SUPERVISION: A GUIDE FOR MENTAL HEALTH PROFESSIONALS

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Learning Objectives:

Upon completion of the course, the participant will be able to:

1. Differentiate the provision of supervision from the provision of psychotherapy.
2. Describe various approaches to supervision.
3. Differentiate the roles and responsibilities of supervision
4. Explain ethical and legal issues in supervision, including informed consent, confidentiality, and competence.
5. Recognize the essential components of multicultural competence in supervision.
6. Explain the use of technology in supervision.
7. Describe supervision methods and techniques.
8. Identify ways to encourage supervisee reflectivity.
9. Describe supervisee evaluation, including use of evaluation instruments, and communicating feedback.
10. Explain ways to manage conflict in supervision.
11. Discuss the role of documentation and record keeping in supervision.

Syllabus:

INTRODUCTION

Case Vignette

Sam is a social worker who has recently completed her master's degree and has started in her first position working in an inpatient psychiatric hospital setting. Prior to this position, most of her training and experiences were outpatient settings. Sam is unsure about how to handle the demands of this setting and starts to feel overwhelmed. Sam's supervisor, Liam, has observed that Sam often appears anxious in team meetings and noticed Sam telling others that she hasn't been sleeping well and feels overwhelmed. In supervision, Liam validates the challenges of working in this environment and asks if Sam would like some supervision on strategies to manage the work environment of an inpatient psychiatric hospital setting. Liam helps Sam with strategies in setting boundaries with patients and helps her understand what a positive work-life balance is for her. Although the work remains challenging, Sam is learning a lot, knows that she can go to Liam for supervision related to this position, and feels less overwhelmed.

The case vignette above illustrates the importance of supervision in training mental health professionals. Supervision is "a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and

diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus - and evidence-based practices" (Center for Substance Abuse Treatment [CSAT], 2007, p. 3). For hundreds of years, many professions have relied on more senior colleagues to guide less experienced professionals in their crafts. Clinical supervision has been acknowledged as a discrete process with its own concepts and approaches. The significance of supervision is apparent in the following statements:

- Organizations have an obligation to ensure quality care and quality improvement of all personnel. The first aim of clinical supervision is to ensure quality services and to protect the welfare of clients.

- Supervision is the right of all employees and has a direct impact on workforce development and staff and client retention.

- Supervision is necessary to oversee the clinical functions of staff and meets legal and ethical responsibilities to ensure quality care to clients, the professional development of counselors, and maintenance of program policies and procedures.

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

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2014)

All mental health professionals (social workers, psychologists, marriage and family therapists, and counselors) have had the experience of having their work supervised by a more seasoned mentor. Not only is supervision a requirement for training, these supervisory 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 critical in ensuring that clients working with newer clinicians have the benefit of them being guided by someone more experienced. Furthermore, the ethical codes for various professional associations highlight the significant role supervision plays in the standards, values, and principals that guide mental health and human service professionals (e.g., NASW, APA, ACA, NBCC, and AAMFT).

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. Some supervisees even report that they feel inadequate or that they have been shamed within the supervision process, likely inadvertently. In a recent meta-analysis, Wilson, Davies, and Weatherhead (2016) enumerate the both the positive and negative aspects of trainees' experiences in supervision.

Although positive and negative experiences exist, supervisor training is a key factor in ensuring that supervisors are prepared for the mentoring role. It is also invaluable to receive supervision on the provision of supervision prior to conducting it independently. There are a number of models that a supervisor may follow based on their own background and orientation, but within these theoretical differences there is emerging literature in the field of supervision research and a general consensus on what steps professionals can take to become effective supervisors.

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 for an enhanced learning experience.

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?
How do you learn to become a "good" supervisor?
What issues may be connected to the evaluative nature of supervision?
What role should the supervisor play as gatekeeper to the profession?
What qualities or competencies does a supervisor need to be an effective, competent and ethical supervisor?

Case Vignette

Reece 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 and information from his peers, Reece feels unprepared by the demands of working with clients with severe mental health disorders. His experiences with Tammy, his supervisor, have not helped to allay his concerns. Although Reece feels that Tammy will thoroughly answer specific questions about client care and ensures that Reece is providing evidence-based treatment to clients, Reece rarely feels guided or supported when he shares about feeling overwhelmed and unprepared. When the mid-semester point arrives, Reece asks to be transferred to a different setting.

How do you define mental health supervision? How does supervision diverge from the concept of psychotherapy? Is it different? Although there may be some similarities between supervision and psychotherapy, it varies in terms of its structure and purpose. Good supervisors understand the multiple roles of the clinical supervisor, including consultant, mentor, leader, teacher, team member, evaluator, and administrator (CSAT, 2007). It is helpful to consider the following definitions, which stress the distinct purpose of supervision as well as its evaluative component.

Broadly speaking, supervision is integral clinical practice, wherein the main goal is for a more senior clinician to improve the knowledge and skills of a novice clinican through supervisory feedback (Davidson, et al., 2017). In a general sense, this helps to promote the well-being of clients. Supervisees often provide therapy to clients under the supervisor's license; therefore, the well-being of the clients is ultimately the responsibility of the supervisor and supervision is the mechanism by which client care is ensured. In addition to supervision serving the purpose of ensuring client well-being, a secondary and equally important purpose of supervision is to provide specific learning goals for the supervisee.

In the case vignette above, it is clear that the focus of supervision was on ensuring the well-being of the clients. In this case, Reece was a social work student who was new to seeing clients in general, and new to this particular setting. He was having difficulties coping with the stress of the work environment, and although Tammy gave supervision regarding how to treat the clients effectively, Reece did not feel supported and ultimately did not decide to stay in the field placement. It can often be challenging for supervisors to understand why a supervisee decides to leave a placement, similar to clients discontinuing psychotherapy. It is possible that if Tammy would have focused on the learning goals for the supervisee in addition to ensuring the well-being of the clients, Reece may have decided to stay in the setting and learned how to cope with the work environment and treating the client population. Similar to psychotherapy, it can be helpful to check in with supervisees, like with clients, to ensure that they have time to provide feedback on the process and discuss any changes they would like to make so that they can meet their goals.

The term *training supervision* is used to denote the process of supervision with early stage therapists. Training supervision is typically what one thinks of when defining supervision, as all individuals in training receive supervision. However, more advanced therapists regularly seek out supervision as well. *Consultative supervision* is another option that a supervisor may extend their work. Specifically, in this regard, consultative supervision refers to the process of a more experienced, and often independently licensed professional, seeking consultation from a seasoned and expert practitioner to provide feedback to the professional in specific clinical applications (Morrissey, 2015). Supervisors often receive consultation on their clinical practice and supervision from peers and more experienced practitioners. Consultation can also be used when solidifying a new skillset after they have received training and supervision for that new skillset. As a consultant, you can provide alternative case conceptualizations, help consider ethical considerations, and guide the therapist or supervisor to new readings and trainings that might be helpful.

As defined by Milne and Watkins (2014), the supervisor is responsible for establishing ''relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues.'' Milne and Watkins' (2014) 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. Similarly, Fulton, Kjellstrand Hartwig, Ybañez-Llorente, and Schmidt (2016) summarize that "supervision is a disciplined, tutorial process wherein

principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive."

In a more comprehensive definition, Bernard and Goodyear (2019) define supervision as being "critical to the training of new therapists, wherein an experienced therapist (i.e. supervisor) directly contributes to the ongoing training of the therapist-in-training (i.e. supervisee). In an effort to accomplish this, supervisors strive to establish an educational environment where the supervisees professional learning goals can be achieved." 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 junior members' clients; and, c) serving as a gatekeeper for those who are to enter the particular profession.

Others suggest a similar definition of supervision, wherein supervisors employ a competency-based model to evaluate, instruct and model skills that facilitate supervisee development and self-assessment (Dunlap, 2017). In a competency-based model, supervisors focus primarily on the skills and learning needs of the supervisee and on setting goals that are **s**pecific, **m**easurable, **a**ttainable, **r**ealistic, and **t**imely (SMART). They construct and implement strategies to accomplish these goals. The key strategies of competency-based models include applying social learning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using various supervisory functions (Simpson-Southward, Waller, & Hardy, 2017).

Herbert and Caldwell (2015) distinguish two types of supervision. *Clinical Supervision* is the process of providing consistent observation and evaluation of the counseling process by a trained and experienced professional. *Administrative Supervision* focuses on issues connected to organizational roles such as timekeeping and documentation. "Clinical supervision is distinguished from administrative supervision in some models of supervisory practice, and many believe that administrative duties take precious time away from the provision of direct supervision to clinical staff; however, in [most] treatment settings, the two kinds of supervision significantly overlap in real-world practice" (CSAT, 2007, p.4).

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 (2005, later incorporated into the 2014 ACA code of ethics). 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,"(p1) 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.(p2)" 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, d. evaluating and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment, and credentialing purposes."(p. 3)

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.

Supervisors accept the ethical and legal responsibilities of their supervisee and often need to be competent in working within organizational systems (Falender & Shafrankse, 2017). Supervisors serve to function as the organization's gatekeeper for ethical and legal issues; are responsible for upholding ethical, legal, and moral practices; and, are a model of practice to supervisees. Some 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. According to Watkins and Milne (2014), qualities of an effective supervision model can be broken into 4 competencies. These include: 1). *generic supervision competencies*: where there is an ability to help supervisee reflect on their own work and on the usefulness of supervision; 2.) *specific supervision competencies*: focusing on helping the supervisee practice their learned clinical skills; 3). *application of supervision to specific models/contexts*: where the focus shifts to the supervision and oversight of clinical case management; 4.) *meta-competencies*: where the focus shifts to oversee the acquisition and development of supervisor and supervisee meta-competencies. Pilling and Roth (2014) expand upon these four general competencies, and recommend overall abilities of clinical supervisors, in whatever model of supervision they may choose. These include the ability to a.) utilize educational principles that enhance and promote supervisee learning; b.) foster ethical practice; c.) work across a spectrum of diverse clientele; d.) adapt supervision to organization context; e.) form and maintain adequate supervisee/supervisor alliance.

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 the supervisor or supervisee. Falender and Shafranske (2017) 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, Willcoxon, and Norem (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. McMahon and Hevey (2017) build upon these principles, positing that poor supervision is linked to numerous negative outcomes, including counselor burnout, decreased work satisfaction and heightened workplace stress, and reduced professional confidence. Johnson (2017) contends that negative supervision erodes both the trust and safety that are crucial to the supervisor relationship. Alarmingly, Ellis, Berger, Hanus, Ayala, Swords, and Siembor (2014) found that more than half of supervisees reported having received harmful clinical supervision at some point in their training. Therefore, it is imperative for supervisors to receive training in supervision. It is a distinct skill set that is not learned simply from having experience providing psychotherapy and yet, the study of how to effectively deliver supervision is relatively new in the field. It is important to note that each state and profession varies when it comes to defining supervisory qualifications/requirements, delineation of progress, etc.

Key Learning Points

- Supervision is a distinct intervention that differs from training, psychotherapy and consultation
- Supervision is a training and mentoring relationship and provided by a member of the same profession (e.g., psychologist, social worker, counselor)
- Supervisors accept the ethical and legal responsibilities of their supervisee
- Supervision is not a "voluntary" relationship, although supervisees may have some discretion over who they choose as a supervisor
- Supervision is evaluative and contains clear boundaries (a type of "contract")
- Supervision is ongoing and extends over time
- Goals of supervision include enhancing professional functioning and monitoring client care
- Ethical codes outline the importance and mandate of supervision (see table 1 for a reference list of the ethics codes and, to avoid redundancy, only a sample of relevant summaries related to supervision are provided).

TABLE 1: REFERENCE LIST OF ETHICS CODES AND RELEVANT SUMMARIES RELATED TO SUPERVISION	
Informed Consent	
AAMFT	1.2 Informed Consent
ACA	A.2 Informed Consent in the Counseling Relationship, F.1.b Counselor Credentials, F.1.c Informed Consent and Client Rights, F.4.a Informed Consent for Supervision *Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which supervisors are to adhere and the mechanisms for due process appeal of individual supervisor actions. The issues unique to the use of distance supervision are to be included in the documentation as necessary.*
APA	3.10 Informed Consent, 10.01 Informed Consent to Therapy *Psychologists obtain informed consent prior to providing supervision or consultation.* *When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.*
NASW	1.03 Informed Consent
NBCC	Directives 1, 27, 45, 69, 72, 74, 78, and 90
Confidentiality	
AAMFT	Standard II Confidentiality, 4.7 Confidentiality with Supervisees, 6.3 Confidentiality and Professional Responsibilities *MFTs do not share confidential information that could reasonably lead to the identification of a supervisee without written consent.*
ACA	B.1.b Respect for Privacy, B.1.c Respect for Confidentiality, B.1.d Explanation of Limitations
APA	4.01 Maintaining Confidentiality, 4.02 Discussing the Limits of Confidentiality, 7.04 Student Disclosure of Personal Information
NASW	1.07 Privacy and Confidentiality, 2.02 Confidentiality
NBCC	Directives 12, 15, and 56 *Supervisees shall protect client's confidentiality and unnecessary invasion of privacy by providing only relevant information and in a manner that protects the client's identity.*

Multiple Relationships	
AAMFT	1.3 Multiple Relationships
ACA	F.3.a Extending Conventional Supervisory Relationships, F.3.d Friends or Family Members, F.10 Roles and Relationships Between Counselor Educators and Students *Supervisors are prohibited from engaging in supervisory relationships with individuals with whom they have an inability to remain objective.* *Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Supervisors consider the risks and benefits of extending current supervisory relationships in any form beyond conventional parameters. In extending these boundaries, supervisors take appropriate professional precautions to ensure that judgment is not impaired and that no harm occurs*
APA	3.05 Multiple Relationships, 3.06 Conflict of Interest, 3.08 Exploitative Relationships
NASW	1.06 Conflicts of Interest, 3.01 Supervision and Consultation, 3.02.d Education and Training *Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee, including dual relationships that may arise while using social networking sites or other electronic media.*
NBCC	Directives 5, 6, 11, 14, 68, and 84 *Counselors who provide supervision shall not have multiple relationships with supervisees that may interfere with professional judgement or exploit supervisees. Supervisors do not provide supervision to relatives.*
Sexual Issues	
AAMFT	3.7 Harassment, 4.1 Exploitation, 4.3 Sexual Intimacy with Students or Supervisees *MFTs do not engage in sexual or other forms of harassment or exploitation of supervisees.* *MFTs do not exploit the trust and dependency of supervisees.*
ACA	F.3.b Sexual Relationships, F.3.c Sexual Harassment *Sexual Relationships Sexual or romantic interactions or relationships with current supervisees are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.* *Counseling supervisors do not condone or subject supervisees to sexual harassment.*
APA	7.07 Sexual Relationships with Students and Supervisees *Psychologists do not engage in harassment or exploitation.* *Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority.*

Sexual Issues (continued)	
NASW	2.07 Sexual Relationships, 2.08 Sexual Harassment *Supervisors do not sexually harass or engage in any form (i.e. verbal, written, physical, or electronic) of sexual contact with supervisees.*
NBCC	Directives 7, 8, and 11 *Clinical supervisors shall not engage in sexual or romantic intimacy with current students or supervisees, or with former students or supervisees for a period of 2 years from the time of last supervisory contact.*
Competence	
AAMFT	3.1 Maintenance of Competency, 3.10 Scope of Competence, 4.4 Oversight of Supervisee Competence *MFTs pursue knowledge of new developments and maintain their competence through supervised experience, among other activities.* *MFTs practice in specialty areas new to them only after appropriate supervised experience, among other activities.*
ACA	C.2 Professional Competence, F.2.a Supervisor Preparation *Prior to offering supervision services, counselors are trained in supervision methods and techniques. Counselors who offer supervision services regularly pursue continuing education activities, including both counseling and supervision topics and skills.*
APA	2.01 Boundaries of Competence, 2.03 Maintaining Competence *Psychologists provide supervision and teach in areas only within the boundaries of their competence, based on their supervised experience, among other activities.* *Psychologists have or obtain the supervision necessary to ensure the competence of their services, among other activities.* *Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant supervised experience, among other activities.* *In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.*
NASW	1.04 Competence, 4.01 Competence *Supervision is a tool to ensure competence.* *Social workers who provide supervision or consultation (whether in-person or remotely) should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.*

	Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.
NBCC	Directives 13, 22, 23, 24, 25, and 63 *Counselors perform only professional services for which they are qualified by supervised experience, among other activities.* *Counselors will seek supervision and consultation with other qualified professionals when unsure about client treatment or professional practice responsibilities.*
Impairment (Problems of Professional Competence)	
AAMFT	3.3 Seek Assistance, 3.12 Professional Misconduct
ACA	C.2.g Impairment, F.5.b Impairment, F.6.b Gatekeeping and Remediation
APA	2.06 Personal Problems and Conflicts, 7.04 Student Disclosure of Personal Information *Psychologists do not require supervisees to disclose personal information unless it is clearly identified as a requirement during informed consent or the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be impairing their performance of duties.*
NASW	2.09 Impairment of Colleagues, 2.10 Incompetence of Colleagues, 2.11 Unethical Conduct of Colleagues, 4.05 Impairment
NBCC	Directives 13, 23, and 63v *Counselors who provide supervision intervene in situations where supervisees are impaired or incompetent and thus place client (s) at risk.*
Sensitivity to Issues of Diversity	
AAMFT	1.1 Non-Discrimination
ACA	A.2.c Developmental and Cultural Sensitivity, B.1.a Multicultural/Diversity Considerations, F.2.b Multicultural Issues/Diversity in Supervision *Counseling supervisors are aware of and address the role of multiculturalism/ diversity in the supervisory relationship.*
APA	2.01(b) Boundaries of Competence, 3.01 Unfair Discrimination
NASW	1.05 Cultural Competence and Social Diversity, 4.02 Discrimination *Social workers who provide supervision or consultation are responsible for setting boundaries that are clear, appropriate, and culturally sensitive.*

Sensitivity to Issues of Diversity (continued)	
NBCC	Directives 4 and 26
Evaluation	
AAMFT	4.5 Oversight of Supervisee Professionalism
ACA	F.6.a Evaluation, F.9 Evaluation and Remediation, F.9.a Evaluation of Students
APA	7.06 Assessing Student and Supervisee Performance *In supervisory relationships, psychologists establish a process for providing feedback to students and supervisees. Information regarding the process is provided to the supervisee at the beginning of supervision.* *Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.* *When psychologists provide consultation or supervision, psychologists explain the sources of information on which they based their conclusions and recommendations.*
NASW	3.03 Performance Evaluation *Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.* *Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.*
NBCC	Directives 28, 45, and 64

Adapted from "AAMFT Code of Ethics," by the American Association for Marriage and Family Therapy, 2015, retrieved from http://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx; "ACA Code of Ethics," by the American Counseling Association, 2014, retrieved from http://www.counseling.org/knowledge-center/ethics; "Ethical Principles of Psychologists and Code of Conduct," by the American Psychological Association, 2017, retrieved from http://www.apa.org/ethics/code/; "Code of Ethics of the National Association of Social Workers," by the National Association of Social Workers, 2017, retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English; and "National Board for Certified Counselors Code of Ethics," by the National Board for Certified Counselors, 2016, retrieved from http://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf

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?
How did you resolve any issues with previous supervisory relationships? What worked? What did not?
How did your supervisory relationship influence your relationship with your patients?

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. She has detailed questions about how to effectively provide therapy for each client and is eager to learn new evidence-based techniques. Dr. Martinson does not answer Donna's specific questions for each client, and often seems annoyed at times by her approach. He told Donna that 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 the evidence-based skills she needs to work with this population. She believes that Dr. Martinson is a good psychologist and that she could learn a lot from him, but he does not seem to be the right supervisor for her. He does not seem to ask for feedback in supervision, so she doesn't feel comfortable telling Dr. Martinson how she feels. She is also concerned about telling him because he is in an evaluative role.

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*. Defined as, 'the formal provision, by approved supervisors, of a relationship-based education and training that is case-focused, and which manages, supports, develops and evaluates the work of junior colleagues' (Milne 2007, p. 440), it is a complex and significant part of professional development and monitoring. One major finding has been that successful supervision is substantially linked to the supervisor-supervisee relationship (Beinart, 2012), regardless of the supervision model adopted. Additionally, the emerging consensus suggests that a 'good' supervisor-supervisee relationship embodies a safe, secure base established by a consistent, responsive supervisor sensitive to their

supervisee's needs (Beinart & Clohessy, 2009) – all of which emphasize the importance of establishing and maintaining this relationship between supervisor and supervisee. Given the numerous implications that come from establishing a sound supervisor-supervisee relationship, or lack thereof, Cliffe, Beinart, and Cooper (2010, 2016), developed the first theoretically sound and psychometrically valid instrument to measure the strength of the clinical supervision relationship. Originally developed in 2010, the Supervisory Relationship Questionnaire (SRQ) is a reliable tool designed to evaluate a supervision relationship from the perspective of the supervisee. Supervisees rate 67-items on a 7-point rating scale (i.e., strongly disagree through to strongly agree) which assess six components of the supervisor-supervisee relationship:

1. safe base,
2. structure,
3. commitment,
4. reflective education,
5. role model, and
6. formative feedback.

Examples of the statements rated in the SRQ include:

- Safe Base
    - I felt safe in my supervision sessions.
    - My supervisor was non-judgmental in supervision.
    - Supervision felt like an exchange of ideas.
    - I felt if I discussed my feelings openly with my supervisor, I would be negatively evaluated.
    - Feedback on my performance from my supervisor felt like criticism.
    - The advice I received from my supervisor was prescriptive rather than collaborative.
    - I felt able to discuss my concerns with my supervisor openly.

- Structure
    - My supervision sessions took place regularly.
    - My supervisor made sure that our supervision sessions were kept free from interruptions.
    - Supervision sessions were regularly cut short by my supervisor.
    - My supervisor and I both drew up an agenda for supervision together.

- Commitment
    - My supervisor was enthusiastic about supervising me.
    - My supervisor appeared to like supervising.
    - I felt like a burden to my supervisor.
    - My supervisor paid attention to my spoken feelings and anxieties.
    - My supervisor appeared interested in my development as a professional.

- Reflective Education
    - My supervisor drew from a number of theoretical models flexibly.
    - My supervisor gave me the opportunity to learn about a range of models.

    - My supervisor encouraged me to reflect on my practice.
    - My supervisor linked theory and clinical practice well I learned a great deal from observing my supervisor.
- Role Model
    - My supervisor was knowledgeable.
    - I respected my supervisor's skills.
    - Colleagues appeared to respect my supervisor's views.
    - My supervisor gave me practical support.
    - My supervisor was respectful of clients.
    - My supervisor appeared uninterested in his / her clients.
    - My supervisor treated his / her colleagues with respect.

- Formative Feedback
    - My supervisor gave me helpful negative feedback on my performance.
    - My supervisor was able to balance negative feedback on my performance with praise.
    - My supervisor paid attention to my level of competence.
    - My supervisor helped me identify my own learning needs.
    - As my skills and confidence grew, my supervisor adapted supervision to take this into account.

The SRQ provides much useful data that can aid in supervisor training and clinical settings, facilitate supervisee development and learning, and improve client outcomes. However, its lengthiness makes it difficult to use. Because of this the developers produced a shorter version (the Short Supervisory Relationship Questionnaire [S-SRQ]) that measures only the safe base, structure, and reflective education domains by rating18-items culled from the SRQ. The S-SRQ is a quick and accessible way for supervisees to assess the quality of their relationship with their supervisor and helps inform discussions with their supervisors on this topic.

There is also the Supervisory Relationship Measure (SRM; Pearce, Beinart, Clohessy, & Cooper, 2013) by the same developers which is a 51-item tool that measures the quality of the supervisory relationship from the supervisor's perspective using the same 7-point scale to rate statements about 5 supervisory relationship components. The following is a list of the relationship components with examples of statements for a supervisor to rate from the SRM. The S-SRQ and SRM can then be used together to engage the supervisee and supervisor in a discussion about the quality of their clinical supervision relationship.

- Safe Base
    - My trainee is open about any difficulties they are experiencing.
    - My trainee is reflective in supervision.
    - There is a good emotional atmosphere in supervision with my trainee.
    - My trainee is willing to learn new things.
    - My trainee appears able to give me honest and open feedback.
    - I like my trainee.
    - Supervision provides a safe space for my trainee to learn.
    - My trainee's style and my own style interact well.

- Supervisor Commitment
    - I keep my trainee's needs in mind.
    - I try to ensure my trainee has adequate space and resources.
    - I prepared for my trainee prior to their placement.
    - I am available and accessible to my trainee.
    - I attempt to facilitate reflection in supervision with my trainee I set up regular supervision for my trainee.
    - I give clear and honest feedback to my trainee.
- Trainee Contribution
    - My trainee is able to hold an appropriate case load.
    - My trainee appears to be doing the minimum required.
    - My trainee works hard on placement.
    - My trainee copes well with multiple demands.
    - My trainee shows poor professional values.
    - My trainee takes appropriate responsibility for their work.
    - I am disappointed by my trainee's level of skill.
- External Influences
    - My trainee tries to use supervision as therapy.
    - My trainee's past experiences of supervision interfere with our relationship.
    - My trainee has other life stressors which distract them from their work.
    - I have stressors in my life which make it difficult for me to focus on supervision.
    - I sense that my trainee worries because I am evaluating them.
    - My trainee is too anxious to engage in supervision.
- Supervisor Investment
    - I am aware of what interests my trainee.
    - I try to get to know my trainee.
    - Supervision is a safe place for me to give negative feedback.

In the case vignette about Donna and Dr. Martinson, it is possible that Dr. Martinson's approach to supervision was not developmentally appropriate. Donna is still a trainee and may still be mastering the basic skills of psychotherapy, or perhaps the skills of a new psychotherapy, and is in need of supervision that developmentally matches where she is in her training. Considering the big picture when conceptualizing cases is an advanced skill that requires teaching. Dr. Martinson, rather than being frustrated by Donna's approach, could have validated her approach to their meetings by indicating that it is developmentally appropriate to seek out supervision related to the specifics of a case, but at the same time as she is learning that, he would like to expand her training to include more sophisticated case conceptualization practices if she is open to that. This collaborative style to supervision ensures that the supervisee receives the training that they need at a developmentally appropriate level, but also allows supervisors to expand the training goals to further learning and perhaps allow for a better match of supervisor-supervisee expectations of each supervision. Some supervisors prefer to only supervise individuals who are more advanced in their training, and therefore, do not require "training" in supervision. However, it is important to note that as a supervisor, trainees come at all

different skill levels and you may have a very experienced supervisee in your supervision who has perhaps never worked with your population of choice. For example, a supervisee who has years of experience working with individuals who are depressed may need help and specific training with techniques that help individuals who have substance use disorders. Therefore, when possible, a supervisor should have some flexibility in his or her ability to match the developmental level of each supervisee.

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 (MBTI; Myers, 1962; Furnham, 2017). 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 they 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 and learn from each other, 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 or misuse of power in 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. Various models describe an *authoritative* form of supervision. These models tend to be prescriptive (i.e. they direct behavior), informative, instructional, and confrontational or challenging to supervisees. Ultimately, the goal of authoritative approaches is to encourage a more collaborative and symmetrical relationship, based on the idea of giving 'power to' rather than 'power over' (Bond & Holland, 2011). *Facilitative* supervision models tend to encourage self-exploration and are 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 – along with having a more delicate balance between both approaches. Further, it may be possible that a supervisee's preference may change based on their developmental stage.

Given the power dynamic between Dr. Martinson and Donna, who should be the one to check-in regularly about how supervision is going? Did your supervisors ask you regularly how supervision was going and how it could be improved or how it could be changed to be more helpful to the patients or to you as a supervisee? Regular assessment is helpful in psychotherapy, but is also helpful in supervision. Without regular assessment, issues like this one can arise and because Dr. Martinson is technically in a "gatekeeper" role, providing unwanted feedback about how supervision is going may have negative consequences for Donna's career. It is helpful when going into supervision to understand the power dynamics to ensure that the supervisee is comfortable talking about issues that arise both in supervision and with patients.

SUPERVISOR TASKS

Questions to consider:
What overall tasks should supervisors complete?
How important is the role of modeling?

At its fundamental core, one of the key functions of the supervisor is to construct an environment where effective supervision can take place (Lambie & Blount, 2016).This extends to include that another one of the supervisor's primary responsibilities is to mentor and teach the supervisee to help clients attain the best possible therapy result, to support the development of the supervisee's own style, to boost the supervisee's self- confidence, to help the supervisee better understand work with clients. Depending on the therapeutic orientation and supervision style this could include the supervisee's internal attitudes, thoughts, behaviors or emotions (Weck, Kaufmann, & Witthöft 2017).

The author's cited above provide a comprehensive list of supervisory tasks. These include:

- understanding the case and its conceptualization
- choosing therapeutic strategies logically resulting from case conceptualization
- making critical moments conscious, releasing blocks and blind spots in therapy
- understanding the therapeutic relationship and creating it with a particular patient
- clarifying the borders of one's competencies and realizing one's own limits
- understanding the context in which therapy is provided
- realizing countertransference in thoughts, emotions, bodily reactions, behavior and attitudes
- increasing awareness of ethical issues in therapy
- development of specific therapeutic skills
- supporting the therapist's autonomy
- caring for oneself – preventing burnout.

Despite some overlap supervision and therapy are distinctly different tasks. A good therapist/clinician does not always make for a good supervisor. There are a number of supervision-specific competencies that support excellent supervision and guidance.

Table 2 is a summary of the AAMFT Code of Ethics as it relates to supervisor responsibilities to supervisees.

TABLE 2. SUMMARY OF THE AAMFT SUPERVISOR RESPONSIBILITIES TO SUPERVISEES
Standard 4.1 Exploitation MFTs who supervise are aware of their influential positions. They avoid exploiting the trust and dependency of their supervisees. MFTs, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When there is risk of impairment or exploitation MFTs take appropriate precautions.
Standard 4.2 Therapy with Students or Supervisees MFTs do not provide therapy to current students or supervisees.
Standard 4.3 Sexual Intimacy with Students or Supervisees MFTs do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee.
Standard 4.4 Oversight of Supervisee Competence MFTs do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.
4.5 Oversight of Supervisee Professionalism MFTs take reasonable measures to ensure that services provided by supervisees are professional.
4.6 Existing Relationship with Students or Supervisees MFT supervisors make every effort to avoid conditions and multiple relationships with supervisees that could impair professional judgment or increase the risk of exploitation. Examples of such relationships include, but are not limited to, business or close personal relationships with supervisees or the supervisee's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, supervisors document the appropriate precautions taken.

4.7 Confidentiality with Supervisees
MFTs do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

4.8 Payment for Supervision
MFTs providing clinical supervision shall not enter into financial arrangements with supervisees through deceptive or exploitative practices, nor shall MFTs providing clinical supervision exert undue influence over supervisees when establishing supervision fees.

SUPERVISOR COMPETENCIES

Questions to consider:
What are the specific competencies that a supervisor should have?
Are some of these more important than others?
How should supervisors improve upon their 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 and Shafranske (2017) reported that only about 60% of interns in a recent survey indicated that they had taken coursework in supervision. In 2004, the Association of Psychology Postdoctoral and Internship Centers (APPIC) workgroup, presented these competencies at their annual conference. Table 3 summarizes their discussion.

TABLE 3. SUPERVISION COMPETENCIES FRAMEWORK	
Knowledge	
	1. Knowledge of area being supervised (psychotherapy, research, assessment, etc.)
	2. Knowledge of models, theories, modalities, and research on supervision
	3. Knowledge of professional/supervisee development (how therapists develop, etc.)
	4. Knowledge of ethics and legal issues specific to supervision
	5. Knowledge of evaluation, process outcome
	6. Awareness and knowledge of diversity in all of its forms

Skills	
	1. Supervision modalities
	2. Relationship skills – ability to build supervisory relationship/alliance
	3. Sensitivity to multiple roles with supervisee and ability to perform and balance multiple roles
	4. Ability to provide effective formative and summative feedback
	5. Ability to promote growth and self-assessment in the trainee
	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	
	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

Assessment of Supervision Competencies (continued)	
	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

CSAT (2007) generated a list of clinical supervision competencies and identified them under two major headings: foundation areas and performance domains.

Foundation areas identify the broad knowledge and concepts essential to supervisory proficiency. The competencies representing these foundations of supervision are grouped into five areas:

1. Theories, Roles, and Modalities of Clinical Supervision:

   Clinical supervision has its own knowledge base, and supervisors must understand different theoretical perspectives. They also must understand the roles clinical supervisors are expected to fill and the various modalities, or ways of implementing supervision, that are available.

2. Leadership:

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

3. Supervisory Alliance:

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

4. Critical Thinking:

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

5. Organizational Management and Administration.

   Almost all clinical supervisors have responsibility for some management and administrative activities, but the scope of these activities can vary widely depending on the organization.

Performance domains identify the specific responsibilities and abilities essential to protecting client welfare, improving clinical services, developing a competent staff, and fulfilling an organization's mission and goals. The competencies relating to these specifics of supervisory practice are also grouped into five domains:

1. Counselor Development:

   Counselor development is a complex process that involves teaching, facilitating, collaborating, and supporting counselor self-efficacy. Supervisors must facilitate this process in the context of a collaborative supervisor–supervisee relationship and within professional, ethical, and legal guidelines. Supervisors also must consistently maintain a multicultural perspective.

2. Professional and Ethical Standards:

   Supervisors work in a complex environment subject to professional, statutory, and regulatory guidelines. The necessary competencies are related to protecting the public, clients, and staff members including the development of supervisors' professional identity and integrity in the context of professional supervisory practice.

3. Program Development and Quality Assurance:

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

4. Performance Evaluation:

   It is a professional and ethical responsibility of clinical supervisors to regularly monitor the quality of supervisees' performance, to facilitate improvement in supervisees' clinical competence, and to assess supervisees' readiness to practice with increasing autonomy.

5. Administration:

   Clinical supervisors' administrative responsibilities are the executive functions of the position, those duties that help the organization run smoothly and efficiently. Administrative responsibilities include following the organization's policies and procedures (including those related to human resource management), ensuring the maintenance of case records, monitoring case documentation, assisting in financial resource development (e.g., grant proposal writing), and developing relationships with referral sources in the community. Many competencies in this domain overlap

significantly with clinical skills and serve to ensure the quality of services being delivered within the agency. As noted previously, the range of administrative functions clinical supervisors are responsible for will vary from setting to setting.

See Substance Abuse and Mental Health Services Administration (SAMHSA) CSAT TAP 21-A *Competencies for Substance Abuse Treatment Clinical Supervisors* for their full discussion on the necessary competencies of clinical supervisors and guidelines for credentialing at state and agency levels.

SUPERVISOR BEHAVIORS

Questions to consider:
Are there specific behaviors that help the supervisor/supervisee relationship?
Are there specific behaviors that hinder the supervisor/supervisee relationship?
What can the supervisor/supervisee dyad do to address these behaviors?

The above recommendations begin our discussion, and this section further outlines the behaviors that make for an effective supervisor/supervisee relationship. Think back to your own experiences in supervision. If you are like most clinicians you have worked with several supervisors, some more effectively than others.

There are three main dimensions of competent supervision, including: foundational (broad knowledge of the provision of therapy), functional (the skills necessary to implement form of therapy), and developmental (the cumulative effects of supervision provision). In addition, Falender and Shafrankse (2017), have written extensively about clinical supervision, and have delineated essential components of clinical supervision, which include:

- Interpersonal competence – such as the utilization of communication and relationship building skills (i.e. empathy & respect).
- Transparency regarding the hierarchical nature of supervision, and clearly outlining responsibilities of both the supervisor and supervisee.
- Collaborative development of supervision goals and the processes to be utilized to attain these training goals.
- An environment that is safe for learning, particularly during the observation and evaluation of supervisee metacompetencies.

- Attention to the personal factors that influence the supervisee/supervisor relationship – along with attending to the legal and ethical aspects of client care.

- Facilitation of continuous learning and professional development that are adherent to the competency model of supervision.

- Attention to diversity, multiculturalism of the supervisee in their work with diverse populations.

- A good sense of humor.

Case Vignette

Anna is a supervisor for a large community health agency. Her supervisee Caren appreciates the attentive and thoughtful supervision Anna offers. Most recently, Anna saw a flyer for an upcoming Dialectical Behavior Therapy (DBT) training which was offered by a different part of the agency. Knowing of Caren's interest in learning about DBT, Anna contacted the presenter to ask if Caren could attend. Caren did, and while she learned a lot, she equally appreciated the steps that Anna had taken, and the investment in her development.

Similarly, Herbert & Caldwell (2015), have identified key behaviors that constitute poor clinical supervision. These include:

- Perceived disinterest (i.e. canceling supervision meetings, providing irrelevant feedback)
- Unprofessional behaviors (e.g., apathy, gossiping, high absenteeism)
- "Taking over" for supervisee during co-counseling sessions

Other behaviors that are related to poor supervisory behavior include:

- Dogmatic
- Closed minded
- Defensive
- Dishonest
- Unaccountable
- Prejudiced
- Intolerant
- Inflexible
- Arrogant
- Critical
- Disorganized
- Neglectful
- Untrustworthy
- Poor at setting boundaries

It should be noted that behaviors that are problematic may differ based on the developmental stage of the supervisee. For example, when supervisees are seeing their first patient ever, it may be worthwhile to be more encouraging rather than critical at that time. New clinicians can experience a lot of anxiety related to seeing their first patient and may be more likely to be self-critical and additional critical feedback from a supervisor can be extremely discouraging. Of course, critical feedback is needed to improve and if there are any problematic or endangering behaviors being exhibited by the supervisee. However, the supervisor's influence on the supervisee's behaviors and skills may have a differential affect based on the developmental stage of the supervisee.

SUPERVISEE OBJECTIVES

Questions to consider:
What are the skills and objectives that the supervisee needs to develop as a result of the supervision process?
Will these goals vary from supervisee to supervisee? Remain consistent?
Will these goals vary from supervisor to supervisor? Remain consistent?

The information shared in the prior section provides a template for supervision competencies. But, what about supervisee objectives?

Corey, Haynes, Moulton, and Muratori (2014) list features that contribute to personal and professional development of supervisees. These include:

- knowledge about counseling theories, methods and practice
- a broad understanding of diagnosis and treatment methods
- awareness of the limits of personal competence and when to seek supervisory support
- development of skills that generate empathy, compassion and genuineness
- awareness of how personal issues affect clinical work
- identification of clients who are easy or difficult to work with
- knowledge about how to recognize and work with client resistance
- access and exposure to the relevant ethical codes of the professions and application of these codes when needed
- sound judgment and clear decision making regarding ethical decisions
- directed awareness of how multicultural issues influence therapy
- the ability to examine one's personal role as a counselor
- acquired self-confidence and competence with increased practice
- development of one's personal style of counseling
- development of self-evaluation skills

Each supervisee may have different objectives with different patients or at different developmental stages. For example, a new supervisee may be focused on ensuring that they are able to acquire self-confidence and competence as well as developing skills, while a more seasoned supervisee may be more focused on broader issues related to one's personal style, and different case conceptualization and theoretical models. It is important to regularly check in on the goals of the supervisee, as they may change from patient to patient, or even from one week to the next. For example, it is possible that the supervisee is focused on learning how to work with client resistance, but the client could bring up an issue that is personally affecting the supervisee so the supervisee and supervisor may switch goals in their supervision session to address learning how to cope with personal issues during a client session. Therefore, regular check-ins and assessment regarding supervisee objectives is essential.

SUPERVISION APPROACHES

Questions to consider:
How varied have your own experiences of supervision been?
How much training in the provision of supervision have you received?
How active or inactive a supervisor are you?
On what factors do you believe you base your supervision approach?
How does your approach to supervision vary based on trainee knowledge and experience?
How has your approach to supervision changed over time?

There are a number of ways to approach the supervision process. Falender and Shafranske (2017) 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 Approaches

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 (Sarnat, 2016; Diener & Mesrie, 2016); psychoanalytic (Langs, 2018) person-centered (Tangen, Borders, & Fickling, 2019); cognitive-behavioral (Bearman, Schneirderman, & Zoloth, 2017); solution-focused (Dewane, 2015); and feminist multicultural (Brown, 2016). 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 may utilize Beck's principles of cognitive therapy and apply it to the supervisory process. Shaffer and Friedlander (2017) summarize that cognitive-behavioral supervisors use a structured, problem-solving approach, are active and directive and make use of assignments, whereas psychodynamic supervisors may be more likely to explore affective reactions and the subjective experiences of the supervisee.

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) (Stein, 2017) to the counseling process (Bernard & Goodyear, 2014; Bernard & Luke, 2015). Counseling theories provide concepts for explaining human behavior and interventions for promoting positive change (Sharf, 2015), and offer useful guides for conceptualizing client situations, as well as choosing and implementing interventions.

Additionally, theorists have looked at disadvantages of psychotherapy-based approaches. For instance, Bernard and Goodyear (2015), who are pioneers in the field of psychotherapy supervision, summarized advantages and disadvantages of psychotherapy-based supervision models. When the supervisee and supervisor share the same orientation, theory is more integrated into the training and modeling is maximized as the supervisor. When orientations clash, conflict or parallel process issues may predominate. Thus, a match between supervisor and supervisee theoretical orientation may be needed to ensure the success of psychotherapy-based supervision models.

Psychodynamic Approaches

Psychodynamic supervision is a form of psychotherapy supervision. Psychodynamic approach in psychotherapy has been losing a dominant position in the last decades, although many traditional programs continue to look at ways to make psychodynamic theory, and supervision, relevant to today by ensuring only evidence-based psychodynamic practices are taught and implemented with patients.

The term "psychodynamic" envelops great number of theoretical conceptualizations. Perhaps the most important element of psychodynamic approaches is the idea that human behavior is rooted in unconscious motivations. The other major tenet is the importance of early childhood development and presumption of the formative role of early childhood.

Psychodynamic supervision draws on the key pillars of psychodynamic therapy: affective reactions, defense mechanisms, transference and countertransference.

Dr. Joan Sarnat (2016) classifies psychodynamic supervision into three categories: patient-centered, supervisee-centered, and supervisory-matrix-centered:

- **Patient-centered supervision** focuses discussions on the patient's presentation and behaviors. The supervisor's role is didactic, with the goal of helping the supervisee understand and treat the patient. The supervisor is seen as the authority that has the knowledge and skills to assist the supervisee. The supervisor should also support and direct her/his colleagues work using professional methods, external monitoring, feed-back information, assessment and references to empirical and theoretical knowledge.

- **Supervisee-centered supervision** focuses on the content and process of the supervisee's experience as a therapist, which includes addressing anxiety, resistance, and supervisee learning difficulties (Lambie & Blount, 2016). Since the supervisee is the center of attention, this approach tends to be less didactic and more experiential (Falender & Shafranske, 2017). It should be noted that one of the advantages to this approach also happens to be one of its limitations. Specifically, in that the supervisee gains understanding of their own psychological processes, however it is subject to stress because of the close examination (Sarnat, 2016). It also may be difficult for new supervisees to engage in this type of supervision because it does not necessarily focus on the teaching the needed new skills required to see a first patient. Therefore, it is again imperative that this supervisee-centered supervision matches the developmental stage of the supervisee.

- **Supervisory-matrix-centered supervision** not only attends to material of the client and the supervisee, but also introduces examination of the relationship between supervisor and supervisee. In this supervisory model, the supervisor is more centrally integrated, no longer having a role of the uninvolved expert. This approach tends to be relational where the supervisor "participates in, reflects upon, and processes enactments, and to interprets relational themes that arise within either the therapeutic or supervisory dyads" (Smith, 2009; Bohall & Bautista, 2017). This also includes an examination of parallel process, which is defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Corey, Haynes, Moulton, & Muratori, 2014). Many supervisors that adhere to this model believe that addressing any issues in the supervisor-supervisee relationship will translate to addressing issues in the supervisee-client relationship over time.

Psychodynamic supervision has also been applied to group settings (Hilsenroth, Kivlighan Jr., & Slavin-Mulford, 2015; Weck, Kaufmann, & Witthöft, 2017).

The purpose of group supervision will be discussed later in this learning material, but in terms of psychodynamic supervision, Laverdière, Beaulieu-Tremblay, Descôteaux, and Simard (2018) makes the distinction between *direct countertransference*, induced by the client as a reaction to client behavior, and *indirect countertransference*, reactions that appear only in the counselor and have their origins in the counselor's unresolved issues - with the power of the group being in its ability to identify countertransference as objective or subjective.

Person-Centered Approaches

Supervision was a central concern of Carl Rogers, the father of person-centered therapy. The key tenet of person-centered therapy is the belief that the client has the capacity to effectively resolve life problems without interpretation and direction from the therapist (Carruth & Field, 2016). Similarly, 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 supervisees can be open to experience and fully engaged with clients (Bryant-Jeffries, 2017). The supervisory relationship is based upon trust, empathy, warmth, and genuineness.

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” (Bryant-Jeffries, 2017) Zoffmann and colleagues (2016), proport that the person-centered supervisor "*has no other concern, no other agenda than to facilitate the therapist's ability to be open to her experience so that she can become fully present and engaged in a relationship with the client*.” The person-centered supervisor accepts the supervisee as a person *in-process* and trusts the supervisee's potential for growth.

This approach was one of the first to use recorded interviews and transcripts within supervision. The following statements and questions would be examples of a person-centered supervisor's work with a supervisee:

- Talk to me about what it was like for you during your session with that client.
- I encourage you to trust your own thinking more.
- If you did know how to work with this client, what would that look like?
- What was really important to you in your session with your client today?
- Tell me about the type of relationship you are trying to establish with your client.
- How well do you think you understand your client?
- What would you like to accomplish in today's supervision session?

Person-centered approaches, specifically that of Motivational Interviewing is of particular importance to those supervising within the field of substance abuse. Motivational Interviewing (MI) is an evidence-based program that has demonstrated its effectiveness to treat substance use disorders (Miller & Rollnick, 2013).

Some critics of using Person-Centered Supervision approaches have urged caution in that it can be difficult to evaluate the effectiveness of supervision. To address these concerns, Martino and colleagues (2016) determined that the competency-based approach of supervision for MI, called Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA: STEP) was an effective supervisory approach. Most interestingly, it was found that the clinicians who were supervised with MIA-STEP significantly increased their MI knowledge, skills, and competency, compared to those who received supervision as usual (Martino, et al., 2016). In other words, clinicians that were supervised using this competency-based model were better at using the skills necessary to effectively deliver MI than were their peers. This raises interesting questions about the future development of supervisory models, and how their effectiveness can impact clinicians and the populations treated.

This type of supervisory model would likely not be effective if a supervisee's objective is to learn a new type of evidence-based treatment. However, like all other supervisory models, it can be paired with other models to match the needs of the supervisee. As previously mentioned, it is critical that the supervisor is flexible in matching the needs of the supervisee or the relationship will likely not be fruitful in terms of supervisee learning. Therefore, the spirit of the person-centered approach could be intertwined with other approaches from time to time if needed within a supervisory relationship over time.

Solution-Focused Supervision

Solution-focused supervision is based on a brief form of psychotherapy developed by de Shazer (1985) that is most well-known for the *miracle question* from which many variants have been created. As a psychotherapy, the principles of a solution-focused approach emphasize competence, strength, a focus on the future, and possibility (Dewane, 2015; Thomas, 2013). It attempts to build upon what is already working to create solutions, rather than in-depth examination of problems or problem solving. In solution-focused psychotherapy clients are viewed as experts on their own situation; in solution-focused supervision supervisees determine their own goals and pathways to meeting those goals. Supervisors would then:

- identify what is working well already and increase those actions
- emphasize what is possible rather than explore the genesis of what's not going well
- flag what is not working and find ways to do something different.
- guide supervisees through the miracle question (i.e., imagining that their problem was miraculously resolved – what would that look like, how would the supervisee know it, and what would be different?)

Solution-focused supervision is a useful collaborative approach that fosters clinical and professional development in the supervisee. The approach can be used in two ways: a.) as time-specific, over the length of a supervisory relationship, or b.) as session-specific, in any one individual or group supervisory session (Dewane, 2015). Because of its flexibility it can also be combined with other supervision methods.

Solution-focused supervisors would ask the following questions of supervisees to help them set their goals:

- "In three months from now what will be different about your style of working?" (a fast-forwarding question);
- "What would be the most useful focus for our supervision meeting today?" (for a supervisor setting a session-specific goal);
- "I'd like to learn how to help my client manage her reactivity by practicing DBT skills in our next session" (for a supervisee setting a short-term, session-specific goal);

- “What are you doing differently when you are more attuned to nonverbal behaviors?" (a supervisor's response; this technique of highlighting exceptions can lead the supervisee to build on what's already working);
- "By the end of this semester, I'd like to be more confident using in vivo exposures." (for a supervisee setting a long-term goal);
- "What would be the first thing you noticed if you were more confident?" (a solution-focused supervisor might respond to the long-term goal);
- "If you woke up tomorrow and by some miracle you were the confident worker/counselor you aspire to be, what would be the first thing you notice?" (a variant on the miracle question).
  (Dewane, 2015)

There are a multitude of solution-focused supervision practices and techniques (see Thomas 2013). The following describes a sample of those identified by Thomas (2013, 2016), with special attention paid to those that are hallmark elements of the approach as a way of distinguishing it from other supervision types.

Highlighting successes and exceptions - Learning from success is crucial, and highlighting what works and building on it can start with the following questions. Finding exceptions is one of the hallmark techniques of solution-focused approaches. Finding exceptions is useful in switching from a problem saturated focus, to exploration of the context of when things are going right.

- "What's going well with your case? In what ways have you been successful?"
- "What's the best thing that you did in your work since we last met?"
- "How did you manage to be successful despite your client’s challenges? What did you do?”
- “What did you do to make the exchange better?”
- “I wonder what is different or what is happening that allows your client to engage more fully.”

Complimenting - Complimenting is another hallmark technique of a solution-focused approach that can be done directly, indirectly, or self-reflectively.

- Direct complimenting identifies progress or remarks on positively on the supervisee’s work (e.g., “I can tell you have been able to be more present with your clients and not as distracted by your performance anxiety”, “Your professionalism really shined during your presentation in the team meeting yesterday”)

- Indirect complimenting encourages supervisees to identify their own strengths by using speculation, inquiry, and critical analysis (e.g., "This client seems so shut down. How are you able to stay engaged with her?", “Your client is so angry right now, what did you do to demonstrate that you could tolerate his affect?”

- Self-complimenting draws on an essential principle in a solution-focused approach where the supervisor operates from a stance that the supervisee is the "expert". The supervisor directs attention to the supervisee's experiences and the meaning the supervisee assigns those experiences. Asking questions that probe their change processes, progress toward goals, and moments of pride allows reflections on events that are too often easily dismissed.

Hedging – Hedging is a mindset and a tentative type of indirect and relationship building communication. Using tentative language captures *not-knowing* among other practices important to this supervision approach. It is curious and exploratory, facilitates respectful feedback and reduces defensiveness. Consider the following example:

Supervisee: "The client doesn't do any talking, so I end up doing all of it!"

Supervisor: "Doing all the talking is one way to manage it. I wonder what other options are for you the next time you are with this client and she doesn't talk or respond to any of your prompts to engage her?"

Other follow up phrases may be used with a tentative tone puts forth a not-knowing stance and facilitates a collaboration between the supervisor and supervisee. These include such starters as, "It seems like …," "Could it be …?" "It sounds like …," "Perhaps …," "I am not sure …," "I could be wrong, but I think probably…." or "I wonder …". All of these allows a supervisee to respond with questions, their own ideas, and co-constructed dialogue; further it invites different viewpoints, opinions, alternatives, and even disagreement (Thomas, 2015).

Using *suppose* is related to hedging, but helps to refocus on the future possibilities. Examples for using suppose include:

"Suppose the client thought your relationship had improved. What might she notice you doing differently?"

"Suppose these problems in the therapy were behind you. What would you be doing differently in that case than what you are doing now?"

Assuming Good Intentions -This technique gives supervisees the benefit of the doubt and starts from a position that supervisees are doing the best they can. This is in contrast to pathologizing or attributing a supervisee's challenging behavior to noncompliance or personality problems. For example, a supervisor might ask: "So it may be that I am not totally seeing this situation from your perspective. You must have a very good reason to that you are reticent to be more direct with your client. Can you tell me what that is?" If the supervisee can't identify a good reason, they can be prompted to think about what their good reason is and share this next during the next supervision session. In a solution can still be engendered using different techniques without knowing reasons for the behavior.

Being future-focused - Focusing on the future is another cornerstone of a solution-focused approach. Supervisees are commonly able to easily identify what they don't want, but have a harder time being clear about what they do want. The solution-focused supervisor will ask questions that identify what is desired in the future. These questions determine more than just what the supervisee doesn't want - which is an orientation focused on the past or current situation (i.e., what they have now). The supervisor helps the supervisee determine what she or he wants in the future and then directs the discussion toward that might be achieved.

Promoting self-supervision - As supervisees become more confident, encouraging self-supervision is appropriate. Thomas (2013) refers to this approach as an internal check and balance. Questions might be along the lines of: "As you think about this later, consider what you might do next time;" or, "How could you continue to learn from this situation?"

Inviting feedback - Since solution-focused supervision is collaborative, supervisors using this about are expected to evaluate their own work in supervision. As described earlier in this learning material supervisors can obtain formal feedback by using assessment instruments such as the SRQ. More informally, supervisors can gauge how the supervision is going by revisiting the goals originally. For example, supervisors could ask variations on these prompts:

"Are we on target?"
"What else could we do?"
"What would have to happen for us to get closer to meeting this goal?"

Above all else, solution-focused supervision is curious and respectful. When inviting feedback questions that get to the practical (pragmatic) aspect of learning would resemble the following:

"What did you get from our supervision today?"
"Did you get any tools today?"
"Is there another direction we should take?
"Am I missing something?"
"When do you feel your experience is valued during supervision?"
"Can you think of a time when you felt respected in supervision?"
"Has there ever been a time where you felt that I pushed my own view over yours?"

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 (Brown, 2016). 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 thought to be a result of psychological weaknesses in women are instead viewed as a result of encountering more stress because of sexist practices in our culture (Fickling & Tangen, 2017; Brown, 2016). The goal of Feminist therapy as well as Feminist Supervision, is the empowerment of the client.

Research has emphasized the many complexities of power in Feminist Multicultural Psychotherapy Supervision, stressing the need for both supervisees and supervisors to acknowledge power differentials in the client-therapist relationship (Arczynski & Morrow, 2017). The Ethical Guidelines for Feminist Therapists (Feminist Therapy Institute, 2008) 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, 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

In CBT views supervision as systematic cooperation between the supervisee and the supervisor, aimed at improving the therapeutic competencies of the therapist when working with particular clients

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.

The supervision of Cognitive-Behavioral Therapy is conceptualized as the transfer of knowledge about and practice of the key skills that a therapist may put into psychotherapy. This not only includes knowing 'what' to say, but 'how' to say it. Most skills are taught both in training and supervision and supervisees first learn the rationale for a skill; they watch experts, and model what they have learned in practice with undulating degrees of difficulty. Once trainees have the necessary skills, they can then be supervised with actual clients in a setting of "real world "(Sudak, 2016). Cognitive behavioral supervision also provides supervision on developing case conceptualizations based on cognitive behavioral theories, and these theories may also be used to explain client-supervisee interactions.

Cognitive-behavioral supervision stresses observable cognitions and behaviors such as the supervisee's reaction to the client (Rakovshik, McManus, Vazquez-Montez, Muse, & Ougrin, 2016). Supervision techniques include setting an agenda for supervision sessions, bridging from previous sessions, assigning homework to the supervisee, and capsule summaries by the supervisor (Rousmaniere, 2016).

In cognitive-behavioral supervision the supervisor plays several roles. For example, the role of consultant involves acting as a facilitator and guide. For example, the cognitive-behavioral supervisor may ask (Sudak, Codd, Ludgate, Reiser, Milne, Sokol, & Fox, 2015):

- Tell me about the work you did together in your last session with this client. What were some of your client's reactions to your attempts to examine her thoughts?
- How might some of your client's thought patterns be contributing to this stuck feeling?
- To what degree is your work together coinciding with the treatment plan?
- What do you think about reviewing the treatment plan with your client and evaluating the degree to which goals are being met or need to be revised?

Additionally, there are several other components to cognitive-behavioral supervision. Alfonsson, Parling, Spännargård Andersson, and Lundgren (2018) lists several tasks for supervisors/supervisees using a cognitive behavioral approach. These include:

1. Formulate cases according to the cognitive model for various disorders
2. Develop a strong, active, collaborative therapeutic alliance
3. Employ a cognitive conceptualization to plan treatment within sessions and across sessions
4. Monitor progress on an ongoing basis
5. Structure sessions to maximize progress
6. Focus on helping patients solve or cope with current problems and achieve their goals, using a variety of techniques
7. Identify and help patients modify their key dysfunctional cognitions
8. Facilitate behavioral change
9. Work directly on treatment compliance

Behavioral Supervision

Another psychotherapy model-based supervision approach is behavioral supervision (Leddick & Bernard, 1980). Behavioral supervisors view client problems as learning problems (Carrola, DeMatthews, Shin, & Corbin-Burdick, 2016). In this type of supervision, behavioral principals are instilled throughout. For example, if the supervisee is having difficulties acquiring a new skill, theories of learning can be applied including principals of reinforcement or social modeling. Supervisors naturally provide reinforcement and punishment throughout the supervision relationship, no matter the approach to supervision. Within behavioral supervision, these sets of reinforcement and punishment are used to improve the skillset of the supervisee. Further, modeling behavior and watching other therapists can allow for social learning to occur. Again, this is used throughout other forms of supervision but it is more planned and purposeful within behavioral supervision. Supervisors within this approach may look for functional reasons why a supervisee is behaving a specific way. For example, if a supervisee is working with a client who has posttraumatic stress disorder, the client may inadvertently reinforce the supervisee when they avoid discussing the traumatic experience. However, because the very treatment for posttraumatic disorder is to approach the traumatic experience rather than avoid it, it is the job of the therapist to ensure that the traumatic experience is approached at the very least during the therapy session. A supervisor using a behavioral approach to supervision would likely want to call attention to this when it occurs, and reinforce the supervisee when they approach the traumatic experience even when they are being punished in session by the patient. This can help off-set the reinforcement contingencies that are being placed on the supervisee during the therapeutic session. However, it may be too difficult for the supervisee to naturally engage in that behavior because the in-session contingency may be too strong. Therefore, the supervisor at that time may need to use reinforcement of successive approximations, so providing reinforcement at *any* movement *towards* approaching, and then slowly increasing reinforcement as more approaching is done in session towards talking about the traumatic

experience. Alternatively, the supervisor and supervisee can role play different ways for the supervisee to respond, and when engaging in the role play the supervisor can provide reinforcement. It should be noted that reinforcement within a supervisory relationship can be very simple, it can include smiling, saying "WOW! THAT WAS AMAZING!", and simple positive gestures. In this approach, supervisors can also participate as co-therapists to maximize modeling and increase the proximity of reinforcement.

Developmental Approaches

Developmental approaches, such as McNeill and Stoltenberg (2016), understand that each counselor goes through different stages of development and recognize that movement through these stages is not always linear and can be affected by changes in assignment, setting, and population served. Developmental models look at supervisee development from novice to expert, each stage consisting of unique characteristics and skills. Typical development in beginning supervisees would find it normative for them 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.

Clinical supervisors using this approach are in a position to recognize that each supervisee enters the supervision relationship with a unique set of skills, with diverse backgrounds, levels of knowledge, and experience. Given that, supervisors are in a position to aid supervisees in developing a greater sense of awareness, support autonomy, and maintain motivation as they go through the developmental phases of training (McNeil & Stoltenberg, 2016).

Various paradigms or classifications of developmental stages of clinicians have been developed (Barrio Minton, Myers, & Paredes, 2016; Ivey & Digilio, 2016; Skovholt, 2017; Allan, McLuckie, & Hoffecker, 2016). This most popular of these models, which is adopted most frequently is the Integrated Developmental Model (IDM) of (McNeill & Stoltenberg, 2016). This schema uses a three-stage approach, which occur across the development of new clinicians. These structures include, awareness (self and other), motivation, and dependency-autonomy. The three stages of development have different characteristics and appropriate supervisory methods.

Solomon (2009), highlights three levels of counselor development under developmental models of supervision. Broadly, these can be summarized as follows: 1.) supervisee has limited training and experience with supervision (i.e. case conceptualization, treatment planning, etc.); 2.) supervisee begins responding to structured supervisory practices introduced in level 1; 3.) supervisee begins to develop a personalized approach to counseling – understanding and utilizing "self" within therapy; 3i). supervisee has reached level three across all domains (i.e. self-other awareness, motivation,

autonomy), and has developed a style of counseling where they exhibit high levels of awareness and personal competency.

McNeill and Stoltenberg (2016) 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.

Additionally, a number of models (e.g., O'Donovan, Clough, & Petch, 2017; Watkins, Davis, & Callahan, 2018) apply developmental stage models to supervisor development. Similar to Solomon's (2009) Supervisee Developmental Model, O'Donovan, Clough, & Petch (2017) developed a three-level Supervisor Development Model, which is broken down as follows:

Level 1: Supervisor is highly anxious, confused, and concerned about providing the "right" supervision; supervisor tends to resort to "flight into structure"; tends to draw on past supervisee experiences for direction.

Level 2: Supervisor is conflicted, confused, frustrated; there is a tendency for fluctuations in motivation and affectivity. There is also an assertion of autonomy with lapses into dependency.

Level 3: Supervisor motivation typically tends to be more consistent, with the supervisor being more autonomous, comfortable, and committed. Supervisor is able to be engaged in realistic self-appraisals – and able to consult with colleagues on an "as-needed" basis.

Level 3i: Supervisor reaches "Master Supervisor" level. Highly skilled and integrated. Supervisor is able to effectively work and collaborate with a wide array of supervisees.

Skovholt and Rønnestad's (2016) model identifies themes of counselor development. These 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. During this analysis 14 themes of counselor development were identified.

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 and then back to internal. During formal training, the supervisee drops an earlier reliance on internal, personal beliefs about helping and instead relies on 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. Their later shift is to increasingly develop "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, Colin, and Reese House (1998) describe the synthesized supervision model, a subset of the developmental approaches to supervision, and which focuses on increasing personal reflectivity in the trainee. The concept of reflectivity will be discussed in more detail later in these materials. Their literature review revealed qualities of professional reflectivity were illustrated and stressed as necessary for trainees to adopt in the forms of 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, Colin, and Reese House (1998) further describe 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 focus primarily on the skills and learning needs of the supervisee and on setting goals that are **s**pecific, **m**easurable, **a**ttainable, **r**ealistic, and **t**imely (SMART). They construct and implement strategies to accomplish these goals. The key strategies of competency-based models include applying social learning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using various supervisory functions (teaching, consulting, and counseling). In addition, these 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 & Goodyear, 2019), the *Systems Approach* (Holloway, 2016), and the Task-Oriented Model (Simpson-Southward, Waller, & Hardy, 2017). Process-based models provide a framework for understanding the interconnected factors within supervision.

Discrimination Model

Bernard and Goodyear (2019) 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 identifies 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. Followers of this model have suggested a fourth category, which is not in the original theory. 4) Professional Behaviors: How the trainee "acts" and attends to professional issues such as ethics, dress, paperwork, etc.

Additionally, this model advocates giving attention to supervisory roles with three areas of focus.

- Supervisors might take on a role of "teacher" when they directly lecture, instruct, and inform the supervisee.
- Supervisors may act as "counselors" when they assist supervisees in identifying their own "blind spots" or countertransference process etc.
- Supervisors can act in a "consultant" role to colleagues when offering supportive guidance.

The purpose of these roles is to support clear boundaries and avoid role ambiguity.

Systems Approach

Holloway's (2016) 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 Approaches

Integrative models of supervision rely on more than one theory and technique (Salvador, 2016). Given the large number of theories and methods that exist with respect to supervision, an infinite number of "integrations" are possible. Corey, Haynes, Moulton, and Muratori (2014) 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 (Lazarus, 2015).

The *Common Factors* models of supervision bridge the various approaches to supervision by identifying the essential components that are shared across models, such as the supervisory relationship, the provision of feedback, and supervisee acquisition of new knowledge and skills (Watkins, Budge, & Callahan, 2015). Common factors approaches to supervision draw on psychotherapy outcomes research, aiming to extrapolate common factors of counseling and psychotherapy—such as the therapeutic relationship and the instillation of hope—to clinical supervision approaches (Watkins, Budge, & Callahan, 2015).

Among the most influential common factors approaches is Lambert's model of therapeutic factors (see Crunk & Barden, 2017; Stein, 2017). Lambert and Barley (2001) presented four primary factors that are shared among therapeutic approaches (with the percentage that each factor contributes to therapy outcome (a) *extratherapeutic factors* (i.e., factors associated with the client, as well as his or her environment; 40%); (b) *common factors* (i.e., relationship factors such as empathy, warmth, positive regard, supporting the client in taking risks; 30%); (c) *placebo, hope, and expectancy factors* (i.e., the client's hope and expectancy for improvement, as well as trust in the treatment; 15%); and (d) *skills/ techniques factors* (i.e., components specific to various therapies, such as empty chair or relaxation techniques; 15%).

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?

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. It is also necessary to consider the role of secondary parties, such as the agency where treatment is received and the role of a sponsoring university.

The Client

The definition of "client" is the person or system that seeks change for the purpose of relieving distress or solving problems. 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. He or she must also be open to learning from the supervisor techniques to help support the client. Morrissey (2015) suggests that the 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, Ellis, Hutman, & Chapin (2015) examine supervisees who are experiencing significant levels of anxiety and which are impeding the client from reaching his or her goals. They assert that it is difficult to provide a supportive learning environment while still being certain that the client will be helped. Given this, it is important for supervisors to quickly become aware of the supervisee's issues and helping them with the anxiety. In the event that the anxiety continues 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. 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.

It is also important to note that the supervisor can have a profound impact on the safety of the supervisee. For example, there can be situations in which the client can harm the supervisee in the form of sexual harassment, racial/ethnic discriminatory behaviors, and physical aggression. Although physical aggression is more rare, sexual harassment and racial/ethnic discriminatory behaviors are more common experiences within a therapeutic

relationship. Therefore, it is the responsibility of the supervisor to help guide the supervisee navigate these situations in a way that does not compound the sexual harassment or discrimination. For example, if a female supervisee tells a male supervisor about an experience of sexual harassment that was perpetrated by the client, it is possible for the male supervisor to dismiss this, thereby compounding the effect of the harassment that has occurred and allowing the supervisee to be harmed. It is the responsibility of the supervisor to not only protect the client from the supervisee, but also the supervisee from the client.

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 and Wallerstein (1958) as the therapist's *professional identity*. An important factor in developing this professional identity is the trainee's association with and mentoring by seasoned professionals. The supervisor's role as a "gatekeeper" of the profession is continually in play irrespective of the supervisor's function in the supervisee's professional life (e.g., as trainer, administrative supervisor, consultant).

ATTENDING TO 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 mentoring 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, 2019).

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 a review of trainee experiences of ethical issues within clinical practice, Sinclair, Papps, and Marshall (2016) interviewed trainees about specific ethical dilemmas they faced. In these cases, over two-thirds of respondents experienced breaches of client confidentiality, privacy, dignity, and respect. 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. Levitt, Farry, and Mazzarella (2015) 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 American Counselor Association (ACA) has developed a set of ethical guidelines for counseling supervisors that has recently been incorporated into the 2014 ACA Ethical Code. (See Table 1)

Ethical Issues 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*. Informed consent is important for several reasons, including that: clients are entitled to know and agree to what processes support quality treatment, who will be reviewing information about them, and how this information will be used; supervisees are entitled to know how their work will be evaluated, the process of the supervision, and how this information will be used to support both quality care and their professional development; and, the administration is entitled to know that supervisory processes are articulated to support quality care and address legal and ethical standards.

According to the Association for Counselor Education and Supervision (ACES) Ethical Guidelines for Counseling Supervisors (retrieved from: http://www.saces.org/resources/documents/aces_best_practices.doc), "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 learning material, a brief summary of the components of the informed consent contract follow.

- A Professional Disclosure, listing supervisor credentials (training, specialties) and counseling modalities.

- Delineation of what the supervisor will provide and the 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).

- Description 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).
- Discussion of confidentiality. Because supervisees know that the client-therapist relationship is confidential, they may assume that what is said within the context of supervision is confidential, but that is not typically true given the evaluatory role of supervisors. Therefore, this should be explicitly discussed as it is within a therapeutic setting.
- Logistics of supervision and information about the supervisor and supervisee relationship (e.g., expectations as related to goals, autonomy, teamwork). In addition to the supervisor contract, Falender and Shafranske (2017) provide a supervisee form entitled the Working Alliance Inventory, which is very helpful in assessing the supervisory relationship.

- Supervisee evaluation will be discussed later in this learning material; however, an informed consent contract for supervision should 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.

- It is also important to discuss how disagreements will be resolved. Means to address disagreements is described below.

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.

Some of the components of due process are:

- The supervisee or student should be apprised of the academic requirements and program regulations.
- The supervisee or student should receive notice of any deficiencies.
- The supervisee or student should be evaluated regularly.
- The supervisee or student should have an opportunity to be heard.

Vicarious Responsibility

In addition to being aware of ethical issues, supervisors should also be aware that there are legal implications attached to their role as 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 or if ethical violations occur. Polychronis and Brown (2016) term this as *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].

Helpful resources on legal and ethical issues for supervisors include: Sarnat (2016), Jacob, Decker, & Lugg (2016), O'Donoghue & O'Donoghue (2019), and Egan, Maidment, & Connolly, (2018).

According to the NASW (2013), supervisors can manage vicarious liability—while increasing the likelihood of a favorable ruling in the event of a malpractice action—in several ways: Clearly defined policies and expectations; awareness of high-risk areas; provision of appropriate training and supervision. Additional risk-reduction strategies for supervisors include:

- Understanding supervisee practice strengths and weaknesses
- Developing an adequate feedback system
- Being knowledgeable about their own responsibilities to their supervisees.

The NASW further states that vicarious liability can arise in many ways. It's often associated with a supervisor's failure to:

- Provide supervisees with adequate information to permit proper practice.
- Review a supervisee's work for errors and correctly assess capacity/skill level.
- Determine when a specialist is needed.
- Detect/and discontinue a negligent service plan or service that is continued beyond its effectiveness.
- Review and approve a supervisee's decisions.
- Provide coverage for unavailable supervisees.
- Detect and act on a supervisee's impairment.
- Meet regularly with a supervisee.
- Identify that a supervisee is exerting "undue influence" on a client.
- Identify that a supervisee is sexually and/or romantically involved with a client, even if the supervisee conceals it.

While it is not possible to foresee all of these things, awareness can help. It is also important to note that supervisees will not always disclose every moment of every session, therefore, the only true way to be aware of all sessions is to listen to every session. While this is not always feasible, it is important to consider when taking on a supervisory role.

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 conditions 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 (Polychronis & Brown, 2016; Ellis, Taylor, Corp, Hutman, & Kangos, 2017).

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 (Falender, 2016):

- 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
- When possible, listen to all therapy sessions (or at least random sessions so that the supervisee cannot choose which sessions to share)

Supervisor Safeguards Against Malpractice Suits

NASW (2013) offers the following guidelines for professionals who provide clinical supervision.

1) The supervisor should clarify in writing with the supervisee:
    a. the context/purpose of supervision.
    b. the intent to follow applicable regulations.
    c. a detailed plan of supervision, including learning plan with clear objectives.
    d. the frequency, duration, structure, and format of supervision sessions.
    e. the methods of supervision.
    f. client information and formats for managing client information.
    g. the responsibilities of the supervisor and the supervisee.
    h. the methods for evaluating the supervisee's practice.
    i. the relationship of supervision to personnel evaluations
    j. how conflict-resolution plans are used and implemented.
    k. the termination processes.
    l. any applicable fees.
2) The supervisor should document the supervisory sessions, dates, goals, progress, and recommendations for the supervisee or client.
3) The supervisor should ensure his or her qualifications and practice competencies.
4) The supervisor should supervise with an eye toward professional codes of ethics.
5) The supervisor should ensure that supervisees provide services above minimum standard.
6) The supervisor should obtain consultation whenever a supervisee's need or a client issue exceeds the supervisor's capacity.
7) The supervisor should ensure that the supervisee's clients have properly and specifically agreed to the release of information required for supervision.
8) The supervisor should treat the supervisee with respect, conducting evaluations fairly, maintaining confidentiality about supervisory material, not exploiting him/her, and not providing supervision in instances of dual relationships with the supervisee.

Informed Consent for Clients of Trainees and 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 receives supervision, it is important that this be communicated to the client. This may mean that the client be informed of the fact that the therapist is, in some circumstances, an unlicensed provider and that he or she is being supervised in his delivery of therapy as part of a licensing requirement. Or, it may mean that as part of good professional practice, a licensed clinician receives consultative supervision from a colleague with practice expertise. It may also be helpful to provide the client with the contact information for the 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 ethics code (2017) discusses confidentiality in many places. 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". This provided the basis of current informed consent procedures, which can be seen in the Ethical Principles of Psychologists and Code of Conduct (APA, 2017).

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. In many settings, it is required for the supervisee to provide the name and contact information of the supervisor and in some settings (and for some insurances) the supervisor is required to meet the client. 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 Bernard and Goodyear (2019).

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 Goodyear (2019). They provide the following list of crucial elements 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 would not be as forthcoming or disclose to 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 learning 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 (see *Guidelines for Clinical Supervision in Health Service Psychology* for more information about competence within clinical supervision; APA, 2015).

Although there are many potential ways to define competence, one of the most comprehensive can be found in the guidelines offered by the Association for Counselor Education and Supervision (ACES). ACES list 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 education 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 (2017). 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 is 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 learning 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?

Professional codes of ethics for mental health and human services providers 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 (Manfrin-Ledet, Porche, & Eymard, 2015). Manfrin-Ledet and colleagues (2015), identified seven common characteristics of issues relating to professional boundaries: (1) Dual relations/role reversal, (2) Gifts and money, (3) Excessive self-disclosure, (4) Secretive behavior, (5) Excessive attention/overinvolvement, (6) Sexual behavior, and (7) Social media.

Boundary violations and sexual impropriety represent some of the most legalistically vulnerable issues among psychotherapists (Andreopoulous, 2017). In particular, Herlihy and Corey (2014) describe the complexities of cultural and diversity issues related to boundary violations. What makes these relationships most challenging are the complexities embedded within and that there is a requirement for counselors to make judgment calls and apply the learned code of ethics to these situations.

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 of Social Workers (NASW) Code of Ethics (2017), 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 strong statements regarding dual relationships, the 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. Valente (2017) examines some of the most relevant questions raised on 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 (2014) 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 (see Rosenzweig & Shantis, 2015). 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 (2019) 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]"

Rosenzweig and Shantis (2015) summarize helpful differences in differentiating between supervision and therapy or counseling. The following lists identify their differences.

Supervision

- Targets helping supervisees to develop skills, overcome obstacles, increase competency, and to practice ethically.
- Focuses on supervisee's activities with clients.
- Makes suggestions and provides corrective feedback concerning cases.
- Provides ongoing evaluation as to the fitness of the supervisee to continue preparation or to practice independently.

Therapy or Counseling

- Focuses on personal growth, behavior changes, and better self-understanding.
- Is responsible for understanding behavioral, cognitive, and affective practices – including listening, exploring and teaching.
- Has timeframes and agendas that are based on the needs of clients.
- Evaluates outcomes also based on the needs of clients and remain open-ended.

A good general rule 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 acted 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 relates to 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 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 (Scaife, 2019). 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 (2019) states: "*Clinical social workers do not use clients for self-interest, do not socialize with clients in a manner detrimental to treatment, and do not exploit clients or 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 (Alpert & Steinberg, 2017).

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

It should be noted that although most supervisors are significantly more experienced than their supervisees, there are some clinics and institutions that need supervisors and encourage newly licensed therapists to become supervisors. Although this is less common, it does happen in some institutions. Therefore, the supervisor and supervisee may have similar social circles and there may be issues related to dual relationships that may arise. If this is a concern, like all other ethical issues, it would be important for the supervisor to discuss this with their own supervisor to ensure that they can proactively address any potential concerns that may arise in the supervisory relationship.

Parallel Process

Another boundary issue concerns the idea of parallel process. 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 Giordano, Clarke, & Borders, (2013); Shulman, (2013); and, Grinberg (2018).

In addition to discussion of parallel process, authors have also discussed the issue of the supervisor's countertransference. Grinberg (2018) describes the possibility that there may be interference in the task of supervision that might arise as transference or countertransference – both due in part to the supervisor and supervisee. Grinberg (2018) continues to explain that this might imply that there is some unconscious conflict that either the supervisor/supervisee has with their client – or possibly one in that the client has with them.

Many supervisors that do not adhere to the psychodynamic model may interpret the behaviors that psychodynamic therapists call parallel process using different language and a different world view, and therefore, address it very differently. However, it is helpful to understand what parallel process is if you adhere to the psychodynamic theoretical model in the supervisory process.

Case Vignette

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. The patient often has outbursts of anger, and Alex is frustrated that the patient is not responding to their work on developing 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.

Given the many ethical issues discussed in this section, it is helpful to summarize some key points. Barnett & Molzon (2014) give specific recommendations with respect to 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 DIVERSITY

Questions to consider:
Review your history of receiving 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 not, what were the effects?
How did these differences in culture impact the supervisory relationship?
From your retrospective view, what effect did a supervisor's management of cultural variables have on your practice?

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?

Cultural competence in clinical supervision extends to include that both supervisees and supervisors maintain and foster the ability to be open with each other in an effort to achieve the goals of supervision, despite potential differences, which include diversity and/or contextual issues (Tsui, O'Donoghue, & Ng, 2014). Tsui et al. (2014) explain that cultural competency consists of four elements. These include:

1. Awareness of one's own cultural background
2. Attitudes and behaviors towards differences in culture
3. Knowledge of different cultures, diversity issues, and worldviews
4. Skills and ability to interact and work with people within different cultures and contextual backgrounds

With the diversity evident in 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 not only in their clinical practice but in their supervisory practice as well. Yet, there is a disconnect between perceived cultural competence and actual clinical practice (Warner, 2015). 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). Warner (2015) notes that "low level of competence may exist in the area of skillful actions; whereas higher levels of competence are present in cultural awareness and cultural sensitivity" (p.33) This imbalance may occur because of the historical focus on multiculturalism and diversity in training programs, the limitations of self-report, and other characteristics of the client and therapist interaction.

Models of supervision have been strongly influenced by contextual variables and their influence on the supervisory relationship and process, such as Holloway's Systems Model (Meier & Davis, 2019) and Constantine's Multicultural Model (Drinane, Owen, Adelson, & Rodolfa, 2016; Constantine, 2003). Becoming culturally competent and able to integrate other contextual variables into supervision is a complex, long-term process. Jernigan, Hearod, Tran, Norris, & Buchwald (2016) and Kersey-Matusiak (2018) have identified several stages on a continuum of becoming culturally competent, which are:

- Cultural destructiveness: forced assimilation, subjugation, rights and privileges for the dominant group only.
- Cultural Incapacity: Displays of racism, maintains problematic stereotypes, unfair hiring practices.
- Cultural blindness: differences ignored, displays principle of "treat everyone the same"; only meets needs of the dominant group.
- Cultural pre-competence: explores cultural issues, displays commitment, assesses the needs of both the organization and individuals.
- Cultural competence: recognizes individual and cultural differences, seeks advice from diverse groups, tendency to hire culturally unbiased staff.
- Cultural proficiency: implements changes to improve services based on cultural needs.

Phillips, Parent, Dozier, & Jackson (2016) examined multicultural supervision and noted some of the following limitations:

- Minority (i.e. sexual/gender, racial/ethnic) supervisees are engaged in more discussion regarding multiculturalism compared to non-minority trainees.
- Focus is on race and ethnicity exclusively.
- Lack of comprehensive framework provided for multicultural issues within a supervisory context.
- Tend to provide global suggestions to overcome difficulties.

Multiculturally responsive supervisors have a key role in mentoring, guiding, supporting, and facilitating learning of culturally specific issues within supervisory process (Iwamasa & Hays, 2018; Estrada, 2018; Tohidian & Quek, 2017). As important as these roles are, Inman & DeBoer Kreider (2013) identify a number of challenges to effective multicultural supervision. These include:

- Unintentional "ism's" and biases - *Overemphasis or underemphasis on cultural explanations for psychological difficulties.*
- Internalized racial oppression - *An inability to appropriately present information, 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, and passing premature judgments*
- Differences in values, interactional styles, acculturation, educational and socioeconomic status levels.

- Lack of acknowledgement of power differentials at cultural and professional levels - *Lack of self-disclosure, safety, and trust; and, guarded communication*
- Supervisees may have more formal training in cultural competence than supervisors who may have trained prior to the profession's incorporation of values regarding culturally competent practice.

As the case vignette illustrates, even supervisors who work in culturally diverse areas may not be aware of their own biases and prejudices. Multicultural supervision and training have typically focused on White and privileged communities, which leads to a needed expansion to include populations that may be silenced, underrepresented, or marginalized (Inman & DeBoer Kreider, 2013). 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 & DeBoer Kreider, 2013).

Warner (2015) has identified several supervision skills to that clinical supervisors can adhere to in an effort to mitigate cultural differences:

1. Assess supervisee characteristics, which include awareness, openness, cultural empathy, and clinical skills.
2. Possess working knowledge about culturally competent supervision models.
3. Explicitly explain how culture is integrated into the specific supervisory style used.
4. Incorporate and adapt activities that encourage dialogue surrounding culture.
5. Have supervisees explore sociopolitical influences of culture – such as racism, power, privilege.

The case vignette presented at the beginning of this section illustrates many of these key 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. Tonya's supervisor also suggested that Tonya is somehow "better than" her patients because she is training to be a therapist and is a role model for them due to her race (although if they had never discussed race, it may even be her assumed race by the supervisor). It is certainly not Tonya's responsibility to teach her supervisor how to gain multicultural competence, it is instead the responsibility of the supervisor. New supervisors who have not had training in multicultural supervision may consider additional training and readings after this training as well as obtaining consultation when supervising supervisees of other races.

Inman and Ladany (2014) have developed six dimensions of multicultural supervision. These include:

1. *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;
2. *supervisee-focused personal development* - the ability of the supervisor to foster supervisee self-exploration, awareness, and knowledge and to help supervisees explore their own identity development (e.g., race, ethnicity, gender, sexual orientation);
3. *conceptualization* – the supervisor helps supervisees conceptualize an understanding of the effects of individual and contextual factors on clients' lives;
4. *skills* - encouraging supervisee flexibility with regard to psychotherapy interventions including the use of nontraditional or alternative therapeutic interventions (e.g., indigenous helping networks);
5. *process* - the relationship between supervisor and supervisee characterized by respect and open communication and awareness of power differentials;
6. *outcome/evaluation* - evaluating supervisees on their multicultural psychotherapy competence.

There are a number of questions that can help move supervisors/supervisees through these dimensions. Table 4 provides some suggestions from Garriott, Reiter, & Brownfield (2016). By attending to these variables, supervision can become a richer, more culturally responsive medium and help prepare supervisees to work with diverse populations.

TABLE 4 QUESTIONS TO MOVE SUPERVISORS AND SUPERVISEES THROUGH MULTICULTURAL DIMENSIONS OF SUPERVISION

Dimensions	**Questions**
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' development. 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 divers 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 multicultural 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?

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. This continues to be a training priority of the internship program and Alyssa is encouraged to learn more about the culture of the patients she is treating and to continue to discuss issues related to treating diverse cultures as they arise.

THE SUPERVISORY SESSION: FORMATS FOR SUPERVISION

Questions to consider:
Have you received individual supervision, group supervision, 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 described earlier, 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.

Use of Technology in Supervision

Case Vignette

Overview
Maria is a licensed clinical psychologist who supervises three masters and doctoral-level clinicians, Marquis, Tracey, and Amy, all working to deliver a Motivational-Interviewing based intervention to college students who have had an alcohol violation while on campus. Although they are all working in similar settings, each of these clinicians, including Maria, are located at different college campuses across the United States. As such, this vignette will highlight best-practices of integrating technology within clinical supervision settings. This vignette will highlight how Maria uses different technologies with each of her supervisees to maximize their supervision experience. We begin with Maria providing supervision to Marquis.

Background (Training & Group Supervision)
Over the span of one month Maria will be supervising weekly trainings for the clinician supervisees to train them in necessary Motivational Interviewing competencies and skills. After the 4-week training, Maria will host weekly group supervisions/check ins, to address highlights and concerns that have come up for her clinicians during the past week. Because each supervisee is in a distant location across the United States, the group uses a web-based video platform to meet. In addition, during supervision, each clinician distributes their audio or video tapes to the group, to get peer-to-peer feedback. This example will highlight Maria providing an overview to her supervisees on how she intends to use technology to accomplish both her training and group supervision goals.

Maria: Hello everyone! As you know, our goal over the next 4-weeks is to make sure you are all competent at delivering a Motivational Interviewing-based intervention to college students. We will be meeting as a group once a week for the next four weeks using this web-based video platform. Through this, I will be able to show you slides that I've prepared, a few videos, and then we will even be able to break up into two groups to practice, and then come back to the larger groups to discuss. After our training is complete, we will be continuing to meet as a group throughout the duration of you delivering this program, twice a week. Once a week, we will be meeting as a group, and the other time I will be meeting with you one-on-one. Marquis, I know you are unable to video your sessions, so please audiotape your sessions so I can provide you feedback. Tracey, I'll be directly observing one of your sessions each week via webcam. Amy, you'll be videoing your sessions and sending them to me. I know many of you have voiced your apprehensions about supervision, but I want to emphasize that this is a learning process for everyone, myself included! This is a new role for me, so I'm also looking forward to getting your feedback and suggestions on how I can be a better supervisor in the process! Before we get started just a reminder that during our supervision times you are expected to be dressed reasonably professionally and in an environment where we can discuss openly information necessary to your training; imagine you are coming to my office for these meetings – this means no pajamas and no public spaces like coffee shops where confidential information will be compromised.

Note: this example highlights how technology can be integrated into training and group supervision

Background (Marquis)
Marquis is a masters-level clinician working at a small liberal arts college in the southeastern United States. Although Marquis has used an array of technologies during his clinical training, his institution is not equipped to support videotaping or direct observation via web-conferencing. Therefore, Marquis audiotapes his sessions and sends to Maria for her review. In this process, Marquis identifies two sessions over the past week where he feels he could use supervision. In addition, Maria selects one audio file at random to review. For supervision, Marquis and Maria use a HIPAA-compliant web-based video conferencing platform to meet on a weekly basis. We will begin with Marquis telling Maria about his apprehensions with supervision.

Marquis: I know that audiotaping my sessions is going to help me, but I can't help but feel like my mistakes are being amplified when it's recording.

Maria: That makes a lot of sense, and it is perfectly normal for supervisees to feel that way, especially in the beginning. I want to emphasize that from what I've heard, you're doing a really great job so far. And you're right, the point of this is so that we can work together to address the concerns you have to ultimately improve the treatment that you're able to provide your clients.

Marquis: I appreciate that. In reviewing the files that I sent you, there was one point I got stuck working with my client on Tuesday. I was hoping to get more feedback on that. Could we both listen to minute 15:30 to minute 16:00 on the audio file to see how you would have addressed that, Maria?

(Maria listens to audio tape and provides Marquis with specific feedback about his concern)

Note: This example highlights how supervisors can integrate audiotapes into their supervision practice.

Background (Tracey)
Tracey is a doctoral-level clinician working at a large academic-research institution in the northeastern United States. Tracey's practice is housed within a community-based counseling center on campus. Given the widespread access to cameras on computers, Maria is able to directly observe one of Tracey's sessions each week through webcam. This example begins with Maria giving her client a brief introduction of why Maria is watching the session through webcam, and then concludes with Maria providing some feedback to Tracey.

Tracey: Hello, Ann! As I mentioned to you the last time we met, for today's session, my supervisor, Dr. Maria, will be watching our session through webcam. The purpose of this is for Dr. Maria to watch how I interact with you, and provide me feedback to improve

some of my skills. So, although Dr. Maria will be listening to what we talk about, her primary focus is on what I say to you, to help me become a better therapist. Does all of this sound okay to you?

(Ann agrees) – fast forward to after session

Maria: Tracey, I think you did a really nice job, overall! I really like how you introduced me into the session, and it helped make my presence feel more personal, although I wasn't really in the room.

Tracey: Thank you! I know I could that could have gone better, but I am happy to have had you there in the moment to see what I was seeing. What feedback do you have?

Maria: You've really improved a lot over the past few weeks. Your use of simple and complex reflections has really come a long way. It would be great if while ending the session you could do a bit more summarizing of some of the main points that you and Ann discussed in the session. Next time, try giving a summary of what you've discussed before wrapping up the session.

Note: this example highlights how supervisors can directly observe sessions via webcam

Background (Amy)
Amy is a Master of Social Work Student at a mid-size university in the midwestern United States. Amy has cameras within her counseling center, so she is able to record her sessions with clients. This provides Maria with more context on body language that both Amy and clients are displaying within the session. This example begins with Maria providing feedback to Amy.

Maria: Thanks so much for sharing your video sessions from the past week with me. It is really helpful in being able to identify things such as body language and the overall feel of the room itself. I would not be able to pick up some of the things that I did if I were just listening to audio tapes!

Amy: I can see how that would be helpful. Were there things about my body language you noticed I could change?

Maria: I think you did a really great job. One thing I would change is the position which you are sitting in the room. Right now, you were behind your desk, while your client was sitting in a chair across the room. Although it seemed like you had a good rapport, I am concerned that the distance between you, and the desk in the way, could be hindering the process. Next time, I'd like to see you move to be closer to the patient, and with nothing in between the two of you.

Amy: I didn't even think about that. Thank you. I've also noticed that there have been a few clients this past week who have expressed they do not want to be recorded through video. What might I say to them to make them more comfortable?

Maria: That's a great question. I wonder if you could emphasize the fact that this will only be shared with your supervisor, and once the tape is watched, it will be completely erased. Outside of being shared with me, it won't be shared with anyone else. You might also want to emphasize that they main purpose of this is to ensure that you give them the best treatment possible, and that your supervisor is primarily listening to what you say to provide you with feedback. You can also give your clients the option to be audiotaped if they are not comfortable with video.

Note: this example highlights how Maria integrated video technology to give specific postural and environmental feedback to her supervisee.

Techniques, such as audio/videotaping, role-playing and co-therapy may also be helpful. Gonsalves, Brockman, and Hill (2016) assert "there is now expert consensus that directly observing the work of trainee therapists versus relying upon self-report of sessions, is critical to providing the accurate feedback required to attain a range of competencies. In spite of this expert consensus however, and the broadly positive attitudes towards video review among supervisees, video feedback methods remain under-utilized in clinical supervision" (p. 1). In fact, according to the ACA (2014) 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." Therefore, part of this section seeks to outline the ways in which technologies matter within clinical supervision, and strategies that you can utilize to enhance the role it plays within your own supervisory settings. Table 5 summarizes AAMFT Code of Ethics Standard VI as it relates to supervision provided via technology assisted professional services.

TABLE 5 SUMMARY OF AAMFT CODE OF ETHICS TECHNOLOGY ASSISTED PROFESSIONAL SERVICES AS IT RELATES TO THE PROVISION OF SUPERVISION

This standard addresses basic ethical requirements of offering therapy, supervision, and related professional services using electronic means. This table summarizes those elements specific to the provision of supervision

6.1 Technology Assisted Services
Prior to commencing supervision services through electronic means (including but not limited to phone and Internet), MFTs ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted supervision is appropriate for supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic supervision after appropriate education, training, or supervised experience using the relevant technology.

6.2 Consent to Supervise
Supervisees, whether contracting for services as individuals or groups, must be made aware of the risks and responsibilities associated with technology-assisted services. MFTs are to advise supervisees in writing of these risks, and of both the therapist's and supervisee's responsibilities for minimizing such risks.

6.3 Confidentiality and Professional Responsibilities
It is the supervisor's responsibility to choose technological platforms that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Supervisees are to be made aware in writing of the limitations and protections offered by the supervisor's technology.

6.4 Technology and Documentation
Supervisors are to ensure that all documentation containing identifying or otherwise sensitive information which is electronically stored and/or transferred is done using technology that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Supervisees are to be made aware in writing of the limitations and protections offered by the supervisor's technology.

TABLE 5 (continued)
6.5 Location of Services and Practice Supervisors follow all applicable laws regarding location of practice and services, and do not use technologically-assisted means for practicing outside of their allowed jurisdictions.
6.6 Training and Use of Current Technology MFTs ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are made in order to optimize quality and security of services, and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of supervisees.

Technology has allowed for trainees in remote locations to receive supervision. “Video conferencing based supervision", or tele-supervision, involves a trainee at one site securely receiving supervision via a video link with a supervisor at another site. It is important to note that tele-supervision laws differ from state to state, and it is important to ensure that the state laws allow tele-supervision. Most states require the supervisor and supervisee to be in the same state at the time of supervision. Luxton, Nelson, & Maheu, (2016) mention a number of benefits of tele-supervision including decreased chance of multiple relationships for clinicians in small communities, the opportunity to 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. Gonsalvez, Brockman, and Hill (2016) contend that “video feedback methods fit seamlessly into CBT supervision providing direct, accessible, effective, efficient and accurate observation of the learning situation, and optimizing the chances for accurate self-reflections and planning further improvements in performance” (p.1).

Across a variety of supervision goals, there are both basic and advanced technologies that can be used for clinical supervision. For a brief list of these technologies, see table 6 below.

TABLE 6. TECHNOLOGIES FOR CLINICAL SUPERVISION		
Supervision Goal	**Basic Technologies**	**Advanced Technologies**
Increase Communication (*between ONE supervisee and the supervisor*)	Email Instant Messaging Phone Texting	Online Document Editing Online File Sharing Videoconference
Increase Communication (*between MORE THAN ONE supervisee and the supervisor*)	Email Group Messaging Phone Conference	Online Document Editing Online File Sharing Videoconference
Increase Communication (*between supervisees)*	Email Phone Conference Texting	Wiki Online Document Editing Online File Sharing Videoconference
Provide Asynchronous Viewing/Hearing of Counseling Sessions	Mail an encrypted CD or USB	HIPAA-Compliant Online File Sharing
Provide Asynchronous Feedback of Audio or Video Counseling Sessions	Email	Online Document Editing Wiki
Provide Synchronous Feedback of Counseling Sessions	Phone Conference	Online Document Editing Videoconference
Increase Supervisee Knowledge Base Through Sharing Content	Email Texting	Blog Wiki Online File Sharing

Rousmaniere & Renfro-Michel (2016) have outlined several of the potential benefits of supervision with respect to the integration of technology. These include:

- High levels of supervisee satisfaction
- Greater types of effective modalities for increasing supervisee self-efficacy

- Increased supervisee self-disclosure and overcoming barriers to disclosing sensitive information
- Sustainable, scalable, and accessible to a wide variety of audiences
- Encourages increased levels of preparation
- Effective for international and cross-cultural supervision
- Videoconferencing serves as an effective proxy for a live one-way-mirror supervisory system

Rousmaniere & Renfro-Michel (2016) also outline some of the drawbacks of technology and the potential risks for its use within clinical supervision. These include:

- Difficulties in contextualizing and understanding non-verbal communication
- Supervisors may not understand local laws or regulations
- There is a possibility of an increased risk for cultural misunderstandings – which may be increased through distance between supervisor and supervisee
- Although effective, trainings such as videoconferencing may not be as effective as an in-person training.

To mitigate some of these potential risks, Rousmaniere & Renfro-Michel (2016) make several recommendations that clinical supervisors can adhere to. They suggest that supervisors should:

- Start by focusing on the supervision process rather than the technology.
- Use technology to support and enhance the supervision process, rather than utilizing it just for the sake of it.
- Create a list of supervision goals and questions that are intended to be achieved and answered through supervision.
- Think about the types of technology that could be included in the supervision process. This includes assessing for comfort level with technology, along with the project costs of its use.
- Not integrate more than one new technology at a given time.

Using video-review is another specific set of skills that supervisors must practice and master if they are to effectively use this method. The use of video-review allows supervisees to gradually learn to accurately reflect on, appraise, and improve upon their work as a therapist. Gonsalves and Crowe (2015) advise that the use of video-based feedback should follow best practice guidelines for providing formative feedback including that supervisor's feedback should:

- focus on important patterned aspects of the supervisee's work, ignore trivial or isolated instances.
- be interpersonally sensitive, non-harsh, clear, specific, functional, and tailored to the supervisee's development.
- identify specifically how a supervisee contributed to a client outcome.
- not gloss over supervisee inadequacies or needs.
- be challenging and validating of supervisee strengths.

There are many potential benefits to integrating technology into clinical supervision, and the use of technology promises to both increase the breadth and depth of supervision. However, supervisors must be aware of some of the drawbacks as well to make this an efficacious and effective practice.

Supervision Methods and Techniques

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. (Whittle, Rycroft, Wills, Weir, & Rottem 2013) 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. Table 7 below describes methods of supervision.

TABLE 7. METHODS OF SUPERVISION

Method	Benefits	Challenges
Case Discussion/Presentation The supervisee selects a client case to review with his or her supervisor, describes the client's presenting problem(s), summarizes the work done so far, conceptualizes the situation and reflects upon effective interventions and sticking points.	Useful when caseload is high. Supervisees have to articulate specifically what they want from supervision. Easy to arrange. Adequate for developing conceptual skills. Potential to give positive feedback.	Relies on the supervisee's self-report. Less helpful with specific skill development, beyond conceptualization. Can be a challenge for the supervisees to convert the supervisor's verbal feedback into effective actions.

Observation of Recorded Session The supervisor and supervisee review selected segments of a client session that has been recorded on video or audio tape by the supervisee (with the prior expressed permission of the client).	Allows for specific feedback about skills and case management. Less anxiety provoking than live supervision. Supervisor or supervisee can stop recording at various points to discuss.	Anxiety at being observed. Difficulties deciding how to deal with so much information (e.g., which parts of session to view and where to focus attention). Time consuming.
Live Supervision The supervisor directly observes a client session (by prior arrangement with the supervisee and expressed permission of the client), usually through a one-way mirror, or via camera. The supervisor usually offers input regarding process and interventions during the session.	Provides direct opportunity to shape and develop the supervisee's skills. Can be very supportive for the supervisee. Supervisor's direct input can allow the supervisee to feel empowered by intervening effectively beyond his or her usual level of skill (knowing she or he has backup). May be helpful to the client, especially if she or he has an inexperienced counsellor	Initially, potentially highly anxiety provoking. Stressful for the supervisor managing multiple and simultaneous direct responsibilities for the supervisee(s) and the client(s). Possible contradiction for the supervisee, who is expected both to be competent and to take direction: could lead to feeling de-skilled. May be a challenge finding the time and the best process to communicate feedback effectively to the supervisee.

Live Consultation Supervisor conducts a one-off interview with the supervisee's client(s) while the supervisee observes (by prior arrangement with the supervisee and expressed permission from the client).	Observation of the supervisor's intervention as well as possible effect on client(s) can help move the work forward and help the supervisee to get 'unstuck'. Demonstration of clinical skills on part of the supervisor can be useful. Can be useful for future case discussion for the supervisor to experience client(s) directly.	Requires advanced skills on the part of the supervisor (e.g., how to explore supervisee's stuckness and the supervisee/client interaction without undermining supervisee) Potential for the supervisee to feel de-skilled by observing a supervisor's successful intervention with client(s) whom he or she feels unable to help.

*Adapted from: Whittle, Rycroft, Wills, Weir, & Rottem (2013); Moloney, Vivekananda & Weir (2007)

INDIVIDUAL SUPERVISION

During their careers as psychotherapists, most individuals will experience some form of individual supervision. Many states and licensure boards have a minimum requirement for a certain amount time a provider must receive supervision prior to applying for their license to practice. 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. Other techniques such as the use of audio or videotapes or *live supervision* (where the supervisor observes the supervisee and/or offers suggestions throughout the client session), allows for the availability of more complete information for the supervisor to then provide the supervisee with richer feedback.

In evaluating an approach and degree of structure for individual supervision it is helpful to consider Bernard and Goodyear's (2019) 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 Bernard and Goodyear's (2019) statement above, structured supervision is considered more training-oriented and less structured supervision is considered more consultative. For the beginning trainee, structured supervision can be beneficial. 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 learning material.

Bernard and Goodyear (2019) 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 - 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 (Borders, 2014).

Although supervision will vary based on a number of factors including client population served, theoretical orientation, and the 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's (2019) 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, 2019.) Bernard and Goodyear (2019) 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 each of which can be found throughout a single supervision session:

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, 2014).

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. Moore and Hortsmanshof (2016) provide some excellent information about preparing for/structuring the first supervision session, including creating a "safe place" for supervision. They cite 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 (Bernard & Goodyear, 2019; Scaife, 2019).

Sample Supervision Session

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

1. Discuss and reflect upon the purpose and goals of the supervision session. Include the supervisee in planning the session and assess what the supervisee needs might be (e.g., "How do you want to use your time today?" "What do you need most from this session?"
2. Start with successes. Discuss successful interventions, strategies, etc. Discuss 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. Discuss case or review session notes and audio or videotapes.
4. Employ other interactive methods, such as role play or modeling.
5. Engage in didactic discussion, or a topical learning component, such as the identification and analysis of theoretical issues, ethical issues, or treatment of a specific issue such as trauma.
6. In all of the above, include questions to stimulate thinking, such as
    - What are you feeling in response to the client (i.e., transference)?
    - Can you identify any multicultural issues that may affect your ability to work with this client?
    - What are you aware of in the client's verbalizations or nonverbal body language?
    - What is your course of action?
7. Review of how the session went for the supervisee and the supervisor. Was supervision helpful? Why or why not? What worked? What was missing? Where did it get off track?
8. Evaluate and provide feedback, if appropriate to the session. This is an important component of supervision and will be discussed later in this learning material.
9. Document the supervision session, optionally with notes available to the supervisee. At a minimum documentation should include the meeting date and time, the length of the supervision session and modality (e.g. individual, group). It is helpful here to be familiar with the specific requirements base on the 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 need to be retained.

Case Vignette: Supervision Session

Supervisor: Hi, Desmond. 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?

Desmond: 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 Mr. B? What have the successes been?

Desmond: 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?

Desmond: I've tried but am not sure how to explain it clearly though.

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 about affect modulation]

Desmond: 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/diversity issues in this case, including transference and countertransference]

Supervisor: [combining feedback to supervisee and about the session] Well, Desmond. 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?

Desmond: 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 supervision 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. Self-report is not without its limitations and difficulties. Bishop (2017) highlights some of the challenges of self-report, including the risk of conscious or unconscious distortion of therapy material and the possibility of failure to report. Bernard and Goodyear (2019) 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. It is also the easiest form for a busy supervisor because it does not require additional preparation for the supervisor outside of the supervisory session. 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 Bernard & Goodyear, 2019), but generally process notes will document

1. Goals for the session
2. Things that happened during session that caused questioning of goals
3. Major theme/s 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 or Video Tapes

Although the use of audio and videotaping is a choice that will not work for every supervisee or for every setting, there are some helpful aspects to these tools. Scaife (2019) 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 and may be only a result of supervisee anxiety.

Important concerns related to the use of these tools pertain to confidentiality, consent, and the security of audio or 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.

Scaife (2019) identifies the advantages of audio or video taping sessions as:

- allowing the opportunity for detailed review and multiple perspectives;
- removing doubts about competence;
- encouraging confidence in the role of therapist;
- providing an opportunity to participate then observe;
- enhancing empathy by allowing the therapist to replay the session and give full attention to the client rather than relying on notes;
- increasing accountability; and
- an adjunct to therapy because tapes can also be used with clients.

Within supervision, audio or video 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. The written critique can include timestamps

to allow the supervisee to go back and watch the tape at particular parts to practice trying a new technique outload while the tape is playing to model the new behavior and it can be used to reinforce behaviors that the supervisee did well. Given that both the patient and supervisee have varying levels of comfort with the use of audio and video tapes, research supports supervisors using a developmental approach when using these methods (Briggie, Hilsenroth, Conway, Muran, & Jackson, 2016).

Scaife (2019) further provides some excellent guidelines to assist the supervisor in reviewing audio or video taped sessions with trainees. Scaife (2019) advises that is good practice to keep comments aligned with and limited to the supervision goals, 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. Some supervisors also opt to request the supervisee to pick a section of the tape in advance where the supervisee believes they did something well and a section of the tape where they needed some supervisory direction and guidance. Campbell (2011) states that the goal of this review is to encourage supervisee self-reflection and self-exploration.

Live Supervision

Live supervision can be done via two methods. One method includes co-facilitating sessions with the supervisee as well as observing supervisees as they conduct therapy sessions. This is less common than other formats because of scheduling difficulties, programmatic structure, insufficient resources (i.e., supervisor time, client needs, reimbursement requirements), and possibly supervisor or supervisee anxiety. Despite these obstacles this method, however, offers a number of benefits, especially for the supervisee. Scaife (2019) describes a number of scenarios with regard to co-facilitation as a form of live supervision, referred to as *co-working,* in which both supervisor and supervisee jointly share responsibility for the individual or group therapy session, and which are appropriate for supervisees with some experience. This method includes *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).

The second method for conducting live supervision is the use of rooms where there is a one-way mirror and audio can be heard in a separate room where an observer may sit. This can allow for the supervisee to step out of the room if they need to consult with the supervisor, or for immediate supervision to occur after the session. It can also happen with the "bug in the ear" technique where the supervisee wears an earpiece in which the supervisor can talk to the supervisee from another room while watching.

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. With respect to a developmental perspective of reflectivity, Skovholt and Rønnestad (2016) 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 & Rønnestad, 2016). 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 & Rønnestad, 2016).

Calvert, Crowe, & Grenyer (2016) highlighted the role that reflectivity plays in therapist development. These authors propose that the supervisory relationship may operate as a transformational learning arena whereby enhanced relationship competencies that can be transferred into therapeutic outcomes. A purposeful approach of using reflectivity is proposed, whereby supervisors use relational engagement within supervision to develop supervisee relational competence.

Akopyan (2019) describes a number of supervisor strategies that encourage supervisee reflectivity. These strategies may be categorized into basic strategies for teaching, counseling and consulting functions, and advanced functions. Examples of these strategies are:

- 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 1984, it is still widely used today (see Kagan 1984; Jones, Latchford, & Tober, 2016; Wass & Moskal, 2017). 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, 2019). During the recall session the supervisor or supervisee stops the tape and asks a relevant leading question (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 allows the supervisee to explore thoughts and feelings to some resolution (Bernard & Goodyear, 2019).

Sample Leading Questions (Bernard & Goodyear, 2019; Clarke, Milne, & Bull, 2011).

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 her work with a client named Karla. Karla is a young woman with a history of childhood sexual abuse. Dawn 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.

Many supervisors choose to implement 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 exposure to the use of consultation among colleagues. Group supervision provides an opportunity for counselors in training and those already licensed to experience mutual support, share common experiences, learn new behaviors, increase interpersonal competencies, and develop insight (Buus, Delgado, Traynor, & Gonge 2018). The core of group supervision is the interaction of the supervisees.

Like individual supervision, group supervision has advantages and disadvantages. Group supervision also requires the supervisor to employ different skills than are used in individual supervision. Group supervision allows for supervisors to impart knowledge to a larger audience, can be extremely time efficient, and creates an opportunity 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 Driscoll (2006).

Group supervision requires that supervisors be prepared to use their knowledge of group process (Bernard & Goodyear, 2019). Guidance and self-understanding have also been cited by supervisors and supervisees as some of the most important "therapeutic factors" present in their group (Herbert & Caldwell, 2015).

There are a number of differences from individual supervision, both for the supervisor and supervisee. Herbert & Caldwell (2015) illuminate the differences between group and individual supervision, stating that group supervision allows supervisees to present their work publicly, 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.

In a recent paper, Daniel, Clarke, & Nath (2018) enumerate on prior research regarding styles of group supervision. 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.

LeBlanc & Luiselli (2016) offer the following guidelines to adhere to in 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 the 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 (Child, 2015). 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 (2019) 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. Bishop (2017), provides a comprehensive overview of evaluation within clinical supervision, and advises that supervisees should be afforded to following:

- 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 (2019) make the distinction between *formative* and *summative* evaluation and state that the supervisor's ability to discriminate between these types of evaluation is critical. Bishop (2017) describes 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 (2019) 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 & Goodyear, 2019). Bernard and Goodyear (2019) 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, 2019). 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, Vannucci, Whiteside, Saigal, Nichols, and Hileman (2016) 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 (2019) 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, Bernard and Goodyear (2019) suggests that subjectivity be reduced by employing (1) structured criteria to evaluate success, (2) multiple ways to rate supervisee competence, (3) gathering evaluation information about the supervisee from other sources. They stress 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. Bernard and Goodyear (2019) provide examples of such tools in their section on evaluation. They include 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, review of documentation during 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.
5) Document, document, document.
6) Be prepared. Negative evaluation will likely be met emotionally with anger, sadness, accusations, and tears.

If a supervisor expects that a negative evaluation is likely, it can very helpful to follow #2 – to evaluate frequently. This can ensure that the supervisee is aware that there are concerns and that they have time to address them. And if the supervisee does not address the concerns, then the supervisor will have had time to provide that feedback and address any barriers that are related to why the concerns were not addressed with ample time prior to a formal evaluation being submitted. This not only mitigates complaints against supervisors, it allows supervisees the chance to learn over time to address any weaknesses they have as an emerging therapist.

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 conflict with supervisors or supervisees 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 what his expectations are for her, and that the expectations seem to change on a daily basis. Rita also feels like he is demanding and critical, and that he is dismissive when addressing 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. Knox (2015) and Gibson, Ellis, and Friedlander (2019) identify some common factors that may play a role in lack of disclosure between supervisees and supervisors, including:

- 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 a lack of engagement (e.g., such as basic counseling skills including active listening). Additionally, many of the skills discussed in previous sections of this learning material, such as providing support, setting clear goals and objectives and providing well-rounded feedback on performance in relation to setting 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. Or they may have tried to enact a behavior that the supervisor asked of them but did not do so effectively and are too ashamed to tell their supervisor. Supervisee shame is an area that has been the focus of a body of writings (see Watkins, 2017; Wilson, Davies, & Weatherhead, 2016). There are many ways that supervisors can help to reduce these feelings of shame and enhance the supervisory relationship. Mehr, Ladany, & Caskie (2015) assert that the most important factor lies in the supervisor's style. In addition, they describe 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. Had Rita felt guided and supported and if Dr. Bellmont had been more aware of her work with clients their supervision relationship would have benefitted not just them, but ultimately their client.

Some general guidelines for resolving conflict within the supervisor and 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 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 recommend 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 (Ellis, Hutman, & Chapin, 2015). 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 – indicating that a referral to therapy may be warranted.

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 might be helpful with Anna 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.

<u>Examples of Exaggeration</u>:

"You want a perfect outcome for this client?"
"You want to get an "A" with this client."

<u>Examples of Reframing</u>:

"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?"

It may also be possible to help Anna turn in "incomplete" work so that way she can expose herself to not being perfect with her supervisor. This may help build rapport in the relationship by allowing Anna to not be perfect on purpose.

The Defensive or Resistant Supervisee

Ken, a social work intern, is an example of a defensive or resistant supervisee. His supervisor, Jean, has become use 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,* which is a paradoxical intervention that entails the supervisor pulling back and agreeing with the supervisees' position, *use of tentative language* (Campbell, 2011), *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."

In situations like the example above, there may be some gender or racial/ethnic power dynamics that need to be addressed. For example, at times, men supervisees may have a difficult time accepting guidance and supervision from women supervisors and similar to individuals of different races in the supervisory relationship. Therefore, if the therapist is noticing that this is a pattern, it can be discussed to ensure that it does not continue and to ensure it does not impact the manner in which the supervisee relates to clients as well.

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 is at the root of Jim's apparent apathy. Some of the possible causes of this are discouragement, anger, burnout, anxiety, and confusion (see Maslach, 2017; Wagaman, Geiger, Shockley, & Segal, 2015). 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 is emotionally difficult. In the latter, and if a pattern arises, it may be helpful to consider a referral for psychotherapy for the supervisee.

It is essential that clinical supervisors provide the necessary support by establishing and maintaining working relationships with supervisees – in that they are able to address stress reactions and compassion fatigue in the workplace as a natural part of their experience, rather than an individual failing or pathology (See Carruth & Field, 2016).

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.

Example 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 ones' own gain
- Engaging in boundary crossings, especially dual or sexual relationships
- Engaging in behavior that is sexist, racist, or any other form of discrimination against the client
- 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 Bernard and Goodyear (2019) 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.

Herbert and Caldwell (2015) 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

The NBCC Code of Ethics states:
Counselors who provide clinical supervision shall keep accurate records of supervision goals and progress and consider all information gained in supervision as confidential except to prevent clear, imminent danger to the client or others or when legally required to do so by a court or government agency order. In cases in which the supervisor receives a court of governmental agency order requiring the production of supervision records, the counselor shall make reasonable attempts to promptly notify the supervisee. in cases in which the supervisee is a student of a counselor education program, the supervisor shall release supervision records consistent with the terms of the arrangement with the counselor education program.

While it is of critical importance, documentation is one of the most commonly neglected and disliked tasks for many supervisors. It is an *essential* administrative task and professional skill. Documentation serves as the legal record for the delivery of supervision, and demonstrates that a reasonable effort was made to supervise. Because of vicarious liability concerns, supervisors should document every supervisory encounter with supervisees. 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.

Although supervisors may stress the importance of documenting clinical services by their supervisees, equal emphasis on documenting supervision is not common practice. According to Barnett and Molzon (2014), documentation of supervision can

"(a) help reduce the chance of misunderstandings occurring, (b) help increase accountability on the part of the supervisee, (c) be an excellent aide for both parties when reviewing to track progress both of the supervisee's clients and the supervisee's professional development, and (d) serve an important risk management role in providing a tangible record of what has transpired in supervision and the supervisor's efforts so provide high-quality clinical supervision. (2014, p, 1057).

Furthermore, documentation should be a frequent topic in supervision. Supervisors should model for supervisees the value of good documentation and it should be considered

a skill, equal to any other clinical skills the supervisees are directing effort to mastering (Sidell, 2015). Although supervisors might expect, formalize goals, and demand high quality and thorough documentation of a supervisee's clinical encounters with clients, they are often less attentive to record keeping about their own work with their supervisees. Further, in consideration of parallel process, supervisors should be documenting supervision sessions for all the same reasons that interactions with clients are documented. Supervisors should document the date and time, content, and any discussions pertaining to ethical decision making. Themes noted, cases discussed, educational needs, and supervisor's impressions and recommendations are all appropriate content for a supervision note. Documenting supervision for licensure purposes is particularly important for potential audits.

A clinical supervision record should include the following elements (Bernard & Goodyear, 2019; Herbert & Caldwell, 2015):

- 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.

- Discussions related to ethical dilemmas and ethical decision making.
- Significant problems encountered in the supervision, and how they were resolved or whether they remain unresolved.

Alternatively, Sidell (2015) proposes a guide to structure supervisory notes using the acronym SUPERS:

S – supervisee-initiated items

U – useful feedback or suggestions from the supervisor

PE – performance expectations that have been discusses

R – recommendations for future goals

S – strengths of the supervisee (p. 191).

Sidell (2015) also provides a sample format for documenting group supervision which records date, participants, topics explored, follow-up, and next meeting.

SUMMARY

This learning material has laid out the foundations of clinical supervision. Clinical supervision is important as it is required for graduate training and licensure. While there have not been many studies that actually focus on efficacy, one study bears mentioning. Snowdon, Leggat and Taylor (2017) looked at whether clinical supervision can improve quality measures (care that is clinically effective, care that is safe and care that provides a positive experience for patients). The researchers looked at seventeen studies across multiple health professions (medical, nursing, allied health [including counseling] and combination of nursing, medical and/or allied health). They concluded that clinical supervision of health professionals was associated with effectiveness of care. The review found significant improvement in the process of care that may improve compliance with processes that are associated with enhanced patient health outcomes. While few studies found a direct effect on patient health outcomes, when provided to mental health professionals clinical supervision may be associated with a reduction in psychological symptoms of patients diagnosed with a mental illness.

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 are 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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