Introduction

Case Vignette

Samantha is a social worker who has recently completed her degree and has started in her first position working in a women’s inpatient psychiatric facility. Most of her previous, school-related experiences have been in outpatient settings and she soon realizes that she is overwhelmed by the needs and demands of the patients in this setting. Samantha’s supervisor, Monica, has observed how difficult a time Samantha is having. Monica pulls Samantha aside and validates the challenges of working in this environment. She helps Samantha with strategies in setting good boundaries and educates her about the personality styles she is encountering. Although the work remains challenging, Samantha realizes that she is learning a lot and feels less overwhelmed and frustrated.

The case vignette above illustrates the importance of supervision in training mental health professionals. “Supervision and supervisory relationship are the medium through which therapy is taught” (Kaiser, 1992). This deceptively simple statement evokes a plethora of memories and experiences for most clinicians. All mental health professionals have had the experience of having their work supervised by a more seasoned mentor. These experiences are often key in providing grounding in the profession, helping the newer practitioner to gain practical knowledge and skills, and providing direction on ethical and therapeutic issues that arise. Supervision is also helpful in ensuring that clients working with newer clinicians have the benefit of them being guided by someone more experienced. Despite the potentially positive aspects of supervision, many supervisees have also had the experience of feeling that they are not being effectively trained or understood by supervisors, or that the difficulties of being a newer therapist are not properly addressed. More concerning is the notion that some supervisees are made to feel inadequate, or are shamed within the supervision process. Anne Kearns (2005), a Humanistic practitioner, eloquently discusses this phenomenon in a chapter in her book on supervision that she titles “Living With the Enemy.” Of course this does not represent the bulk of supervisory experiences.

Although positive and negative experiences exist, a key factor in ensuing that supervisors are prepared for the mentoring role is supervision specific training. There are a number of models that a supervisor may follow based on the own background and orientation, but within these theoretical differences there is consensus on what steps professionals can take to become effective supervisors.
Objectives:

After finishing this course, the participant will be able to:

- Define “supervision” and distinguish it from the process of psychotherapy
- Discuss characteristics of effective supervision and ineffective supervisors
- Discuss broad issues related to the supervisory relationship
- Explain the use of the Myers-Briggs Type Indicator and how MBTI traits reflect individual differences between supervisor and supervisee
- Compare and contrast authoritative and facilitative approaches to supervision
- List supervision competencies proposed by Association of Psychology Postdoctoral and Internship Centers (APPIC)
- Compare and contrast the various approaches to supervision (Psychodynamic, Cognitive Behavioral, Feminist, Person-Centered, Developmental, Systems Approach)
- List the responsibilities involved in supervision (supervisor, supervisee, client)
- Discuss ethical and legal issues in supervision, including informed consent, confidentiality, and competence (including ACES best practices)
- Discuss the issue of conditional confidentiality
- Discuss issues related to multicultural competence in supervision
- List questions that may be helpful in promoting multicultural competence
- Describe the importance of the supervisory contract and list some components that may be included in this contract
- List challenges and opportunities related to boundaries in supervisory relationships (dual relationships, supervision versus therapy, intimate/sexual relationships, parallel process and countertransference reactions)
- Describe the various supervision formats the benefits of structured versus unstructured supervision, including when each is appropriate
- Discuss the use of self-report as a form of supervision
- Discuss issues connected to live therapy supervision
- Describe the use of other methods such as audio or videotaping and use of process notes
- Define Kagan’s method of Interpersonal Process Recall (IPR)
- List ways to encourage supervisee reflectivity
- List the possible components of an individual supervisory session
- Discuss ways to encourage supervisee reflectivity
- Define authoritative, participative, co-operative and peer group formats
- List the components of a fair evaluation
- Distinguish between formative and summative evaluation
- Discuss evaluation of supervisees, including use of evaluation instruments, supervisee self-assessment and communicating feedback
- Discuss common issues that may lead to conflict between supervisor and supervisee and ways to address these conflicts
- Discuss supervisee-specific strategies (e.g., the anxious supervisee, the apathetic supervisee)
- Discuss supervisor administrative functions, including the reasons for record keeping and the components of a supervision record

Included in each section of this material is a list of “questions to consider.” These questions are designed to stimulate thought about the content in each section. Taking some time to consider each of these questions is helpful in consolidating the material.

**Definition of Supervision**

**Questions to consider:**
What have your own experiences of supervision been like?
Why is supervision important?
How do you define supervision?
What constitutes “good” and “bad” supervision?
What issues may be connected to the evaluative nature of supervision?

Case Vignette

Jim is a social work student who has just begun a field placement in a psychiatric emergency center. Although he was aware that the pace of this placement would be intense based on the nature of the work, Jim feels unprepared by the demands of working with severely ill clients. His experiences with Robert, his supervisor, have not helped to allay his concerns. Jim feels that although Robert will answer specific questions that arise, he is “burned out” and generally appears rushed. He rarely feels guided or supported when questions arise. When the mid-semester point arrives, Jim asks to be transferred to a different setting.

How do you define mental health supervision? How does supervision diverge from the more studied concept of psychotherapy? Is it different (Sarnat, 1992)? Although there are some similarities between supervision and psychotherapy, it varies in terms of its structure and purpose. It is helpful to consider the following definitions, which stress the distinct purpose of supervision as well as its evaluative component. Campbell (2000) offers a basic starting point for defining supervision. Campbell uses the term supervisor to denote a “counselor or therapist designated with the responsibility to train and evaluate the expertise and skills of the supervisee.”

Campbell’s (2000) definition does stress training, although supervision and training are not synonymous. Training differs from supervision in that it is more limited in scope and focuses on a specific set of skills.

In a more comprehensive definition, Bernard & Goodyear (2004) define supervision as “A distinct intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes: a) enhancing the professional functioning of the junior members; b) monitoring the quality of professional services offered to the clients he/she/they see(s) and; c) serving as a gatekeeper for those who are to enter the particular profession.

Falender & Shafranske (2004) suggest a similar definition of supervision. They propose a competency-based model in which supervisors evaluate, instruct and model skills that facilitate supervisee development and self-assessment. These authors acknowledge that due to setting and client population, there may be differing goals with regard to knowledge and skill sets, but that the ultimate
objective of their model is attainment of a “broad spectrum of personal and professional abilities relative to a given requirement.”

In addition to these theoretical definitions, the ethical guidelines of mental health professions also define supervision/supervisors. For example, counseling supervisors are guided by the Ethical Guidelines for Counselor Educators and Counseling Supervisors. These guidelines define supervisors as “Counselors who have been designated within their university or agency to directly oversee the professional clinical work of counselors. Supervisors also may be persons who offer supervision to counselors seeking state licensure and so provide supervision outside of the administrative aegis of an applied counseling setting,” and state that “The Primary obligation of supervisors is to train counselors so that they respect the integrity and promote the welfare of their clients.” The ACES guidelines further clarify the supervisory role as “Inherent and integral to the role of supervisor are responsibilities for: a. Monitoring client welfare; b. encouraging compliance with relevant legal, ethical, and professional standards for clinical practice; c. monitoring clinical performance and professional development of supervisees; and evaluating and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment, and credentialing purposes.”

In considering these definitions of supervision, it is evident that supervision must accompany client contact so that students in the mental health professions can acquire the necessary practice skills and conceptual abilities. The case vignette illustrates why supervision is imperative for the early career professional. Recognition of the significance of supervision is evident in the fact that supervision requirements are found in the licensing and accreditation requirements for all mental health professions. These supervision requirements vary from state to state, but all require supervision while the supervisee is enrolled in a formal degree program as well as requiring postgraduate supervision.

Campbell (2000) and Madden (2000) stress the fact that supervisors accept the ethical and legal responsibilities of their supervisee and often need to be competent in working within organizational systems. Other significant distinctions between the supervisory and therapeutic relationship are the evaluative nature of the supervisory relationship as well as the “involuntary” (required) nature of supervision. We will return to these distinctions later in this material when discussing the boundaries of the supervisor/supervisee relationship.

In addition to defining supervision, it is also helpful to consider the qualities of effective supervision and successful supervisors. A number of authors (e.g., Bradley, 2000; Campbell, 2000; Campbell, 2006; Corey, Corey & Callahan, 2006; Magnuson & Wilcoxon, 1998) have discussed these qualities. Effective supervisory behaviors include clarifying expectations, maintaining
appropriate boundaries, being accessible and available, fostering exploration of new ideas, providing constructive criticism and positive reinforcement, communicating effectively, and working collaboratively. These authors have also identified personal qualities and characteristics of the supervisor. These include having a sense of humor, being sensitive and understanding, being honest, openness and flexibility and professional competence.

Contrasting these effective qualities are supervision styles and issues leading to negative or problematic interactions. Negative experiences in supervision may be the result of actions on the part of either supervisor or supervisee. Falender and Shafranske (2004) list several examples, with the theme of boundary crossing between supervisor and supervisee. For example, they discuss a situation in which a supervisee excessively flattered the supervisor, leaving the supervisor unable to provide accurate feedback. They point out, however, that it is the supervisor's role to attend to such process issues.

Magnuson et al. (2000) describes principles of “lousy supervision.” These included unbalanced supervision, developmentally inappropriate supervision, problems with the relational-affective, organizational-administrative, or technical-cognitive spheres, poor teaching and role modeling, and inflexibility or intolerance. Ellis et al., (2014) found that more than half of supervisees reported having received harmful clinical supervision at some point in their training.

**Key Points**

- Supervision is a distinct intervention that differs from training, psychotherapy and consultation
- Supervision is a mentoring relationship and provided by a member of the same profession (e.g., psychologist, social worker)
- Supervision is not a “voluntary” relationship, although supervisees may have some discretion over who they choose as a supervisor
- Supervision is evaluative
- Supervision extends over time
- Goals of supervision include enhancing professional functioning and monitoring client care

It is important to note that each state and profession varies when it comes to defining supervisory qualifications/requirements, delineation of progress, etc.

**The Supervisory Relationship**

**Questions to consider:**

*How important is the supervisory relationship?*
Looking back over your own experiences in supervision, were there times when relationship issues helped with your training? Were there times the supervisory relationship hindered your training? What did you find valuable in the relationship between yourself and your supervisor?

Case Vignette

Donna is a doctoral intern currently completing a rotation in a community mental health setting. Her supervisor for this rotation is Dr. Martinson. Donna has done well in supervision to this point, but recently she has found herself struggling. She presents for supervisory sessions as she always has, detailed session notes in hand, ready to discuss her client sessions. Dr. Martinson seems annoyed at times by her approach and has told her he would like her to “relax” and look more at the big picture the client presents rather than getting hung up on details of each therapy visit. He often reminds Donna that she needs to work with clients from a more detached and impartial stance. Donna leaves sessions frustrated, feeling like she is not developing to skills she needs to work with this population. She knows that Dr. Martinson is a good psychologist, but he does not seem to be the right supervisor for her. She feels intimidated by Dr. Martinson, however, and cannot express how she is feeling.

What do you believe is occurring here? Can this relationship be saved?

Although the discussion thus far has highlighted a number of different factors in supervision, supervision is first and foremost a relationship. As such, it is important to look at how supervisor and supervisee interact as individuals.

Is the relationship between supervisor and supervisee important? The answer is yes. Ellis (2006) conducted a naturalistic study in which Loganbill, Hardy, and Delworth’s (1982) and Sansbury’s (1982) propositions regarding supervision issues were applied to the supervision of supervisors in training and to counselor supervision and then tested. The doctoral-student participants consisted of beginning counselors and their supervisor trainees. Critical incidents, which were obtained after each counselor-supervision session and each supervisor-supervision session, were rated on 10 supervisory issues. When asked to identify critical incidents in supervision, the most cited factor is the supervisory relationship (Ellis, 2006). Aten et.al. (2008) has used this study as a springboard to develop the “supervision genogram,” a tool that may be used to enhance supervisors'-in-training self-awareness and understanding of the supervisory process.

Cognitive or learning styles refer to an individual’s way of processing information. When a supervisor and supervisee have differing styles of learning, this present a number of challenges. One instrument that has been used to look at this is the Myers Briggs Type Indicator (Myers, 1962) or MBTI. This
assessment is a psychometric questionnaire designed to measure psychological preferences in how people perceive the world and make decisions. The MBTI produces a profile that shows the following differences in learning styles and ways of relating.

**Attitudes:** Each of the cognitive functions can operate in the external world of behavior, action, people and things *(extraverted attitude)* or the internal world of ideas and reflection *(introverted attitude)*. People who prefer extraversion draw energy from action: they tend to act, then reflect, and then act further. Conversely, those who prefer introversion become less energized as they act: they prefer to reflect, then act, then reflect again.

**Information Gathering:** *Sensing* and *intuition* are the information-gathering functions. They describe how new information is understood and interpreted. Individuals who prefer sensing are more likely to trust information that is in the present, tangible and concrete: that is, information that can be understood by the five senses. They prefer to look for details and facts. Those who prefer intuition tend to trust information that is more abstract or theoretical and may be more interested in future possibilities.

**Decision-making:** *Thinking* and *feeling* are the decision-making functions. Those who prefer thinking tend to decide things from a more detached standpoint, measuring the decision by what seems reasonable and logical. Those who prefer feeling tend to come to decisions by associating or empathizing with the situation, and weighing the situation by, considering the needs of the people involved.

**Information management:** *Judging* types approach life in a structured way, creating plans and organizing their world to achieve their goals and desired results in a predictable way. They get their sense of control by taking charge of their environment and making choices early. *Perceiving* types prefer to keep their choices open so they can cope with many problems that the know life will put in their way.

In looking back at the case vignette it is clear that Donna and Dr. Martinson did not share many of the same preferences, particularly in the area of information gathering. Donna prefers sensing, while Dr. Martinson prefers intuition. In times when the relationship was challenged by these situations such as Donna seeking detailed information on case formulation, the two did not talk through these differences or find ways to compromise. Understanding and discussing these differences would have helped tremendously.
In addition to cognitive or learning styles, the case vignette also points to the use of power with supervision. We will return to this topic in our discussion of supervision approaches as well as formats for supervision. Several quick definitions may be helpful. Heron’s (1988) model of supervision describes Authoritative supervision Interventions that are prescriptive, that is they direct behavior, informative, giving information and instructing and confronting or challenging supervisees. Facilitative supervision Interventions are cathartic, that is they release tension and strong emotions, catalytic – encouraging self-exploration and supportive, validating and confirming. Although there is no clear cut information that says one approach is more effective than the other, it is likely that supervisees benefit from having both authoritative and facilitative supervisors during their training.

Supervision Competencies

Another view of supervision is the competency model. There has been little consensus in what constitutes the appropriate competencies for supervisors. In fact, Falender & Shafranske (2014) reported that only about 60% of interns in a recent survey indicated that they had taken coursework in supervision. Falender et al. (2004) attempted to define these competencies and produced a comprehensive list. In 2004, the Association of Psychology Postdoctoral and Internship Centers (APPIC) workgroup, presented these competencies at their annual conference. The following table summarizes their discussion.

**Supervision Competencies Framework**

<table>
<thead>
<tr>
<th>Knowledge</th>
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<tr>
<td>1. Knowledge of area being supervised (psychotherapy, research, assessment, etc.)</td>
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<tr>
<td>2. Knowledge of models, theories, modalities, and research on supervision</td>
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<td>3. Knowledge of professional/supervisee development (how therapists develop, etc.)</td>
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<td>4. Knowledge of ethics and legal issues specific to supervision</td>
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<td>5. Knowledge of evaluation, process outcome</td>
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<tr>
<td>6. Awareness and knowledge of diversity in all of its forms</td>
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<table>
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<tr>
<th>Skills</th>
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<tbody>
<tr>
<td>1. Supervision modalities</td>
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<td>2. Relationship skills – ability to build supervisory relationship/alliance</td>
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<td>3. Sensitivity to multiple roles with supervisee and ability to perform and balance multiple roles</td>
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<td>4. Ability to provide effective formative and summative feedback</td>
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<td>5. Ability to promote growth and self-assessment in the trainee</td>
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6. Ability to conduct own self-assessment process
7. Ability to assess the learning needs and developmental level of the supervisee
8. Ability to encourage and use evaluative feedback from the trainee
9. Teaching and didactic skills
10. Ability to set appropriate boundaries and seek consultation when supervisory issues outside domain of supervisory competence
11. Flexibility
12. Scientific thinking and the translation of scientific findings to practice throughout professional development

**Values**
1. Responsibility for client and supervisee rests with the supervisor
2. Respectful
3. Responsible for sensitivity to diversity in all its forms
4. Balance between support and challenging
5. Empowering
6. Commitment to lifelong learning and professional growth
7. Balance between clinical and training needs
8. Value ethical principles
9. Commitment to knowing and utilizing available psychological science related to supervision
10. Commitment to knowing one’s own limitations.

**Social Context** Overarching issues:
1. Diversity
2. Ethical and legal issues
3. Developmental process
4. Knowledge of the immediate system and expectations within which the supervision is conducted
5. Awareness of the socio-political context within which the supervision is conducted
6. Creation of climate in which honest feedback is the norm (both supportive and challenging)

**Training of Supervision Competencies**
1. Coursework in supervision including knowledge and skill areas listed
2. Has received supervision of supervision including some form of observation (videotape or audio-tape) with critical feedback

**Assessment of Supervision Competencies**
1. Successful completion of course on supervision
2. Verification of previous supervision of supervision documenting readiness to supervise independently
3. Evidence of direct observation (e.g., audio or videotape)
4. Documentation of supervisory experience reflecting diversity
5. Documented supervisee feedback
6. Self-assessment and awareness of need for consultation when
necessary

7. Assessment of supervision outcomes – both individual and group

Supervision Approaches

<table>
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<th>Questions to consider:</th>
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<tr>
<td>How varied have your own experiences of supervision been?</td>
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<tr>
<td>How active or inactive a supervisor are you?</td>
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<tr>
<td>On what factors do you believe you base your supervision approach?</td>
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<tr>
<td>How does your approach to supervision vary based on trainee knowledge and experience?</td>
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There are a number of ways to approach the supervision process. Falender and Shafranske (2004) make the distinction that some approaches to supervision look at the interpersonal interaction between supervisor and supervisee, while others emphasize the development of technical skills. The following section summarizes some of these methods.

Psychotherapy Based

In psychotherapy-based approaches to supervision, the supervisor draws upon his or her own theoretical orientation to inform the supervision process. Examples of psychotherapy-based approaches to supervision include psychodynamic (Frawley-O’Dea & Sarnat, 2001); person-centered (Tudor & Worrall, 2004); cognitive-behavioral (Rosenbaum & Ronen, 1998); and solution-focused (Presbury, Echterling, & McKee, 1999). As the various approaches to therapy highlight different goals and seek differing data about therapeutic goals and success, so do the different approaches to supervision. For example, cognitive behavioral supervisors utilize Beck’s principles of cognitive therapy and apply it to the supervisory process. These supervisors use a structured, problem-solving approach, are active and directive and make use of assignments (Bennett-Levy, 2001). This can be contrasted with psychodynamic supervision, which explores and stresses affective reactions and the subjective experiences of the supervisee (Frawley-O’Dea & Sarnat, 2001).

Psychotherapy-based models have many strong points. The strengths that each theoretical approach brings to the counseling setting are echoed in the strengths they bring to the supervision environment. Psychotherapy-based approaches contribute positively to the supervision environment. Theories of psychotherapy are designed to promote growth and change in clients, and are similarly helpful in promoting growth and change in supervisees. Contributions of theory-based supervision approaches in general include the following: providing therapeutic relationship conditions, modeling counseling interventions, and providing a supervision environment that is isomorphic (i.e., equivalent in
structure) (Thomas, 1994) to the counseling process (Bernard, 1992; Bernard & Goodyear, 2004; Bradley & Gould, 2001). Counseling theories provide concepts for explaining human behavior and interventions for promoting positive change (Corey, 2005; Day, 2004), and offer useful guides for conceptualizing client situations, as well as choosing and implementing interventions.

**Psychodynamic Approaches**

Psychodynamic supervision is a form of psychotherapy supervision. Psychodynamic supervision draws on the key tenets of psychodynamic therapy: affective reactions, defense mechanisms, transference and countertransference. Frawley-O'Dea and Sarnat (2001) classify psychodynamic supervision into three categories: patient-centered, supervisee-centered, and supervisory-matrix-centered. In **patient-centered supervision** focuses the therapy patient's presentation and behaviors are the main area of discussion in the supervision process. The supervisor’s role is didactic, with the goal of helping the supervisee understand and treat the patient. The supervisor is seen as the authority that has the knowledge and skills to assist the supervisee. **Supervisee-centered supervision** focuses on the content and process of the supervisee's experience as a therapist (Frawley-O'Dea & Sarnat, 2001; Falender & Shafranske, 2008; Teitelbaum, 1995). Process focuses on the supervisee's resistances, anxieties, and learning problems. The supervisor’s role is that of the authoritative expert. **Supervisory-matrix-centered supervision** attends to material of the client and the supervisee, and also introduces examination of the relationship between supervisor and supervisee. 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” (Frawley-O'Dea & Sarnat, 2001, p. 41). A key concept of the supervisory-matrix-centered approach is the idea 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, 2003).

Psychodynamic supervision has also been applied to group settings. The purpose of group supervision will be discussed later in this material, but in terms of psychodynamic supervision, Rosenthal (1999) makes the distinction between **objective countertransference**, induced by the client as a reaction to client behavior, and **subjective countertransference**, reactions that appear only in the counselor and have their origins in the counselor’s unresolved issues. Rosenthal (1999) states that the power of the group is in identifying countertransference as objective or subjective.

**Person-Centered Approaches**

Supervision was a central concern of Carl Rogers, father of person-centered therapy. The key tenet of person-centered therapy the belief that the client has the capacity to effectively resolve life problems without interpretation and
direction from the therapist (Haynes, Corey, & Moulton, 2003). Person-centered supervision assumes that the supervisee has the resources to effectively develop as a counselor. 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, 2000).

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, 2003, p. 118). This approach was one of the first to use recorded interviews and transcripts within supervision.

**Feminist Supervision**

Feminist theory centers on societal structures and gender. Feminist psychology was developed in response to the fact that historically psychological research has been done from a male perspective with the view that males are the norm. Feminist psychology is oriented on the values and principles of feminism. Key in this is the idea that social context forms the basis of an individual’s experiences. Feminist supervision emphasizes key aspects of this Feminist psychology: That the personal is political — an individual’s experiences are reflective of society’s institutionalized attitudes and values (Feminist Therapy Institute, 1999). Feminist therapists assess the client’s experiences within the world in which they live. Feminist therapists view women's psychological problems as a symptom of larger problems in the social structure in which they live. Internalizing disorders such as depression, anxiety, and eating disorders are thought to result of psychological weakness in women and instead view it as a result of encountering more stress because of sexist practices in our culture (Feminist Therapy Institute; Crawford & Under, 2000; Haynes, Corey, & Moulton, 2003). The goal of Feminist therapy as well as Feminist Supervision, is the empowerment of the client.

The Ethical Guidelines for Feminist Therapists (Feminist Therapy Institute, 1999) emphasize the need for therapists to acknowledge power differentials in the client-therapist relationship. The Ethical Guidelines state:

A. A feminist therapist acknowledges the inherent power differentials between client and therapist and models effective use of personal, structural, or institutional power. In using the power differential to the benefit of the client, she does not take control or power that rightfully belongs to her client.

B. A feminist therapist discloses information to the client that facilitates the therapeutic process, including information communicated to others. The
therapist is responsible for using self-disclosure only with purpose and discretion and in the interest of the client.

C. A feminist therapist negotiates and renegotiates formal and/or informal contacts with clients in an ongoing mutual process. As part of the decision-making process, she makes explicit the therapeutic issues involved.

D. A feminist therapist educates her clients regarding power relationships. She informs clients of their rights as consumers of therapy, including procedures for resolving differences and filing grievances. She clarifies power in its various forms, as it exists within other areas of her life, including professional roles, social/governmental structures, and interpersonal relationships. She assists her clients in finding ways to protect themselves and, if requested, to seek redress.

While the Ethical Guidelines do not specifically address the supervisee-supervisor relationship, but it can be assumed that the same ideas apply to this relationship. The supervisor-supervisee relationship strives to be egalitarian, with the supervisor maintaining focus on the empowerment of the supervisee.

An offshoot of the Feminist model is the Feminist Psychodynamic model. This model combines Feminist and Psychodynamic theory and takes a distinctly relational approach. Key in this model is the idea that a person's early relational images continue to influence their current relationships. Supervision looks closely at these ideas in both the client/therapist relationship and the supervisor/supervisee relationship.

Cognitive-Behavioral Supervision

As with other psychotherapy-based approaches an important task of cognitive-behavioral supervision is to teach CBT techniques. Competence in CBT involves adherence to the model and application of treatment methods in caring for patients. Cognitive behavioral supervisors first teach general psychotherapy skills then the model of cognitive psychopathology and conceptualization, and finally the tools and techniques of treatment, including guided discovery.

Cognitive-behavioral supervision stresses observable cognitions and behaviors such as the supervisee’s reaction to the client (Hayes, Corey, & Moulton, 2003). Supervision techniques include setting an agenda for supervision sessions, bridging from previous sessions, assigning homework to the supervisee, and capsule summaries by the supervisor (Liese & Beck, 1997).

Sudak, Beck and Wright (2003) list several components for interns/residents using a cognitive behavioral approach. These include:
1. Formulating cases according to the cognitive model for various disorders
2. Developing a strong, active, collaborative therapeutic alliance
3. Using a cognitive conceptualization to plan treatment within sessions and across sessions
4. Continually monitoring progress
5. Structuring sessions to maximize progress
6. Focusing on helping patients solve or cope with current problems and achieve their goals, using a variety of techniques (20)
7. Identifying and helping patients modify their key dysfunctional cognitions
8. Facilitating behavioral change
9. Working directly on treatment compliance

**Behavioral Supervision**

Another supervision approach based on a psychotherapy model is behavioral supervision (Leddick & Bernard, 1980). Behavioral supervisors view client problems as learning problems. There are two primary skill sets in behavioral models: 1) identification of the problem, and (2) selection of the appropriate learning technique. In this approach, supervisees often participate as co-therapists to maximize modeling and increase the proximity of reinforcement. Supervisees also can engage in behavioral rehearsal, practicing skills under simulated conditions, such as the use of role-playing.

**Developmental Approaches**

Developmental approaches are not based on clinical orientation but utilize a sequence conceptualizes the training process as a sequence of identifiable stages through which the trainee progresses (Stoltenberg, 1997). Developmental models look at supervisee development from novice to expert, each stage consisting of unique characteristics and skills. Particular attention is paid to (1) self-and-other awareness, (2) motivation, and (3) autonomy. For example, typical development in beginning supervisees would find it normative for newer supervisees to be more dependent on the supervisor to diagnose clients and establish plans for therapy than either intermediate or advanced supervisees. Intermediate supervisees would depend on supervisors for an understanding of difficult clients, but would likely need much less guidance on client matters that are more routine. Supervisees in this stage are seen as more prone to resistance, avoidance, or conflict, because the supervisee’s self-concept is easily threatened. Advanced supervisees function independently, seek consultation when appropriate, and feel responsible for their correct and incorrect decisions.

A key task for supervisors using this approach is to identify the supervisee’s current stage and provide feedback and support appropriate to that developmental stage, while at the same time facilitating the progression to the next stage using an interactive process, called "scaffolding" which encourages the supervisee to use prior knowledge and skills to produce new learning.
(Zimmerman & Schunk, 2003). Stoltenberg and Delworth (1987) also highlight content of eight growth areas for each supervisee. The eight areas are: intervention, skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics.

Similarly a number of models (e.g., Rodenhauser, 1997, Stoltenberg et al., 1998) apply developmental stage models to supervisor development. 

Ronnestad and Skovholt’s Model

Ronnestad and Skovholt’s (2003) model is outlined here due to the researcher’s identification of themes of counselor development. Theses themes were developed based on a longitudinal study of 100 therapists, ranging in experience from graduate students to professionals with an average of 25 years of experience.

Ronnestad and Skovholt’s (2003) analysis found 14 themes of counselor development. These are:

1. Professional development involves an increasing higher order integration of the professional self and the personal self. Across time, a professional’s theoretical perspective and professional roles become increasingly consistent with his or her values, beliefs, and personal life experiences.

2. The focus of functioning shifts dramatically over time, from internal to external to internal. During formal training, the supervisee drops an earlier reliance on internal, personal beliefs about helping and instead rely professionally based knowledge and skills to guide clinical practice. Clinicians gradually regain an internal focus and a more flexible and confident style.

3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience. Thus, supervisees benefit from supervision that promotes a self-reflective stance.

4. An intense commitment to learn propels the developmental process. Importantly. Enthusiasm for professional growth tends to continue over time.

5. The cognitive map changes: Beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise. In the earlier stages of supervision, supervisees seek “received knowledge” of experts and therefore prefer a didactic approach to supervision. They later shift increasingly is to developing “constructed knowledge” that is based on their own experiences and self-reflections.
6. Professional development is a long, slow, continuous process that can also be erratic.

7. Professional development is a life-long process.

8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.

9. Clients serve as a major source of influence and serve as primary teachers.

10. Personal life influences professional functioning and development throughout the professional life span. Examples of these personal life influences include family interactional patterns, sibling and peer relationships, one’s own parenting experiences, disability in family members, and other crises in the family.

11. Interpersonal sources of influence propel professional development more than ‘impersonal’ sources of influence. Growth occurs through contact with clients, supervisors, therapists, family and friends, and (later) younger colleagues. When asked to rank the impact of various influences on their professional development, therapists ranked clients first, supervisors second, their own therapists third, and the people in their personal lives fourth.

12. New members of the field view professional elders and graduate training with strong affective reactions. It is likely that the power differences magnify these responses, which can range from strongly idealizing to strongly devaluing teachers and supervisors.

13. Extensive experience with suffering contributes to heightened recognition, acceptance and appreciation of human variability. It is through this process that therapists develop wisdom and integrity.

14. For the practitioner there is realignment from self as hero to client as hero. Over time, the client’s contributions to the process are more easily understood and appreciated and therapists adopt a more realistic and humble appreciation what they actually contribute to the change process.

Synthesized Supervision Model

Ward (n.d.) describes the synthesized supervision model, a subset of the developmental approaches to supervision, and which focused on increasing personal reflectivity in the trainee. The concept of reflectivity will be discussed in more detail later in these materials. In his discussion the author states in his review of the literature, authors stressed qualities of professional reflectivity were
illustrated as necessary for trainees to adopt conceptual and interactive skills representative of advanced counselor trainees. Supervisees progress through a sequence of definitive stages while experiencing increased levels of emotional and cognitive dissonance. Transforming dissonant counselor-training experiences into a meaningful guide for practice is largely a factor of increased conceptual complexity, and articulates the difference between novice and advanced trainees. As in many of the approaches, a trusting and supportive supervision is essential.

Ward describes several phases of supervision. In the Contextual Orientation, the supervisee experiences cognitive and emotional dissonance in adjustment to the counseling climate. The next phase involves establishing trust in the supervisory relationship. In the Conceptual Development phase the supervisor promotes advanced conceptual complexity through thematic and reflective dialogue. The final phase is that of Clinical Independence, in which the supervisor facilitates supervisee autonomy by encouraging self assessment and self generation activities.

**Process-Based Approaches**

Process-based approaches (social role supervision models) provide descriptions of the roles, tasks and processes within supervision as a way to make supervision more consistent across experiences. Several such models have been used including the Discrimination Model (Bernard, 1997) and the Systems Approach (Holloway, 1995). Process-based models provide a framework for understanding the interconnected factors within supervision.

**Discrimination Model**

Bernard (1997) established the discrimination model of supervision to provide a map for supervisors to follow. This model addresses the delivery of supervision skills by presenting a model for identification and training of those skills, the roles in which skills are demonstrated, and types of choices or discriminations necessary to make in mentoring trainees. Bernard identified three areas which she feels are key to supervision: 1) process: intervention skills used by the trainee; 2) conceptualization: trainee's ability to understand what the client is communicating and 3) personalization: skills related to the trainee as an individual.

**Systems Approach**

Holloway’s (1995) systems approach is another process-based approach. Holloway’s premise is that the “learning alliance” between supervisor and supervisee is based on multiple but interrelated factors. Key to this is the supervision relationship, and she looks at such factors as power differentials, expectations and supervisory contracts. She states that the other facets of
supervision — the client, the supervisor, the trainee, the institution, and the functions and tasks of supervision influence the supervisory relationship. There is a specific focus on the needs of the supervisee within the relationship.

**Integrative/Eclectic Models of Supervision**

Integrative models of supervision rely on more than one theory and technique (Haynes, Corey, & Moulton, 2003). Given the large number of theories and methods that exist with respect to supervision, an infinite number of “integrations” are possible. Haynes, Corey, & Moulton (2003) note that most counselors practice what they describe as “integrative counseling,” integrative models of supervision are also widely practiced. There are two approaches to integration: technical eclecticism and theoretical integration.

*Technical eclecticism* focuses on differences, chooses from many approaches, and is a collection of techniques. In technical eclecticism the supervisor uses techniques from different schools without necessarily subscribing to the theoretical positions of these orientations. *Theoretical integration* refers to a conceptual or theoretical creation beyond a mere blending of techniques. This synthesizes the best of two or more theoretical approaches to produce an outcome richer than that of a single theory. (Haynes, Corey, & Moulton, 2003).

**Responsibilities of Supervision**

**Questions to consider:**

*As a supervisor, what are your responsibilities? Is it important to discuss these responsibilities with the supervisee?*

*Does your supervisee also have specific responsibilities? If so, what are these?*

Now that we have defined supervision and looked at the various models of supervision, let’s turn our attention to the responsibilities involved in supervision. As suggested in the process-based approaches to supervision, a number of parties play a role in supervision. These parties include the supervisor, the supervisee and the client. We may also need to consider the role of secondary parties, such as the agency where treatment is received and the role of a sponsoring university.

**The Client**

We define the client as the person or system that seeks change for the purpose of relieving distress or solving problems (Scaife et al., 2001). Based on this definition, the primary responsibility of the client is in identifying the problem to be addressed in treatment, and working with the therapist to resolve or change the problem.
The Therapist Supervisee

Within the context of supervision, the therapist supervisee has joint responsibilities to the client and to the supervision. The therapist supervisee supports the client within his or her quest for change. They must also be open to learning from the supervisor techniques to help support the client. Scaife (2001) and her colleagues also suggest that the therapist supervisee has a responsibility to be an active participant in supervision. Some of the factors involved in taking responsibility for supervision include:

- Being aware of strengths and weaknesses
- Identifying ideas about boundaries in supervision
- Being clear about expectations of supervisors
- Letting the supervisor know what is helpful or not helpful
- Acknowledging errors and learning from them

The Supervisor

Supervisors have a number of interrelated responsibilities. These may vary somewhat based on organizational setting, but generally fall into three broad categories: 1) responsibilities that ensure the welfare of the client, 2) responsibilities to provide effective supervision to the trainee; and 3) responsibilities to the profession.

With regard to ensuring the welfare of the client, this is a basic task: the supervisor acts as a form of quality control to be certain that the trainee is adequately supporting the client in attaining his or her treatment goals. Due to the nature of the supervisee being a newer, less experienced therapist, there may be times when conflicts of interest arise. For example, Scaife et al. (2001) provide the example of a supervisee who is experiencing significant levels of anxiety and which are impeding the client from reaching his or her goals. It is difficult to provide a supportive learning environment while still being certain that the client will be helped. Scaife suggests that in quickly becoming aware of the supervisee’s issues and helping him or her with the anxiety, the supervisor’s responsibilities are met. Should resolution of the anxiety continue to unduly impede the treatment, the supervisor may need to take a more active role, such as in modeling a treatment session with the client.

There is also the responsibility of the supervisor to the supervisee/trainee. Although this was illustrated in the previous example, there is also the issue that the supervisor must work to establish an effective learning environment. Depending on the framework for supervision, this could include tasks such as the use of a learning contract and the supervisor’s openness to improving his or her own skills.
Lastly there is the issue of responsibility to the profession. This entails the supervisor’s ability to transmit the values and standards of the profession. In fact, this is one of the earliest discussed issues in supervision, and has been termed by Eckstein (1957) as the therapist’s *professional identity*. He states that an important factor in developing this professional identity is the trainee’s association with and mentoring by seasoned professionals.

### Ethical Issues in Supervision

**Questions to consider:**

*How often do you discuss ethical issues in supervision?*
*What common ethical issues relate to supervision?*
*What common boundary issues have you seen (or experienced) in supervision?*
*How have you handled them?*

**Case Vignette**

Sara is a doctoral intern completing her internship in a university counseling center. As a professional who has made a mid-life career change, Sara presents as more seasoned than many of the other interns, although she is equally new to the profession. Sara has been working with Ginny, a young woman who had originally presented with depression. As Sara continues to work with her Ginny discloses not only that she has a history of severe sexual abuse but also that she has incidents of dissociative behavior. Sara soon begins to feel overwhelmed but does not discuss this in supervision, fearing that her supervisor will suggest transferring the case to a more experienced staff member who has treated sexual abuse and dissociative disorders.

An integral part of supervision is in teaching trainees the standards of the profession. The supervision setting is an ideal place to support supervisees in resolving ethical issues. In addition to mentioning supervisees, there are a number of ethical issues may arise during the process of supervision including those of informed consent, competence and relational boundaries. These issues are important to consider and allow the supervisor to model ethical principles.

As gatekeepers of the profession, supervisors must be diligent about their own and their supervisees’ ethics. Ethical practice includes both knowledge of codes and legal statutes, and practice that is both respectful and competent. "In this case, perhaps more than in any other, supervisors' primary responsibility is to model what they hope to teach" (Bernard & Goodyear, 2004).

As counselors in training, it is inevitable that supervisees will face ethical issues. When this occurs, an important indicator of the supervisor relationship is whether the trainee brings this matter in to discuss with his or her supervisor or whether the trainee attempts to handle the matter on his or her own. In an interesting study of clinical psychologists in training, Kent and McAuley (1995)
interviewed third year trainees. In this study of 85 respondents, only 14 of 85 indicated that they had faced a specific ethical dilemma. In these cases, which were discussed in supervision, only 65 percent agreed on the same course of action as the supervisor. Their responses to the situation showed that in many cases there was a lack of trust as to how these issues would be handled, or a negative reaction from the supervisor (for example, a trainee being told that he was “too sensitive.”).

One of the fundamental tasks of supervision is teaching supervisees the fundamentals of ethical decision-making. These principles offer a framework through which to process ethical dilemmas that arise for the trainee through the process of conducting therapy as well as within the supervisory relationship. Scaife et al. (2001) offers a concise description of the general principles of ethical decision-making. They include the following factors:

- Autonomy — the right of individuals to make independent choices
- Beneficence — the ethical principle that requires therapists, to do what will further the patient’s interests and promote human welfare
- Fidelity — faithfulness to promises made to clients, such as during the outset of treatment
- Justice — being sure that people are fairly treated
- Non-maleficence — striving not to do harm

While helping the supervisee to learn about and apply ethical issues in the counseling relationship, the issues described above are of course also applicable to the supervisory relationship. It is helpful to consider the supervisee as a client when thinking about these issues. Counselors in training should be allowed to make independent choices (while receiving the guidance of the supervisor when appropriate), to have their interests and talents furthered, to be aware of the purposes and goals of supervision, to be treated fairly and not be harmed in the supervisor relationship.

The issue of ethics in supervision is so important that the Association For Counselor Education And Supervision (ACES) has developed a set of ethical guidelines for counseling supervisors that has recently been incorporated into the 2005 ACA Ethical Code. These guidelines are available on the ACA website at the following address: www.acesonline.net/ethical_guidelines.asp.

*Ethical Issues As Applied to Supervision*

**Informed Consent to Supervision**

There are a number of ethical issues related specifically to the supervisory process. One such issue is that of *informed consent*. As applied to the supervisory process, trainee therapists should be informed at the outset of the
relationship about a number of aspects of supervision. This is often referred to as contracting. Falender and Shafranske (2004) provide an excellent sample of a supervision contract in their book. Scaife et al. (2001) also stresses the importance of a supervisory contract. They state that participants in supervision need to be aware of the expectations of the relationship and that a mismatch in this understanding is quite difficult to recover from.

According to the ACES Ethical Guidelines for Counseling Supervisors [standard 2.14], “Supervisors should incorporate the principles of informed consent and participation; clarity of requirements, expectations, roles and rules; and due process and appeal into the establishment of policies and procedures of their institutions, program, courses, and individual supervisory relationships. Mechanisms for due process appeal of individual supervisory actions should be established and made available to all supervisees.

Although too comprehensive to fully describe in this training program, a brief summary of the components of the informed consent contract follow.

• Definition of what the supervisor will provide/purposes of supervision (e.g., frequency and type of supervision/model, areas of competence, supervisor qualifications, availability, any financial arrangements if allowed by state/professional codes)

• Definition of what the trainee is expected to provide in supervision, including roles and responsibilities (e.g., adherence to ethical principles, recordkeeping, attendance, disclosure, needs for session, such as case presentation, information about the supervision process)

• Logistics of supervision and information about the supervisor/supervisee relationship (e.g., expectations as related to goals, autonomy, teamwork). In addition to the supervisor contract, Falender and Shafranske (2004) also provide a supervisee form entitled the Working Alliance Inventory, which is very helpful in assessing the supervisory relationship.

• Evaluation will be discussed later in this training material. Include a description on how trainees are evaluated, methods of evaluation, and timing of evaluations. Part of this discussion should include information on goal setting – creating SMART (Specific, Measurable, Achievable, Realistic and Time-framed) goals that are subject to review, as well as how feedback (clear and constructive feedback concerning the degree to which goals have been achieved) will be given to supervisees.

• If supervision is a step to licensure, it is also helpful to review
specific licensure requirements.

- Means to resolve disagreements. It is also important to discuss how disagreements will be resolved.

**Due Process**

Due process is a legal term that refers to protections that ensure fairness. A person, whether client or supervisor, should have their rights protected. Supervisors are responsible for protecting the rights of both clients and supervisees. Examples of due process violations include client abandonment or premature/abrupt termination of a client relationship. An example that relates to the supervisee/supervisor relationship is poor final evaluation of a supervisee, without taking steps to have the supervisee remediate deficiencies.

**Vicarious Responsibility**

In addition to being aware of ethical issues, supervisors should also be aware that there are legal implications to the fact that they are supervisors. Simply put, they are responsible for the actions of supervisees and may be held accountable for these actions should ethical guidelines not be adhered to. Scaife et al. (2001) terms this issue *vicarious responsibility*. According to the ACES Ethical Guidelines for Counseling Supervisors: “Counseling supervisors are responsible for making every effort to monitor both the professional actions, and failures to take action, of their supervisees [standard 1.06]. For additional descriptions of the legal aspects of supervision see Harrar, VandeCreek, & Knapp (1990) and Knapp, Vanderscreek & Watkins (1997). A frank discussion of ethical and legal practice, provided during the outset of the supervisory relationship, is beneficial to both parties.

**Avoiding Malpractice**

Malpractice is defined as “harm to another individual due to negligence consisting of the breach of a professional duty or standard of care.” For example, if a clinician fails to follow acceptable standards of care, and all of the following are met, a clinician may be found guilty of malpractice. These conditions are: 1) a professional relationship with the therapist or supervisor; 2) the therapist or supervisor’s conduct must have been improper or negligent and have fallen below the acceptable standard of care; 3) the client (or supervisee) must have suffered harm or injury, and 4) a causal relationship must be established between the injury and negligence or improper conduct (Corey, Corey & Callahan, 1993).

Psychiatric malpractice lawsuits may include the following components:

- Failure to diagnose
- Failure to treat
• Sexual Misconduct
• Negligent use or monitoring of psychopharmacological drugs
• Failure to get signed consent for treatment
• Failure to prevent patients from harming selves
• Failure to prevent patients from harming others
• False imprisonment (restraints or seclusion)
• Breach of confidentiality
• Defamation
• Abandonment
• Fraud & malfeasance
• Negligent supervision
• Negligent psychotherapy
• Assault and battery
• Wrongful death

Although malpractice suits against supervisors are rare, they are a source of potential anxiety, and can occur. It is also important to note that negligent supervision, although very difficult to prove, may be the basis of a malpractice suit.

Case Vignette

Tori, a psychology intern, is working with Dr. Cantor. Tori has felt uncomfortable with the relationship since the start of her internship, and after one failed attempt to speak with the internship director, has decided that she will simply avoid supervision whenever possible. When faced with a difficult client situation that results in a serious suicide attempt by the client, Tori does not disclose the situation to Dr. Cantor. Months later, he is shocked to be named in a malpractice suit.

Practicing risk management strategies are important. The following strategies are helpful in avoiding malpractice (Campbell, 2005):

• Establish an open and trusting supervisory relationship
• Maintain professional liability insurance
• Practice within the boundaries of your competence
• Document carefully
• Consult with colleagues
• Keep up to date on evolving ethical standards and legal developments

Informed Consent for Clients of Trainees/Confidentiality

Informed Consent and Conditional Confidentiality
Case Vignette

Juanita is a 25-year-old client currently in therapy with Mark Mattison, a doctoral intern. Prior to her therapy with Mark, Juanita had strongly resisted seeking therapy for the lingering effects of a traumatic childhood, including severe sexual abuse. She and Mark have developed a trusting relationship, and Juanita is making progress. She is devastated, however, when Mark provides a suggestion to her that comes from his supervisor. She is angry and upset, stating that he has violated her again, and that she did not know that he was talking with anyone else about her personal business. Juanita does not appear for their next scheduled session.

This case looks at two of the most important ethical issues with the supervisee/client relationship: informed consent and conditional confidentiality. Informed consent requires that clients understand and agree to the process of therapy prior to beginning it. When a client is working with a therapist that is in supervision, it is important that this be communicated to the client. This typically means that the client be informed of the fact that the therapist is an unlicensed provider and that he or she is being supervised in his delivery of therapy. It is also helpful to provide the client with the contact information for the trainee’s supervisor. While these aspects of informed consent are key, perhaps even more critical is the idea that confidentiality is conditional, as many clients are under the impression that confidentiality is an absolute. This is certainly the case with Juanita.

The APA code discusses confidentiality in many places. According to Fisher (2008), when the initial APA Ethics Code was published exceptions to confidentiality was extremely rare. The code, however, did set the standard: “When… some departure is required from the normal expectation that clinical or consulting relationships are confidential, it is expected that the psychologist will make clear to the client the nature of his role before the client enters the relationship” (APA, 1953, p. 56). This provided the basis of current informed consent procedures.

A significant exception to absolute confidentiality is the supervisory relationship. It is necessary for supervisees to let clients know that they will be discussing the client’s therapeutic disclosures with the supervisor, and that this will be done to guide the supervisee and to provide better care. The bottom line is that clients must be told that someone else will be privy to what is occurring in therapy. The extent of this may vary based on supervision techniques, but could include case presentation, supervisors reading psychotherapy process notes or audio or videotapes of therapy sessions. If supervision is in a group format, this should also be communicated to the client. There are a number of samples of informed consent documents, including that of Scaife et al. (2001).

Certainly the sharing of this information is ethically permissible. Supervisors must be aware that it is important that they must also treat client
data with care to preserve confidentiality, such as shredding notes that are no longer being used for training or erasing old audio or video sessions. Supervisors share the same obligations for client confidentiality as supervisees.

As client confidentiality is a hallmark of excellent therapy and supervision, it is helpful to consider the following summary by Bernard and O’Laughlin (1990). They state that the following are crucial to ensuring confidentiality:

- Supervisors must identify and discuss ethical standards regarding confidentiality
- Supervisors and supervisees must maintain confidentiality and security of client materials
- Supervisors and supervisees must not engage in non-professional discussion of clients
- Supervisors and supervisees must limit disclosure of client identity wherever possible
- Clients must be informed of rules and policies regarding confidentiality and ethics
- Supervisors and supervisees must identify exceptions to confidentiality and privileged communications and discuss these with clients

Case Vignette

Gerald is a supervisee, working with Ann Maier, LCSW. Ann was surprised to hear that Gerald is routinely neglecting to inform his clients about the limits of confidentiality and possible reasons that social workers would break confidentiality (e.g., harm to self and others). When she spoke with Gerald to ascertain why, he told her that he thought that clients not be as disclosing with him if they thought that he did not agree to absolute confidentiality. Ann discussed the seriousness of this omission with Gerald and supported him in speaking with each of his clients.

Competence

In many discussions of ethics, the idea of competence sounds like a deceptively simple one. Most people who are picked to be supervisors are seasoned professionals and many are excellent therapists themselves. This training material has already alluded to the fact that being even a highly competent psychotherapist does not necessarily mean that one will be an
excellent supervisor. There are additional skill sets required for supervision. As with other areas of competence, competence in supervision can be acquired through a combination of training, credentials and experience (Campbell, 2006).

Although there are many potential schema for defining competence, one of the most comprehensive can be found in the guidelines offered by the Association For Counselor Education and Supervision (ACES). ACES lists the following best practices for supervisors, which are an excellent reflection of the knowledge and skill components involved in supervision. They state that supervisors should meet the following guidelines:

1. Professional counseling supervisors are effective counselors whose knowledge and competencies have been acquired through training, education, and supervised employment experience.

2. Professional counseling supervisors demonstrate personal traits and characteristics that are consistent with the role.

3. Professional counseling supervisors are knowledgeable regarding ethical, legal, and regulatory aspects of the professional, and are skilled in applying this knowledge.

4. Professional counseling supervisors demonstrate conceptual knowledge of the personal and professional nature of the supervisory relationship and are skilled in applying this knowledge.

5. Professional counseling supervisors demonstrate conceptual knowledge of supervision methods and techniques, and are skilled in using this knowledge to promote counselor development.

6. Professional counseling supervisors demonstrate conceptual knowledge of the counselor developmental process and are skilled in applying this knowledge.

7. Professional counseling supervisors demonstrate knowledge and competency in case conceptualization and management.

8. Professional counseling supervisors demonstrate knowledge and competency in client assessment and evaluation.

9. Professional counseling supervisors demonstrate knowledge and competency in oral and written reporting and recording.

10. Professional counseling supervisors demonstrate knowledge and competency in the evaluation of counseling performance.
11. Professional counseling supervisors are knowledgeable regarding research in counseling and counselor supervision and consistently incorporate this knowledge into the supervision process.

ACES also provides guidelines for the training and experience that is recommended for the supervisor. These training and experience components include graduate training, successful supervised employment as a professional counselor, state licensure, graduate training in supervision, seminar, laboratory courses, and supervision practica, and continuing educational experiences specific to supervision theory and practice.

While the ideas discussed in the ACES ethical guidelines span professions, it is also helpful to look at specific guidelines contained in the APA ethical code. The following applies to supervision:

7.02 Descriptions of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.04 Student Disclosure of Personal Information
Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.06 Assessing Student and Supervisee Performance
(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.
(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

Monitoring Supervisee Competence
Another important competence issue concerns monitoring the competence of supervisees. As Standard 7.06 above states, a major component of supervision involves monitoring supervisee competence. More about this will be discussed in the evaluation section later in this training material.

**Boundary Issues in Supervision**

**Case Vignette**

*Michael is a psychology intern working in an inpatient setting. He seeks the support of his supervisor, Dr. Martin, due to his difficulty with a patient he has been seeing in individual therapy. The patient is a 50-year-old woman and Michael is having reactions to her that are unanticipated. He imagines that she is dismissive of him, and does not really want to come to therapy. Dr. Martin explores this with Michael, and together they are able to connect this to Michael’s unresolved issues about his mother, who was emotionally absent during much of his life. Dr. Martin feels that this will be a key factor in helping Michael to become a better therapist, and suggests that they continue to explore his history together. Has Dr. Martin acted within the scope of his role? Are his actions ethical?*

All of our professional codes of ethics discuss the issue of boundaries in therapeutic relationships. Boundaries are defined as the personal and the professional roles and the differences that characterize interpersonal encounters between the client and the mental health professional (Sarkar, 2004). Although this definition is specific to the client/therapist role, something that is also critical to delineate to supervisees during the supervisory process, are boundaries within the supervisor/supervisee relationship. This creates unique challenges and opportunities (Ryder, & Hepworth, 1990).

In looking at the boundaries in psychotherapy supervision, it is helpful to consider the concept of dual relationships. Within the supervisory relationship, there exists a potential for a number of potential dual relationships including friendships/intimate relationships and therapeutic relationships. The primary concern with dual relationships is the power differential that exists between the two parties, which could result in exploitation, as well as the potential to cloud the objectivity of the person in the guiding role. The National Association for Social Work code of Ethics, for example, states: “Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries (Standard 3.02[d]).” Similarly the ACES ethical guidelines state “Supervisors who have multiple roles (e.g., teacher, clinical supervisor, administrative supervisor, etc.) with supervisees should minimize potential conflicts. Where possible, the roles should be divided among several supervisors. Where this is not possible,
careful explanation should be conveyed to the supervisee as to the expectations and responsibilities associated with each supervisory role.”

Despite a strong statement regarding dual relationships our ethical codes do recognize that some dual relationships are not always harmful. In supervision, the differences in power between supervisor and supervisee are unavoidable, and at times boundaries may be less clear. Reamer (2009) presents an interesting discussion of these issues in a recent article. The most relevant question that he and others raise is how to manage the boundaries in the supervisor/supervisee relationship in a way that promotes ethical decision-making.

Another factor that is potentially problematic is the dual role of the supervisor to provide guidance, facilitate learning and self-awareness and also to evaluate. The American Association for Counseling and Developmental Ethical Standards (1988) states: “When educational programs offer a growth experience with emphasis on self-disclosure or other relatively intimate or personal involvement, the member must have no administrative, supervisory or evaluating authority regarding the participant.” Certainly there is a conflict between the need to assess trainee performance and the inevitable process of self-disclosure in supervision.

A question, then, is how to distinguish supervision from therapy. Certainly the supervisor must not provide psychotherapy to trainees, however, there is the issue of how to manage the personhood of the supervisee (Campbell, 2006). Although the supervisor should encourage supervisee self-reflection, shifting the focus of supervision to a therapeutic relationship does not enable a basic tenet of supervision: a focus on promoting the welfare of the client. Bernard and Goodyear (2004) stress that any intervention with supervisees that may fall more traditionally under the realm of therapeutic should be aimed at helping supervisees be more therapeutic with clients. They state that to provide therapy with wider goals is unethical. The ACES ethical guidelines for counseling supervisors states that “supervisors should not establish a psychotherapeutic relationship as a substitute for supervision. Personal issues should be addressed in supervision only in terms of the impact of these issues on clients and on professional functioning. [standard 2.11]”

A good rule of thumb is that if a supervisee’s personal issues interfere with their ability to provide appropriate treatment, the supervisor should refer him or her to an outside therapist.

The distinction between supervision and psychotherapy is not always clear-cut. In the case vignette presented in the beginning of this section, Dr. Martin acting appropriately in exploring Michaels’s reactions to his client, and this necessitated delving into areas that may be considered “therapeutic” in nature. In electing to continue this exploration, however, Dr. Martin may be diverging from
his supervisory role.

Another supervisory boundary concerns intimate or sexual relationships between supervisor and supervisee. This is a relatively clear-cut guideline: such relationships are prohibited. The ACES Code of Ethics states: “Supervisors should not participate in any form of sexual contact with supervisees. Supervisors should not engage in any form of social contact or interaction that would compromise the supervisor-supervisee relationship. Dual relationships with supervisees that might impair the supervisor’s objectivity and professional judgment should be avoided and/or the supervisory relationship terminated. (Standard 210).

In addition to discussing sexual relationships, it is also important to review the concept of sexual harassment. Within a supervisor/supervisee relationship, sexual harassment refers to unwanted sexual advances and/or contacts, while sexual involvement between supervisors and supervisees may appear to occur by mutual consent (Bartell & Rubin, 1990). The problem with this, however, is twofold: any type of sexual relationship blurs objectivity; and there is generally not “mutual consent,” when there is a power differential, such as the one that occurs between supervisor and supervisee.

American Board of Examiners in Clinical Social Work (ABE) Ethics Code (2006) states: “Clinical social workers do not … engage in sexual harassment or sexual relationships with supervisees, students, employees, research subjects, or current and former clients. The clinician carries the burden of determining that a relationship is appropriate, not detrimental, and does not violate boundaries of roles.”

Another disturbing finding in this area of sexual contact is that the behaviors perpetuate themselves. Students or trainees who become involved with supervisors are more likely to accept this as a norm and repeat the pattern themselves (Pope, Levenson, & Schover, 1979).

As supervisees near the end of their supervision period, there may be some relaxing of boundaries, and supervision may become more consultative in nature.

Parallel Process

Another boundary issue concerns the idea of parallel process. One of the first authors to discuss this concept was Searles in 1955. The concept of parallel process has its origin in the psychodynamic concepts of transference and countertransference. Transference takes place when the supervisee unconsciously recreates the presenting problem and emotions of the therapeutic relationship within the supervisory relationship. Countertransference occurs when the supervisor responds to the supervisee in the same manner that the
supervisee responds to the client. Thus, the supervisory interaction replays, or is parallel with, the counseling interaction.

Authors have some disagreement about how and when parallel process should be discussed in supervision. Some, for example, believe that as a transference reaction, discussion of parallel process should be limited to the supervisee’s individual therapy. Others believe that discussion of this dynamic is critical and should be an integral part of the learning process, shedding additional light on therapy dynamics. For more information on parallel process, please see Morrissey, (2001), McNeill & Worthen (1989) and Gre & Fiscalini (1987).

In addition to discussion of parallel process, authors have also discussed the issue of the supervisor’s countertransference. In an older but comprehensive work, Lower (1972) suggested that supervisor countertransference can be categorized into four areas: 1) general personality characteristics, the supervisor’s own characterological defenses which affect the supervisory relationship, 2) inner conflicts reactivated by the supervision situation, which Lower suggests are Oedipal in nature, 3) countertransference reactions to the individual supervisee, and 4) countertransference reactions to the supervisee’s transference.

Case Vignette (Parallel Process)

Alex is a doctoral intern in supervision with Dr. Vincent. As an intern in a hospital setting, Alex works with many types of issues and recently has begun working with a patient with borderline personality disorder and who is experiencing severe difficulties managing affect. She often has outbursts of anger, and Alex is frustrated that she is not responding to his work on self-soothing skills. In this week’s supervision session with Dr. Vincent, Alex responds in an uncharacteristically angry and abrupt way to Dr. Vincent’s suggestions. Dr. Vincent feels that some parallel process could be occurring, but does not address this in session, preferring to wait and see what occurs next week.

Summary of Ethical Decision-Making in Supervision

Give the many ethical issues discussed in this session, it is helpful to summarize some key points. Corey et al. (1993) provides the following recommendations for ethical decision making in supervision:

- Identify the problem or dilemma
- Identify the potential issues involved
- Review relevant ethical guidelines
- Discuss and consult with colleagues
- Consider possible and probable courses of action
- Enumerate the possible consequence of various decisions
• Decide what appears to be the best course of action

**Multicultural Competence/ Working With Client Diversity**

**Questions to consider:**
*Review your history in supervision. How was how each supervisor similar or different from you in terms of cultural variables? Were there any discussions about these similarities/differences? If so, was this proactive? If now, what were the effects? How did these differences in culture impact the supervisory relationship?*

**Multicultural Competence**

**Case Vignette**

Tonya is a doctoral student completing a field placement at a community mental health center in a city. Tonya is a Black female raised in a middle class home. She is finding the field placement to be an excellent experience, and learning a lot. Tonya has had a good experience with her supervisor, Dr. Charles Lenard, a White male in his early 50s. During one of their supervisory sessions, Dr. Lenard compliments Tonya, stating that she is a great role model for this population as she has been able to move beyond her roots. Tonya realizes that she and Dr. Lenard have never discussed their racial differences. Tonya is surprised and offended by the comment. How should she handle this?

The influence of cultural competence is an area that has received increased interest in the mental health fields (Pederson, 1991). With the diversity evident in our client populations, there has been increased cultural diversity within the mental health professions. Thus, supervisors should also be aware of multicultural issues and demonstrate cultural competence. Multiculturally competent individuals have the knowledge, awareness, and skills that enable them to interact successfully and respectfully with people of different backgrounds, viewpoints, and values. “Diversity competence is an inseparable and essential component of supervision competence,” and supervisors are to “develop and maintain self-awareness regarding their diversity competence . . . [and to] planfully strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of their supervisees” (APA, 2015, p. 36).

There are a number of models of multicultural supervision. These include:

• Counselor developmental model (Carney & Kahn, 1984): a) knowledge of cultural groups, b) attitudinal awareness, c) cross-cultural sensitivity, and d) specific cross-cultural counseling skills.
• Multicultural training model (Sabnani, Ponterotto & Borodovsky, 1991): white counselors & white racial identity model

• World view congruence triadic model (Brown & Landrum-Brown, 1995): values, guiding beliefs, how one knows, reasoning process, ontology (nature of reality), concept of time, & concept of self

• Multicultural Counselor Competency: (Constantine & Ladany, 2001): Self-awareness, knowledge, understanding of unique client personal & situational variables, therapeutic alliance, self-efficacy, and skills

In a recent paper presented at the American Psychological Association conference, Inman (2006, 2008), lists the following limitations to many models of multicultural supervision. They:

• Focus on supervisee multicultural competence without focus on supervisor’s competence
• Exclusively focus on race and ethnicity
• No comprehensive framework provided for multicultural issues within a supervisory context
• Tend to provide global suggestions to overcome difficulties
• Lack empirical support

Multiculturally responsive supervisors have a key role in mentoring, guiding, supporting, and facilitating learning of culturally specific issues within supervisory process (Fukuyama, 1994, Leung & Wagner, 1994, Williams & Halgrin, 1995).

As important as this role is, Inman (2006, 2008) identifies a number of challenges to effective multicultural supervision. These include:

• Unintentional “ism’s” and biases
  - Overemphasis/underemphasis on cultural explanations for psychological difficulties
• Internalized racial oppression
  - An inability to appropriately present questions and responses that elicit valuable information or feedback
• Lack of interpersonal awareness within the supervisory relationship
  - An insensitivity to supervisee’s nonverbal cues
  - Undiscussed racial-ethnic issues
  - Passing premature judgments
• Differences in values, interactional styles, acculturation, educational & SES levels
• Lack of acknowledgement of power differentials at cultural and professional
levels
- Lack of self-disclosure, safety, trust;
- Guarded communication
• Supervisees may have more formal training than supervisors

As the case vignette illustrates, even supervisors who work in culturally diverse areas may not be aware of their own prejudices. Priest (1994) and Williams and Halgin (1995) studied the effects of supervisors working with supervisees of a different race. They found that trust issues may hamper communication. It is likely that these difficulties extend to other areas of diversity such as cultural and gender differences. One of the key strategies for multicultural competence is the supervisor’s ability to model openness and support for cultural Issues and to provide opportunities to work in multicultural activities. Multiculturally competent supervisors also help to increases supervisee perception of their own multicultural competence (Inman, 2008).

The case vignette presented at the beginning of this section encompasses many of these issues. Tonya’s supervisor certainly displayed a characteristic lack of interpersonal awareness within the supervisory relationship and had ideas about what was “typical” (although stereotypical is more accurate) in a particular racial group.

Ancis and Ladany (2001) have developed six dimensions of multicultural supervision. These include supervisor-focused personal development, the supervisor’s self-exploration regarding her or his own values, biases, and personal limitations and participation in educational, consultative, and training experiences to promote self-exploration and knowledge; supervisee-focused personal development, the ability of the supervisor to foster self-exploration, awareness, and knowledge of supervisees to help them explore their own identity development (e.g., race, ethnicity, gender, sexual orientation); conceptualization to help supervisees conceptualization an understanding of the impact of individual and contextual factors on clients’ lives; skills, encouraging flexibility with regard to psychotherapy interventions including the use of nontraditional or alternative therapeutic interventions (e.g., indigenous helping networks); process, the relationship between supervisor and supervisee characterized by respect and open communication and awareness of power differentials; outcome/evaluation, evaluating supervisees on their multicultural psychotherapy competence.

There are a number of questions that can help move supervisors/supervisees through these dimensions. Some suggestions are provided below (University of Denver, 2010):

Supervisor-focused personal development: What are the facets of my own worldview? What is my allegiance to the culture of psychology, which is based on White, middle-class values (if applicable)? What biases do I have about any minority or cultural
group? What diverse groups do I have limited experience/exposure to? Can I effectively teach trainees about these groups?

Supervisee-focused personal development: Many of the questions above can apply to supervisees. In addition, the supervisor may ask supervisees about their own experiences of being “minorities.” What cultural group do you most identify with? Are there times that you felt different or discriminated against for having been a member of this group? How can you use this experience to increase your empathy with diverse populations?

Conceptualization: How does the client’s race/ethnicity influence this situation? Would a client of a majority group respond in the same way? How do cultural variables influence the presenting problem? Do you understand how MC issues are addressed (or not addressed) by your theoretical orientation? Could you recall specific ways in which you have dealt culturally-specific problems or concerns?

Skills: What alternative or nontraditional intervention may be effective for a client of this ethnicity? What role can spirituality play? What is the role of extended family or helping networks?

Process: How is it for you to work with someone of my (gender, race, ethnicity)? Do the differences/similarities between us feel comfortable? What can we do to bridge differences?

Outcome/Evaluation: Do you feel that there are variables related to your cultural ethnic background that should be considered in terms of evaluation?

By attending to these variables, supervision can become a richer, more culturally responsive medium and help prepare supervisees to work with diverse populations.

Case Vignette

Alyssa is just beginning her doctoral internship at an inner-city hospital in Newark, NJ. Alyssa was raised in a white, middle-class household, and attended doctoral program in a rural program setting. This is her first experience working in a city, or with clients of a diverse racial background. She is educated enough about multiculturally sensitive therapy to be nervous.

Alyssa is delighted that her internship director addresses the racial/ethnic differences immediately. They talk about cultural differences, and Alyssa’s trepidation. The group of doctoral interns also explores the neighborhood, in
subsequent weeks, shopping in the local stores, and eating in two area restaurants. Alyssa appreciates the diversity in the area, and feels that she at least has an introduction to the richness of Latino and African American culture.

The Supervisory Session: Formats for Supervision

Questions to consider:
Have your own experiences of supervision been conducted individually, in a group, or both?
What have been the advantages and disadvantages of each?
If you are an experienced supervisor, how do you prepare to work with a new trainee?
What are some difficulties inherent in the use of supervisor self-report? Contrast this method with direct observation.
Have you utilized aids such as audio/video tapes, session notes, etc.?
How can you help the supervisee become more self-reflective?

As we have already seen there are a number of models and approaches to supervision. The supervisor’s approach will drive the format for supervision, but this section contains some things to think about and consider when structuring (or choosing not to structure) supervision, Although many people think of supervision as a process during which the supervisor and supervisee meet to discuss cases, supervision can include a number of different components that transcend case discussion. It can also be conducted in a number of different formats including group supervision, peer supervision and team supervision. Techniques, such as audio/videotaping, role-playing and co-therapy may also be helpful. In fact, according to the ACES ethical guidelines “actual work samples via audio and/or video tape or live observation in addition to case notes should be reviewed by the supervisor as a regular part of the ongoing supervisory process.”

Technology has allowed for trainees in remote locations to receive supervision. “Videoconferencing-based supervision”, or telesupervision, involves a trainee at one site securely receiving supervision via a video link with a supervisor at another site. Luxton, Nelson, & Maheu, (2016) mention a number of benefits of telesupervision including decreased chance of multiple relationships for clinicians in small communities, the opportunity consult with experts in clinical specialties that might not be available in their community, and addressing feelings of isolation and burnout that can result from working in private practice in an isolated area.

Prior to looking at the advantages and disadvantages of the supervision structures, it may be helpful to consider the overall goals of the various methods and techniques. Campbell (2006) states that the goals of supervision include improving knowledge, skills and self-awareness of supervisees, increasing
objectivity to avoid bias and impaired judgment, improving and monitoring control of supervisees' activities, and facilitating independent functioning and decision making.

**Individual Supervision**

During their careers as psychotherapists, most individuals will experience some form of individual supervision. Many states and licensure boards have a minimum time requirement for individual supervision. The belief is that such individual monitoring is needed for the development of supervisees and to allow for performance assessment. Individual supervision is the method most tailored to the training needs of each supervisee. One disadvantage of individual supervision when based solely on discussion in session is that a supervisee's self-narrative may not always be accurate or objective. By relying on other techniques such as use of audio or videotapes or through *live supervision*, where the supervisor observes the supervisee and/or offers suggestions throughout the client session.

In evaluating an approach and degree of structure for individual supervision it is helpful to consider Bernard and Goodyear's (2004) statement that “supervision best placed between training and consultation... the supervisee should come to supervision with some ability to articulate learning goals based on initial experiences in training, but cannot be expected to function autonomously with only occasional need for consultation (p. 90).”

**Structured versus Unstructured Supervision**

Keeping in mind the statement above, one can consider structured supervision to be more training-oriented and less structured supervision to be more consultative. For the beginning trainee, structured supervision can be of benefit. For those supervisors considering a more structured approach, the following format and ideas may be helpful. Thus, structured or planned supervision will be discussed in the subsequent sections of this training manual.

Bernard and Goodyear (2004) discuss the importance of a supervision plan. They reiterate that this is the essential ingredient in planning an efficient training experience that will "culminate in the emergence of a capable and realistic practitioner, while safeguarding client welfare" (p. 205). There have, in fact, been a number of studies that concur that trainees often associate a supervisor’s effectiveness with a well rounded supervisory plan that includes a variety of training modalities (e.g., group discussion of cases, peer observation). This supervisory plan would include opportunities for training and consultation, monitoring and accountability, work design and coordination and discussion of and linkage to external resources (Hardcastle, 1991).

Although supervision will vary based on a number of factors including client population served, theoretical orientation, and needs and experience level of individual trainees, there are a number of tasks common to all supervisors.
These tasks include *time management*, setting priorities and sticking to them, including adequate time to devote to supervision (see Scaife et al. (2001) and their discussion of the “disinterested or busy supervisor”), choosing supervision methods, such as use of audio or videotaping, record keeping, with details about each supervisory session or missed session, any supervisory contract (see informed consent section), notations about cases discussed and any problems encountered (Bernard & Goodyear, 2004.) Bernard and Goodyear (2004) also include a supervisory record form, which is helpful to reduce the onerous task of documentation.

In general there are three functions of supervision interventions. 1) assessing the learning needs of the supervisee, 2) changing, shaping or supporting the supervisee’s behavior, and 3) evaluating the performance of the supervisee (Borders, et al., 1991). Each of these interventions can be found throughout the course of a supervision session.

Prior to looking at what a sample supervision session may look like, it is helpful to consider the pre-work that the supervisor needs to do in order to prepare to supervise a new trainee. Campbell (2006) provides some excellent information about preparing for/structuring the first supervision session, including creating a “safe place” for supervision. She cites a number of studies that indicate that a supervisor’s “sensitivity to the needs and concerns of supervisees, their openness to consider different points of view, or low levels of dogmatism and criticalness are significant factors that influence supervisee’s openness in supervision (Bischoff et al. 2002, Daniels & Larsen, 2001, Fitch & Marshall, 2002).

Keeping these things in mind, the following suggestions will provide a sample structure for an individual supervisory session.

**Sample Supervision Session**

1. Discussion/reflection of the purpose and goals of the supervision session. Include the supervisee in planning the session and assess what the supervisee needs are (“How do you want to use your time today?” “What do you need most from this session?”)

2. Start with successes. Discussion of successful interventions, strategies, etc. Discussion of challenges involved in a particular case or situation. The supervisee is tutored through this case/situation by the supervisor. Be sure to assess for ethical, therapeutic, and multicultural issues.

3. Case discussion or review of session notes, audio or videotapes

4. Other interactive methods, such as role play or modeling

5. Didactic discussion, or a topical learning component, such as discussion of theoretical issues, ethical issues, treatment of a specific
issue such as trauma, etc.

6. In all of the above, include questions to stimulate thinking. Examples include: a) What are you feeling in response to the client e.g., transference; b) Can you identify any multicultural issues that may affect your ability to work with this client; c) What are you aware of in the client’s verbalizations? Nonverbal/body language? d) What is your course of action?

7. Review of how session went for supervisee and supervisor. Was supervision helpful? Why? What was missing?

8. Evaluation and feedback, if appropriate to the session. This important component of supervision will be discussed later in this material

9. Documentation of session, optionally with notes available to the supervisee. At minimum documentation should include meeting date and time, length of session and modality (individual, group, etc.) It is helpful here to be familiar with the specific requirements based on state of licensure and profession. Some states require expanded activity logs that detail cases reviewed, treatment plans, copies of client communications and specific supervisor recommendations. It is important to note that many states also have requirements about how long documentation needs to be retained.

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**Example of supervision session**

Supervisor: Hi Bill. How are you today? I got your note indicating that you were anxious to meet this week to discuss the problems you have been having working with Mrs. B. Is that how you’d like to use your time today?

Bill: Yes, she has been so resistant to the suggestions I am giving her. I don’t know what to try next.

Supervisor: We can review your session notes in just a moment. First, though, what has gone right in your treatment with Mrs. B. What have the successes been?

Bill: Well, she did have a day last week when she did not self-injure. I had suggested that she snap a rubber band against her wrist rather than cut herself. She was able to try that and it helped. I don’t know why she can’t just do that all the time.

Supervisor: It is frustrating sometimes when a client is able to do something successfully once but not to continue it. Let’s look at your session notes together and review how the session last week went.

[Review of session notes]
Supervisor: It looks like you are trying to use some of Linehan's techniques, which is a good choice when working with clients who self-injure. Have you discussed the concept of emotional modulation?

Bill: I've tried, but am not sure how to explain it clearly enough.

Supervisor: Well, why don't we role-play? I'll put myself in your role, and you can ask any questions you think Mrs. B. might have.

[Role-play of discussion of affect modulation]

Bill: Thanks. That was helpful. Do you have any other suggestions about how I can work with Mrs. B?

[Didactic discussion of self-injury and personality disorders]

Supervisor: In addition to what we have already discussed about self-injury, I notice from your notes that Mrs. B was talking about her lack of family support. You noted that this often seems to be the norm for patients that come from African-American backgrounds and are raised by single parents. I'd like to commend you for thinking about issues of race and culture, but also like to challenge you here about that assertion.

[Discussion of racial/ethnic issues in this case, including transference/countertransference]

Supervisor: [combining feedback to supervisee and about the session] Well, Bill. As you can see, you are working with some challenges. You are showing a good deal of persistence in working with Mrs. B. I noticed that you are seeking out suggestions on how to work with clients with personality disorders, and have been proactive in seeking my help. How do you feel today's session went? Are there additional things you'd like to discuss in our meeting next week?

Bill: Thank you. I thought the role-play was very helpful. I'll let you know how it works in my session.

Supervisor: Great. I'll see you next week. At that time, we can also discuss your quarterly progress.

[Documentation of session]

**Self Report**

The sample session described above relied on the use of session notes, which is a documented type of supervisee self-report. Self-report is probably the most widely used supervisee self-report. In self-report formats, the trainee narrates what occurred in the therapy session. This is often a spontaneous process in which supervisees talk about their clients and what occurs in therapy.
Many authors suggest that self-report is not without its difficulties. Noelle (2001) suggests that self-report may carry the risk of conscious or unconscious distortion of therapy material and Wynne et al. (1994) suggest that this method is also subject to failure to report. Bernard and Goodyear (2004) feel, however, that self-report provides a good way for supervisees to fine tune and elucidate material.

Because self-report is the “grandfather” of supervision forms there is a tendency to return to this method. A key element in the choice of self-report versus other forms of supervision discussed below is whether there is planning on the part of the supervisor and for novice supervisees, whether other methods, such as direct observation, are part of the overall supervisory plan.

Session/Process Notes

As previously discussed, although the use of session process may be considered a form of self-report, this method provides a systematic approach to supervision that congruent with supervisors who prefer a more direct approach. Process notes are the supervisee’s written explanation of the content of the therapy session. These notes also include a description of the interactions between therapist and client, the therapist's feelings about the client and the foundation and rationale for therapist interventions.

There are a number of possible formats for process notes (see Schwartz, 1981, Bernard & Goodyear (2004). The latter is outlined below:

1. Goals for the session
2. Things that happened during session that caused questioning of goals
3. Major theme of session and critical content
4. Interpersonal dynamics between client and therapist
5. Individual/cultural differences
6. Rating of successfulness of session
7. Things supervisee learned
8. Plans and goals for next session
9. Specific questions for supervisor

Use of Audio/Video Tapes

Although the use of audio and videotaping is a choice that will not work with every supervisee and in every setting, there are some helpful aspects
to these tools. Scaife et al. (2001) provides a comprehensive discussion of the advantages and challenges of using audio and videotapes. One of the primary hesitations that supervisees often express regarding the use of these tools is that it will affect the client’s level of comfort and disclosure. While there may be some hesitation on the part of some clients, explaining the rationale behind the use of this tool can be very helpful. Additionally, some supervisees express concerns that use of audio or videotaping can affect empathy. This has generally not been borne out by the literature.

Two important issues concern confidentiality and consent and security of audio/videotaped material. As with other forms of therapy providing appropriate informed consent is critical as is maintaining security of data. Coding tapes rather than labeling with client information can be one way to increase security. Like other forms of psychotherapy data, audiotapes should be stored in a locked cabinet. To ensure maximum security, the tape should be completely erased when the teaching task has been completed.

There are a number of advantages to taping sessions. Scaife et al. (2001) lists the following:

- Provides the opportunity for detailed review and multiple perspectives
- Removes doubts about competence; encourages confidence in the role of therapist
- Provides and opportunity to participate then observe
- Enhanced empathy by allowing the therapist to replay the session and give full attention to the client rather than relying on notes
- Increased accountability
- Adjunct to therapy; tapes can also be used with clients

Within the supervision, tapes can be used in a number of ways. Many supervisors choose to play the tape and discuss the session with the supervisee. Others choose to provide a written critique of the tape. Some authors advocate a developmental approach (Huhra et al., 2008).

Campbell (2006) provides some excellent guidelines to assist the supervisor in reviewing audiotaped sessions with trainees. She states that it is important to keep goals limited so as not to overwhelm the supervisee with critical comments. Thus the supervisor may select to review only a section of the tape. The supervisor would then discuss why that section of the tape was selected. Campbell states that the goal of this review is to encourage supervisee self-reflection and self-exploration.

*Live Supervision*
Live supervision includes co-facilitating sessions with the supervisee as well as observing supervisees as they conduct therapy sessions. Traditionally this is less commonly utilized than other formats due to scheduling difficulties as well as anxiety that may occur (Costa, 1994). This method, however, does deserve consideration as it offers a number of benefits, especially for the supervisee. Scaife et al. (2001) describes a number of possible scenarios with regard to live supervision, including co-working, in which both supervisor and supervisee jointly share responsibility for the individual or group therapy session and which is appropriate for supervisees with some experience and observing of one party, in which the supervisee observes the supervisor conducting a session and which is excellent for the beginning practitioner (the parties can switch roles when the supervisee is ready).

In situations in which the primary teaching method will be the supervisor sitting in on a live therapy session, it is important that the supervisor explain to both the supervisee and the therapy client that they are there to play a supportive role and that the supervisor gain the client’s consent to sit in on the session. It is helpful to ask both parties where the supervisor can observe from that would be least distracting to both. If a problem occurs during the session that requires intervention, again it is helpful to ask permission prior to intervening.

Encouraging Supervisee Reflectivity

No matter what format one chooses for delivery of supervision, one of the primary goals of supervision is to encourage supervisees to be self-reflective. In a developmental perspective of reflectivity, Skovholt and Ronnestad (1995) state that therapists-in-training progress through sequential stages toward increased competency and autonomy, and that the supervisory relationship changes over time, as do the needs of the trainees. The core assumption of this model is that therapists either stagnate or develop depending upon the use of a central mediating process they term continuous professional reflection (Skovholt & Ronnestad, 1995). Personal and professional interactions play a key role in therapist development, as does time to reflect, an open and supportive environment, and a reflective stance. These authors also point to the importance of a reflective stance. A reflective stance is defined as “the individual is consciously giving time and energy to processing, alone and with others, impactful experiences. An active, exploratory, searching, and open attitude is of extreme importance. Asking for and receiving feedback is crucial. “ (Skovholt & Ronnestad, 1995, p. 107).

Neufeldt, Karno, and Nelson (1996) have highlighted the role that reflectivity plays in therapist development. These authors assert that reflectivity improves supervisees’ work and professional judgment. They argue that an important supervisory responsibility is to “facilitate the process of reflectivity” (Neufeldt et al., 1996, p. 3).
Neufeldt (1994) describes a number of supervisor strategies that encourage supervisee reflectivity. Neufeldt divides these strategies into basic strategies for teaching, counseling and consulting functions and advanced functions. Some of the recommendations include:

- Evaluate observed counseling session interactions
- Ask supervisees to provide hypotheses about the client
- Explain the rationale behind counseling strategies
- Explore trainee feelings during the therapy and supervision sessions
- Encourage supervisee discussion of client problems, motivations, etc.
- Ask trainees to conceptualize cases
- Help supervisees process feelings to facilitate understanding
- Explore trainee-client boundary issues

Interpersonal Process Recall (IPR)

No discussion of increasing supervisor reflectivity is complete without reference of the technique of Interpersonal Process Recall or IPR. Developed by Kagan in 1980, it is still widely used today (see Kagan 1980, Bernard, 1989). Kagan’s theory is based on the assumption that many models of supervision are task oriented, emphasizing such competencies as case conceptualization and the attending skills of the counselor. However, attention is also needed to increase self-awareness regarding the therapeutic relationship. IPR is a supervision strategy that allows supervisees to increase their awareness of hidden thoughts and feelings of client and self, practice expressing these thoughts and feelings without negative consequences, thus deepening the therapist/client relationship.

IPR is most commonly used with sessions that are audio or video taped. The steps involve the supervisor reviewing the tape prior to the supervision session and selects sections of tape that are the most interpersonally weighted (Bernard & Goodyear, 1992). During the recall session the supervisor or supervisee stops the tape and asks a relevant leading session (see below) to influence the discovery process. If the supervisee stops the tape, he or she talks about thoughts or feelings that were occurring in the session. The supervisor facilitates the discovery process by asking open-ended questions. The supervisor does not adopt a teaching style or ask what could have been done differently, but allow the supervisee to explore thoughts and feelings to some resolution (Bernard & Goodyear, 1992).

Sample Leading Questions (see also Bernard & Goodyear, 2004; Borders & Leddick, 1987; Kagan, 1980).

1. What do you wish you had said to him/her?

2. How do you think he/she would have reacted if you had said that?
3. What would have been the risk in saying what you wanted to say?

4. If you had the chance now, how might you tell him or her what you are thinking and feeling?

5. Were any other thoughts going through your mind?

6. How did you want the other person to perceive you?

7. What do you think he/she wanted from you?

8. Did he/she remind you of anyone in your life?

**Group Supervision**

**Case Vignette**

*Dawn is a social work student attending group supervision. In the supervision group, Dawn has presented the history of Karla, a young woman with childhood sexual abuse. On the case, she has been supervised by her individual supervisor (who is very knowledgeable about abuse) very closely and with this degree of support has felt that the therapy has been manageable. In her most recent session with Karla, however, Karla reveals that not only has she been a victim, she has also been a perpetrator of sexual abuse with a child that she had babysat many years ago. Dawn has a very strong reaction to this, and although she has discussed her feelings in individual supervision and has learned that many victims go on to abuse others, she is upset. Dawn discussed her reactions in her group supervision session. She is relieved when peers validate that they would feel the same way, and Dawn is able to continue to process the situation with the group and in her individual supervision.*

*In addition to individual supervision, many supervisors choose to utilize concurrent use of individual and group supervision. Group supervision is unique in that growth is aided by the interactions occurring among group members. Supervisees do not function in isolation, so the group becomes a way to enable professional socialization and to increase. Group supervision provides an opportunity for counselors in training to experience mutual support, share common experiences, learn new behaviors, increase interpersonal competencies, and develop insight (MacKenzie, 1990). The core of group supervision is the interaction of the supervisees.*

*Like individual supervision, group supervision has advantages and disadvantages. Group supervision also requires different skills of the supervisor*
and supervisee than individual supervision. Group supervision allows for supervisors to impart knowledge to a larger audience, can be extremely time efficient, and also allows for rich discussions of case material by diverse trainees. It can have the disadvantage, however, of “losing” a particular trainee who is less comfortable in a group format. For a comprehensive discussion of group supervision, it is helpful to refer to the discussion by Proctor and Inskipp (2001). The follow section will provide a summary of these issues based on Proctor and Inskipps’s model, as well as other authors cited below.

Group supervision requires that supervisors be prepared to use their knowledge of group process (Yalom, 1985). Werstlein (1994) found that guidance and self-understanding were cited by supervisor and supervisees as the most important "therapeutic factors" (Yalom, 1985) present in their group.

There are a number of differences from individual supervision, both for the supervisor and supervisee. Proctor and Inskipp (2001) state that group supervision allows supervisees to present their work publically, which will be an important skill in the career of a mental health professional, to develop “group manners,” being aware of how their communication affects a group, develops them in the role of practitioners and as co-supervisors. Supervisors develop the roles of facilitating group discussion and reflection, of promoting group awareness skills and addressing potential conflict in the group.

There are four types of supervisory style and supervision mentioned by Proctor and Inskipp (2001). Although specific to group supervision the first two styles also apply to individual supervision. The styles are:

- **Authoritative supervision** — the supervisor is the “expert” and supervises each group member individually. This is supervision in a group that does not encourage group input.

- **Participative supervision** — the supervisor teaches supervisees to become active parties in the supervision, but he or she is still the leader. This is moving the group more towards co-operative supervision.

- **Co-operative supervision** — members of the group fully engage in the supervisory session with the supervisor acting as a facilitator.

- **Peer supervision** — members fully supervise one another.

Werstlein (1994) provides the following guidelines on group supervision:

1. Five to eight supervisees meeting weekly for at least one and one half hours over a designated period of time provides an opportunity for the group to develop.
2. Composition of the supervision group needs to be an intentional decision made to include some commonalities and diversities among the supervisees (i.e., supervisee developmental level, experience level, or interpersonal compatibility).

3. A pre-planned structure is needed to detail a procedure for how time will be used and provide an intentional focus on content and process issues. This structure can be modified later in accordance with group's climate.

4. A pre-group session with supervisees can be used to communicate expectations and detail the degree of structure. This session sets the stage for forming a group norm of self-responsibility and does not interfere with group development.

5. Supervisors may use "perceptual checks" to summarize and reflect what appear to be occurring in the here-and-now in the group. Validating observations with the supervisees is using process. Be active, monitor the number of issues, use acknowledgements, and involve all members.

6. Supervisees' significant experiences may be the result of peer interaction that involves feedback, support, and encouragement (Benshoff, 1992). Exploring struggles supports learning and problem-solving.

7. Competition is a natural part of the group experience. Acknowledge its existence and frame the energy in a positive manner that fosters creativity and spontaneity.

Bernard and Goodyear (2004) provide additional guidelines and steps of a structured group supervision model.

Evaluation: Issues and Concepts

Questions to consider:
When does the process of evaluation begin? End?
Why is evaluation important?
What are consequences that may occur if supervisees are not evaluated?
What have your own examples of evaluation been like? Have you considered them fair? Why or why not?
How has constructive feedback been communicated to you?

Of all components of supervision, one of the most critical is providing feedback to the trainee. Evaluation is not a final process that occurs following a supervision, but is an ongoing process that occurs at the start of the training
process. Although evaluation is an ongoing process, it is important to note that the supervisor’s final evaluation can have significant implications on program completion, licensure and certification. Consider the following case:

Case Vignette

Patricia, a clinical social work student, has just completed a psychotherapy externship. She is called into the office of the dean of her social work program, who is concerned about the recent externship experience Patricia has completed. He begins to discuss with her a number of issues that have occurred during the externship. Patricia is upset and confused and tells him that she has had little feedback throughout her experience there, and that she thought that she had been doing “fine.” In asking further questions, it is clear that Patricia was provided with no guidelines or expectations during the supervision experience, and that her supervisory sessions, which were self-report in nature, did not indicate that there were problems. In speaking with her supervisor, Patricia’s final evaluation was based on a single observation with a challenging client. What went wrong here?

Many authors provide guidelines for “fair” evaluations. Campbell (2006), for example states that supervisees should be given:

- Information, from the beginning, as to what is expected of them
- Information as to who will receive the evaluative feedback
- The criteria on which they will be judged and copies of any evaluation forms
- Several examples of what is desired with goals tied into specific behaviors
- Ongoing feedback as to how they are progressing with regard to specific goals
- Plenty of opportunities to be successful and helpful suggestions for improvement

Bernard and Goodyear (2004) make the distinction between formative and summative evaluation and state that the supervisor’s ability to discriminate between these types of evaluation is critical. Robiner, Fuhrman and Rievedt (1993) describe formative evaluation as the process of facilitating skill acquisition and professional growth through direct feedback. Summative evaluation is the sum total of evaluation and contains room for supervisor subjectivity. Bernard and Goodyear (2004) state that summative evaluation is “the moment of truth when the supervisor steps back, takes stock, and decides how the trainee measures up.”

When viewed within the scope of these definitions, supervision should contain both types of evaluation. The process of evaluation contains four steps. The first step is establishing supervision goals at the outset of supervision
Bernard and Goodyear (2004, Campbell, 2006). Bernard and Goodyear (2004) suggest that an expedient format for this is the Supervision-Evaluation contract, which they compare to a course syllabus. Each contract is individualized based on the needs of the trainee. The supervisee and supervisor meet at the outset of the supervision experience and review the contract together. This provides the blueprint not only for evaluation but also for the supervision experience.

The next step in the evaluation process involves providing supervisees with ongoing feedback regarding the various goals established at the outset of supervision. This may include feedback on individual skills, such as conducting intakes, report writing or assessing client needs, evaluation of counseling or psychotherapy skills (responding to clients, empathy, termination), performance when a client is in crisis (assessing for suicidal ideation, hospitalizing clients when necessary), sensitivity to diversity issues, use of supervision time (active participation and preparedness, response to feedback), ethical sensitivity and consultation, and testing or assessment skills. The previous step can be done formally or informally but it is often helpful to have at least one formal or written evaluation at the midpoint of the supervision experience. There are a number of forms that have been developed to support formal evaluation (see for example Bernard and Goodyear, 2004). Formative feedback should be communicated in a constructive, but non-judgmental way.

Another important component of evaluation is encouraging supervisee self-assessment, that is assisting supervisees in evaluating their own work. In discussing reflective learning based supervision, Little et al. (2005) suggest that supervisors can promote self-assessment in supervisees by encouraging (a) an identification of goals regarding client issues and the counseling process, and (b) an increased self-direction in identifying professional gaps and strategies for development of the skills necessary for addressing supervisors' own professional learning needs. Supervisors can support this by encouraging supervisees to reflect on their "visions of professional learning". Closely related to supervisee self-assessment is the issue of peer assessment. Bernard and Goodyear (2004) have found that peers can be excellent reviewers for one another. They suggest that the supervisor help structure the evaluation process.

The final stage of evaluation involves summative evaluation. This is the final evaluation of supervisees’ successful completion of the supervisory experience. Due to the importance of this process, Campbell (2006) suggests that subjectivity be reduced by employing (1) structured criteria to evaluate success, (2) multiple ways to rate supervisor competence, (3) gathering evaluation information about the supervisee from other sources. She stresses that the evaluation criteria should be consistent, objective, and based on descriptions that are easily understood by supervisees.

In addition to rating supervisees, no discussion of evaluation is complete without reference to rating supervisors. This is an area that could benefit from
additional research. Campbell (2006) provides one such tool in her section on evaluation. It is a preformatted checklist in which supervisees rate the effectiveness of various supervisor behaviors such as structuring sessions. Providing feedback, encouraging questions, flexibility and openness, making adequate use of clinical discussion, review of tapes, and review of documentation in supervision, discussing supervisee’s progress, aiding supervisee in developing case conceptualizations, exploring various therapeutic processes and techniques with supervisee and addressing multicultural issues.

*Providing a Negative Evaluation*

One of the most challenging supervisory situations is when there is a need to provide a supervisee with a negative evaluation. In the case vignette, this situation was handled poorly. The following suggestions are helpful:

1) Adequately define criteria for evaluation, including what constitutes positive and negative performance. It may be helpful to provide this information in writing, so that there is no question that it has been communicated.
2) Evaluate frequently, not only when the final evaluation is to occur. Provide feedback and examples of how the supervisee can improve.
3) Use different techniques in evaluation. Use of case discussion only does not constitute a fair evaluation. When possible use objective rather than subjective methods.
4) Seek consultation if needed.
6) Be prepared. Negative evaluation will likely be met emotionally, anger, sadness, accusations, tears.

*How to Manage Conflict in Supervision*

Questions to consider:
*Is conflict inevitable in supervisor/supervisee relationships? Why or why not?*
*What are some potential sources of conflict?*
*Why is conflict within this relationship often ignored or not addressed?*
*What have your own experiences of relationship conflict been like?*

Case Vignette

*Rita is a doctoral intern who is currently working in a psychiatric hospital setting. Since her first day at the hospital Rita has not felt like she connected with her supervisor, Dr. Bellmont. Rita feels that Dr. Bellmont is unclear of what his expectations for her, and that they sometimes change on a daily basis. Rita also feels like he is demanding and critical, and that she is dismissive about problems.*
Rita feels ashamed when asking Dr. Bellmont for guidance. When Rita runs into a challenge with a difficult patient, who threatens to hurt herself in response to Rita’s perceived lack of “concern,” Rita is fearful and uncertain what to do. She knows that she needs help, but cannot approach Dr. Bellmont.

What should Rita do?

Situations like this are not uncommon and need to be addressed. As many supervisees are in the beginning stages of their training, they sometimes lack the necessary skills to address these problems. Research indicates that psychotherapy trainees often withhold information from supervisors even though they are expected to be self-disclosing in the supervisory process. Campbell (2006) identifies some common factors that may play a role in lack of disclosure between supervisees and supervisors include:

- Anxiety
- Issues of control
- Transference/countertransference
- Differences in personality style or viewpoint
- Differences in needs or goals
- Multicultural differences
- Stress, burnout or compassion fatigue

Supervisors should be alert to and able to recognize a supervisee’s difficulty in engaging and use skills for dealing with lack of engagement (e.g., such as basic counseling skills including active listening). Additionally many of the skills discussed in previous sections of this training material, such as providing support, setting clear goals and objectives and providing well-rounded feedback on performance in relation to set goals and objectives can be helpful in minimizing conflicts.

Another contributing factor to nondisclosure by supervisees is shame. By its very nature, supervision is an endeavor in which supervisees are likely to experience feelings of self-doubt, which can easily lead to shame. Supervisee shame is an area that has been the focus of a body of writings (see Yourman, 2003; Pack, 2009; Ladany, 2010). There are many ways that supervisors can help to reduce these feelings of shame and to enhance the supervisory relationship. Ladany (2010) feels that the most important factor lies in the supervisor’s style. Ladany (2010) describes the most effective style as one that is non-judgmental, warm and supportive without being therapeutic, one that is instructive without being blaming, and one that can be evaluative without being disrespectful. Good supervisors are also aware of the power differential in the relationship. They empathize with supervisee concerns and balance critical feedback with acknowledgment of supervisee strengths.

Many of the factors described above would have clearly mitigated any
potential conflicts between Rita and Dr. Bellmont. This would have benefitted both of them, as well as the client, ensuring that Rita felt guided and supported and that Dr. Bellmont was more fully aware of her work with clients.

Some general guidelines for resolving conflict with the supervisor/supervisee relationship:

Recognize the conflict, especially conflict that is not being directly expressed. Some signs may include withdrawal or disengagement during supervision, or a disconnect between what is discussed in session and actual behavior outside of it.

Identify the source of the conflict. Often times this is connected to lack of clear communication. There may be differing expectations from supervisor/supervisee, conflicts due to supervisee developmental level, or interpersonal dynamics that play a role in this conflict. Identifying the source will assist in selecting the strategy that will work the best to repair the problem.

Assess transference/countertransference. Are there things about the other person that push one another’s’ buttons? Identify any anger or attempts to control. These are common transference/countertransference responses and may rupture relationships.

Each person should share feelings and responses to your the others’ behavior. Describe the specific instances or examples that you believe draw forth these reactions.

Use of empathic statements opens discussion and communicates understanding. Setting the tone as one of mutual exploration and to find a solution will maximize the chances of a productive outcome. Be aware that there are natural power differentials in this relationship, and that working as a team will often help reduce conflict.

Use statements such as, "I wonder if..." or "It seems like..." When these issues that arise in the supervision extend beyond what can be addressed within the boundaries of supervision, therapy as a supplement to your sessions.

Keep feedback focused on behaviors, not personality.

Example of a conversation between supervisee/supervisor that addresses conflict:
Supervisor: I wanted to talk with you about some things that I have noticed. I’ve been concerned that there seems to be some things happening between us and wanted to see if you’d noticed it to. Many of our sessions feel “superficial” and end prior to the end of our allotted time. Have you noticed that?

Trainee: Yes, I have. I’m not sure what you mean by superficial though (defensive tone).

Supervisor: I probably should have elaborated on what I meant. Often it seems like you list what clients you have seen, and tell me that things are going well. When I ask what challenges there may have been, you don’t seem to have any that you identify. I have challenges with so many of my own clients (light tone).

Trainee: Hmmm … I’ll have to think about that

Supervisor: Are there any obstacles to you being able to discuss challenges with me? For example, do you feel hesitant to talk with me because I will “judge” you, or do you think that you need to always have the right answers? Those are a few examples; what do you think the problem is?

Trainee: I’m not sure.

Supervisor: Well, sometimes you have to think about these things. I’d like you to do that before our next meeting. I’d like to talk with you more about that. Perhaps it would help, too, to make some quick notes after meeting with clients about some things that came up in session that would be good for us to discuss together.

Supervisee-Specific Strategies

Being a beginning therapist is often wrought with anxieties and demands. There are a number of supervisee “types” that are commonly seen. Below is a brief summary of these types and some strategies for working with them (Campbell, 2010). It is always important to consider that in some cases, these client presentations are about the supervisory relationship; in other cases it may be about unresolved issues for either the supervisor or supervisee. In this case a referral to therapy may be indicated.

The Anxious or Perfectionistic Supervisee

Anna, a beginning doctoral intern at a community mental health center, fits the description of the anxious or perfectionistic supervisee. Currently on an intake rotation, Anna spends so many hours on her reports that she is rarely on time with them, and this has become an issue in supervision. When gently
questioned by her supervisor, Anna admits to doing and re-doing the reports because she is fearful that she has diagnosed the client incorrectly.

How can Anna be helped?

In this example, Anna’s anxiety has clearly interfered with the learning process, a common problem in the early stages of training. Thus, it is important for supervisors to be tolerant of the normalcy of perfectionism. Some strategies that may be helpful with Anna (as well as other anxious or perfectionistic supervisees) include exaggeration, rephrasing supervisee concerns with absolutes or “grades,” and which points out the ridiculousness of the situation and reframing, which changes the conceptual and/or emotional viewpoint by placing it in a different frame that fits the “facts” of the situation equally well, thereby changing its meaning.

Examples of Exaggeration

“You want a perfect outcome for this client!”
“You want to get an “A” with this client.”

Examples of Reframing

“I see that you are focusing on the potential negatives that can occur with not diagnosing a client one hundred percent accurately, but what are the potential positives?”

The Defensive or Resistant Supervisee

Ken, a social work intern, is an example of a defensive or resistant supervisee. His supervisor, Jean Kleiman, has become used to Ken’s style. He spends much of the supervision time describing his treatment approach with clients, and often seems to solicit suggestions, only which are often met with “yes, but” or body language that indicates that the suggestions are not being met with openness. Jean recognizes that this has affected not only Ken’s work with his clients, but also the supervisory relationship. She often leaves sessions with Ken feeling frustrated, and sometimes fantasizes about not meeting with Ken. She also sometimes wonders if her suggestions are really as bad as Ken seems to feel that they are, and she hates these feelings of self-doubt.

How can Ken be helped? How can Jean be helped?

The example above is one that again is not uncommon, and can occur especially in the intermediate or later stages of training. Jean would do well to try to consider the root cause of the problem. Is she coming across as somehow critical, or is this more of a problem with Ken? It is often helpful to record a supervisory session, and to consult with a colleague.
Some other suggestions that may be helpful include *honoring resistance* (Minnuchin, 1974), which is a paradoxical intervention that entails the supervisor pulling back and agreeing with the supervisees’ position, *use of tentative language* (Campbell, 2010), *storytelling*, a technique that depersonalizes feedback, and *humor*. For the latter, it is important to check in with the supervisee to see if they hear the response as humorous and not critical.

**Examples of Honoring Resistance**

“You’re right. My idea probably won’t work. I see that I can’t be of much help with this client.”

**Example of Use Of Tentative Language**

“Here’s something you can try. I don’t know if it will be helpful or not, so you can try it if you want. We’ll see what happens.”

**Example of Humor**

“Wrong again (laughs). My husband/wife would love to be a fly on the wall here.”

The Apathetic or Uninvolved Supervisee

*Dr. Miller is not looking forward to his supervisory session with Jim, a doctoral intern. He bristles at what he considers Jim’s apathetic, distant tone when describing clients, and feels that his feedback, is met with assent but never seems to be followed through on. Jim often tells him that everything is fine, and that he has nothing to really talk about. Dr. Miller, unsatisfied with this response, presses Jim, and asks him to describe his work with the client he has just seen in session. The situation comes to a head when Jim describes a particularly sad client situation that involves significant child abuse in an almost off-hand manner.*

*How can Dr. Miller help Jim?*

As with the other difficult client presentations, it is important to consider what I at the root of Jim’s apparent apathy. Some of the possible causes of this are discouragement, anger, burnout, anxiety, and confusion (Campbell, 2010). In addition, in a case like the one described above, it is also helpful to consider that this apathy is a countertransference reaction or a way of distancing from something that us emotionally difficult. In the latter, and if a pattern arises, it may be helpful to consider a referral for psychotherapy for the supervisee.

There are a number of techniques that can be helpful with the apathetic supervisee. These include: *the Columbo approach (acting confused), honoring*
the resistance, and changing the session focus. Although all are good tools, the direct approach is generally the most effective.

**Use of the Direct Approach**

“Jim, I have seen that when we meet to discuss cases, you often tell me that everything is fine, and that we have nothing to talk about. When I pressed you today, it is clear that you are actually working with a very difficult client situation, but your tone in talking about it is unemotional. I am concerned. Is there something more going on here in the supervisory relationship? My role is to guide you. What needs to change?

**Distinguishing Poor Service Quality from Harm**

The cases above also illustrate the need for supervisors to distinguish between what may be poor service quality, and what may actually be harmful to a client. In the case of poor service quality, such in the example with Jim, eventual harm to the client may occur if the situation is not addressed.

Examples of behaviors that indicate direct harm and should always be addressed are:

- Belittling or manipulating clients for one's own gain
- Engaging in boundary crossings, especially dual or sexual relationships
- Client abandonment
- Failing to recognize need for a client referral
- Failing to recognize a crisis situation
- Withholding support from clients
- Withholding information from a supervisor

Behnke (2014) refers to interventions which increase a trainee’s competence and move them toward graduation as “remedial”. Interventions that will eventually result in a trainee’s termination are referred to as “disciplinary”.

**Program Administration**

Program administration is also an important component of supervision. The administrator of a supervision program is responsible for the quality of supervision provided and the effectiveness of supervisory staff. According to Henderson and Lampe (1992) a supervision program includes the supervisors, but also the activities they do, outcomes they strive to help their supervisees achieve, materials and resources they use, and means by which the activities, outcomes, and staff performance are evaluated. Administrators must have the necessary skills in program management, and personnel management.
Kadushin & Harkness (2002) discuss social work supervision and the administrative “hats” that supervisors wear: staff recruitment and selection; orientation and placement of employees; work planning and assignments; monitoring, coordinating, reviewing, and evaluating work; staff communication both up and down the chain of command; advocating for client and clinician needs; acting as a buffer between administrators and counselors; and acting as a change agent and community liaison.

In implementing a clinical supervision program, an important step is to evaluate the organization’s preparedness to support the functions of clinical supervision by identifying the agency’s culture and organizational structure:

- How decisions are made within the organization (centralized versus decentralized, vertical or horizontal).
- How authority is defined and handled (top down, bottom up, through the chain of command, or ad hoc).
- How power is defined and handled (reward, coercion, legitimate power through status, prestige, titles, expert power through skills and experience, or referent power through respect for an individual—or all of the above).
- How information is communicated (structured/formal/informal, on a need-to-know basis, bidirectional feedback and communication).
- How the organizational structure influences supervisory relationships, process, and outcome.
- The overall cultural proficiency of the organization.

**Documentation and Record Keeping**

One of the most disliked (but important) tasks for many supervisors is documentation. This is an essential administrative task. Documentation is to serve as the legal record for the delivery of supervision, and demonstrates that a reasonable effort was made to supervise. The supervisory record is also important in developing a plan for both client care and professional development. The supervisory record also provides a reliable source of data in evaluating the competencies of counselors and provides information concerning staff ability to assess and treat clients.

A clinical supervision record should include the following elements (Munson, 2009; Kadushin, 2002; Campbell, 2002):

- The supervisory contract, if required by the agency, and signed by the supervisor and the supervisee.
- A copy of the informed consent document, signed by the supervisor and the supervisee.
• Requirements for therapist credentialing (certification/licensure) and the extent to which each supervisee meets those requirements.

• A brief summary supervisee experience, training and learning needs

• A copy of the performance evaluations and all relevant updates to these evaluations.

• A log of clinical supervision sessions, dates, times; and a summary of key issues discussed; recommendations given by the supervisor and actions taken by the therapist

• Documentation of cancelled or missed sessions by either the supervisor or supervisee.

• A brief summary of each supervision session, including specific examples that support learning goals and objectives.

• A risk management review summary, including concerns about confidentiality, duty to warn situations, crises, and the recommendations of the supervisor concerning these situations.

• Significant problems encountered in the supervision, and how they were resolved or whether they remain unresolved.

Summary

Supervision is an essential training component for mental health professionals. The most effective supervisors plan for the supervisory experience and individualize supervision to the needs of the supervisee. Although therapy skills and case conceptualization comprise the bulk of supervision, supporting supervisees in other areas, such as multicultural awareness and ethical practice is also key functions, as is providing feedback on progress and a fair summative evaluation. Many of the skills that are found in psychotherapy, such as the ability to empathize and to support growth and change, are also important for supervisors.

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