernard & Goodyear, 2014). Supervisors balance protection of the client/patient with the secondary responsibility of increasing supervisee competence and professional development. Supervisors ensure that supervisees understand the multiple aspects of

this responsibility with respect to their clinical performance (Falender & Shafranske, 2012). Supervisors understand that they are ultimately responsible for the supervisee's clinical work (Bernard & Goodyear, 2014). Supervisors serve as gatekeepers to the profession. Gatekeeping entails assessing supervisees' suitability to enter and remain in the field. Supervisors help supervisees advance to successive stages of training upon attainment of expected competencies (Bodner, 2012; Fouad et al.). Alternatively, if competencies are not being attained, in collaboration with the supervisee's academic program, supervisors devise action plans with supervisees, with the understanding that if the stated competencies are not achieved, supervisees who are determined to lack sufficient foundational or functional competencies for entry to the profession may be terminated to protect potential recipients of the supervisee's practice (Forrest et al.). Descriptions of such processes are in the training program's or organization's explicit plans for addressing competency problems or the unsuitability of the supervisee for the profession. 4. Supervisors provide clear information about the expectations for and parameters of supervision to supervisees preferably in the form of a written supervisory contract. A supervision contract serves as the foundation for establishing the supervisory relationship by specifying the roles, tasks, responsibilities of supervisee and supervisor and performance expectations of the supervisee (Bernard & Goodyear, 2014; Osborn & Davis, 2009; Thomas, 2007, 2010). Supervisors convey the value of the points in the supervision contract through conversations with supervisees and may modify the understanding over time as warranted as the goals for supervision change. The contract includes a delineation of the following 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 g. Limits of confidentiality of supervisee disclosures, behavior necessary to meet ethical and legal requirements for client/patient protection, and methods of communicating with training programs regarding supervisee performance h. Expectations for supervisee disclosures including personal factors and emotional reactivity (previously described, and worldviews (APA, 2010, 7.04) i. Legal and ethical parameters and compliance, such as informed consent, multiple relationships, limits of confidentiality, duty to protect and warn, and emergent situation procedures j. Processes for ethical problem-solving in the case of ethical dilemmas (e.g., boundaries, multiple relationships) 5. Supervisors maintain accurate and timely documentation of supervisee performance related to expectations for competency and professional development. Keeping supervision records is an important means of documenting the conduct of supervision and supervisee progress (e.g., APA, 2007b; Falvey & Cohen, 2004; Luepker, 2012; Thomas, 2010).

CONCLUSION

The Guidelines on Supervision address seven domains of supervision and offer specific suggestions in each of these domains that delineate essential practices in the provision of competency-based clinical supervision. The overarching goal of the Guidelines on Supervision is to promote the provision of quality supervision in health service psychology using a competency framework to enhance the development of supervisee competence while upholding the highest duties of

supervision, ensuring the protection of patients, the public, and the profession. The Guidelines on Supervision are intended to be aspirational in nature and are responsive to current trends in education and training in health service psychology. They are considered a living document. Accordingly, they should be reviewed periodically and informed by developments, including the evidence-base regarding clinical supervision.

For the complete APA Guidelines on Supervision please visit APA Supervision Guidelines

7. California BBS (Board of Behavioral Sciences) Updates/Changes

Changes Effective 1-1-22

Supervision Regulations and Other Updates (For Full Changes, Visit BBS Supervision https://www.bbs.ca.gov/pdf/law_changes_2022/supervision_reg_changes.pdf)
The recent changes to supervision regulations for LMFT, LCSW, and LPCC licensure aim to provide a more comprehensive and unified framework. Key updates include:

1. Unified Regulations for Licensure:

- Applicable to LMFT, LCSW, LPCC candidates.
- Requires a weekly log signed by the supervisor.
- Requires a Supervision Agreement, replacing the Supervisor Responsibility Statement and Supervision Plan for new supervisors post-1-1-22.
- Updated training requirements for new supervisors (15 hours, consistent across license types, with content updates), and six hours of continuing professional development (CPD) per renewal cycle (not psychiatrists or psychologists)
- Supervisor yearly assessments of supervisee strengths and limitations of the supervisee.
- Supervisors must notify the Board of their supervisory role and confirm qualifications through a completed "Supervisor Self-Assessment" form.

2. Additional Supervisory Responsibilities:

- Specifies supervisor competence in clinical practice areas being supervised.
- Mandates self-monitoring for and addressing supervision dynamics such as countertransference, intrapsychic, interpersonal, or trauma-related issues that may impact supervision.
- Requires notification to supervisees of any licensure conditions affecting the supervisor's ability to practice.
- Requires ongoing assessments of supervisee strengths and limitations, providing a copy to the supervisee at least once a year and at the completion or termination of supervision.
- Requires supervisors to establish written procedures for supervisees to contact the supervisor or, in the supervisor’s absence, procedures for contacting an alternative on-call supervisor to assist supervisees in handling crises and emergencies. The supervisor shall provide these procedures to the supervisee prior to the commencement of supervision

- Written oversight agreement between supervisor and employer when supervisor is not employed by site
  - ➡ Requires supervisor to complete an assessment of the ongoing strengths and limitations of the supervisee at least once a year and at the completion or termination of supervision, and to provide the supervisee with a copy (new for supervisees pursuing LPCC or LMFT licensure, previously required for LCSW).
  - ➡ Requires a supervisor to establish written procedures for supervisees to contact the supervisor or, in the supervisor's absence, procedures for contacting an alternative on -call supervisor to assist supervisees in handling crises and emergencies. The supervisor shall provide these procedures to the supervisee prior to the commencement of supervision.
  - ➡ Supervisor self-assessment form for all currently supervising; within 60 days of beginning if onset later

3. Telehealth Best Practices:

- AB 1758 allows face-to-face or two-way real-time videoconferencing for supervisor-supervisee contact until January 2026.
- Within 60 days of supervision commencement, the supervisor must complete a meeting with their supervisee assesses the appropriateness of allowing the supervisee to receive supervision via two-way, real-time videoconferencing .
- Assessment must include supervisee abilities, preferences of both parties, and the privacy of locations during supervision.

4. Removal of LPCC-related Requirements:

- Elimination of certain LPCC licensure prerequisites, such as
  - ➡ Completed clinical experience of at least 150 hours in a hospital or community mental health setting;
  - ➡ The requirement that LPCCs must complete additional specified education (6 semester or 9 quarter units, or a named specialization/emphasis in marriage and family therapy), supervised experience (500 hours working directly with couples, families, or children), and continuing education (6 hours specific to marriage and family therapy each renewal cycle) in order to assess or treat couples or families

(See handbooks for Future LCSWs, LMFTs, LPCCs on BBS website.)

5. Remote Supervision:

- AB 2754 permits remote supervision of psychology trainees, effective since September 2022.
- Remote supervision must occur in real-time and protecting patient confidentiality.
- AB 2754 states that "supervision may be provided in real time, which is defined as through in-person or synchronous audiovisual means, in compliance with federal and state laws related to patient health confidentiality."

6. BBS Email Update:

- Licensees supervising candidates must submit a one-time Supervisor Self-Assessment Report by January 1, 2023, affirming their qualifications. The form is available on the Board's website.
- See Verification of Experience Scenario Guide and Checklist https://www.psychology.ca.gov/laws_regs/ voe_checklist.pdf
- Supervision Agreement https://www.psychology.ca.gov/forms_pub s/sup_agreement.pdf
- Only licensed psychologists can serve as the primary supervisor of a psychological associate. [16 CCR § 1391.5(a)]
- Pursuant to section 2936 of the California Business and Professions Code, all licensees and registrants are required to post a notice in a conspicuous location in their principal psychological business office informing consumers how to contact the board regarding any questions and comments

7. SB 401 - Unprofessional Conduct:

- Effective January 1, 2023, SB 401 defines sexual abuse, behavior, contact, and misconduct as unprofessional conduct.
- Definitions from SB 401 include:
  - ➡ "Sexual abuse" means the touching of an intimate part of a person by force or coercion
  - ➡ "Sexual behavior" means inappropriate physical contact or communication of a sexual nature with a client or a former client for the purpose of sexual arousal, gratification, exploitation, or abuse.
  - ➡ "Sexual behavior" does not include the provision of appropriate therapeutic interventions relating to sexual issues.
  - ➡ "Sexual contact" means the touching of an intimate part of a client or a former client
  - ➡ "Sexual misconduct" means inappropriate conduct or communication of a sexual nature that is substantially related to the qualifications, functions, or duties of a psychologist or registered psychological associate.

8. COVID-19 Related Updates:

- California COVID Public Health Emergency ended on February 28, 2023.
- Medi-Cal continues to allow telehealth services, but providers may need to offer in-person services starting in 2024.

9. Federal PHE Extension:

- Federal Public Health Emergency will remain until mid-April 2023, with potential renewal. Extension includes Medicare coverage flexibilities concerning telehealth.
- Medi-Cal will continue to allow services to be provided using telehealth, including audio-only.

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8. Monitoring Preformance

The goal of supervision is to ensure quality care for the client, which entails monitoring the clinical performance of supervisees. Your first step is to educate supervisees in what to expect from clinical supervision. Once the functions of supervision are clear, you should regularly evaluate the supervisee's progress in meeting organizational and clinical goals as set forth in an Individual Development Plan (IDP) (see the section on IDPs below). As clients have an individual treatment plan, supervisees also need a plan to promote skill development.

Behavioral Contracting in Supervision

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

Individual Development Plan

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

Evaluation of Supervisees

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

The two types of evaluation are formative and summative. A formative evaluation is an ongoing

status report of the supervisee's skill development, exploring the questions "Are we addressing the skills or competencies you want to focus on?" and "How do we assess your current knowledge and skills and areas for growth and development?"

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

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

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

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

Direct observation of the supervisee's work is the desired form of input for the supervisor. Ethical and legal considerations as well as evidence support that direct observation as preferable. The least desirable feedback is unannounced observation by supervisors followed by vague, perfunctory, indirect, or hurtful delivery (*Powell & Brodsky*).

Clients are often helpful assessors of the skills of the supervisee. Supervisors should routinely seek input from the clients as to the outcome of treatment. The method of seeking input should be discussed in the initial supervisory sessions and be part of the supervision contract.

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

Addressing Burnout and Compassion Fatigue

Have you ever heard a supervisee say, "I came into counseling for the right reasons. At first I loved seeing clients. But the longer I stay in the field, the harder it is to care. The joy seems to

have gone out of my job. Should I get out of counseling as many of my colleagues are doing?" Most supervisees come into the field with a strong sense of calling and the desire to be of service to others, with a strong pull to use their gifts and make themselves instruments of service and healing. The field risks losing many skilled and compassionate healers when the life goes out of their work. Some supervisees simply withdraw, care less, or get out of the field entirely. Most just complain or suffer in silence. Given the caring and dedication that brings supervisee into the field, it is important for you to help them address their questions and doubts.

You can help supervisees with self-care; help them look within; become resilient again; and rediscover what gives them joy, meaning, and hope in their work. Supervisees need time for reflection, to listen again deeply and authentically.

You can help them redevelop their innate capacity for compassion, to be an openhearted presence for others. You can help supervisees develop a life that does not revolve around work. This has to be supported by the organization's culture and policies that allow for appropriate use of time off and self-care without punishment. Aid them by encouraging them to take earned leave and to take "mental health" days when they are feeling tired and burned out. Remind staff to spend time with family and friends, exercise, relax, read, or pursue other life-giving interests.

It is important for the clinical supervisor to normalize the supervisee's reactions to stress and compassion fatigue in the workplace as a natural part of being an empathic and compassionate person and not an individual failing or pathology.

Rest is good; self-care is important. Everyone needs times of relaxation and recreation. Often, a month after a refreshing vacation you lose whatever gain you made. Instead, longer term gain comes from finding what brings you peace and joy. It is not enough for you to help supervisees understand "how" to counsel, you can also help them with the "why." Why are they in this field? What gives them meaning and purpose at work? When all is said and done, when supervisees have seen their last client, how do they want to be remembered? What do they want said about them as clinicians? Usually, supervisee's responses to this question are fairly simple: "I want to be thought of as a caring, compassionate person, a skilled helper." These are important questions that you can discuss with your supervisees.

Other suggestions include:

- ✓ Help staff identify what is happening within the organization that might be contributing to their stress and learn how to address the situation in a way that is productive to the client, the supervisee, and the organization.
- ✓ Get training in identifying the signs of primary stress reactions, secondary trauma, compassion fatigue, vicarious traumatization, and burnout. Help staff match up self-care tools to specifically address each of these experiences.
- ✓ Support staff in advocating for organizational change when appropriate and feasible as part of your role as liaison between administration and clinical staff.
- ✓ Assist staff in adopting lifestyle changes to increase their emotional resilience by reconnecting to their world (family, friends, sponsors, mentors), spending time alone for self-reflection, and forming habits that re-energize them.
- ✓ Help them eliminate the "what ifs" and negative self-talk. Help them let go of their idealism that they can save the world.

- ✓ If possible in the current work environment, set parameters on their work by helping them adhere to scheduled time off, keep lunch time personal, set reasonable deadlines for work completion, and keep work away from personal time.
- ✓ Teach and support generally positive work habits. Some supervisees lack basic organizational, team-work, phone, and time management skills (ending sessions on time and scheduling to allow for documentation). The development of these skills helps to reduce the daily wear that erodes well- being and contributes to burnout.
- ✓ Ask them "When was the last time you had fun?" "When was the last time you felt fully alive?" Suggest they write a list of things about their job about which they are grateful. List five people they care about and love. List five accomplishments in their professional life. Ask "Where do you want to be in your professional life in 5 years?"

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

Methods of Observation

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

- A supervisee will recall a session as he or she experienced it. If a supervisee experiences a session positively or negatively, the report to the supervisor will reflect that. The report is also affected by the supervisee's level of skill and experience.
- The supervisee's report is affected by his or her biases and distortions (both conscious and unconscious). The report does not provide a thorough sense of what really happened in the session because it relies too heavily on the supervisee's recall.
- Indirect methods include a time delay in reporting.
- The supervisee may withhold clinical information due to evaluation anxiety or naiveté.

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

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

- Simply by observing a counseling session, the dynamics will change. You may change how both the client and supervisee act. You get a snapshot of the sessions. Supervisee's will say, "it was not a representative session." Typically, if you observe the supervisee frequently, you will get a fairly accurate picture of the supervisee's competencies.
- You and your supervisee must agree on procedures for observation to determine why, when, and how direct methods of observation will be used.

- The supervisee should provide a context for the session.
- The client should give written consent for observation and/or taping at intake, before beginning counseling. Clients must know all the conditions of their treatment before they consent to counseling. Additionally, clients need to be notified of an upcoming observation by a supervisor before the observation occurs.
- Observations should be selected for review (including a variety of sessions and clients, challenges, and successes) because they provide teaching moments. You should ask the supervisee to select what cases he or she wishes you to observe and explain why those cases were chosen. Direct observation should not be a weapon for criticism but a constructive tool for learning: an opportunity for the counselor supervisee to do things right and well, so that positive feedback follows.
- When observing a session, you gain a wealth of information about the counselor. Use this information wisely, and provide gradual feedback, not a litany of judgments and directives. Ask the salient question, "What is the most important issue here for us to address in supervision?"
- A supervisee might claim client resistance to direct observation, saying, "It will make the client nervous. The client does not want to be taped." However, "client resistance" is more likely to be reported when the supervisee is anxious about being taped. It is important for you to gently and respectfully address the supervisee's resistance while maintaining the position that direct observation is an integral component of his or her supervision.
- Given the nature of the issues in any counseling, you and your supervisee need to be sensitive to increased client anxiety about direct observation because of the client's fears about job or legal repercussions, legal actions, criminal behaviors, violence and abuse situations, and the like.
- Ideally, the supervisee should know at the outset of employment that observation and/or taping will be required as part of informed consent to supervision.

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

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

9. Clinical Vignettes and Application

Through the following vignettes, you will meet supervisors with a variety of skill level. The supervisors face supervisees with a variety of issues. The supervisors also have issues of their own. One grapples with the challenges of a new position, and another works to create a legacy. Each vignette provides an overview of the agency and of the backgrounds of the supervisor and other individuals in the dialogue. A list of the learning objectives for each vignette is also

included. Embedded in the dialog are additional features:

Master Supervisor Notes are comments from an experienced clinical supervisor about the strategies used, what the supervisor may be thinking, how supervisors with different levels of experience and competence might have managed the situation, and information supervisors should have. *"How-to" Notes* contain information on how to implement a specific method or strategy.

The master supervisor represents the combined experience and wisdom of the TIP Consensus Panel and provides insights into the counselor's relationships with clients and suggests possible approaches. The notes provide some indication of the breadth of the master supervisor's clinical skills as well as the extent to which the supervisor moves effortlessly among clinical, supportive, evaluative, and administrative roles.

"How-to" notes reflect the collected experience of the TIP Consensus Panel along with information gleaned from a variety of textbooks, manuals, and workbooks on clinical supervision. Not all "how-tos" will apply in every situation, but this information can be adapted to meet the specific needs of your case.

This format was chosen to assist clinical supervisors at all levels of mastery, including those who are new in the position, those who have some experience but need more diversity and depth, and those with years of experience and training who are true master supervisors. The Consensus Panel has made significant efforts to present realistic scenes in supervision using clinical approaches that include motivational interviewing (MI), cognitive–behavioral therapy (CBT), supportive psychotherapy, crisis intervention methods, and a variety of supervisory methodologies including live observation, education, and ethical decision-making. In all of these efforts, basic dynamics of supervision, such as relationship building, managing rapport in stressful situations, giving feedback, assessing, and understanding and responding to the needs expressed by the supervisee are demonstrated. The Panel does not intend to imply that the approach used by the supervisor is the "gold standard," although the approach shown does represent competent supervision that can be performed in real settings.

Vignette 1—Maintaining Focus on Job Performance

Overview

In this supervisory session, a supervisee with marital problems carries this stress into the workplace. She feels overwhelmed by the complexity of her caseload, misses work, and cancels client appointments. Observe how the supervisor must address the supervisee's job performance, provide emotional support for the supervisee, and, at the same time, not get involved in the supervisee's personal life.

Background

Juanita has worked as a counselor at the agency for over a year and brings a number of valuable attributes to her job. She is bilingual, understands the stresses and cultural dynamics faced by recent Central American immigrants living in the United States, works well with female clients, and gets along well with other staff. Her husband is a recovering alcoholic, and Juanita has been

active in Spanish-speaking Al-Anon. She recently received her addiction counselor credential.

Since receiving her license as a counselor, Juanita has been given new job assignments that involve working with more complex and difficult clients. She now conducts educational and support groups by herself, does intake interviews, provides individual counseling to her caseload, and has recently increased her caseload to accommodate the increased number of clients at the agency. She is also seeing several clients with co-occurring disorders.

While she is friendly and outgoing with others, her natural response to stress is to withdraw and isolate herself, rather than ask for help. To Melissa, her supervisor, Juanita seems more tentative and less energetic in their supervision sessions. She seems to be meeting most of her work performance goals established in the supervision, but the quality of discussion about her cases and her lack of vitality in the meetings concerns Melissa.

In the past month, Juanita has come late to work on a number of occasions and missed several client appointments. She has called in sick three times in the last 3 weeks. In supervision, she seems distracted, which is a change from her prior behavior. Melissa, in her concern, asked in supervision "is everything OK?" Juanita replied, "No, Jorge has been laid off his construction job, and he has been drinking." She explains that she is quite distressed, having trouble sleeping, and feeling overwhelmed. Though clearly worried, Juanita did not elaborate, and Melissa did not pursue the questioning. Juanita did ask if she could talk to Melissa at another time to discuss her personal problems and to seek Melissa's advice on how to handle her current situation at home. Melissa was uncomfortable agreeing to this but also was uncomfortable not responding to Juanita's distress. She hesitatingly said that they could discuss this at the next supervisory meeting.

In the upcoming supervisory session, Melissa feels it is important to clarify the differences between providing help for personal problems and maintaining supervision goals. Melissa also thinks it is important to address Juanita's job performance issues in the next meeting.

Learning Goals:

- To illustrate how work-related stresses and personal problems can interact and affect one another.
- To demonstrate the boundary between clinical supervision and personal counseling.
- To demonstrate how to help an employee get the help necessary to address personal (non–work-related) life problems that affect the work environment.
- To illustrate how to monitor and maintain adequate clinical performance when an employee is facing difficult personal dilemmas that affect job performance.
- To demonstrate awareness of and sensitivity to cultural issues that arise in the context of personal issues that affect job performance.

[*The vignette picks up with the beginning of the next clinical supervisory session.*]

MELISSA: Juanita, hi! Come on in. Before we start talking cases today, I would really like to go over some of what we discussed last week and see where things stand.

JUANITA: That's fine, but I think I owe you an apology about our last session. I really want to apologize for saying all those things to you about my family and how that is affecting me and all

that, and I just want to apologize. I know it had nothing to do with anything work related. We were doing supervision and should just have talked about cases, and I just want to assure you that that will never happen again.
MELISSA: Well, Juanita, I'm sorry you have to cope with all that's going on, but I don't feel you need to apologize for anything last week. I know that what's happening is stressful to you. I hope we can work out a plan to help you get the help you need and also be sure that the pressures you are experiencing don't spill over into your work with clients.
JUANITA: I appreciate that. I just want you to know that that's not me. That's not me.
MELISSA: And I appreciate that, and I want you to know that I value your work. You've worked hard. You've really worked hard in learning not only your job, but also as a professional counselor and you've made a valuable contribution to working with our clients.
JUANITA: I love my job. I love it.
MELISSA: Juanita, I want to be really clear with you that I am concerned about what is going on in your personal life, and I want to work with you to get help for that. I don't feel that it's something that we should address in supervision though, except to the extent that it affects your job performance. The goal of our supervision time is to help you to be the best counselor possible. When personal issues come up, those may keep you from being the best *person* you can be. These are important issues for you to address in your own personal counseling and therapy. I hope that distinction is clear for you. But I really want you to hear my concern for you.

JUANITA: I'm still kind of worried that I told you about my personal life, but I do want to be the best counselor I can be.

MELISSA: I'm concerned about the time you have been missing from work and especially the times you have had to cancel patient appointments as a result of your situation at home.

JUANITA: I know I've missed a couple of sessions, but I called. The clients were okay with me rescheduling, and I've continued to meet with them. I don't think there's any problem. It was the first time I ever had to reschedule those clients, and we caught up on their visits later in the week.

MELISSA: I hear that you were concerned about missing some sessions so you made a strong effort to reconnect with your clients later. I really appreciate your effort. I had a chance to review a videotape of a session you did last week. I'm pleased with the skills you've developed in group counseling. In the middle of the session we videotaped, there were some issues that came up about men that I thought might be a concern and might illustrate what we're talking about. Can we view that section of the tape and discuss what was happening for you at that point?

JUANITA: Sure, if you have the tape there.

How To Address Personal Issues That Affect Job Performance

Consider the following points when you need to confront a supervisee in clinical supervision with problems of job performance that are exacerbated by personal difficulties, such as emotional, familial, interpersonal, financial, health, or legal concerns:

- You can help your supervisees see the relationship between their personal difficulties and work-related problems. The key question you need to return to is "How is this personal issue affecting your job performance?" This prevents you from becoming the counselor's therapist and turning supervision into therapy.
- You can clarify the boundaries of what constitutes acceptable job performance, as some

counselors may be uncertain where the boundaries lie.

- ➡ You should continually focus on approaches to improve job performance, providing useful suggestions and recommendations for improvement. It is also helpful to provide measurable benchmarks by which counselors can assess their own improvement.
- ➡ You and your supervisee should develop a written work plan for how the employee will take the necessary steps to improve job performance.
- ➡ You can help the counselor examine how personal stressors might affect interactions with coworkers or clients.
- ➡ Finally, you and your supervisee can explore how you and the agency can support the employee in confronting and resolving personal issues that are affecting job performance, such as a referral to the EAP, use of personal or sick time, rescheduling the clinician's time, and the like.

Master Supervisor Note: Although the distinction between personal counseling and supervision may be contingent on the supervisor's theoretical orientation, and both are interpersonal relationships, there are differences between the two, as summarized in the table below.

Personal Counseling	Supervision
1. The goal is personal growth and development, self-exploration, becoming a better person.	1. The goal is to make the counselor a better counselor.
2. Requires exploration of personal issues.	2. Requires monitoring of client care and facilitating professional training.
3. The focus of exploration is on the origins and manifestations of cognitions, affects, and behaviors associated with life issues and how these issues can be resolved.	3. The focus is on how issues may affect client care, the conceptualization of the client problems and counseling process, and accomplishment of client goals.

[*Together, Juanita and Melissa watch the tape, cued to the segment about clients actively drinking while in treatment. Juanita appears surprised to see her response to the client on tape and notes the impact she might be having on clients. For example, there was an interaction between Juanita and a male client in group where she saw herself being judgmental and overly critical. Melissa and Juanita continue to discuss the tape and the meaning of counter- transference in the counseling relationship. From the discussion of being angry at clients who continue to drink, Juanita becomes aware that the sessions she has cancelled with clients were all with drinking men*.]

MELISSA: I'm glad you can stand back objectively and see the relationship between your

personal issues and your clinical functioning. So, what do you think you need to do now?
JUANITA: Well, first maybe I shouldn't see any more male patients?
MELISSA: That is an option. But I think we can find a better resolution. For right now, let's focus on what else needs to change.
JUANITA: Well, I just won't cancel any more appointments. I didn't realize rescheduling was such a problem. But I just won't do it anymore. And about the missed days, I think that is beyond me now. If I need a day off for personal reasons, I'll schedule them in advance from now on.

MELISSA: OK. I think I would like you to go through me for the next few months if you need either time off or if you have to cancel patient appointments. I know emergencies happen, but just let me know if you need time off and we'll see where we go from there.

JUANITA: I understand. I am so sorry that my personal life is intruding on my counseling. I never thought that would happen. And I'm going to get back to my work. I'm going to make sure I get the paperwork and everything done, and I will be on time tomorrow.

MELISSA: Let's put the paperwork aside and talk about your work with the clients and what you need to do to maintain your high level of work performance. Let's get back to the countertransference. I'd like to hear more about the clients you work with. Let's go back to the videotape and discuss what else is happening in the session.

JUANITA: Basically, I've moved into working with some of the more difficult clients in the last several months. It's been very challenging developing plans with them and encouraging their attendance and working with their treatment plans on a more active level because I'm definitely sensing the resistance.

MELISSA: So, not only are you working with more complex clients but you also have a higher caseload than you had not so long ago. So your job responsibility has increased significantly recently. I think you'll see some different features of supervision as you continue to see clients with more complex problems and as you begin to work in other treatment modalities, such as group. Let's discuss how you're dealing with the more complex clients.

[A discussion follows, using the videotape, about how Juanita has been working with these clients, some of her concerns about working with clients with more difficult co-occurring disorders, some specific points about counseling interventions and her counter-transferential reactions to men who are drinking. She acknowledges that her reaction to the client who has relapsed is in part a response to her current life situation with her husband. Now that Juanitarecognizes where her work is being impacted by her personal issues, Melissa returns to the issue of the EAP and re-introduces the possibility of a referral.]

Master Supervisor Note: It is important for the supervisor and counselor to understand the impact of countertransference in a counseling relationship, including:

1. It can distract from the therapeutic relationship.
2. A counselor's personal issues may contaminate how he or she sees the client's issues.
3. The counselor may distance him- or herself or avoid discussion when the client's issues come too close to home, or conversely, the counselor may focus on client issues that resemble her own.
4. The counselor may have negative reactions to the client, based on the counselor's current life issues, as Juanita did with the men in her group who were actively drinking.

MELISSA: Juanita, you may remember that, as part of your professional development plan, we talked about a personal care plan: knowing when you need support and where you could get it. Your Al-Anon program has been a strong support for you, and you've used it in a very effective way. I'm wondering if you have used or would consider using our EAP to help you address the crisis you are experiencing now. I think it would be helpful if you had the opportunity to sit down with someone and assess how things are going and what could help. I hope you'll use our EAP for that. As you know, using the EAP is optional. I'm not mandating that you go. But if you think it would help, I hope you'll take advantage of it. This booklet has some information about the EAP and how to access their services. As you know, the EAP is strictly confidential, and nothing is reported back to the agency. I'm also wondering how I can be of support to you.

JUANITA: Just be there for these sessions. Just be there as the supervisor when I come and have questions. I'll call the EAP this afternoon. Do you think they would also be willing to help Jorge if he is willing to come with me?

MELISSA: The EAP is for the whole family, and I'm sure they would be available to see Jorge too, either with you or separately. I'm glad you are going to follow up on that.

[*Melissa and Juanita continue to discuss some of her cases and her efforts to work with more challenging clients. At the end of the supervision session, Melissa and Juanita schedule two sessions in the coming week for Melissa to sit in on Juanita's sessions again. Melissa reaffirmed that she hoped Juanita would consider using the EAP to address some of the issues in her personal life.*]

 **Master Supervisor Note:** Note that Melissa doesn't ask Juanita to report back to her about using the EAP. The EAP referral is to address personal life issues that are not the concern of her employer. It is Melissa's role to monitor job performance and to use all of the resources that are available to help Juanita improve her job performance. In most organizations, an employee's use of the EAP is not the concern of the supervisor. The focus of the supervisor needs to be on improving job performance. Statements such as "Let me know if you use the EAP" are not within the supervisor's scope. Remember, the goal of clinical supervision is not necessarily to make the supervisee a better person, but a better worker. It is tempting for clinical supervisors to focus on the personal issues of staff—after all that's what they do for a living. However, personal issues are a part of clinical supervision only insofar as they affect the counselor's interactions with clients.

Vignette 2—Mentoring a Successor

Overview

This vignette illustrates the process of mentorship as a supervisor faces retirement and needs to mentor a successor from within the agency.

Background

Margie is a certified clinical supervisor with 25 years' experience in the field. She is in her early 60s, has worked at the agency her entire career, and is, in fact, the longest term employee at the agency. She is approaching retirement in the next 2 years. It is agency policy to promote from within whenever possible.

Betty has been in the field for 10 years and has been employed by this agency for 3 years. She is an excellent clinician and is well respected by colleagues in the agency. She has the potential to

be promoted to Margie's position as clinical supervisor. However, she has professional development issues that need to be addressed before she could be promoted. For example, she would need training in clinical supervision skills and eventually will need to get her certification as a supervisor. She also has a managerial style that needs to soften a bit. She sometimes comes off as too authoritarian and abrupt. Previous attempts by other supervisors to address this style have not been successful in changing the behavior. Margie has worked with Betty for 3 years as her clinical supervisor but without a mentorship training plan.

The vignette focuses on how Margie can mentor her successor and the next generation of personnel so they could be promoted upon her retirement. The vignette addresses the necessary systems of mentorship that can be involved, what ought to be in Betty's IDP, and the coaching Margie will provide to Betty.

The dialog begins with a discussion about current and future personnel issues and Margie's pending retirement. Margie's goals in this session are to begin to define Betty's learning needs, to establish a mentoring relationship, and to pave the way for Betty to be accepted as a supervisor by others in the agency. Margie's approach is to be a positive, supportive coach and to encourage Betty to begin the professional development and training required to be a supervisor.

Learning Goals:

- ➡ To illustrate how to design a mentorship program for personnel, including the writing of mutually agreed upon IDPs for potential successors and all clinical staff.
- ➡ To illustrate the process of establishing a supervisory alliance that incorporates principles of mentorship and training.
- ➡ To suggest how to develop and maintain a strong collaborative and professional supervisor–supervisee relationship.

MARGIE: Betty, as you know, I'm beginning to wind down my career and am looking forward to retirement in 2 years. Our agency strongly believes in the idea of fostering our own leaders and promoting people from within. You and I have had a great relationship over these past few years. I've seen your skills and feel you have great potential to grow professionally and as an important professional in this agency. Your clinical skills are excellent, you always complete your paperwork on time, and you're a joy to supervise.

BETTY: Thanks so much, Margie. That really feels good. I really like my job and would like to continue working here.

MARGIE: I hope you continue working here. You're a great asset to the agency. You've just implemented some innovative ideas, and you're enthusiastic about the work. Whenever I ask you to take on an assignment, you're always the first to complete it. I like that. You've worked hard to become an excellent clinician. So, I'd like to have an idea where you want to be in 5 years.

Would you be willing to discuss that with me?

BETTY: Sure. I hope I'm still here. I like the clients, my colleagues, and this agency. I like that I get to try new things. You've been supportive of that. This is a place where I'm able to make a contribution to my community.

MARGIE: So this is "home" for you: That is so evident. It's working really well for you. Perhaps we can discuss what's ahead for you. What would you like to be doing differently here in the future?

BETTY: I don't know. I'd like to continue to improve my clinical skills, maybe even advance up the ladder a bit. I think I have good individual and group counseling skills, but I also know administration involves another whole set of competencies.

MARGIE: You're right, there are different skills in administration and that's important to recognize. And I'm excited that you want to move up.

BETTY: Oh, that scares me a bit. I like seeing clients and wouldn't want to become a paper-pusher, not that that's all you do. [*Laughter*.]

MARGIE: I like that you want to stay anchored in clinical work. I think that is important and I appreciate your concern for clients. That's one reason you're so good at counseling. You have a real caring and compassionate nature for the people you work with.

[*A discussion follows about Margie's job and what it means to be in a supervisory position at that agency. Margie outlines the roles and requirements of being a supervisor*.]

MARGIE: Another way to look at your contribution to clients and legacy in counseling might be in the fancy word used by Erik Ericson, who spoke of "generativity": getting to a stage of life when you want to give something over to the next generation of people to follow you. You're having a great impact now on your clients. As you progress into a supervisory role, you have the potential of affecting even more clients and staff, as you train and supervise clinicians.

BETTY: What do you mean?

MARGIE: Remember years ago in school? Can you recall any teachers that left their mark on you, people that helped you become the professional you are today?

BETTY: Yes, there were many.

[*A discussion follows about these mentors and how Betty benefited from their teaching*.]

MARGIE: As you supervise, you have the opportunity to touch more people's lives. Yes, there is more dreaded paperwork. But, at the end of my day, I go home with a rich sense of legacy that I've had the chance to touch even more people's lives as a result of being a supervisor, even more than I might have as a counselor alone.

BETTY: Yes, I see that in you. You've had a profound impact on my life and that of so many counselors here.

✓ **Master Supervisor Note:** One of the most effective ways to lead is by example. Mentorship should include something of attraction; people should see something in you

> that they want. “Whatever she has, whatever she does, I want to have and do that.” People are imitative; they find role models they want to be like. So, when mentoring, use personal examples for the potential to grow and impact on others. It is important to identify the qualities and characteristics of a positive mentor and role model for staff, such as eliciting, rather than imposing, their judgment; drawing ideas from the supervisee, and being positive and affirming. Mentorship is a special kind of professional growth opportunity, differing from other supervisory models. In mentorship, the mentee asks questions, shares concerns, and observes a more experienced professional in a safe learning environment. Through reflection and collaboration, the mentee can become more self-confident and competent in his or her integration and application of the knowledge and skills gained. Mentorship addresses the unique needs, personality, learning styles, expectations, and experiences of each person. Mentorship can be defined in numerous ways. One definition is a working alliance offering regular opportunities for discussion, training, and learning to occur between less experienced and more experienced people in various settings, addressing practical, hands-on work experience to enhance the knowledge, skills, attitudes, and competencies of everyone.

MARGIE: So, perhaps we can discuss how you can increase your skills, both clinically and in supervision. This is the beginning of our developing and updating your IDP. One place to start would be for you to attend clinical supervision training. There are online courses, self-study programs, and classroom programs. I have a list of upcoming training events. I’d encourage you to take a look at these options and see whether you’d be interested in one of them.

BETTY: Sure, of course. I’m always open to training, especially if it’s held on the beach, in a nice location.

[*Laughter*.] Will the agency pay for the training? You know a clinician’s salary will only stretch so far.

MARGIE: Yes, it would be part of your IDP. We fund professional development as much as possible.

BETTY: Thanks for the vote of confidence.

MARGIE: Further, I’d like you to start doing more staff training, using your clinical experience and conducting sessions for other staff.

BETTY: You mean like some of the presentations I do in the community, to staff here? That’s a little intimidating, presenting to my peers.

MARGIE: It can be intimidating, presenting to people you work with.

BETTY: I assume you’ll help me with that?

MARGIE: Yes. I also think you have the potential to present at State and national conferences. This would expand your repertoire of material, hone your speaking skills, build your confidence, and help you become better known outside the agency. We know you’re good. It’s time for others outside

to see in you what we see.

BETTY: Really?

MARGIE: Really. I have a call for papers for a counselors' conference in Cincinnati this fall. I think you should submit a proposal. The conference's theme is PTSD and substance use disorders. I've heard you present here at the agency on this topic. The people attending the conference will be your peers. That's a good place for us to take another step in the mentorship process, and you can begin with an area where we know you're especially strong. I'll attend the conference, too, and we can discuss afterward how it went for you. I'm interested if you've ever thought of being acknowledged outside of the agency for what we all know you know.

BETTY: If I'm really honest with you, yes. I've gone to conferences and thought "I can talk on that subject." But it's always seemed immodest to say that out loud.

MARGIE: Yes, it's difficult stepping forward, not wanting to seem arrogant, but also acknowledging that you might have something others would benefit from hearing. So, how about putting your thoughts together for a proposal? It's due in 3 weeks. You and I can review the proposal together. I'm confident it will be accepted for presentation. When it comes to your actual presentation, you can do the outline and slides and we can discuss your ideas.

BETTY: So is this what you meant by mentorship?

MARGIE: It's a good place to start. I'll never forget my mentor, Todd. He saw in me something I couldn't see in myself at the time. He believed in me when I was feeling uncertain and insecure about my abilities, when I wasn't even sure I wanted to stay in counseling for the rest of my life. He got me to do things I didn't think I could do. He made me really stretch and taught me some invaluable lessons I still remember. Perhaps I can discuss what I mean by mentorship. Would that be okay with you?

BETTY: Sure, I want to hear.

MARGIE: Well, this is my own view and from my own experience, but it seems to me that mentorship is when someone with more experience and professional maturity helps someone coming along to want to reach out for more and develop new skills. There are lots of new opportunities for mentorship that weren't available just a few years ago. Mentorship is different from our supervision relationship. Together we can identify areas of growth for you, and then we'll meet to discuss what we need to do so you can achieve your goals.

BETTY: I am honored (and a wee bit embarrassed) that you see that potential in me, and want to invest in my professional growth. I'm not sure anyone else has expressed that interest to me before. I'm really flattered.

Master Supervisor Note: One of the four foci of supervision is supportive, which includes at times cheerleading and encouragement. Often counselors may lack the confidence in themselves to step forward. Supervision should build on strengths, nurture assets, and support and encourage all personnel to grow. Identifying staff with high potential for advancement is a key function of a supervisor. Through mentorship, personnel can grow professionally, and leadership succession can become a key aspect of the organization and field.

MARGIE: It has been an honor for me to work with you these last 3 years. It also gives me great joy to see you grow professionally, and perhaps advance into supervisory and administrative positions here in the future. Speaking nationally will give you better exposure. We'll start with that, if that's okay. Then we'll move on into other areas that we identify together on your IDP.

BETTY: Okay, if you really think I can do this.

MARGIE: You can help our agency. We will see the scope and the focus of how you want to shape your career as it moves on.

BETTY: And you would be willing to make that kind of investment in me, Margie?
MARGIE: I sure am. The agency surely is.
BETTY: You know how exciting this is? I am fluttering inside.
MARGIE: It's exciting for me too. I enjoy seeing staff use their potential to the fullest. It's something I can leave behind when I retire that will last far beyond my years of service. It's like looking into the eyes of children and seeing the future in them that I will never realize myself. If I can help mentor you and others, that will be the icing on the cake of my career.

BETTY: If I can grow to become a representative of the agency and to work more closely with you and learn from your experience and your wisdom, I'd love that.

MARGIE: Here are some other ideas where you might consider growing professionally: learning about leadership, creating a vision, business and financial management, continuous quality improvement, organizational development, conflict resolution, and on and on. I know that might all sound rather intimidating at this point, but there are many areas we can address. I'll be there with you throughout the learning and mentorship process.

[*Discussion continues about the next steps for Betty. First, they arrange to begin to revise and update her IDP and the strategies to reach her learning goals. The supervision session then turns to the future needs of the agency and how Margie and Betty can be part of the evolving future. The session ends with an agreement to begin writing an IDP and decide on the next steps for their mentorship.*]

Resources on Mentorship

ATTC Leadership Institute (http://www.nattc.org/leaderInst/index.htm). After an assessment of leadership and management interests, values, and skills, participants attend a 5-day training

session designed to present the necessary body of information. With their mentors, participants develop an individualized training plan and individualized project. They then return to their organizations for 6 months of mentoring and working on their projects.

Michael E. Townsend Leadership Academy (http://www.mhmr.ky.gov/mhsas/files/KSAODSCatalog.pdf). A 3-day onsite workshop continues in followup sessions throughout the year in this program sponsored by the Kentucky Division of Mental Health and Substance Abuse.

South Carolina Addiction Fellows Program (http://www.addictionrecoveryinstitute.com/Southcarolina/welcome.htm). Participants meet in six 3-day sessions during the year.

North Carolina Addiction Fellows Program (http://www.addictionfellows.com/). Twenty participants meet to create a group of leaders for the field in North Carolina.

Unique Issues in Supervision for Substance Abuse Counselors

Clinical supervision for substance abuse counselors differs from supervision for other clinicians in several important ways.

1. Historically, many substance abuse treatment providers were themselves in recovery, with 38 percent of counselors (and 30 percent of supervisors) self- reported in recovery (*Eby et al*.). The field has traditionally supported individuals in long-term recovery with appropriate training as counselors. They are eligible for a variety of certifications and/or licenses, according to a certifying body or the laws of the State in which they practice. Counselors without professional preparation are valued for their life experience as well as for the skills they bring to an organization. For these counselors who are alsorecovering from substance use disorders, relapse could be an issue that a supervisor would need to monitor (*Culbreth & Borders*). In a survey, one study compared recovering with non-recovering counselors. There were no between-group differences in satisfaction with supervision; however, both recovering and non-recovering counselors were significantly more satisfied with supervision when their supervisors had the same recovery status (*Culbreth & Borders, Eby et al.*). Eby showed that "counselors not in recovery report significantly lower job satisfaction, organizational commitment, perceived organizational support and higher turnover intentions than those personally in recovery" (p. 40). Non-recovering counselors say they have significantly lower professional commitment, but believe they have better employment options in other counseling fields.

2. Eby et al. report that substance abuse counselors and clinical supervisors are only moderately satisfied with the supervisory relationships, and generally dissatisfied with both their pay and opportunities for promotion within their organizations. The average response to one's perceived organizational support for their work is well below average when compared to published data from employees in other mental health disciplines. Counselors and supervisors report moderate stress levels and client/case overload. Between 35 and 40 percent of substance abuse counselors and 22 percent of clinical supervisors report a strong intention to leave their current job. High turnover rates contribute to job stress for many clinical supervisors in the substance abuse treatment field.

3. Historically, many substance abuse counselors finished their formal education in high school and lack the graduate degrees of others. Traditionally, they may have less supervised practice and less theoretical background. However, this picture is changing, as an increasing number of master's-trained clinicians are entering the field, with 60–80 percent of the counselors now having at least bachelor's degrees, and almost 50 percent have master's degrees (CSAT, 2003; Eby et al., 2007). Substance abuse treatment administrators find it difficult to recruit academically trained staff due to the low salaries offered for these types of positions compared with similar positions in other mental health disciplines. Thus, in some instances, long-term clinical supervisors without formal academic training are supervising master's level counselors. The new entrants into the field, with master's degrees and experience in being clinically supervised, are presenting interesting challenges to organizations and long- term supervisors without formal academic training.

4. The nature of substance use disorders themselves makes counseling and clinical supervision unique. In addition to their chronic, relapsing nature, they are often accompanied by co-occurring mental disorders; suicidal thoughts and behaviors; and problems with interpersonal relationships, housing, employment, and the criminal justice system (Kavanagh, Spence, Wilson, & Crow). Clients also have to deal with the social stigma attached to substance abuse and to seeking treatment for mental health and substance abuse disorders. Substance abuse counselors are increasingly being asked to treat clients whose illnesses are medically and psychiatrically severe *(Minkoff)*.

5. Finally, Eby et al. states that the "quality of the clinical supervisory relationship is clearly important to counselors. As the clinical supervisory relationship is viewed more favorably by counselors, job satisfaction, organizational commitment, and perceived organizational support increase".

10. The Use of Technology in Clinical Supervision

Supervision and Training Using New Technologies

Many clinician training and education activities are already conducted using computers and the Internet, and research generally indicates that these technologies are effective for this purpose (*Ferreira, Liebowitz, Murdock, Williams, Becker, Bruce, & Young*). Computer technologies also offer a number of potential benefits for the training of clinicians, such as the ability to provide real-time feedback to trainees who are conducting practice sessions. Trepal, Haberstroh, Duffey, and Evans discussed some of the issues involved in teaching counseling skills via the Internet, especially in terms of establishing a relationship. A review by Hayes discussed the use of computers in training and supervising counselors, including such factors as use of computer-based simulations, student attitudes toward new technology, and ethical issues. Individual and

group instruction can be conducted using Web-based technology; at least one study has found the latter to be an effective training platform for teaching CBT to counselors (*Weingardt, Cucciare, Bellotti, & Lai*). Different types of technology may have different specific applications to training and supervision, just as they do to counseling. Video conferencing and text-based interactions, such as using instant messaging or online chat forums, can be effective ways to improve counselor attitudes and skills (*Abbass et al.*). *Carlson-Sabelli* discussed the use of Internet forums as an adjunct to counselor training and supervision. *Coursol, Lewis, & Seymour* discussed the application of video conferencing technology to counselor training and supervision. However, not all studies have found Web-based training as effective as that delivered in person. For example, Sholomskas et al. found the effectiveness of a training Web site with written materials superior to written materials alone, but somewhat less effective than an in- person seminar with supervised casework for the teaching of CBT. The Internet can also be used to train auxiliary staff members and peer assistants. Worrall and Fruzzetti discussed the use of a Web-based training program using online videos for peer supervisors working with therapists delivering dialectical behavior therapy. Vaccaro and Lambie reviewed options for conducting computer-based training and supervision, as well as advantages and disadvantages and ethical concerns for this type of supervision/training.

Smith, Carpenter, et al. randomly assigned 97 substance use disorder treatment counselors who were enrolled in a 2-day motivational interviewing workshop to receive live supervision conducted using video conferencing technology, supervision using videotaped practice sessions, or the workshop alone without an additional supervision component. Participants' sessions with clients were rated 1, 8, and 20 weeks after the workshop using the Motivation Interviewing Treatment Integrity Coding System. Participants who used teleconferencing for supervision had significantly better compliance compared with those who used the workshop alone, and they did a significantly better job in maintaining a proper ratio between questions and reflections than did those in either of the other groups.

Clinical supervision can also be conducted using phone and Internet technologies. *Abbass et al.* reviewed literature on the use of Web conferencing technology to supervise psychotherapists. They noted its benefits in terms of reducing costs, enabling long-distance supervision, and integrating supervision with training and educational materials. They also reviewed some potential problems, such as technical difficulties, the absence of local support during times of crisis, and possible difficulties/anxieties relating to the supervisory alliance. Wood, Miller, and Hargrove provided a model for a four-part training process for counselors and supervisors and discussed the use of telephone and computer technology to provide clinical supervision to counselors working in rural areas.

Peer supervision and support can also be provided to counselors via Internet or phone. Yeh et al. suggested that an online peer supervision group is a viable alternative to in-person groups, and they found that participants in an online peer supervision group for counselors felt comfortable and confident using this form of interaction. A related issue is the need to train therapists in the use of electronic media to conduct therapy. As Abbott et al. observed,

> training is needed to communicate effectively via computer, with attention to tasks such as communicating empathy via text instead of in person and handling ethical issues that might arise in the e-therapy situations.

According to the NASW, “The use of technology for supervision purposes is increasing. Video-conferencing is a growing technological tool used to provide supervision, especially in remote areas. Some jurisdictions allow electronic means for supervision; others may limit the amount of supervision that can be provided from a distance. When using technology to provide distance supervision, one must be aware of standards of best practice for providing this tool and be knowledgeable of the statutes and regulations governing the provision of such services.”

According to the ASWB, “When using or providing supervision and consultation by technological means, social work supervisors and supervisees shall follow the standards that would be applied to a face-to-face supervisory relationship and shall be competent in the technologies used.”, The ASWB further clarifies it’s interpretation of this by stating, “Social workers should follow applicable laws regarding direct services, case, or clinical supervision requirements and the use of technology for the purposes of licensure. Supervision for purposes of licensure is governed by regulatory boards that may have specific definitions and requirements pertaining to the use of technology in supervision. Social workers receiving supervision for the purposes of licensure have a responsibility to become familiar with these definitions and meet the requirements. Third-party payers and professional entities may have additional requirements that need to be followed. Social workers should retain a qualified supervisor or consultant for technology concerns that may arise. When using technology for client services, proper training should be obtained to become familiar with the technologies being used. As with all supervisor–supervisee relationships, the supervisor may share the responsibility for services provided and may be held liable for negligent or inadequate practice by a supervisee.”

Technology-Assisted Care (TAC) and Supervision: Principles to guide TAC in the Behavioral Health Arena

Supervisor Competencies

There are distinct competencies that supervisors who oversee TAC must master. These competencies are generally derived from using technology in their own practice. In addition, supervisors who use technology to deliver long distance clinical supervision must have a distinct set of competencies if they are to be adequately prepared to use technology to conduct supervision effectively. Sample Telehealth Policies Policies and procedures vary based on the type of technology used, risks associated with the intervention, the organization’s regulatory climate, and the size and scope of the organization itself. The sample policies that are available at https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924 are adapted from an internal policies and procedures manual developed by The Billings Clinic in Billings, MT, and provided by TIP Consensus Panelist Thelma McClosky Armstrong, M.A. They provide a snapshot of some issues that organizations may wish to consider in developing policies for technology assisted services. Some of the sample policies clearly relate to telehealth for physical disorders or when a telehealth provider may need a close or thorough physical view of the client. Although telebehavioral health will not often require such a physical review of the client, the policies have been included to foster integrated care in case the

telebehavioral health administrator wishes to share these sample policies with a general telehealth administrator.

11. The Changing Face of Telesupervision and Digital Training in Response to COVID-19

The COVID-19 pandemic has rapidly changed the ways in which marriage and family therapists (MFTs)/couple and family therapists (CFTs) engage in clinical supervision. Traditional face-to-face supervisory relationships have transitioned to telesupervision, which refers to supervisors using the internet as a training medium for their supervisees. Supervisors and supervisees alike are necessarily adapting to telesupervision relationships in an evolving world. As emergency protocols begin to give way to more routine procedures, it is important for supervisors to engage in meaningful conversations around the benefits, the challenges, and the future of telesupervision. This section discusses the various facets of telesupervision, including ethical implications, supervision modalities, the virtual supervisory alliance, the impact of telesupervision upon self-of-the-therapist work, and the potential benefits of telesupervision.

Practitioner points:

- Establishing effective telesupervision requires increased intentionality on part of the supervisor. Authenticity and transparency become more critical in establishing connections and trust with supervisees in an online format.
- Supervisors should collaborate with supervisees to establish processes for the times technology-related problems occur.
- Supervisors must also understand the unique ethical issues that are presented with providing supervision through an online format.

Supervision is a core foundation within the field of marriage and family therapy (MFT)/couple and family therapy (CFT) because it guides the personal and professional development of therapists-in-training. Traditionally, case supervision and self-of-the-therapist work has been engaged through in-person individual or group supervision on a campus or at a placement site. A review of training programs, accredited within the United States by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), reveals that the majority of programes are still campus based, with a small percentage of programes now offered online or in a hybrid format (COAMFTE, 2021). Family therapists have lagged behind other mental health professions in their utilization of teletherapy and telesupervision (Pickens et al., 2020; Sahebi, 2020; Watters & Northey Jr, 2020). However, for most in-person masters and doctoral CFT programes, the coronavirus disease 2019 (COVID-19) pandemic necessitated a shift from both in-person therapy and supervision to teletherapy and telesupervision in response to social distancing and shelter-in-place orders. Specifically, the shelter-in-place order in the United States required that, unless deemed essential personnel, citizens were to remain at home and leave only to complete tasks outside of their residence necessary to sustain life and health. This rapid pivot was important to maintain continuity for both clients and supervisees alike during COVID-19 (Simms et al., 2021; Tarlow et al., 2020). It is likely that many CFT program faculty had difficulty transitioning to these modalities owing to a lack of experience with virtual formats. Managing issues of informed consent, confidentiality,

documentation, supervisory alliance, technology, professionalism and all other related procedures requires significant modifications in operating processes when providing virtual therapy and supervision. While the pandemic will eventually diminish, it is presumed that the use of teletherapy and telesupervision will only increase moving forward. This will allow clinical training programs to reach clients who may not have otherwise been able to access their services, which may be particularly important for disadvantaged and/or low-resourced communities (Augusterfer et al., 2020). It will also expand opportunities for clinical supervisors to provide telesupervision to clinicians working in remote and/or potentially international settings. Goodyear and Rousmaniere (2019) asserted that it will not be long before clinical supervision in various settings is influenced by technology in some form. Consequently, it is important to discuss the benefits, challenges, ethics, repercussions for self-of-the-therapist work and implications for how telesupervision is conducted.

TELESUPERVISION

The onset of the pandemic caused universities across the world to shut down and pivot to online education quickly. Digital knowledge and skill sets varied widely among faculty and students, creating a sizeable learning curve for many and increased anxiety in the ability to adequately teach and/or learn effectively in this new modality (Sherbersky et al., 2021). Additionally, university programmes with mental health training ceased in-person therapy and shifted to teletherapy and telesupervision.

Accredited programs require a certain number of supervision hours to be based on raw data. Raw data, defined as audio, video or live supervision, is an important part of enhancing CFT supervisee competence. One of the advantages of raw data is that supervisors can provide feedback and suggestions based on observable therapist–client interactions. Raw data collected through asynchronous formats such as video or audio review allow one to watch and re-watch sections of a session, providing the supervisee increased opportunity for self-observation and self-reflection (Topor et al., 2017) while allowing the supervisor to attend to particular behaviors, skills and interactions that occurred during a session. Synchronous formats would include video conferencing programs (e.g., Zoom) where supervisors and supervisees are interacting in real time (Montalvo, 1973; Nadan et al., 2020). Live supervision is an integral intervention for supervisee development because they get immediate feedback and can implement interventions in real time. Traditionally, feedback in live supervision takes place through a knock on the door, midsession break or a phone call to the therapist in the room, whereas now, live telesupervision occurs via videoconferencing technology.

Nadan et al. (2020) described live supervision of teletherapy sessions with the therapist and the clients being visible and audible to one another, while the supervisor and any other supervisees watching are muted with no video but are able to hear and see the therapist working with a client. They suggested there are three primary ways in which supervisors can intervene during live videoconferencing supervision. First, the supervisor is able to talk or text the supervisee during the session to provide interventions and feedback to the therapist. Second, they can ‘enter’ the therapy room by activating their camera and microphone, enabling them to talk directly to the therapist as

well as the client(s). Third, the supervisor may choose to have the camera and microphone on during the entirety of the session (Nadan et al., 2020). Most videoconferencing platforms also provide a feature called ‘breakout rooms’ where the therapist, supervisor and other supervisees can sequester themselves away from the client to deliberate about the case. A breakout room is analogous to a knock on the door or a midsession break in traditional live supervision formats. Generally, live supervision sessions have individual or group discussion prior to the session regarding case conceptualization, any pertinent self-of-the-therapist (Aponte & Kissil, 2014; Simon, 2006) concerns (which are defined and discussed in a later section), identification of what the supervisee needs from the supervision group and conversations regarding interventions. Following a live supervision session, there is a debriefing time where the supervisee and supervisor review the session and discuss the case moving forward. Telesupervision offers a different way to go about this process, but the process in and of itself remains unchanged (Nadan et al., 2020; Sahebi, 2020).

Telesupervision assumes technological competence on the part of the therapist, client and supervisor, and lack of competence can create anxiety in teletherapy and telesupervision. Additionally, internet connections issues due to low bandwidth or bad weather, limitations to internet access or lack of knowledge about or openness to telesupervision can make telesupervision more challenging (Augusterfer et al., 2020). Regarding live supervision specifically, other members of the supervision team are unable to engage in ‘sideways talk’, where they can whisper to one another during the session (Nadan et al., 2020). Although having a group text chain (e.g., WhatsApp) can mitigate some of this, trainees will likely be more selective on what they discuss in the text chain, not to mention that there is a delayed response and it is much more cumbersome to type ideas compared with talking with someone else. Additionally, it can be difficult to assess group dynamics within the supervision team (Nadan et al., 2020).

Although telesupervision has been available for over a decade, many training clinic supervisors resisted this format prior to the COVID-19 pandemic (Sahebi, 2020; Watters & Northey Jr, 2020). One reason for hesitance to use telesupervision in training programs is the potential impact on the supervisory alliance and self-of-the-therapist work.

SUPERVISORY WORKING ALLIANCE

Supervisory working alliances, as defined by Bordin, are relationships built on mutual understanding with goals, tasks and strong emotional bonds between supervisors and their supervisees. Relational therapists typically value in-person supervisory processes, which are an extension of their own clinical training, to achieve this alliance and question if supervisors and supervisees can effectively connect when not in physical proximity with one other (Watters & Northey Jr, 2020). Indeed, a study by Hertlein et al. found that the majority of relational therapists are reluctant to providing online therapy owing to impact on the therapeutic alliance, a similar construct to the supervisory alliance. Additionally, many supervisors may be digital immigrants born before the widespread use of technology and are less digitally fluent than digital natives, possibly contributing to some of the resistance (Watters & Northey Jr, 2020).

Digital immigrant or not, supervisors are tasked with understanding the process of teletherapy as well as telesupervision. Supervisors must understand policies and procedures for online services as well as be prepared to manage technological issues that arise. However, since telesupervision is relatively new, digital competencies are only recently beginning to emerge, but the focus is on clinical practice rather than supervision (Pote et al.). Suggested competency guidelines are particularly salient for relational therapists, who must develop complex communication skills to effectively work with multiple clients in the room. This is also true for supervisors working with multiple supervisees in the room. The supervisor's knowledge and confidence in this area will influence the supervisory alliance, as he or she is able to instill confidence in their supervisees (Sherbersky et al., 2021).

Nadan et al. (2020) reported their experiences utilising Zoom for telesupervision at their training clinic in Israel. Owing to the social distancing guidelines implemented in Israel, all supervision and clinical sessions were moved to a virtual format for fourteen supervisors working with twenty-eight supervisees and their clients. Supervisors reported their perception that the supervisory relationship was unchanged by the pivot to telesupervision. Supervisees reported that the safety they felt in supervision remained intact through the transition, and some noted that they felt more secure and less vulnerable receiving supervision online as opposed to being seated face to face with their supervisor. The authors noted that group supervision was also used successfully via Zoom, and supervisors and supervisees alike reported feeling safe and that the new format actually enhanced the group discussions (Nadan et al., 2020). Tarlow et al. (2020) transitioned three doctoral students from in-person supervision to telesupervision and found no differences in supervision satisfaction or supervisory alliance. In a content analysis on the effectiveness of telesupervision, Inman et al. found three consistent variables: the effectiveness of supervision, therapist development and the supervisory relationship. Analysis of these studies suggests that telesupervision is at least as effective as in-person supervision and that supervisors and supervisees are able to establish a strong working alliance (Inman et al.). However, almost all studies utilized a hybrid model where supervisors and supervisees met in-person at some point in the supervisory process. In fact, most authors recommended that supervisors and supervisees meet in-person prior to videoconferencing.

The self-of–the-therapist

A component of the supervisory working alliance that has not been examined is the impact of telesupervision on self-of-the-therapist work. Self-of-the-therapist is defined as ‘who the therapist is, their personal characteristics, and the role they play in the delivery of therapy’ (Niño et al., p. 163). Historically, many CFT training programmes integrate some form of the self-of-the-therapist or personal growth work into their training and/or supervision of clinicians (Simon, 2006). This work generally entails part, or all, of the following: family-of-origin exploration; personal growth/self-of-the-therapist-focused supervision; self-reflection; exploration of beliefs, values and cultural biases; and personal therapy (Aponte & Kissil, Aponte et al.; Mason et al.; Simon,; von Haenisch). Self-of-therapist training, therefore, helps the therapist-in-training to connect the self, and to understand the personal aspect of the therapeutic relationship, with the profession.

The goal of personal growth training is to develop more authentic and effective therapists (Aponte & Carol Carlsen,; Aponte & Kissil, Simon). Personal growth requires supervisees to be introspective and self-reflective; increase awareness of their thoughts, emotions, behaviors and psychological responses; work through their personal issues; and develop a therapeutic presence (Gehart, 2017; Simms et al., 2021), and requires trust and safety. Small-group and individual supervision is the mechanisms for creating a safe space for this work. Experiential activities have the power to reduce resistance, enhance insight and help clients and supervisees alike to work through unresolved pain and family-of-origin issues (Moreno). How well the experiential process of self-of-the-therapist work can be adapted to a virtual format remains to be seen, and guiding supervisees through this personal growth process will require creative and adaptive supervision methods (Sahebi).

Many experiential activities take place during in-person group supervision and utilize relational space and physical positions to engage in the process. For example, family sculptures (Constantine) are designed to allow participants to create visual, symbolic representations of the internal conceptualizations of relationship maps they have with important family members. A variation on the sculptures described by Constantine is used with supervisees in the master's program where the authors teach. Students are instructed to use furnishings (chairs, lamps, small tables) in the clinic to represent self and family members and are to arrange the furnishings in relation to one another according to his or her view of the family, and to the relationship family members have with one another. While each student starts in one room of the clinic, they may place furnishings anywhere in the clinic. Students will often use children's chairs to represent family members they perceive have little power. Two chairs placed very closed together may represent enmeshment. A chair placed outside of the room may represent a cut-off family member.

Once completed, students move around their arrangements and make any needed adjustments until it feels right. After all students have finalized their sculptures, the facilitators give each student time to process his or her sculpture with the supervision group. Questions are posed that help each student consider what changes he or she would like to occur and are then encouraged to move the furnishings around to reflect those changes. Each student reflects on how his or her relationships may change because of insights gained through this process. Insights are gained not only from one's own sculpture but also in experiencing one another's sculptures. This very powerful activity relies on safety, openness, transparency and support from fellow students and from faculty.

Individual-based self-of-the-therapist interventions may be more adaptable to telesupervision. One intervention, based on the Internal Family Systems model, is the room technique (Schwartz & Sweezy). When a supervisee is experiencing countertransference with a client, the room technique can be an effective way to mitigate reactivity. To use the room technique, the supervisor guides the trainee to, in their imagination, place the client in a room with a one-way mirror where the trainee is outside the room and looking at the client through the mirror. The supervisor has the trainee imagine the client doing ‘the thing’ that activates the trainee (e.g., being combative, insulting, disengaged or longwinded) and the trainee monitors their emotional reactions. Through mindful awareness, the supervisor helps the supervisee identify their cognitive, emotional and somatic reactions to their client and guides them to become curious and open towards their reaction. Once the supervisee has become

mindful of their reactions, they ask those reactions to ‘step back’ so the therapist can be compassionate and open towards the client. Once the supervisee's personal reactivity has ‘stepped back’, the supervisee goes into the room where their challenging client is waiting for them. Once again, the client does the thing that activates the supervisee, and they monitor their reactivity once again. For most supervisees, their experience is very different the second time around, and they are able to be curious about the client, and they interact with them in a very different way. If, however, there is additional reactivity, the supervisor engages in the same process as before and guides the trainee to be in a mindful state and to separate themselves from their reactivity. This is an intervention that one author (Fitzgerald) has used in supervision and has found to be effective in both in-person and online formats.

Self-of-the-therapist interventions such as the room technique may effectively be done virtually; what may be lost is the group process around self-of-the-therapist work. As scholars have noted regarding teletherapy (Abbass & Elliott, 2020), one of the problems is that valuable non-verbal (i.e., body language) information is lost because generally only supervisee's head is visible (Duan et al.). It can be extraordinarily difficult to identify how supervisees are reacting to the personal work of their group members. Group supervision is the venue for group members to engage in understanding their own issues but also to work out issues between one another. Unresolved issues between group members can also significantly hamper the personal and professional development of supervisees. The ability to capture the contextual nuances of non-verbal communication in a virtual format will require new supervisory strategies and technologies. Practically speaking, one important strategy to maximize the supervisor's ability to observe non-verbal communication is to provide information on camera positioning and etiquette to supervisees. Within the telesupervisory relationship, each person's distance from the camera, positioning within the camera's view, eye contact with the camera and room lighting all contribute significantly to the way that person is experienced virtually (Inman et al., 2019b; Sahebi, 2020). Supervisors should model appropriate positioning, distance, lighting and eye contact for their supervisees, as well as provide an overview of their expectations to their supervisees at the onset of telesupervision. This seemingly small opening conversation can have a great impact on the supervisor's ability to identify the supervisee's reactions and provide helpful nonverbal context throughout the telesupervision sessions.

Finally, supervisors must remain sensitive to individual and group disparities when conducting telesupervision. The universalist mindset resulting from the COVID-19 pandemic declaring ‘we are all in this together’ has the potential to decrease the supervisor's vigilance to attend to issues related to race and ethnicity, socioeconomic status and other relevant cultural dimensions that might have been more easily recognised in pre-pandemic face-to-face settings (Todd & Rastogi). Supervisors must remain attentive to their own personal experiences and biases related to the COVID-19 pandemic and create safe spaces to broach and work through these topics with their supervisees. Although these conversations may be more challenging in a virtual format, supervisors are encouraged to provide focused time for self-exploration during supervisory meetings. Utilizing a culturally informed model of supervision can remind both the supervisor and their supervisees to tune in to the multidimensional and multisystemic aspects of the supervision and therapy process, keep a universalist mentality from

contributing to blind spots within the supervisory relationship and strengthen the telesupervisory working alliance (Sahebi, 2020).

Ethical Considerations of Telesupervision

Regardless of method of delivery, clinical supervision is a multi-layered endeavor owing to the supervisor's responsibility for the quality, professionalism and ethics of both their supervision and their supervisees' therapy (AAMFT Code of Ethics, 2015; Vaccaro & Lambie, 2007). Telesupervision, with its reliance on technology, adds yet another layer to supervisory ethical concerns that include confidentiality (Hames et al., 2020; Orr, 2010; Wood et al., 2005), informed consent (Abbass et al., 2011; Barnett, 2011; Vaccaro & Lambie, 2007), competency (Barnett, 2011; Barnett & Johnson, 2008; Inman et al., 2019a), regulatory issues (Hames et al., 2020; Orr, 2010; Wood et al., 2005), documentation and record-keeping (Falender & Shafranske, 2004; Orr, 2010) and self-care (Bernard & Goodyear, 2014; Hames et al., 2020). A common belief before the COVID-19 pandemic was that supervisors who were proficient at providing face-to-face supervision were also competent to provide telesupervision; however, it is now clear that the competencies required in face-to-face supervision do not always transfer directly to telesupervision formats (Watters & Northey Jr, 2020). The following discussion explores the ethical challenges of telesupervision that unfold differently than face-to-face supervision.

Supervisors are responsible for maintaining the confidentiality of their supervisees and their supervisees' clients (AAMFT Code of Ethics, 2015). Telesupervision takes place in cyberspace where there are no 100% guarantes of privacy, and therefore, the threat of unauthorized access to confidential material is increased (Inman et al., 2019a; McAdams & Wyatt, Vaccaro & Lambie, Wood et al.). However, as in therapy, video-conferencing platforms are vulnerable to unauthorized access unless they are equipped with appropriate security protocols (Abbass et al., Inman et al.). Unlike providing therapy services, though, supervisors often supervise by viewing recorded therapy sessions. Although a very useful mode of supervision, it could constitute a potential threat to confidentiality unless the videos are stored, maintained and viewed in secure physical and electronic settings (Abbass et al. ; Hames et al., 2020). In addition, when telesupervision entails the transmission of documentation or other materials for review, there exists a potential risk of breaching client confidentiality (Abbass et al; Wood et al.). Even with the use of encryption software, there is still the risk that a person other than the supervisor might retrieve the communication and documents (Orr). The use of HIPPA (Health Insurance Portability and Accountability Act of 1996; USA)-compliant websites or cloud storage sites that allow documents to be securely accessed by authorized individuals could be a better choice for the sharing of supervision materials. Other recommendations for addressing email confidentiality include disclaimers on emails stating that it is of a confidential nature (Morissette et al.), clear and documented agreements between supervisor and supervisee about how these issues will be handled and development of a standard operating procedure (Inman et al., Orr). Additional suggested protocols for maintaining confidentiality while engaging in telesupervision include ensuring that supervisor and supervisee's physical space is private, with reduced potential for interruptions or being overheard (Hames et al., 2020), and refraining from the use of identifying client information when discussing cases online or engaging in electronic communication (Abbass et al., Wood et al.).

The utilization of telesupervision also has ethical implications for the supervisors' informed consent or supervision contract (Barnett & Molzon), as well as the supervisee's informed consent for therapy (Wood et al.). Recommendations for supervisors' contracts include an agreement of how to maintain privacy while online; policies for confidentiality, security and encryption for the period of the contract and an agreement of whether sessions are audio or videotaped, how they will be stored securely, how long they will be kept and what they will be used for (Orr). The supervisee must also inform their clients that they are engaging in telesupervision and of the risk to confidentiality that may entail (Barnett; Vaccaro & Lambie; Wood et al.). Furthermore, the client should be informed (and included on the Consent for Treatment) that their information may be transmitted electronically to the supervisor (Vaccaro & Lambie), and if therapy recordings are being utilized, clients must be informed of the video conference process in plain language (Abbass et al.).

Supervisors are expected to oversee supervisees' competence and professionalism (AAMFT Code of Ethics, 2015). They are also expected to possess competence in the clinical areas to be supervised and in the practice of clinical supervision (Barnett; Barnett & Johnson, Sahebi, 2020). Therefore, supervisors must be competent in the technology, practice and ethics associated with providing clinical services online in order to supervise ethically, particularly if they are also supervising therapists engaged in providing teletherapy services (Barnett). Suggestions for helping supervisors ensure that they are practicing telesupervision ethically include reviewing the code of ethics (Morissette et al.), training in technology for both supervisor and supervisee (Tarlow et al., 2020; Vaccaro & Lambie), developing protocols and back-up plans in case of technological failure (Hames et al., 2020; Vaccaro & Lambie), routinely reviewing guidelines and updates from software providers (Abbass et al.) and regularly updating virus scan programs (Wood et al.). An upside of telesupervision is the increased availability of and access to supervisors with specific therapeutic expertise, which has the potential to enhance supervisee training and competence (Watters & Northey Jr, 2020).

Another telesupervision ethical challenge is that of jurisdiction (Inman et al., Vaccaro & Lambie, Wood et al.). Supervisors are often required to have a licence in the supervisee's state (Inman et al; McAdams & Wyatt; Wood et al.), or it may be that supervision hours acquired through telesupervision may not be approved to count towards a supervisee's required supervision hours for licensure (Inman et al., 2019a; Tarlow et al., 2020; Wood et al.). In addition, the supervisor should verify that, if the supervisee is providing teletherapy, they are licensed in the jurisdiction in which they are providing services (Orr). If the supervisor is working within a training setting, recommendations are that they should also check their regulatory codes and accreditation bodies to ensure there are no special restrictions on supervisees' practicum supervision experiences (Hames et al., 2020).

Family therapists and therapists-in-training are generally relational people who value contact with others. This contact is experienced differently in online settings. Nadan et al. (2020) noted the challenges of the extended, focused screen time associated with telesupervision. For supervisors providing live supervision, intense divided attention was necessary to stay attentive to the session being supervised, communicating with the supervisees as needed, engaging with an observing supervision group and collaborating with any co-supervisors. Supervisors noted the high level of

fatigue that came from orchestrating all of these activities via a computer screen. Supervisors need to be aware of the potential for this fatigue and provide necessary breaks to help keep themselves and their trainees engaged in the supervision process in order to provide the best learning environment possible (Nadan et al., 2020).

Finally, ethical supervision is supervision that monitors psychological wellness, self-care, distress and burnout, as well as concerns around professional competence of supervisees, regardless of the mode of delivery (Bernard & Goodyear). Supervisees, by definition, have a relative lack of clinical experience, and Tarlow et al. (2020) suggest that, paired with clinical responsibilities, this makes them more vulnerable to secondary traumatic stress and burnout. In addition, researchers are predicting a rise in mental health issues, including anxiety and depression, substance use, loneliness and domestic violence, in the general population as a result of the fear and social isolation surrounding the COVID-19 pandemic (Galea et al., 2020). These factors taken in conjunction may indicate an increased need currently for supervisory focus and monitoring of clinician self-care. Simms et al. (2021) reported the need for supervisors to always show compassion for their supervisees' distress over pandemic-related and transition-to-telesupervision-related distress, regardless of the supervisor's own perception of that distress. Galea and colleagues also suggest that digital technologies have the potential to bridge social distance, particularly when the contact involves voice and/or video. Telesupervision entailing video conferencing and incorporating an intentional focus on self-awareness and understanding may be an important component in reducing social isolation and positively impacting supervisees' self-care.

CONCLUSIONS

There are numerous benefits to telesupervision including increased scheduling flexibility, reaching trainees where supervision would not be otherwise possible and supervisee self-of-the-therapist work, and these benefits can benefit both masters and doctoral CFT programs. There are, however, some downfalls to telesupervision, including issues related to identifying group dynamics and establishing safety to engage in self-of-the-therapist, possible environmental influences (e.g., distractions such as children, partners, surfing the internet) and confidentiality issues. Given the strengths and limitations of telesupervision, training programs should be intentional in determining whether to implement as an alternative to in-person supervision or an adjunctive form, particularly programs that place a strong emphasis on self-of-the-therapist. Furthermore, the discipline should develop technical competency guidelines for telesupervision (Sherbersky et al., 2021). Should programs want to implement telesupervision and also focus on self-of-the-therapist, then we recommend having in-person supervision first to establish rapport and familiarity and then shifting to telesupervision.

Notes

Grames, H. , Sims, P. , Holden, C. , Rollins, P. , Jeanfreau, M. & Fitzgerald, M. (2022) The changing face of telesupervision and digital training in response to COVID-19. *Journal of Family Therapy*, 00, 1–12. Available from: 10.1111/1467-6427.12415 [CrossRef] [Google Scholar]

12. Online Clinical Supervision in Couples and Family Therapy

Online clinical supervision, or telesupervision, is a growing practice in couples and family therapy. This scoping review aims to identify and synthesize the existing body of knowledge regarding the utilization, experiences, and perceptions of telesupervision among the couple and family therapists and to highlight gaps in the literature. The review followed the five-step approach proposed by Arksey et al. Fifteen articles were included and their analysis yielded four themes: 1. telesupervision competence; 2. setting and boundary management; 3. advantages of telesupervision; and 4. challenges of telesupervision. Our review clearly demonstrates the dearth of available conceptual and empirical work. The rapidly growing use of online therapy and telesupervision in couple and family therapy has created a critical need to expand this body of knowledge by collecting evidence that can later be translated into practice. Moreover, we identified several gaps in the existing body of knowledge, including a lack of reports on the efficacy of telesupervision and on the experiences, processes, and ascribed meanings of the supervisors and supervisees. We also noted a lack of practice and ethical guidelines for telesupervision. We conclude our analysis by suggesting areas and directions for further investigation.

INTRODUCTION

Teletherapy (also known as e-therapy or online therapy) refers to the use of technology, including videoconferencing, to deliver mental healthcare remotely, including for couple and family therapy (Whaibeh et al., 2020). This medium has been shown to be clinically efficacious in various clinical settings, different presenting problems, and among different populations (Richardson et al. Simpson, Steel et al.), and received recognition by The American Association for Marriage and Family Therapy (AAMFT) in 2017 (Caldwell et al., 2017). Pennington et al. (2020) assert that AAMFT advertised its first telesupervision documents in summer 2001, when the movement toward online therapy was in its infancy. In those documents, issues related to the potential ethical ramifications of telesupervision and the potential usage of videoconferencing as a method of supervision were identified.

March 2020, when the World Health Organization (WHO) officially declared COVID-19 to be a global pandemic (WHO, 2020), was a crucial point in the world's relationship with the virus. At the time, many governments issued stay-at-home orders, and social distancing was enforced worldwide. This unique situation made in-person methods of working, learning, and socializing nearly impossible. Employees started working from home, schools, and universities transitioned to online learning, and mental health professionals were forced to turn to teletherapy.

Prior to COVID-19, couple and family therapists were slow to adopt teletherapy practices. Researchers found that practitioners were concerned about confidentiality, training, risky clinical situations, licensing and liability, and the overall impact on the therapeutic relationship (Hertlein et al.). Blumer et al. called for more training in using technology in couple and family therapy. Their findings are even more pertinent now, with the expansion of distance-based education programs and the rapid shift to telehealth in response to the COVID-19 pandemic. For this reason, the need for telesupervision grew, on the premise that clinical guidance is an essential and vital tool to enhance the

professionalism of clinicians. Another reason for the growth of telesupervision was social distancing, as COVID-19 regulations prevented supervisors and supervisees from meeting in person.

Telesupervision, or online clinical supervision, can be defined as offering feedback on one's clinical work by electronic means, most often videoconferencing (Inman et al., 2019; Martin et al., 2018; Watters & Northey, 2020). With the beginning of the pandemic, telesupervision became increasingly prominent among various healthcare clinicians, including family and couple therapists (Sahebi, 2020; Simpson et al., 2021). In addition, professional associations responded with recommendations and guidelines for the ethical and effective use of telesupervision (AAMFT, 2020; AFT, 2020; COAMFTE, 2020) and the most recent version (12.5) of COAMFTE accreditation (Commission on Accreditation for Marriage and Family Therapy Education, 2021) allows for greater freedom in adopting the practice. As a result, both the conceptual and empirical bases of knowledge expanded rapidly, some of them already in the early stages of development (Bell et al., 2020; Eppler, 2021; Hardy et al., 2021; Maier et al., 2021; Mc Kenny et al., 2021; Morgan et al., 2021; Simpson et al., 2021). In addition, while most supervisors are not familiar with online work, a small number have engaged in online work through various companies, such as Motivo and Clinical Supervision Now.

A comprehensive synthesis of existing knowledge is, however, lacking. This scoping review aims to fill the gap by identifying and synthesizing the existing literature that focuses on couple and family therapy telesupervision. We believe such a review is timely because of the need to consider the scope and nature of research and theory on telesupervision, with a view to clarifying the concept as it is used in couple and family therapy, and to summarize commonalities and discrepancies in substantive and methodological issues.

We adopted the scoping review methodology because of the broad nature of our objective. Scoping reviews are used to assess the extent, range, and nature of research on a given topic; they are particularly useful when little research is available, as they help to develop conceptual clarity and identify knowledge gaps (Arksey & O'Malley). Scoping reviews provide a transparent and reliable method for mapping research areas. They facilitate discussion of the volume, nature, and characteristics of primary research in the field of interest for a relatively short period of time. Performing such an analysis facilitates the identification of gaps in the evidence, as well as the summation and dissemination of research findings (Arksey & O'Malley).

METHODS

This scoping review adhered to the five-step approach proposed by Arksey & O'Malley, and incorporated the enhancements to scoping reviews recommended by Levac et al.

Stage 1: Identifying the research question

Consistent with the broad nature of scoping reviews (Arksey & O'Malley), our aim was to map the peer-reviewed literature on telesupervision with a particular focus on (i) definitional, (ii) conceptual, and (iii) clinical factors to inform an understanding of the extent, range, and nature of research on this concept. Although imperfect in some respects, the peer-review process enhances the scientific community's confidence in the quality and reliability of work that has been subjected to scrutiny by

academic peers (Bornmann). However, as the search unfolded and the scarcity of data were revealed, we chose to incorporate chapters from edited books as well. Despite not being subjected to rigorous scrutiny (as that employed in peer review), these chapters contain an abundance of conceptual data and frameworks for our chosen topic.

Stage 2: Identifying relevant studies

Search procedure

The authors performed an electronic search on November 17, 2021 of all papers published using six databases: (i) Web of Science (core collection); (ii) Scopus; (iii) Embase; (iv) Medline; (v) PsycInfo, and (vi) Pubmed. Search filters were based on common terminology identified in published literature known to the authors: (i) “Cyber Supervision*” OR (ii) “Telesupervision*” OR (iii) “Distance Supervision*.” These terms have been crossed with the following terms: “Family Therapy*” OR “Family Counseling*” OR “Family Intervention*” OR “Family Systems Therapy*” OR “Couple Therapy*” OR “CFT*” OR “MFT*” OR “Couple's Counseling*.” Depending on the features of each database, we applied these terms to search topics, abstracts, titles, and/or full texts.

Inclusion and exclusion criteria

We considered papers for inclusion if they were written in English, published in a peer-reviewed journal or in edited books, and aimed to explore (e.g., by conceptual analysis) and/or through directly assessed telesupervision, including videoconference consultations. Papers had to report on our article population, which was any person who identifies as a couple therapist or family therapist, or any practitioner who receives online supervision for their couple and family therapy practice. Searches were conducted collaboratively between both authors.

Stage 3: Papers selection

Papers identified in Stage 2 as potentially relevant for this scoping review were screened independently by both authors using a two-step process (Figure 1). First, they screened the titles and abstracts of studies using the inclusion and exclusion criteria detailed in Stage 2. When it was unclear whether a paper was eligible for inclusion based on the information provided in the title or abstract, it was retained for further analysis. Second, the authors read full texts of papers that passed the initial screening using the inclusion and exclusion criteria detailed in Stage 2. Gaps were discussed until a consensus was achieved.

The authors developed a data collection instrument to extract the characteristics of the papers. These included: title; author; publishing body; publication date; peer-reviewed or gray literature; country/countries involved; keywords; aims of the paper; methodology; paper population; satisfaction with technologies used; key findings; and paper recommendations. After a preliminary charting of the first few papers, both authors reviewed their results and refined the characteristics being reviewed/assessed. The data extracted from relevant studies were charted and sorted into themes using a qualitative descriptive analysis approach. The coding process was carried out by both authors using ATLAS.ti software. The first step involved reading all the articles in depth and coding each one according to a codebook developed by the researchers. Among the codes were references

to *experience with telesupervision*, *competency in telesupervision*, and *professional identity in telesupervision*. As the process proceeded, both authors discussed any discrepancies. The codes were then synthesized into major themes. We paid particular attention to the type of telesupervision medium used—such as telephone, email, or video consultation—and how effective both supervisors and supervisees found them to be. After identifying themes from the literature, evidence was synthesized using summary tables with the key themes as headings, which is standard with scoping reviews.

Stage 5: Collating, summarizing, and reporting results

Methodological and conceptual features of extracted data were analyzed. The methodological analysis focused on providing a descriptive account of the types of papers (e.g., conceptual and empirical), clinical settings, geographical location, participant characteristics, and methodological features (e.g., design) of eligible studies. In the conceptual analysis, we examined common and unique themes among definitions of telesupervision and its operationalization, and on primary research findings as they pertained to telesupervision.

FINDINGS

In total, 82 papers were identified at the initial stage of the search process (Table 1). After duplicates were removed ($n = 42$), screening of the titles and abstracts of 40 papers assessed against the inclusion and exclusion criteria excluded 25 papers. A total of 15 full texts were assessed (Borcsa et al., 2021; Eppler, 2021; Harrison, 2021; Heiden-Rootes et al., 2021; Jordan & Fisher, 2016; Luxton et al., 2016; Nadan et al., 2020; Pennington et al., 2020; Perry, 2012; Sahebi, 2020; Schmittel et al., 2021; Sherbersky et al., 2021; Springer et al., 2020, 2021; Watters & Northey, 2020). The 15 papers identified from the search process were published across a 9-year period (2012–2021), with a total of 40% ($n = 6$) being empirical in nature and the remaining ($n = 9$) providing conceptual views of telesupervision in couple and family therapy. Most empirical studies utilized a qualitative approach (*descriptive analysis*, $n = 1$, *phenomenological analysis*, $n = 2$, *reflexive thematic analysis*, $n = 1$, *and thematic analysis*, $n = 2$). In terms of geographical location among the empirical work, studies were conducted in North America (United States, $n = 4$), Europe (Greece, France, and Italy, $n = 1$), and Asia (Israel, $n = 1$).

TABLE 1. Selected articles addressing the usage, experiences, and perceptions of online clinical supervision in couple and family therapy ($n = 15$)

Author	Journal	Method, type of paper	Location	Aim (as described by original author/s)
Borcsa et al. (2021)	Journal of Family Therapy	Empirical: Quantitative (Self-developed online survey)	Greece, France, and Italy	To investigate the use of information and communication technology (ICT) among European systemic family and couple therapists. Descriptive analysis compared systemic family and couple therapists' digital practices and concerns from Greece, France, and Italy with those from the rest of Europe

Eppler (2021)	Journal of Marital and Family Therapy	Empirical: Qualitative (reflective thematic analysis)	USA	To understand clinicians' perceptions of providing relational telehealth during the initial months of the COVID-19 pandemic. The study's research questions included: What were the most and least meaningful experiences of providing relational telehealth during the COVID-19 pandemic? What are the professional and self-of-the-therapist dynamics related to treating couples, families, partnerships, and relationships via teletherapy during a pandemic?
Harrison (2021)	Journal of Marital and Family Therapy	Conceptual	USA	This article builds on the small body of couple and family therapy scholarship on technology in training and supervision, reviewing extant research on distance learning in social work and counselor education. Major themes in this research reveal opportunities and challenges associated with distance learning and offer guidance about ways that couple and family therapy education can evolve to effectively integrate technology and online learning into an educational landscape
Heiden-Rootes et al. (2021)	Journal of Marital and Family Therapy	Empirical: Qualitative (Hermeneutic phenomenological approach to qualitative inquiry)	USA	To understand the experiences of teletherapy trainees with couples and families as these contrast with individual clients and in-person therapy
Jordan and Fisher (2016)	Book Chapter	Conceptual	USA	To explore the use of technology in family therapy training and supervision, including the types of technologies used and ethical concerns
Luxton et al., 2016	Book Chapter	Conceptual	USA	To explore the use of telesupervision and telepractice including discussion regarding telesupervision process, competencies, licensure, and ethical considerations
Nadan et al. (2020)	Family Process	Conceptual	Israel	To outline the author's operational methods and adaptations for conducting live behind-the-mirror supervision online. Based on over 100 PractiZoom sessions conducted between March and May 2020, involving 14 supervisors and 28 therapists-in-training and their clients, the article reflects on this pioneering online practicum for the online live supervision of therapists with geographically distributed participants
Pennington et al. (2020)	Book Chapter	Conceptual	USA	To provide an overview of the current state of cybersupervision literature in psychotherapy, with an emphasis on systemic cybersupervision. It will: (1) provide a historical context of cybersupervision; (2) review definitions and conceptualizations of cybersupervision; (3) discuss the logistics of initiating and maintaining the cybersupervision relationship; and (4) examine the various forms and platforms of cybersupervision. In addition, ethical and legal risk considerations associated with cybersupervision will be infused throughout the chapter. In doing so, this chapter can serve as a learning resource for therapists who plan to engage in cybersupervision
Perry (2012)	Journal of Systemic Therapies	Empirical: Qualitative (semi-structured interviews combined with Giorgi's method of phenomenological analysis)	USA	To examine the process by which master's degree students can construct their professional identity in an online environment
Sahebi (2020)	Family Process	Conceptual	USA	This paper addresses the need for a swift transition from in-person clinical supervision to telesupervision during the time of the COVID-19 global pandemic. Five specific areas are being discussed in the effort to enhance the quality of clinical supervision provided to couple and family therapists in training at this time including the following: (1) COVID-19 and the structural changes and technological adaptation of supervision; (2) culturally and contextually sensitive guidelines for clinical supervision during COVID-19; (3) the supervisee's competence and the clinical supervisory process; (4) the new set of boundaries and the supervisory role; and (5) the supervisory alliance and supervisees' vulnerabilities in the face of COVID-19
Schmittel et al. (2021)	Contemporary Family Therapy	Empirical: Qualitative (phenomenological)	USA	To describe the experiences of faculty telesupervisors who have provided TS as part of an online COAMFTE Accredited MFT master's program since 2012. Eighteen participants completed individual interviews or focus groups, which were analyzed using descriptive phenomenological procedures. Core themes include general experiences with TS as a modality, online university-specific experiences with TS as a modality, a systemic lens is intentionally applied, diversity, equity, and inclusion (DEI) are intentionally addressed, and clinical competencies and ethics are intentionally addressed
Sherbersky et al. (2021)	Journal of Family Therapy	Conceptual	USA	To consider how digital practices might reshape our systemic training, supervision, and competence evaluation, considering issues for students and trainers as they move to digital delivery of training and supervision. This paper explores the historical context of online learning, enhancing online presence, and the ethical and practical implications of teaching and supervising digitally
Springer et al. (2020)	Journal of Marital and Family Therapy	Empirical: Qualitative (phenomenological)	USA	To determine the experience of learning how to use videoconferencing to deliver relationally focused mental healthcare. Participants included 10 graduates of a COAMFTE-accredited master's degree program emphasizing training in telemental health. Each student had practicum placements that required videoconferencing to deliver relationally based psychotherapy

Springer et al. (2021)	Journal of Marital and Family Therapy	Conceptual	USA	This paper presents an important step toward increasing the effectiveness of the supervision of therapists who are delivering relational therapies online through the identification of relational competencies unique to this delivery medium. These competencies have been adopted and integrated into a COAMFTE-accredited master's degree program
Watters and Northey (2020)	Journal of Family Psychotherapy	Conceptual	USA	To facilitate the effective adoption and implementation of OTS authors draw attention to three distinct competencies critical to the effective use of OTS: technological, contextual, and relational. These competencies are in no way exhaustive but lay the groundwork for systemic supervisors to engage and connect with supervisees using video conferencing technology. In addition to the competencies, specific techniques and strategies are suggested to assist supervisors to hone their skills in OTS and subsequently improve the quality and effectiveness of supervision in a virtual environment

Telesupervision competence

One major theme that emerged from our analysis relates to the competencies needed for online clinical and supervisory practice. It has become apparent with the migration of supervisors from an in-person setting to telesupervision that some skillsets which were relevant before are no longer relevant, and that new skills are needed for the shift to this mode of supervision. There is an important distinction to be made between a supervisor's competence in the supervision session (i.e., how does one practice supervision when it takes place online), and training competencies concerning online therapy (i.e., how does one supervise therapists who work with couples and families online). It seems that very little is known regarding which competencies are needed for online clinical and supervisory practice. In the articles analyzed, competencies were mostly presented and discussed through their absence or through the lens of incompetency. Sahebi (2020) points out that hardly any practitioner today has extensive experience in teletherapy. Moreover, they argue that most clinicians and supervisors were forced to move into online practice in March 2020 due to COVID-19, and as a result, adopted their current therapy process and supervision to an online environment ad hoc. In sum, it seems that a supervisor's competence in the supervision session, and competencies concerning training to conduct online therapy, are both underdeveloped concepts.

Familiarization with the technology

Sherbersky et al. (2021) argue that the first step needed when transferring to the virtual arena is to increase supervisors' confidence by familiarizing them with the technology. Supervisors also need to be wary of the de-skilling effect that the switch to online therapy creates for novice and experienced supervisees alike. According to Schmittel et al. (2021), once supervisors had gained confidence in the use of technology, their engagement in supervision increased. Consequently, supervisors and supervisees were able to establish better connections, have access to more effective tools for interacting, and experience better communication.

In most cases, familiarization has been slow, since changes in delivery during the pandemic have largely been a process of learning, which has progressed from initial anxiety to increased familiarity and comfort. Furthermore, supervisees and supervisors in online environments may be concerned about the clinical competency of supervisees. Sahebi (2020) stresses that almost no one today started with an experience of teletherapy. Supervisees may find themselves with a decreased level of confidence about themselves and the quality of training in an environment where almost everyone is new to the experience. This may increase their apprehension about issues such as isolation and uncertainty about the future.

Dealing with non-verbal communication

The embodied experience is limited online (Sahebi, 2020). Lacking body language means supervisors should help supervisees pay greater attention to non-verbal cues, which is harder to do in an online environment. This can be especially problematic when providing couple, family, and other relationally based therapies where there is normally a heavy reliance on nonverbal cues and information needed for assessment and intervention that may only be available through physical proximity (Springer et al., 2020). Sahebi (2020) suggests that one reason for the slow adoption of technology by MFTs in the years before the pandemic may have been the centrality of space and physical positioning in many systemic models, as well as the importance of emotional attunement and experiential therapy.

Supervisory alliance

In Sahebi's (2020) view, supervisors should assist supervisees with the challenge of developing an alliance with clients whom they meet online. This can be made more effective through modeling when the supervisory relationship is collaborative and honest (Pennington et al., 2020). Online supervision may affect the development and continuance of alliance and rapport in the supervisory relationship. By helping their supervisees resolve technology issues or at least empathizing when these occurred, supervisors were able to establish meaningful relationships (Schmittel et al., 2021). Conversation in an online, two-dimensional reality may prove to be far more challenging than in an in-person supervision. However, this does not rule out a meaningful relationship. Watters and Northey (2020) suggest that the difference lies in the techniques used to facilitate a supervisory relationship. It was argued that it is the supervisor's role to take responsibility for this process and create engagement, which reflects the quality of the supervisee's participation, commitment, and motivation for learning and developing clinical and virtual competence (Bloomberg & Grantham).

Watters and Northey (2020) put forward the construct of "presence," relying on Lehman (2010), who viewed telesupervision as a dynamic interplay, the supervisor engages the supervisee in an interactive and iterative process. This process demands a focus on three types of presence: social, psychological, and emotional.

Social presence is the desire to be perceived as "real" and to perceive others as "real," even when communicating in a virtual world. When a supervisor starts the meeting and disappears into the background, there is a lack of "realness." A supervisor's ability to present himself or herself as multidimensional is crucial to maximizing the supervision experience for supervisees. To establish a sense of trustworthiness and safety in the online environment, one key factor is social presence, or "being real." Nadan et al. (2020) depict a situation in which supervisors in practi-zoom—live supervision during an online family therapy session—would text the supervisees during sessions to "ensure equal footing" (Nadan et al., 2020); this is an example of how supervisors can experience a challenge to the "realness" of their intervention. Watters and Northey (2020) stress that social presence is all about conveying a sense of safety and trustworthiness in an online environment.

Psychological presence in the supervisor-supervisee relationship is manifested when the technology becomes only the medium used and the relationship itself becomes the primary focus (Lombard &

Ditton, 1997). When supervisees trust and feel connected to their clinical supervisors, they are more willing to be vulnerable in the online supervisory relationship (Belsak & Simonic). Supervisors may be able to create a sense of psychological presence through individualized communication and intentionality in their conversations regarding the modality.

Emotional presence is the ability to convey feelings and emotions through words and interactions. This pertains to what is known as the supervisor's "use of self" in assisting the supervisee with any difficulties they may be facing in the supervision or therapy process. An emotional presence can serve both as a modeling tool for the supervisee and as a way to explore the supervisory relationship. Despite the examples given, our analysis revealed little information on how supervisors can guide their supervisees to develop social, psychological, or emotional presence.

Latency and technological understanding

This skillset relates to the supervisor's competencies in using the technology of telesupervision. Competent supervisors must pay attention to the focus of the camera, the background, how much light is in the room and that it is behind the camera maintaining eye contact through the camera, making sure the sound quality is good—as all of these, and more, influence the way supervisees experience supervisory alliance. Furthermore, supervisors are expected to understand the concept of "Latency," the length of delay between the original signal sent and the signal arriving at its destination (Luxton et al., Pennington et al., 2020). Basically, low latency is associated with a good user experience, whereas high latency is associated with a poor one. When latency is as close to zero as possible, it is ideal. However, in the case of most modern computers and/or other means of communication, the better the connection (bandwidth) the lower the latency (Friston & Steed).

Clearly, in an in-person setting, we experience zero latency, which creates greater fluidity and flow in the conversation, even when multiple speakers are present. In a virtual setting, there is a limit to the degree of latency, and this is usually influenced by multiple factors: the software/application being used (Skype, Zoom, etc.), the location of the router, the WIFI plan, and other factors. Severe latency or delay makes it impossible to continue a conversation, whether supervisory or therapeutic; this results in the parties' inability to hear or to see each other (Pennington et al., 2020; Watters & Northey, 2020). As a by-product of latency, competent supervisors learn the effect of this on timing. Awareness of timing, for instance, by reading body language, using silence, or any other method, is vital in a physical setting but may become a challenge in telesupervision, especially in group telesupervision. Using tools such as mute, chat rooms, hand-raising, and so on might prove to be helpful in creating structure and order in the session (Jordan & Fisher, Watters & Northey, 2020).

Acquiring new telesupervision competencies can be daunting, given the fast pace of technological change and the overall changes in healthcare, clinical settings, and mental health agencies (Harrison, 2021; Pennington et al., 2020). New supervisees are often technologically savvy and are excited to learn about online therapy. Supervisors who want to assist supervisees in recognizing all aspects of online therapy and the competencies associated with its thoughtful, cautious, and responsible practice, need careful adaptation of current skills. For example, observational skills linked to assessing dyadic and systemic functioning will have to be intensified to detect subtleties easily lost in a virtual setting. Therapy skills, such as offering reflecting teams, will need to draw on new

methods to monitor the impact of reflections on family members (Sahebi, 2020; Sherbersky et al., 2021; Watters & Northey, 2020).

Managing setting and boundaries

Thinking about the context of supervision, one must also consider the use of space boundaries, as Watters and Northey (2020) suggest. Where are the supervisor and supervisee located? Home/office? Public sector/private practice? Supervision from one's home is different from meeting in an office. When using videoconference from one's home, each side discloses additional personal information, intentionally or unintentionally. An example of this may come in the form of kids making a noise in the other room, barking dogs, and so on. According to Watters and Northey (2020), the setting chosen is neither good nor bad but is an added factor requiring attention. However, it is recommended to be included in the supervisory conversations, according to several authors (Luxton et al.; Pennington et al., 2020; Sahebi, 2020). These discussions may involve ongoing assessment and evaluation of the clients' needs and the session environment as new challenges are presented. It is also possible that other topics may be discussed, such as confidentiality, recording, utilizing a shared screen to assess any forms required, or monitoring the use of self. Furthermore, supervisory discussions may address liminality, that is, movement between two spaces (e.g., moving from staying at home to entering telesupervision; Stein, Van Gennep). In telesupervision (or telepsychotherapy), the liminal space may include preparing a hot drink or a glass of water, opening the computer, closing unnecessary applications, putting on headphones, and so on (Sherbersky et al., 2021).

By bringing boundary issues into supervision dialogue, we may start to negotiate with ourselves and with supervisees and clients in regard to our relationship with space. Home space provides comfort but could also be professionally challenging. Supervisors, according to Watters and Northey (2020), are expected to invite reflections on the issue of space, and as a result they facilitate the process of joining. Additionally, this allows them to serve as a model for how the supervisee may conduct online therapy conversations.

Ideally, the supervisor would be able to use the data received through the screen to help the supervisee do a better job with a client. Interruptions can be problematic if they create distractions and do not assist the supervisory process (Watters & Northey, 2020). Sahebi (2020) points out that there is a need to monitor online supervisory processes. For example, supervisors may show more readiness to become available outside of the dedicated supervision time through other means, such as through text messages and phone calls outside the supervision hour. Even though this may demonstrate flexibility on the supervisor's part, there is an additional risk of burnout, as well as of setting a precedent for breaking the boundaries of the relationship (Rosenberg & Pace).

Using the space to interact becomes intentional and can be utilized by the supervisor to establish a connection with the supervisee. The supervisor can acknowledge the space by commenting on it or comparing it to their own environment, which facilitates joining and even creates a space for modeling (Watters & Northey, 2020). During supervision in a trainee's bedroom, for example, a supervisor might ask how having a client in this room could affect therapy. Greater supervisor flexibility may serve as modeling for the supervisee and, as a result enhance the growth of therapists in training. This is because one of their developmental tasks is to develop their ability to be present

with their client-related anxieties and to become more curious about expanding their case conceptualization.

Advantages of telesupervision

The main advantage of telesupervision that emerged from our analysis is related to the online domain. Telesupervision has a major ability to bring together supervisors and supervisees from different geographical zones. Moreover, telesupervision has the power to increase the variety of internships offered, allowing supervisees opportunities beyond their immediate location. It can benefit the seasoned therapist by increasing access to experts on a specific topic of interest. Greater geographical flexibility may also contribute to a multicultural experience for both trainees and graduated therapists (Perry).

Convenient scheduling and effective use of time were found to be the most documented advantages in the literature reviewed (Jordan & Fisher, Luxton et al., Nadan et al., 2020; Pennington et al., 2020; Sahebi, 2020; Watters & Northey, 2020). Jordan and Fisher contend that easier access to supervision may result in greater job satisfaction for supervisees and a lower rate of clinical burnout. The access may have different dimensions such as time, location, and different specialties of supervisors or supervisors who speak certain languages. As a result of telesupervision, working hours can be extended, making it more convenient for all parties involved. Supervisors and supervisees are no longer tied to their local time. Furthermore, since the pandemic has forced many people to leave their offices for home, time flexibility is a crucial factor when juggling the delicate work-life balance. Nevertheless, there is a risk that too much flexibility will lead to an erosion of the importance of supervision time (Martin et al.). It is therefore recommended for the supervisor and supervisee to discuss best practices for scheduling supervision (Watters & Northey, 2020).

Challenges of Telesupervision

Our analysis indicates that the challenges of telesupervision are mostly on the level of technological skillfulness, the use of screens, and creating boundaries.

Technological skillfulness

Nadan et al. (2020) describe a feeling of helplessness and frustration experienced by supervisors and supervisees alike when encountering technical issues; the split attention required by the videoconference platform and the tiredness resulting from looking at a screen for a long time, which is known as Zoom Fatigue (Fauville et al., 2021). Watters and Northey (2020) add that system limitations are bound to happen no matter which videoconferencing platform is used. They stress the importance of supervisory conversations in regard to what to do when the system crashes and the alternatives available. In addition, according to Watters and Northey (2020), watching oneself on a screen is a double-edged sword. Most people seem to tolerate it but would prefer not to look at themselves (or have anyone else look at them). There is no clarity as to whether the reluctance to appear on camera stems from self-consciousness, the desire to engage in other activities during the meeting (multitasking), or something not yet understood.

Scheduling

Watters and Northey (2020) discuss the issue of scheduling. This aspect of telesupervision has two sides. We have mentioned its benefits, but flexibility in scheduling also brings a collapse of boundaries. Expectations are different because the “workday” is not set in stone but is rather a personal choice of the supervisor and supervisee.

Limiting intervention

Furthermore, Sherbersky et al. (2021) agree with Nadan et al. (2020) that the technical aspects of using telesupervision might limit the variety of interventions group supervision could create, and thus hinder the learning and supervisory processes. Sherbersky et al. (2021) also note that for some supervisors, the inability to be present with the supervisee (and his or her clients) in the same room leads to missing non-verbal communication and, perhaps, to overlooking energy that is present in the therapy room. In conjunction with the online disinhibition effect, which refers to the lack of restraint one feels when communicating online in comparison to communicating in person (Suler), a different therapeutic communication is generated.

DISCUSSION

This scoping review was designed to identify and synthesize the existing body of knowledge regarding the utilization, experiences, and perceptions of online clinical supervision among couple and family therapists, also known as telesupervision. Telesupervision is a method, a model, and an approach that is currently in its infancy. Our review clearly demonstrates the very limited conceptual and empirical work available (Martin et al., Phillips et al., 2021). With the rapidly growing use of online therapy and telesupervision in couple and family therapy (Machluf et al., 2021; Mc Kenny et al., 2021; Schmittel et al., 2021), there is a pressing need to expand this body of knowledge in general, and in couple and family therapy in particular, and to collect additional evidence that can be translated later into practice. We have presented the fundamental elements of the supervisor's competence in both supervision and technology, as well as their intersection (Pennington et al., 2020). It is crucial to recognize that supervisors need to be competent not only in their professional domain but also in the virtual domain, and be aware of how these two domains are intertwined and affect each other. Nevertheless, this review serves as an important first step in demonstrating telesupervision as a promising intervention. Supervisors should possess a variety of skills, including technological, contextual, and relational abilities, which will assist both in enhancing the supervisory experience of trainees and educating novice therapists to work effectively in a virtual arena.

Among the studies reviewed, the challenges and benefits of telesupervision have emerged as a key topic of discussion. In earlier studies (Jordan & Fisher, Perry), telesupervision was examined as an effective method for enhancing learning among beginning and novice therapists, along with a few difficulties to be considered. Later studies, however (Nadan et al., 2020; Sahebi, 2020; Sherbersky et al., 2021; Watters & Northey, 2020), focus on supervisors' experience of learning a new way of working and a new system, as well as diving further into the intricacies of the particular dos and don'ts of telesupervision. For example, trainees can be aided in managing conflict between their couples and families in the virtual arena using supervision conversations on therapeutic stance and how it shifts between physical and virtual settings (Sahebi, 2020; Springer et al., 2021).

This scoping review reveals several gaps in the existing body of knowledge. First and foremost, from a quantitative perspective, the data regarding the efficacy of telesupervision for family and couple therapists are thus far insufficient. Nonetheless, they provide some information regarding outcomes of telesupervision and may perhaps serve as a basis for comparison between online couple therapy and the vast scholarship on in-person couple therapy. There is also insufficient qualitative data regarding supervisor and supervisee experiences, processes, and meanings, as well as a lack of ethical guidelines and protocols regarding safe and professional online clinical supervision. Moreover, a more comprehensive exploration of how different circumstances affect themes such as the supervisory relationship and boundaries is needed. For example, how does a better internet connection affect the relationship? Or, what is the effect of having to work from home while one's children are present? Another gap in the research is the product of a generation gap. While it can be argued that, as Prensky has noted, there are digital natives and digital immigrants, further research is necessary to determine whether this assessment can be applied to our field. Indeed, many supervisors who may belong to a pre-internet age, are competent and quick to adapt to the technology. A comparable gap in online therapy is slowly closing (AAMFT, 2020; AFT, 2020; COAMFTE, 2020), and a similar trend is desirable in the area of telesupervision. Working in front of a screen can lead to Zoom Fatigue, which people feel after engaging in videoconferences (Bailenson, 2021; Bennett et al., 2021; Peper et al., 2021). Our review found little research on how to deal with this during telesupervision specifically, or in online therapy in general, or on how supervisors might support their supervisees through such challenges. Thirdly, and perhaps due to the lack of data, there are little to no protocols and recommendations for supervisors and supervisees that could generate a set of guidelines for the use of telesupervision. Therefore, we would strongly recommend the development of specific programs, perhaps even as a subspecialty, for the training of competent and ethical telesupervisors.

Our review yields suggestions for future research in this area. Although the notion of telepresence, the experience of being fully present at any given time and participating fully in the online therapeutic process (Berthiaume et al., Bouchard et al.), has already been investigated by couple therapists (Aviram & Nadan, 2022), we believe that a deeper inquiry concerning telesupervisors is necessary. Furthermore, the concept of liminality—the movement between two spaces (e.g., the movement from staying at home to telesupervision; Stein, Van Gennep)—also requires attention from the scholarly community to fully understand its implications for the online supervisory interaction. It is crucial to clarify that our use of the word “spaces” here is not meant to describe a physical space. Whether supervisors are working from home or from their office, they are in a professional/therapeutic/supervisory space. Liminality refers to the transition from the personal or home space of the supervisor to his or her supervisory space. Lastly, it would be useful to conduct research to determine whether there are any differences in telesupervision when the supervisor views both the supervisee and the couple/family undergoing therapy on the same screen if this affects the supervisors' awareness of the session, and what impact this may have on their ability to supervise the trainees and their clients both safely and ethically.

Certain limitations of this scoping review should be noted. First, its intention was to present a comprehensive review of the findings in this field. The quality of the studies was not evaluated; however, this will be an essential step once more papers are published on this topic. Second, as we analyzed a relatively small number of diverse articles (qualitative, quantitative, and conceptual), we conducted the same analysis for all of them, consistent with the scoping review methodology. Once

this body of knowledge is expanded, it will be essential to conduct additional analysis to clarify which findings were empirically supported. Third, despite an extensive literature search, some studies may have been omitted. Various databases may have produced additional articles, and our exclusion criteria may have excluded other key clinical supervision publications. Furthermore, this review included English-language journal articles, which meant that monographs and gray literature were not systematically considered. There may be additional findings available in other languages that were not included. Lastly, despite our best efforts to make most of the review process collaborative, we are aware that our interpretations are positioned, which will have influenced our interpretations of the included studies.

13. References

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