



Clinical Supervision for Supervisors

15 CEU Home Study

By
Carol Joy Cole, L.C.S.W., B.C.D., S.A.P., MSWAC

Carol Cole Center for Advanced Training
23905 Clinton Keith Rd, 114-196
Wildomar CA 92595-7899

E-mail: custserv@carolcolelcsw.com
Phone: 951-677-2806
Fax: 951-346-9072

www.carolcolelcsw.com



CLINICAL SUPERVISION FOR SUPERVISORS (15 CEU HOME STUDY)

Please note: the terms supervisee and intern will be used interchangeably throughout this study packet, despite the fact that “intern” usually refers to graduate student, while “supervisee” typically refers to post graduate-pre-licensed individuals. Supervisor will refer to you the student of this material who provides the clinical supervision.

The clinical priorities of what is most pertinent to teach to interns and supervisees in order to practice safely is *always* the bottom line. This is delineated by the following:

Cole - Hierarchy Of Needs Assessment Form

1. **Red Flags:** (*suicide ideations, homicide, grave disability, substance abuse, adult, child and elder abuse, perceptual disturbances, eating disorders*)
2. **Medical Issues:** (*medical and psychiatric diagnosis and related family history, head trauma, organic conditions, contraindicated medications*)
3. **Ethical/Legal Issues:** (*case specific such as holder of privilege, custody, probation, guardianship, DUI, arrests, domestic violence, child abuse report, adoption*)
4. **Developmental Factors:** (*delays, arrests, fixations, Erikson’s stages, Piaget, Kohlberg, Phase of life issues, bonding, onset age of persistent drug use, critical periods for mental illness*)
5. **Cross Cultural Issues:** (*cultural specific, if traditional; values on primary issues, help seeking behavior, language barriers, acculturation, socioeconomic*)
6. **Support Systems:** (*who can be counted on as positive support during current crisis, sabotaging supports, emotional and financial availability, clubs, school, church, community, extended family, 12 step, work*)
7. **Diagnosis:** (*Knowledge of DSM diagnosis on all five axes and differential considerations*)
8. **Treatment Plan:** (*phases of treatment in progression toward termination with case-specific goals*)
9. **Interventions:** (*Variety of theorists and most conventional related strategic interventions- directly consistent with established treatment goals*)
10. **Referrals & Adjunctive Resources:** (*knowledge of diverse community resources relevant to primary case issues and how to access*)
11. **Therapeutic Use Of Self:** (*understanding of various transference issues, proactive anticipation and preparation and related intervention strategies*)
12. **Personal Issues/Limitations:** (*Counter-transference issues understood and addressed so as not to interfere with effective treatment*)

(from Everything You Need to Know to Become A Competent Clinician By Carol Joy Cole)



TRANSFERENCE/COUNTERTRANSFERENCE

Why supervise?

Consider your attitudes as a supervisor?

Problems with supervision:

- Inappropriate boundaries
- Increased liability
- Extra work load
- Responding to university curriculum/requirements/paperwork

Many interns get stuck in Counter-transference problems with either supervisors, other staff or interns, or clients or all of the aforementioned.

Counter-transference for our purposes will be defined in a broad sense, not necessarily from a Freudian perspective as *anything in the therapeutic relationship that distorts or clouds the reality of it*.

1. **Parallel Process:** a self healing emphasis, based on the intern having similar issues to that of the client. The intern will try to fix the client in order to address their own unresolved anguish/anxiety/pain. Consequently the needs of the client are ignored. According to Masterson, 1989, many clients will like this approach because there is no need for them to do any of the work, as the *therapist projects their own hurt self on to the client and then treats the client the way they wanted to be treated*.

Freud referred to this process in terms of what is not remembered is repeated through enactment. While parts of the personality are repressed or dissociated, his feelings are close to awareness. The result is demonstrating both anxiety and defense against anxiety. This anxiety and related defensiveness is then demonstrated in supervision.

The therapist/intern is unconsciously trying to express something that is going on with the client, which therapists' own anxiety prevents him from consciously describing in supervision. Gediman (1980) expressed that *the requirement of exposing oneself in order to learn is at the core of resistance to learning*. One of the difficulties in supervisory teaching is the student's narcissistic need to keep his/her image in tact, consequently both desiring and resisting learning.

So how does the intern learn when feeling threatened and fragmented with anxiety?

One essential component is to assess the source of the emotional response to make sure the



origin is not your own counter-transference, as the supervisor.

References:

- Dewald, P.A. (1987) Learning process in psychoanalytic supervision: Complexities and challenges. Madison, CT: International Universities Ness.
- Gediman, H., and Wolkenfeld, F. (1980). The Parallelism Phenomenon in Psychoanalysis and Supervision: Its Reconstruction as a triadic System. Psychoanalytic Quarterly, Vol. 49, p234-255.
- Jacobs, D., David, P., & Meyer, D.J. (1995) The Supervisory Encounter. New Haven and London: Yale University Press.
- Williams, Abi (1997). On Parallel Process in Social work Supervision, Clinical Social Work Journal, Vol 25, p.424-435.

Problem Intern:

1. Told to do something, but doesn't want to.
 2. Feels equipped to deal with a situation you don't feel they are ready for.
 3. Is this an apprenticeship and/or mentorship relationship?
 4. Are there procedures for terminating someone?
 5. Can you recommend therapy?
- Friedman coined the term "creative brainstorming" with the intern regarding how to get their needs met.
6. Mediation, conflict resolution.
 7. Development of realistic goals to not overwhelm and impact self esteem in a negative way.

CHECKLIST FOR RECOGNIZING PARALLEL PROCESS

- ✓ As the supervisor, I am experiencing a very strong emotional response to the supervisee.
- ✓ As the supervisor, I feel like my supervisee is engaging me in his/her own tension.
- ✓ As the supervisor, the supervision is starting to feel more like a therapeutic client-therapist relationship than supervision.
- ✓ As the supervisor, I am able to identify commonalities between the dynamics enacted within the supervisory session and the dynamics of the intern's therapeutic relationships. (Abi Williams (1997).
- ✓ I am aware of and considering the potential anxieties my intern might have that are contributing to the enactment of the parallel process.
- ✓ As the supervisor, I am able to invite my intern to explore their own involvement in the replication. Acknowledge the supervisee's efforts in the discovery process.
- ✓ As the supervisor, I am working with my supervisee to establish mutually accepted efforts to address these issues as they arise in future supervision sessions.
- ✓ As the supervisor, I will work with my intern to develop strategies for working with their clients, despite the parallel process.

2. Approval Needs: this process is not related to any historical connections or unresolved trauma, but solely focuses on the need to be a good clinician and do a good job. In the event that the supervisor is emotionally unavailable or not very demonstrative in their accolades the intern may feel a sense of rejection, which turns to anger at the supervisor.

3. Sex related counter-transference between intern and supervisor: (by Annette Brodsky, Ph.D., University of Alabama from the Clinical Psychologist, Winter 1977, Vol. 30 #2, article:



Counter-transference Issues and the Woman therapist: Sex and the Student therapist), Dr. Brodsky divides this into four specific traits:

1. **Power** (assumption that the supervisor is a respected authority on life in general. The intern often has a strong degree of dependence and will usually not risk challenging or angering the mentor.)
2. **Nurturance** (question of how much to nurture, especially when intern is tearful in regard to fostering dependence, comforting or giving a clear message that the intern is out of control).
3. **Empathy** (be clear on the limitations of individual's life experiences and backgrounds which may hinder their ability to understand the client. There is the danger of over-identification or assumption such as if the supervisor and supervisee are both parents, for instance or have other similar life experiences.)
4. **Seduction** (dilemma with a client whom they neither want to reject nor appear like they are coming on to. In terms of the supervisor-supervisee roles it is a matter of abuse of power by the supervisee who is revered. For the supervisee coming on to the supervisor it may reflect an overall lack of boundaries - which is being carried over to clients or a need to assert their own sense of power in a way they know has typically worked for them.)

4. Transference/Counter-transference Supervisees are consistently concerned with:
If there was unfinished business between you and the supervisee who would bring it up?

ESTABLISHING REALISTIC GOALS FROM A DEVELOPMENTAL PERSPECTIVE:

If the supervisor is a novice more fears focused on client,
Otherwise fears will be more focused on supervisee from a broader spectrum.

Questions for supervisors:

Logistics for time, staff and meetings.

Development of supervisors methods.

Do you have any positive supervision role models?

Clinical questions when supervising:

1. If supervisee can't handle case should it be transferred to supervisor?
2. Differences in male vs. female supervisor or age.
3. Would you take on a client the intern is not capable of?
4. How would you picture supervision?
5. What are your goals with interns?
6. How do your values relate to supervision?
7. What is the distinction between training and supervision? Ideal to get to your own place of self supervision, knowing your own needs and where to go for your own help or assistance.
8. What is your attitude regarding varying degrees of enthusiasm?
9. Are you devoted to improving your own skills?
10. Professional theoretical orientation?
11. What is the agency philosophy on supervision: commitment to training therapists, need to serve the community, need interns to do their jobs.



12. Short or long term contract?
13. Modalities available in your work setting?
14. Types of clients and problems (homogeneous or multiple problems and diversity of all types, mandated attendance. Diff. Challenges to supervisor dependent upon work setting.
15. Relationship issues for supervisors and supervisees (voluntary or paid)
16. Relationship regarding friendship, going to lunch, etc
17. Informal, or highly structured, academic private practice, large clinic, hospital.
18. What are some of the core issues for general training for you as supervisor?

Targeted Competencies (Tomm, K., and Wright, L. 1979)

General case management- comply with agency responsibilities.

Therapeutic Relationship- establishment and maintenance of an ongoing relationship with clients.

Perceptual- therapist's ability to observe interaction.

Conceptual- therapist's ability to integrate observation with theory.

Structuring- therapist's ability to adequately direct therapy.

Intervention- therapist's ability to purposefully behave in a strategic manner to facilitate change.

Professional Development- utilization of resources to promote growth as a professional clinician. The focus of competency development changes dependent upon the developmental phase of the clinician's evolutionary process.

Developmental stage of learning/goals:

Stepping into the next phase of supervision you can forget all you know.

Formal supervision:

Have supervisor look at and review goals and write them down. Must be appropriate to their stage, not their ambition.

Have supervisee select some of the materials

Some typical goals: specific intervention techniques desired, role play, shift from doing interventions to wondering why, video tape.

Stultenberg talks of understanding the developmental stage of the intern in order to help strategize supervision techniques. This is a way to describe the evolving relationship, as well as to address the transference/counter-transference. This may help the supervisor relate to the intern with compassion and empathy.

1. Competency
2. Emotional awareness (your issues)
3. Autonomy (much later) - self directed own learning progression.
4. Respect for individual differences (tolerant and non-judgmental)
5. Purpose and direction of structuring phases of therapy and therapeutic role in those phases.
6. Personal Motivation: novices feel they can fix, intermediates are unsure.
7. Identify theoretical consistency (conceptualize in an integrated way).
8. Book knowledge.

Developmental Stages in Supervision

Kohlberg, L. (1975). Counseling and counselor education: A developmental approach. *Counselor Education and Supervision*, 14(4), 250-257.



“Humans move through a series of stages and developmental tasks or crises and that retardation or conflict at one stage colors task solutions at later stages.” Per Kohlberg. understanding of human behavior is understood through natural development of ego functions. Ekstein, R., & Wallerstein, R.S. (1972). *The Teaching and Learning of Psychotherapy*. New York: Basic Books. Ekstein & Wallerstein in their seminal work identified four roles in supervision systems: trainee, supervisor, client and administrator, with each role struggling through three phases of maturation: beginning, middle, and termination. With each of these four relationships emotional closeness is monitored while avoiding over-involvement and equal engagement with all four relationships is encouraged and monitored. When this equality occurs maturation is considered to have been facilitated. Bowen’s work focused on the level of differentiation increasing to better differentiation from the level of the client and the field of therapy to authenticate their personal theory of therapy.

Phases of therapeutic development for the supervisee:

“The process goes from concrete, undifferentiated understanding, common sense conceptualizations to more complex, sophisticated and abstract ideas requiring greater degrees of introspection”, extrapolated from Ralph, H.B. (1990) resulting from a survey he took of 8 supervisors and their 36 interns.

1. What do I do?
2. How do I begin to understand the client? Rogerian (understanding clients being non directive)
3. What collaborative efforts do the client and I need to implement for the client to stabilize or increase productive functioning?
4. I can begin to trust myself as a beneficial agent of healing in the therapeutic process (both from perspective of diagnostician and change agent).

Six Developmental Stages of a Supervisee (Laurel Cox, Ph.D. for CAMFI7 Supervision)

1. **Novice Stage:** belief that everything they say or do literally hinges on the survival of the client, not sure what to say, dependent upon supervisor, unable to synthesize text book knowledge with practical application, wants techniques. Novice will fail to set the client, only the issues. Emphasis is on doing. Supervisor’s task to provide all round structure, procedures, forms, reading materials and journaling.
2. **Transition Period:** every client brings up the supervisee’s issues of counter-transference “matching interventions with intentions”. Begins to understand the more abstract and deeper components of doing therapy, but feel they don’t know what. Help them understand such things as the impact of their body language such as folded arms - how client may interpret. Supervisor’s task: to positively reinforce strengths and encourage development of their own theoretical framework.
3. **Intermediate Stage:** awareness of personal issues and feeling overwhelmed by the client’s difficulties. The goal is to be able to work with the client without knowing the exact outcome and learning to use self effectively in therapy sessions. This may require some personal therapy, Supervisor’s task: encouraging journaling and using in supervision sessions and intern taking a closer look at countertransference issues. The intern may tend to be somewhat self righteous and there is a danger of abusing the client at some level, without being called on this. It is therefore important for both the intern and supervisor to know what the intern believes. May ask intern what did you do in the session that you liked, or what were you aware of in the session.
4. **Transition Period-** conceptualization, increased comfort and confidence with both “doing and being”, but cannot connect the universal concepts between the cases. Needs to increase



flexibility regarding what specific directives are being followed (support without advice). May no longer need to discuss the specifics of individual cases. Supervisor's task: reinforce therapeutic skills, likely at the evaluation period working toward licensure, encourage further skill development. Intern also needs to understand that they don't need to see every single client and it is often appropriate to transfer.

5. Advanced Stage- self supervision. Focus on the overall role and process of therapy/therapeutic relationship, may now be considering area of specialization, and preparing for licensing exams. Supervisor's task: incorporation of personal style, role understanding, knowledge, responsibility and intentions. There is a need for the intern to be able to find their own answers. Focus on specific advanced training via workshops, books, etc. Conceptualization of all phases of treatment process. Supervision now focuses on generalities rather than specific cases and work toward development of a personal counseling theory/style. the time to explore and integrate and articulate what the intern believes.

6. Transition Stage to Professional - "confident, competent & congruent. Explore resistances to licensing exams and overcome to pass licensing exams, Supervisor's task: to assist with development of personal ritual for transformation from intern to licensed professional, termination with supervisor.

Developmental Stages for Supervisee and Supervisor - Littrell, Lee-Borden & Lorenz (1979) A developmental framework for counseling supervision. *Counselor Education and Supervision*, 19, 129- 136.

Stage 1: establishment of relationship between supervisor and intern, setting goals and clarifying contract.

Stage 2: interpersonal dynamics regard to counseling/teaching relationship.

Stage 3: transition to role of consultant (exploratory and reflecting)

Stage 4: individuation from supervisor and development of a self supervision model.

Loganbill, Hardy & Delwoith, 1982. Supervision: A conceptual model. *the Counseling Psychologist*, 10(1), 3-42. their work on stages of supervision was considered a major contribution. They view eight critical issues which supervisees experience:

1. Issues of competence - skills and techniques.
2. Issues of emotional awareness - knowing oneself, awareness of feelings.
3. Issues of autonomy - self directedness.
4. Issues of identity - theoretical consistency, conceptual integration.
5. Issues of respect for individual differences - tolerant, non-judgmental acceptance of others.
6. Issues of purpose and direction - structuring a therapeutic direction, setting appropriate goals.
7. Issues of personal motivation - awareness of the satisfaction and personal meanings inherent in practicing therapy.
8. Issues of professional ethics - values.

The four functions of the supervisor within this process:

1. Monitoring client welfare
2. Enhancing growth within stages.
3. Promoting transition from one stage to the next.
4. Evaluating supervisee.

Supervisor in the Caregiving Role with Supervisee



Utilizing Winnecott's object relations theory, Winnicott, D. W. (1965)/the *Maturational Processes and the Facilitating Environment*, London: Hogarth Press. Regression - (dependency on and responsibility toward others) can be used in the service of the therapist's ego, the supervisory contexts fosters regression.

The holding environment- from empathetic based activities, just as in a safe environment the infant begins to differentiate between self and others. Without "good enough mothering" the infant develops a premature self, for whom self holding is essential for survival, must involve consistency of sessions. Encourage emotional development Identification - is a primary ego function. According to Padel, J. (1985). Ego in current thinking. *International Review of Psychoanalysis*, 12,273-283. Example of identifying with mother as feeder. Padel says "the very fact of being able to choose to identify with one or the other means that he has adopted a third position from which he could observe self-and mother as a couple and be for a while identified with neither". The detached and observing self forms a third term position.

Supervisor Role- is not the supervisor doing therapy, but therapist doing supervision. (genogram conceptualizing exact phenomena (Bowenian). Supervisor role is to help intern with connections to them self.

Establishment of realistic goals that are not overwhelming and impact self esteem. Think of goals as supervisor (to refine) working up your own requirements for interns. Modify per agency policy.

Identify your philosophy as a supervisor.

How do you determine when to ask a question rather than listen? Have a developmental assessment for interns.

Find ways to challenge yourself and make it meaningful.

(Stoltenberg) understand developmental stage in order to effectively strategize, describe the evolving relationship and address transference/countertransference issues. Misperception: everything you do or say may hinge on survival of client, learn that the client can do a lot of the work. Our job is to remember what it was like to not know.

Transition Stage- interns believe that they need to see every single client, but really need to know when to refer and when to have permission to do so.

Body language - what does it mean to fold arms? Help the intern to identify. Ask how old they are developmentally. What do you like that you did in the session, or what were you aware of in the session?

Self righteous attitude will keep them stuck at this stage (rationalize abuse of the client.) You and they need to know what they believe, help integrate and articulate that.

Taviers- beginning stage: patience, direct structure and instruction,

Intermediate: advise without expectations that it will be followed.

Advanced: need to find their own answers.

Goals as a supervisor:

Development of a learning contract.

What is your philosophy can you appropriately challenge without being hypercritical or punitive?

Open to interns developmental and experience level.

Open to countertransference

Open to increasing interns independent functioning (internalizing the supervisor)

To widen their scope of skills

To direct and advise re: need for continuing education and additional training.



How do you foster creative expression?

Philosophical stage - supervisee to get different perspectives on supervision.

More effectively following up on assignments and keeping up on paper work.

Validate interns when appropriate, they don't have comparison.

Types of Supervision

Advantages to individual supervision:

Disadvantages- closed system, no means of comparison of handling Dyads: 1 supervisor and 2 supervisees - may meet with both every week. Generalized clinical issues, rather than case specific.

Co-therapy- supervised in a room with an intern to assist with therapy as needed.

Group Supervision - cost effective, fewer resources, rich context for creating a learning experience. Role play with group following video. Development of professional collegueship.

Disadvantage - more anxious and competitive. Too great disparity of group (may have both novice and advanced), not as valuable a learning experience. Better for the group, but not for individual, less opportunity to follow the development of a specific case. May go to a specific supervisor in addition to regular supervision for family or couple work, etc.

Supervision Modalities:

Direct observation: of direct and audio/video presentation tapes, as discussed appropriate by supervisor/ees.

Case presentation: relies on supervisees verbal account, useful for redirecting, key words, case formulations (thought rules and decision rules) Carl Rogers was the first to use audio tape. Jay Haley - Use to observe action of therapist, access memory for therapist of experience. However, Doug Breulin "guidelines for using videotaping- if too anxious interns go to fight or flight- such as forget tape or couldn't get it to work. If you want the intern to be excited about it show the intern the tape you flubbed, this may give them permission. Limit the amount of material you view to 4-5 minutes. And set moderate goals. Combine live supervision with video tape. Give ideas from the viewing room. Simple goal - get enactment going, talk to each other. Let the therapist talk when he/she comes out of session (global catharsis).

Post session reactions- feedback will give level of satisfaction with therapist's performance.

Prior to establishment of the relationship with the intern he will not trust enough for videotaping. He will feel the whole videotape is being evaluated and get increased anxiety. Only view the portion of the tape that approximates goal objectives.

Live Supervision: supervision with client and intern or one way mirror and call in input-less intrusive, take a break and give therapist input. Is it suggestion or mandate? Balance supervision dependence versus autonomy. Lean well in the immediacy of moment and more raw data.

There was one study on clients- and clients thought it was of benefit. Supervisee can validate work and develop a sense of competency as supervisor sees directly, also increases sense of trust of feedback. Negative- can violate clients' privacy, interrupt supervisees pace, increase anxiety and power issues with more experienced supervisee.

Reflecting teams: (Anderson, 1982) Facilitate therapy through impasse- 1 way mirror observation of therapist and patient, then swap and hear reflection of supervisor with professional evaluation. Ask about initial trainings they went to and books they read. Validation of all they've done and set goals for next amount of work to do together. Both evaluate supervisee's performance.



Human Diversity: or called contextual issues.

Gender Issues in Supervision

Gender - Elizabeth Register- unconscious and accepted as reality, problems from axis of power. Male needs to not rely on doing and taking over but increase comfort levels with relational communication.

Female needs to increase sense of comfort with an authority role and influence of power.

Male - competition for authority or buddy.

Female - supervisor may have trouble with authority. Women's job to keep men comfortable.

Male supervisor may lead or protect too much.

Keep in mind that our gender and cultural socialization is somewhat unconscious.

Concepts for discussion/thought from a gender perspective:

Patriarchy, Matriarchy, Feminism, Mutuality in terms of labor division, which gender is responsible for change in a relationship, emotional containers, religious hierarchy, those burdened and exonerated from responsibility, who sets the family rules, who is deferred to, who has power with regard to decision making for economics, child rearing, influence of economic dependency upon family rules.

Feminist Model teaching interns an understanding of power and gender roles by example, as well as theory and should include:

Minimization of hierarchy Use of social analysis Understanding sex role learning Structure of power

Gender expectations from socialization perspective

Storm, C.L. & Todd, T.S. (1997). *The Complete Systemic Supervisor* :Context, Philosophy, and Pragmatics. Boston: Allyn and Bacon. Make the following recommendations from a gender sensitive perspective:

Supervisors should ask themselves the following questions:

1. How has the feminist image changed your approach to supervision?
2. What gender issues should you be aware of as a supervisor?"
3. In what ways might your gender and the gender of your supervisee affect the way you do supervision?
4. How do you as a supervisor deal with power differential in the supervisory relationship and in the families that your supervisees treat?

Cultural Concepts:

Universalist says all families are more alike than they are different Believers of this approach ignore contextual material based on race, gender, or ethnicity. In this case the focus is exclusively on issues such as anxiety and differentiation from a multigenerational perspective. A concern with this theory is that families are seen as standard rather than exploration of their individual and culturally nuances.

Particularist: families are more different than they are alike. In this case there are no generalizations and each family is seen as completely unique. In this case culture can be extended to include the individual family's internal beliefs. The concern here is ignoring



environmental factors all together and seeing all issues from an internal unique perspective, exclusively.

Ethnic Focus: emphasizes family differences based on ethnicity, alone. Monica McGolderick-ethnic focused view point. This involves cultural generalizations and includes the danger to over systematize and stereotype shared meanings.

Multidimensional Perspective: this focus looks at the multitude of factors impacting the clinical picture. The approach goes beyond generalizations and includes multiple sub groups. This perspective is so multifaceted that it can easily overwhelm and confuse interns.

Key Comparative Parameters (developed by Falicov, Ci (1988) Learning to think Culturally (pp.335-457). In H.A. Liddle, D.C. Breunlin, & R. C. Schwartz (Eds), *Handbook of Family therapy training and Supervision*. New York: Gui Word Press.

1. Ecological context- family's environmental fit. Impact of societal institutions
2. Migration and Acculturation- heritage, life style, goals, why migrated
3. Family Organization- cultural and family values and roles, dominant dyad based on central emphasized relationship within the family system.
4. Family Life Cycle- culturally patterned developmental stages.

Cultural interview" only information gathering and sensitivity not to be used for clinical interview not to change, (differences in what is viewed as age appropriate behaviors and stages and transitions).

Clarity on what cultural maps the family brings to therapy as well as what cultural maps/beliefs the Intern brings to therapy.

How much work has he done on his family of origin issues, boundaries, countertransference, and level of anxiety?

Focus on exploration of his views of codependence and substance use/abuse. Assist intern in sorting out these issues. By his ability to start where the client is at and discard judgments and frustration, understanding clients' resistances to change and exploring optional modalities or intervention techniques to address clients underlying issues. Not get into being therapist.

Genogratn, paradox, strategic

Howard fiddle (research model) going into the room and viewing the process- Integration models and therapeutic alliance.

Imposing values.

Encouraging the supervisee to pay close attention in sessions to the cultural dynamics rather than assuming.

From: (Cultural Competence in Psychotherapy: A guide for Clinicians and their Supervisors, Steven R. Lopez, UCLA, 1991)

The four largest ethno racial groups in the United States include: African American, American Indian, Asian American and Latino American and groups of ethno-racial heritage and other recent immigrants (e.g. Persians)

Overpathologizing vs. Underpathologizing

Overpathologizing - a highly religious person who hears God's voice directing him to take certain action as psychosis.

Underpathologizing - minimizing pathology such as deciding this person is religious without proper and thorough investigation.

Danger of over generalizing cultural norms to cultural specific belief systems. **Presumed**



culture-specific and culture general norms cannot be applied to psychological testing nor based on low-income and low educational background.

These factors may underestimate the degree of cognitive impairment. It is essential to consider the fit between the individual's socio-cultural background and the normative samples socio-cultural background. Multiple sources of data such as a complete psychosocial history, collateral medical, school and other collateral reports such as significant others and further consider variances in cultural and linguistic backgrounds, assessing in primary language, when possible.

A process model of cultural competence involves moving between two cultural perspectives-that of the client and that of the therapist.

"Ethno graphers also bring with them a liberating distance that comes from their own experience near categories and their existential appreciation of shared human conditions. Getting at mediating psychological processes requires that eventually we shift to the view from afar-we cannot otherwise abstract universalizing processes from the particularizing content of ethno-psychological meaning-but to understand actual situations we must use both lenses." (Kleinman & Kleinman, 1991) Kleinman used this anthropologically informed perspective to several clinical research domains for example the study of depression and neurasthenia in China and more recent studies on pain.

Sue & Zane in 1987 in their influential work on culture and psychotherapy find three primary components related to the clients perception of the effective helper role:

1. Conceptualization of the problem.
2. Means for problem resolution.
3. Treatment goals.

Bernal & Flores-Ortiz (1982) in their work in treating Latino families found particular concern with the engagement and evaluation process.

Engagement: understanding what the client views as the problem and what the client wishes to gain. Validate the client's definition of the problem and work toward the corresponding treatment goals. While the therapist may define parallel problem definitions and treatment goals these additional problems should not be defined by the therapist, unless involving imminent danger, until the therapeutic bond is secure.

The client may hold theoretical models different from that of the practitioner. Understand what the client believes to be the causes of the problem and the means by which the problem is maintained. These beliefs are embedded in their cultural context, so we must work within that context, even if the belief is they are being punished by God. However, the client's beliefs may represent dysfunction and/or an effort to undermine the treatment. It requires a careful balance and an open-ness to working with the client's proposed theoretical model.

Further References (cultural competence)

- Barlow, D. H., & Cerny, J. A. (1988). Psychological treatment of panic. New York: Guilford.
- Betancourt, H., & Lopez, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist*, 48,629-637.
- Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). towards a culturally competent system of care. Washington, DC: CAASP technical Assistance Center.
- Dana, R.H. (1993) Multicultural assessment perspectives for professional psychology. Boston: Allyn & Bacon.
- Gomez Palacios, M., Padilla, E.R., & roll, S. (1984). Escala de inteligencia para nivel escolar



Wechslen WISAC-RM, Mexico, D.F.: El Manual Moderno.



LEGAL & ETHICAL CONSIDERATIONS IN SUPERVISION:

Distinction between Supervision and Consultation:

Consultation - a professional clinician provides advice to an independent professional and has no authority over the services actually provided.

Supervision (Minimum Requirements, as used in regulations):

“Ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; reviewing client/patient record, monitoring and evaluating assessment, diagnosis and treatment decisions of the intern or trainee; monitoring and evaluating the ability of the intern or trainee to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and ensuring compliance with laws and regulations governing the practice of marriage, family, and child counseling. Supervision shall include that amount of direct observation, or review of audio or video tapes of therapy, as deemed appropriate by the supervisor. Supervision shall be credited only upon the following conditions:” (Section 1833 (b) of Division 18, title 16, of the California Code of Regulations).

Common Problematic Legal/ Ethical Issues:

Sexual Attraction to clients: Pope, Keith-Spiegel, and Tabachnick (1986) reported that 87% of psychologist (95% men and 76% women) reported feeling sexual attraction to patients at least once in their careers, yet only 9% felt they could address this issue with their supervisor. Supervision is responsible for investigating all suggestions of harm to patients (not to mention your own liability, investigations and patient-therapist sex).

The potential counter-transference can seriously jeopardize positive transference and successful therapeutic treatment. While supervisors must warn supervisee’s against acting out these intensive sexual feelings it is important for the supervisor to encourage discussion of these feelings on the part of the supervisee by providing a safe, sensitive and open atmosphere to do so, and document such discussion in the notes.

Risk Factors for therapist-Client Sexual Misconduct: (from Professional Psychology: Research & Practice, 1999, Vol. 30, No.3, 318-327 Identifying and Reducing Risk Factors related to trainee-Client Sexual Misconduct by James C. Hamilton & Jean Spruill, the University of Alabama)

1. **Loneliness** - without a significant romantic relationship, somewhat isolated, no close friends and problems with personal relationships, over-involvement with their clients (e.g., Gabbard, 1994; Glaser & Thorpe, 1986). Along with this goes cognitive distortions or beliefs that boundary violation will be in the best interest of the client
2. **Prior “Counseling” Experience** - often in the form of volunteer work in which the volunteer intern served more in the capacity of friend to the client. The student’s boundaries may have been blurred between the role of friend and the role of therapist. This quasi-therapeutic relationship role adapted by the student may inadvertently influence the student’s expectations about real therapy relationships.

What may have in fact been a deepening friendship may be interpreted by the novice as a beneficial and enhancing therapeutic bond. Additionally, there may have been inappropriate boundaries within the context of the interns own therapy which served as a role model.

3. **Professional Inexperience** - not knowing how to properly address resistances or adequately address other issues, or uncomfortable with certain issues may revert to friendship as an easier route. The new therapist may tend to rate therapeutic success on how well liked he or she was by



the client, or have a fear of being disliked or not pleasing the client. This can easily lead to allowing extra time for sessions and even sharing personal information inclusive of home number, etc. It is certainly a way to avoid confrontation. The outcome can only be deterioration of therapeutic boundaries.

4. **Ethics training** - possible lack of training in ethics, or need for further training in such. However, American Psychological Association and other clinical training bodies/boards do provide and require training in professional ethics.

5. **Failure to recognize ethical conflicts** - while there seems to exist an awareness of the criteria the break down appears to occur at the stage of execution. In many ethics studies regarding ethical dilemmas when asked what actions they would take respondents indicated that they would do less than they believed they should, particularly when the dilemma concerned peers, friends, or authority figures (WS. Smith, McGuire, Abbott, & Blau, 1991; Swazey, Louis, & Anderson, 1994).)

6. **Doing what needs to be done** - need for social skills repertoire to respond effectively to these dilemmas. A survey of Canadian psychiatry residents reported in Blackshaw & Patterson, (1992) revealed that 85% of respondents thought it was normal to experience sexual feelings toward clients, and nearly 80% of respondents who held that view thought that it was important to discuss such feelings in supervision, yet, 32% of respondents admitted they would feel uncomfortable in discussing such feelings in supervision. Of those respondents who actually reported sexual feelings toward clients, 45% said they did **not** discuss these feelings in supervision.

7. Having to discuss feelings to a supervisor is a sign of weakness

Are you as a supervisor willing to discuss your own feelings of sexual attraction or otherwise to a client or do you see even having such feelings a sign of not being a good therapist? The need to normalize such feelings and make it safe for the student to discuss these feelings with you is imperative and will serve to reduce their anxiety. This is naturally an inevitability if viewing therapy at all from a psychodynamic perspective. The supervisor serving as an appropriate role model is essential in terms of establishing clear social and sexual boundaries in supervision and general practice interactions. Clearly delineate the line between feelings and actions. Be clear to dispel any possible myths regarding client intimacy promoting their well being. Addressing standards of care (and legal ramifications of failure to comply) and avoiding any boundary violations. Feminist theories of establishing boundaries in therapy (e.g., Biaggio & Greene 1995) offer this definition: "the point at which the needs of the therapist and the needs of the client come into conflict." It has been further suggested that consumer education be offered providing clients with information about appropriate and inappropriate expectations of therapy, explicitly stating that any type of sexual behavior is inappropriate. Brochures regarding sexual misconduct in therapy relationships are available from the APA Committee on Women in Psychology (1987) and the Alabama Psychological Association Committee to Prevent Sexual Misconduct (1990).

Life-Endangering Clients:

Suicidal Clients: Kleespies (1993) reported that 1 out of 9 psychology interns had a patient successfully commit suicide and more than 1 in 4 had a client who made a suicide attempt during his or her training. 40% of the trainees had a patient who either succeeded or attempted. While suicide cannot be completely predictable the trainees believed that were ill trained to deal with suicidal patients, nor the aftershock.

Homicidal Clients: Tarasoff v. Regents of the University of California (1976). The CA court ruled that the psychologist should have done more to prevent the murder committed by his



patient, and it established the duty of a psychotherapist to protect the intended victim when the client presents as an imminent danger to an identifiable victim. In this case the psychologist was supervised by a psychiatrist, who was held responsible, as well, along with the University of CA. If the supervisor had examined the patient and decided that he was not dangerous, the grounds for liability based on foresee-ability might have been less clear.

Written Clarity of Agency Policies and Procedures:

A related case illustrates the need for written policies to guide the agency in the management of dangerous patients. *Peck vs. the Counseling Service of Addison County, Inc. (1985)*. Peck told his therapist that he was considering burning down his father's barn. The counselor discussed this with him and felt this was not a serious threat. Consequently, she did not discuss it with her supervisor or take preventative action other than sending for medical records, but failed to contact any previously treating physicians. Peck burned down the barn the following day. The counselor was found negligent in court, in failing to protect the barn, failure to obtain the past medical records more quickly, failure to take an adequate history and failure to consult her supervisors. The counseling Service was also negligent since they did not have a **written policy** regarding supervision when a patient presents a serious danger. This lack of policy can be seen as the agencies failure to exercise proper control over its supervisees. If they had this policy in place at the time of the barn burning there might have been no grounds for action against it, if the counselor had been acting outside the scope of the agencies policy.

Lack of timely Supervisory Feedback:

In addition to weekly scheduled supervision the supervisor must be available, as needed. This is at the root of many ethical complaints.

Dual Relationships: (conflicts of interest). No sexual relationship.

No blood relative, spouse, friend or business relationship can be supervised. Do not do anything that will jeopardize the supervisee-supervisor relationship.

Marketplace Issue: supervisor signing insurance forms for reimbursement for a trainee when the form requires the signature of the professional who actually provided the service.

This constitutes fraud. At the very least the supervisor should co-sign the form as "supervisor".

Direct Liability: the supervisor may be charged with direct liability despite the fact that the injury occurred at the hands of the supervisee. The question may go back to employee selection. Was the supervisee chosen in accordance with acceptable evaluation procedures regarding minimal standards for trainee status? "Reasonable care" in hiring supervisees might include the following questions.

Potential Supervisee Interview questions:

1. Have you completed course work necessary to perform clinical work duties, as specified?
2. Does the trainee have the recommendation of faculty members or former employers in this field, or others familiar with his/her work?
3. Is the intern able to operationalize concepts to practical application with clients?
4. Are the supervisee's personal people skills adequate and appropriate for the work setting?
5. Have their ever or are there currently any malpractice concerns or allegations of misconduct filed against this individual?

A further issue would involve back up supervision coverage for the intern during the supervisor's extended vacation/illness or otherwise unavailable. Identifying and reviewing ethics and legal issues with the intern(s) Carrying professional liability insurance with supervisee as "additional insured".

Vicarious Liability: "Respondent Superior" ("let the master respond") according to legal theory



the supervisors are the masters and the supervisees are the borrowed servants. The assigned tasks of the supervisee are assumed to be under the direction and control of the supervisor. The issue is who has control over the patient. The supervisor assumes final responsibility and carries the decision-making responsibility/burden.

Intern Advertising: All advertising must be approved of by the supervisor and include no overlap in mutual business earnings. An intern cannot have any financial partnership in supervisor's practice, or otherwise.

The intern cannot be promoting what often appears to look like their own practice. They must use their intern registration number and the exact title they are registered under. It is advisable for the intern to include their supervisor's name and title in all promotional literature.

Use of the term "Psychotherapist" was considered misleading, perhaps making one seem like they are a psychologist, if not. This is acceptable as long as one also states the exact title of their license in the ad, as it appropriately describes qualifications and will eliminate the need to include the license number.

Patient Access to Records: January 1, 1985 (CAMFT) sponsored bill AB 2881). The bill states that MFT's & LCSW's are required to provide patients access to mental health records, under specified circumstances. Section 1795 of the Health and Safety Code specifies that every person has ultimate responsibility for decisions respecting his/her own health care and possesses a concomitant right of access to complete information respecting his/her condition and care. The request must be obliged within 15 days of the written request. However, the law goes on to state that when it is determined by a health care provider that the patient would likely suffer a substantial risk of significant adverse or detrimental consequence in receiving a copy of mental health records a declination can then be made. The provider then must document in writing the date of the request and the reason for refusal, describing the specific adverse or detrimental consequences to the patient if they were permitted to review such a record. Section 1795 of the Health and Safety Code the health care provider is given the additional option of preparing a summary of the record, rather than allow access to the entire record. This same section of the law specifies the content of the information which must be included:

1. Pertinent history and chief complaint.
2. Findings from consultation and ancillary care providers.
3. Diagnosis, when determined.
4. Treatment Plan
5. Progress of treatment
6. Prognosis, inclusive of ongoing and unresolved significant issues.
7. Reports indicating findings of diagnostic procedures, tests, and discharge summaries.
8. Objective findings from the most recent physical examination.

The provider may charge no more than a reasonable fee based on actual time and cost for the preparation of the summary.

*Sept./Oct. 1989 CA therapist, Patient Access to Records, by Richard Leslie, Legal Counsel)

THE THERAPY RECORD

Therapists are required to keep records effective January 1, 2000 (for Clinical Social Workers and Marriage & Family therapists) for a minimum of seven years. These records should include demonstration of sound, clinical judgment, reflecting the standards of the



profession and the nature of the services received. Constitutes “below the standard of care” to not do so by the Board of Psychology and the Board of Behavioral Sciences and in malpractice litigation. Ethical codes including: American Psychological Association and California Society for Clinical Social Work require that each therapist keep accurate and current records of treatment. By doing so, this is the primary defense for a therapist against litigation and malpractice hearings.

Computerized record keeping is allowable providing there is a hard copy in the client record or that the clinician has a mechanism to ensure the record is unalterable and that you have an offsite backup storage system.

Record Content: Medical and psychiatric history, inclusive of records released from other care providers, significant others and related conversations with them; and reasons for seeking treatment, all required patient forms: consents for treatment, financial arrangements, limits of confidentiality, releases of information, consent to be treated by a registered associate, client’s current status, treatment plans and goals, progress, problems in not meeting treatment goals, significant actions taken and outcome, documentation for all issues with legal consequences: client fails to follow clinical directives, telephone conversations with client and others, consultations, gifts from clients and reasons accepted, all information related to suicidal, homicidal or abuse concerns and other legal issues/actions taken, evidence of continuity of care from other providers and to facilitate further continuity of care upon transition to other providers.

Protect against misuse of the record: keep in mind the client may read this in the future, be reviewed by a third party payer, or be subpoenaed in a legal case.

Patient Access to Records Law: requires that the healthcare practitioner respond within a specific timeframe to written requests by patients for their records. the therapist may provide: 1) a copy of the records, 2) access to the records, 3) summary of the record, 4) where the therapist “determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records,” the therapist may decline inspection as long as the therapist follows the specific requirements of the law.

Inspection by parents of child’s mental health records: may be declined where the therapist determines that it would be harmful to the therapy or the child either emotionally or physically. Records for the minor must be kept at least until the minor reaches age 19, but per California law, for at least 7 years.

How long must clinical records be kept: As long as necessary for the future care of the client, and as long as the record may be used in the defense of the therapist. Discarded records should be shredded. The American Psychological Association requires records be kept for a minimum of 3 years for the full record and an additional 12 years for the full record or the summary. The APA however, defers to state law.

Provisions in the event of therapist death or incapacity: the American Psychological Association guidelines require that psychologist make “plans in advance so that confidentiality of records and data is protected” Otherwise this is an ethical issue which should involve a plan for safeguards with the therapy record. The therapist’s estate could be subject to a lawsuit if the confidentiality of the records is not protected.



Ethics for Psychologists: A Commentary of the APA Ethics Code. Canter, Bennett, Jones and Nagy, 1994.

“Ethical and Legal Issues relating to the therapy Record” by Michele Licht, J.D., CSCSW Clinical Update, March 2000.

The American Psychological Association Record Keeping Guidelines (1993)

WHAT IS THIS LICENSING PROCESS ALL ABOUT?

Registration as an Associate Clinical Social Worker

By Carol J. Cole, LCSW, MSWAC, BCD

1. When will my hours of experience begin to count?

MSW* Not until you are issued an Associate Registration. Applicants must have graduated from an accredited School or Dept. of social work (school that is a candidate for accreditation by the Commission on Accreditation of the Council on SW education. The fee for registration is \$90.00. Must send a board prescribed form to apply and a \$90.00 fee. However, school must have received accreditation before candidate can sit for licensing exams. Must not have committed any crimes or acts that would constitute grounds for denial.

MFT up to 750 hours of counseling and direct supervisor contact may be acquired prior to the granting of the degree. Professional enrichment activities are not included, but personal psychotherapy is. Trainee status occurs after completion of no less than 12 semester units or 18 quarter units of coursework in any qualifying degree program.

2. How long is registration good for as an Associate Clinical Social Worker?

It will expire one year from the last day of the month during which it was issued and must be renewed annually for a maximum of six years (at a current cost of \$75.00 - prior to last date of month of which it was issued.

3. Can I get extensions beyond the six years?

If you have not completed your 3200 hours of supervision experience and there are no grounds for denial, suspension or revocation an associate can be eligible for up to three one-year extensions.

Each extenuation must commence on the date of expiration of previous renewal or extenuation expired. Must continue in supervision and cannot practice independently even if all required hours for completion of supervision are met.

4. What happens if I don't obtain an extension before my registration expires?

Your registration will be cancelled and you will need to apply for a new registration number, and you must start gaining hours all over again. No previous hours under old registration will count. You are not required to possess a valid registration while in the examination process unless you are employed in a private practice setting, or as a condition of your employment.

5. What about experience I gained outside of California?

This is examined on a case by case basis to determine substantial equivalency.

MIT for states not holding this license the supervisor, at the time of supervision held a clinical membership for at least 2 years in the American Association of Marriage and Family therapists.



6. When can I begin charging fees for my clinical social work service to the public?

Only after achieving W-2 employee status by a licensed person who is supervising you. You cannot work as an independent contractor in any setting, until you are licensed. As an unlicensed registrant you must inform each client, or patient, prior to performing any professional services that you are unlicensed and under the supervision of a licensed professional. Further, no supervision can be gained under the supervision of a spouse or relative by blood or marriage, or with whom the applicant has had a personal relationship.

7. What is the requirement for Post-Master's Experience?

MSW An applicant is required to have at least 3200 hours of post masters degree experience supervised by a licensed mental health professional acceptable to the board, in providing clinical social work services consisting of psychosocial diagnosis; assessment; treatment, including psychotherapy and counseling; client-centered advocacy; and evaluation as permitted by section 4996.9 If applying after January 1, 1992 this experience shall have been gained in not less than two, nor more than six years and shall have been gained within the six years immediately preceding the date on which the application for licensure was filed.

From the date the board receives your exam application they count back six years. Minimum of 3000 hours to include no more than 300 hours of personal psychotherapy and no more than 250 hours of workshops, no more than 1000 hours gained in supervision or professional enrichment activities, no more than 5 hours of supervision whether individual or group shall be credited during any single week. Must have 52 weeks of individual face to face supervisor contact. Up to 250 hours of experience can be credited for administering and evaluating psychological tests, clinical reports or progress notes.

8. What about experience gained more than six years prior to the date on which the application was filed?

It can apply if there is a showing of good cause, or the applicant is licensed and currently practicing in another state.

If received prior to January 1, 1999 (same as above)

MFT all 3000 must be completed with the exception of 500 hours of practicum.

9. What changes are there if I am applying for registration for supervision postmasters experience effective January 1, 1999?

A minimum of 2000 hours in psychosocial diagnosis, assessment, and treatment, including psychotherapy and counseling.

A maximum of 1200 hours in client-centered advocacy, consultation, evaluation, and research.

Supervision contact shall include at least one hour of direct supervision contact for every ten hours of client contact in each setting where experience is gained. One hour of direct supervision means one hour of face to face contact on an individual basis, or two hours of face to face contact in a group setting of not more than eight persons.

This must include a supervisory plan developed by supervisor and supervisee describing the goals and objectives of supervision. The supervisee must submit this plan within thirty days of commencement of supervision. The supervisor shall submit to the board within thirty days of termination of supervision evidence of satisfactorily completed supervised experience by the supervisee.

You must have at least one hour of direct face to face supervision for each week of experience claimed. The goals should include on the plan, ongoing assessment of strengths and limitations



and the assurance of practice within the laws and regulations. There is no penalty for forms submitted beyond the thirty days however, it may delay examination eligibility.

10. What Are the Required & Optional Forms You Must Fill Out With Your Supervisor Before Beginning Supervision & During?

Associate Clinical Social Worker Registration Application Packet - which includes Supervisory Plan Form.

Responsibility Statement for Supervisors of an Associate Clinical Social Worker.

Termination of Supervision Form.

Provided by Supervisor:

Child Abuse & Neglect Reporting Requirement Form

Agreement form for Requirements for Interns

Supervision Record (optional)

Interns resume and pertinent contact/emergency information

Supervisor-In-training Evaluation Form

Supervisee Self Assessment Form (optional/recommended)

Supervisee Evaluation Form, Clinical skills checklist, skills in utilizing supervision and personal characteristics.

This includes related literature read, workshops, meeting goals and objectives, identification of counter-transference, current theoretical approach and strengths and additional comments.

Supervisor Evaluation by Supervisee

Written contract with the employer to take supervisory responsibility for the registrant's social work services, if not received by employer

11. What disciplines can provide my supervision toward licensure?

A licensed mental health professional acceptable to the board who at the time of supervision possesses a valid license for at least two years as a psychologist, Licensed Clinical Social Worker, Marriage, Family & Child Counselor, or Physician certified in psychiatry by the American Board of Psychiatry and Neurology.

This does not include board eligible psychiatrists, must have full certification.

12. What maximum number of hours of supervision can these “Mental Health Professionals” provide?

Up to 1000 hours of required supervision may be gained under the supervision of a licensed mental health professional acceptable to the board. The rest - 2200 hours, if not all of the hours require a licensed clinical social worker.

13. What constitutes supervision?

Supervision means “responsibility and control of the quality of social work services being provided. “Supervision must include at least one hour of direct supervision for each week of experience claimed. At least one half of the hours of supervision shall be individual supervision Individual supervision means one supervisor meets with one supervisee at a time. Group means a supervisor meets with a group of no more than eight supervisees at a time. Consultation is not considered supervision.

14. What are the requirements for being supervised in a private practice setting?

Definition: “Any setting other than a governmental entity, a school, college or university, a



nonprofit and charitable corporation, or a licensed health facility.”

The requirements for supervision in a private practice setting:

Cannot pay employer for supervision.

Receive fair remuneration from the employer.

Remuneration received from patients or clients shall only be paid by the employer.

Services can only be performed where the employer regularly conducts business.

Cannot have any proprietary interest in the employer’s business.

MFT when employed in private practice must be supervised by someone other than employer.

15. Do I need to be employed or can I count volunteer hours supervised towards licensure?

In a setting that is not private practice, a registrant shall be employed on either a voluntary or paid basis.

If voluntary the registrant shall provide the board with a letter from his/her employer verifying voluntary status upon application for licensure. If employed the registrant shall provide the board with copies of his or her W-2 tax forms for each year of experience claimed upon application for licensure.

16. Can I obtain my supervision hours in a setting other than a private practice or government clinical setting?

It can include a non-profit and charitable corporation, a health facility, social rehabilitation or community treatment facility, a pediatric day health and respite care facility, or alcohol or drug abuse recovery or treatment facilities, school, college, or university. Any of these facilities must possess the appropriate licenses required from the designated governing bodies.

Health facility - must follow health and safety codes and be licensed by the Dept. of Social Services. Social rehabilitation or community treatment facilities licensed by the Dept. of Social Services, Community Care licensing division. Pediatric day health and respite care facility will possess a license from the Dept. of Health Services. Alcohol or drug abuse recovery or treatment facilities will possess a license from the Dept. of Alcohol and Drug Programs.

17. What if I can’t get supervision or adequate supervision at my place of employment?

If employed in a setting other than a private practice you may obtain supervision from a person not employed by the registrant’s employer if that person has signed a written contract with the employer to take supervisory responsibility for the registrant’s social work services.

The contract shall include the responsibilities of the supervisor, employer and associate and must be submitted to the board with supervisee’s experience verification form at the time of licensure application.

18. What are the requirements for Associate Clinical Social Worker Supervisors?

Must sign a ‘Responsibility Statement for Supervisors of an Associate Clinical Social Worker’ or a ‘Responsibility Statement for Supervisors of Marriage, Family & Child Counselor trainee or Intern (new 11/98).

Possess and maintain a current valid California license in good standing, as a licensed Clinical Social Worker or Licensed mental health professional acceptable to the board and specified in the requirements.

Supervisor will notify the associate of any licensing change in status.

All of the above applies to supervisors who are supervising an associate who has been registered with the board on and after May 10, 1999. Disciplinary action, including revocation, suspension, probation, inactive license, lapse in licensure.



The supervisor has practiced psychotherapy as part of his/her clinical experience for at least two years (not been licensed two years), within the last five immediately preceding supervision. The supervisor has had sufficient experience, training and education in the area of clinical supervision to competently supervise associates (a minimum of 15 contact hours in supervision training obtained from a state agency or approved continuing education provider. The supervisor knows and understands the laws and regulations pertaining to both supervision of associates and the experience required for licensure as a clinical social worker. the supervisor shall ensure that the extent, kind and quality of clinical social work performed is consistent with the training and experience of the person being supervised and shall review client/ patient records, monitor and evaluate assessment and treatment decisions of the associate clinical social worker the supervisor shall give at least one week’s written notice to an associate of the supervisors intent not to certify any further hours of experience for such person and complete a “Termination of Supervision” form. The supervisor shall complete an assessment of the ongoing strengths and limitations of the associate (to be completed at least once per year and at time of termination of supervision. Upon written request of the board the supervisor shall provide to the board any documentation verifying supervisor’s compliance with requirements. The supervisor shall develop and complete a “Supervisory Plan” (form no. 1800 37A-521, revised 2-99). Original to be submitted by the associate.

19. What additional training do I need post-graduate before applying for licensure?

Child Abuse Assessment & Reporting (7 contact hours). Human Sexuality (10 contact hours) Alcoholism & Chemical Substance Dependency (1 semester unit with no less than 15 classroom hours). Spousal or Partner Abuse Assessment, Detection & Intervention (number of hours not specified, but required for those beginning their graduate training on or after January 1, 1995).

20. How much money will this application process cost?

Registration as an Associate Clinical Social Worker:	\$90.00.
Costs of additional required course work:	\$200.00-\$500.00
\$100.00 application fee ± \$100.00 written exam fee:	\$200.00
DOJ & FBI fingerprint fees	\$ 48.00
2nd set of prints for an additional	\$ 24.00, if needed.
Approximated costs of Exam Materials, courses & coaching:	\$350.00 -\$ 1500.00
Upon successful completion of written exam +	
An additional costs for Oral Exam	\$200.00

Once successfully passed you will need to submit request for an official licenser this fee will be prorated according to the month of issuance.

21. Is it essential to get a background check?

DOJ & FBI completed ten-print applicant fingerprint cards are required and will be submitted by the board. Previously processed ones are not acceptable- this includes a \$48.00 fingerprint processing fee, takes 6-8 weeks to process) If applicant then goes out of state and obtains additional supervision will need to submit a 2nd set of prints for an additional \$24.00.



All convictions must be reported and will be evaluated individually. Based on nature and severity of crime, subsequent criminal acts, time elapsed since crime, extent of complying with probation, parole or restitution terms, evidence of rehabilitation submitted by the applicant.

License or registration is only issued upon clearance.

This means no criminal conviction or criminal conviction has been evaluated and cleared by the board.

22. Do I need to report any prior disciplines I received against a professional license?

You must disclose all disciplines against licenses, even if they have been previously reported to the board.

You don't need to necessarily resubmit documentation previously on file, but provide a written statement of such. You need to provide the board with a certified copy of the determination made by the licensing entity. A letter from you describing the circumstances, proof of completion of probation, letters of reference from employers, instructors, counselors and parole officers on their letterhead.

23. Under what circumstances can suspension or revocation of my license or registration occur?

Breach of confidentiality of patient, or lack of informed consent, lack of chart note documentation. Disclosure without signed release. Was informed consent obtained and documented, is there proper documentation of events and consequences in the chart notes. This is based on Standard of Care Analysis (extrapolated from law offices of Callahan, McCune & Willis LLP, San Diego & Los Angeles, 1999)

Does it violate: a statute?

Such as a reporting law.

Does it violate: a licensing board regulation?

Supervision requirements for interns?

Does it violate: an ethical principle of a professional association?

Dual relationships, scope of practice?

Does it violate: case law?

Tarasoff/ duty to warn of patient's threat?

Does it violate: the consensus of the community?

What would peers think of you doing it, what would you think if a peer told you they were doing it?

24. What questions can't a potential supervisor ask me in an interview?

This is the same as the laws that apply to any employee (nothing that can be construed as discriminatory). All references can and will likely be checked.

Age, marital status, parenthood status, childcare plan, are you in therapy, citizenship status/country of origin, financial status (own home, bankruptcy, garnished wages, all organization affiliations, religious status, weight, health and disability questions, anything asked in a biased manner.



Clinical Supervision for Supervisors

David Lattman. L.C.S.W., B.C.D.

I. MODELS AND MODALITIES IN SUPERVISION

What is supervision and why is it important?

- provides supervisees feedback about their performance
- offers them guidance about what to do in times of confusion and need
- allows them the opportunity to get alternative views and perspectives about patient dynamics, interventions and course of treatment
- stimulates curiosity about patients
- contributes to the process of forming a therapist identity
- serves as a secure base for supervisees, letting them know that they are not alone in their learning about and performing of psychotherapy.

It also serves a critical quality control function, ensuring that patients are provided with acceptable care, that the therapists do no harm and possess sufficient skills to function as therapist, and ensures those who lack such skills are not allowed to continue without some form of remediation (Watkins, 1997).

Bernard and Goodyear (1992) offer a working *definition of psychotherapy supervision*:

An intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients, she, he, or they see(s) and serving as a gatekeeper for those who are to enter the particular profession. (p. 4)

The components of the supervision definition include the following (Watkins, 1991):

- *Relationship*: Supervision is first and foremost a relationship between professional members. This relationship is viewed as a learning alliance, as the essence of the supervision experience, and as the medium for teaching needed skill and techniques.
- *Evaluation*: Supervision is evaluative because it promotes feedback about supervisee performance, skills and effectiveness and allows patient care to be monitored and protected.
- *Extends over time*: For learning and growth to occur, substantial time is required. This process cannot be rushed if the supervisee is to have the opportunity to work with varied patients, to track and scrutinize their treatment efforts over time, and to watch the therapeutic process unfold. The amount of time required for adequate supervision varies greatly. Often, supervisor and supervisee work together for a full academic year (approximately 9 months), but it is also common for these supervisees to receive more than one year of supervision and to work with more than one supervisor
- *Enhanced professional functioning*: It is the function of supervision that the supervisee functioning is enhanced. It is all about helping the therapist become more effective:
- *Monitoring quality of professional service*: Supervisors are ultimately responsible for the treatment the client receives and must be attentive to the quality of that treatment and how it



services the client. Without good monitoring of service quality, patient welfare can be sorely compromised or even jeopardized.

- *Serving as gatekeeper* Whatever the form of remediation, supervisees are judged not ready to enter the profession. This may mean more training, supervision, or personal therapy. Whatever the case, the supervisor is responsible for making these judgments and in that way serves as a keeper of the gate.

Factors that Compose and Influence Supervisory Functioning (Watkins, 1997)

The elements that make up supervisory functioning, what supervisors do and how and why they do it, include their assumptive world, theory/model, style, roles/ strategies, foci, format and techniques. These factors lead to a multi-layered conceptualization (graphically depicted in Figure 1) and are seen as the most important in understanding how and why supervisors do what they do.

- *Assumptive World*: Refers to the supervisor's past professional and life experience, training, values, and general outlook on life. It is a product of the professional and the personal and reflects the values, assumptions, and overall perspective on life and our place in it. This assumptive world affects the next factor — choice of theory or model.
- *Theory*. Are the practitioner's theory of therapy and theory of supervision the same or different? One's theory of supervision may offer understanding about variables such as the supervisor-supervisee relationship, dynamics, supervisee resistance and transference, interventions, and the process of growth and development. Thus, whatever the nature of the therapy, it reflects one's values, assumption, and perspective about the treatment and supervision endeavors.
- *Supervisory style*: Style refers to the supervisor's consistent, characteristic manner of relating to their supervisees be it facilitative in manner, dictatorial, passive, task-oriented, or confrontive. Style is the characteristic fashion in which the supervisor relates to supervisees and implements his or her assumption world and theory in supervision.
- *Roles / strategies*: Role refers to a function assumed by someone; and strategy, commonly referred to as a technique or specific intervention, can also be defined in the same way. Some of the different roles/strategies include teacher, lecturer, instructor, consultant, counselor, colleague, collegial-peer, monitor, model, administrator and interactor. Supervision requires us to perform different roles at different times and we may give more emphasis to and feel more comfortable with certain roles as opposed to others.
- *Foci*: Refers to the factors or processes that receive primary attention during the supervision session. According to Rodenhauer et al. (1985), four focal points are: (1) professional / organizational factors; (2) assessment / planning processes; (3) implementation/ intervention/ evaluation processes; and (4) personal factors. Each of the four foci are attended to in supervision at various times.
- *Format of supervision*: Format refers to the form or forms by which supervision is delivered. For example, is supervision done individually or in group? It is performed face to face?



Format affected by and flow from the previously identified factors of supervisor functioning.

- *Techniques*: Refers to the supervisors actual interventions used in supervision and can take various forms. Techniques involve doing, are active and are engaged in for a particular reason to bring about some desired result. Technique is the most specific level of operation in supervisor functioning.



FIGURE 1

**FACTORS THAT COMPOSE AND INFLUENCE SUPERVISOR FUNCTIONING:
A MULTI-LAYERED CONCEPTUALIZATION**

[Friedlander and Ward (1984); Rodenhauser et al. (1985)
and Shanfield and Gil (1985)]

SUPERVISORY FUNCTIONING LAYERS

**Assumptive
World**

Theory/ Model

Style

Roles/ Strategies

Foci

Format

Techniques

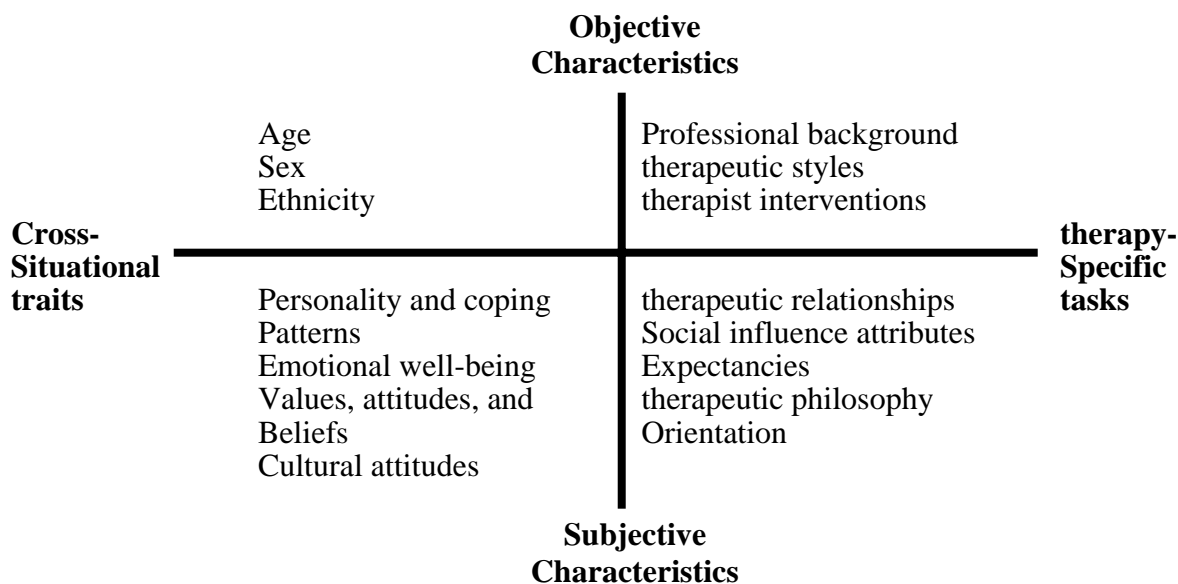
The previously addressed factors lead to this multi-layered conceptualization. The top layer is the broadest and most influential, ultimately affecting all layers that lie below it. Each succeeding layer would be more specific in nature and each would, in turn, affect all layers that lie below it. Although other layers could be added to this conceptualization, those shown identify most if not the most important factors that affect supervisory functioning.



Therapist Characteristics

A variety of characteristics can potentially affect the process and outcome of supervision. Beutler et al. (1994) classified these characteristics into *Figure 2* below. Objective / subjective, refers to whether the characteristics are inferred from therapist's self-report (subjective) or can be determined from other sources (objective). Cross-situational traits / therapy-specific states speaks to whether the characteristics are stable, enduring and exist independently of the supervision or are specific to the supervision.

FIGURE 2
(Watkins, 1997)



Appropriate operationalization of therapist characteristics is crucial because the goal of supervision is to make the supervisee a more effective therapist. The characteristics in Figure 2 were included because they have been thought to be, at one time or another, related to treatment outcomes, if a therapist characteristic is related to treatment outcomes and if the characteristic is modifiable, then supervision could be appropriately focused on changing this characteristic of the therapist. Of course the most obvious therapist characteristics that would be the focus of supervision would be therapeutic skill level.

Supervisor Characteristics (Watkins, 1997)

All of the characteristics displayed in Figure 2 are relevant to supervisors. Although there are characteristics specific to supervision such as supervisory style and interventions, they could be added to the taxonomy. An important issue here is the characteristics of the supervisor as therapist. It is unsupported by research that the characteristics of supervisor and therapist are synonymous. It has also been found that therapists tend to adopt the theoretical orientation of the supervisor which can lead to conflict and affect the supervision process. For example, a



behavioral supervisor may question the therapist about the behavioral antecedents of the patient's behavior. The therapist may not be able to respond as a behavioral analysis was not conducted because of therapist orientation. The supervisor may then make a negative judgment about the therapist's competence. Research has found that similar theoretical orientation and interpretive style contributes to trainee's reported positive supervisory experiences.

Humanistic Approach to Supervision (Lattman)

1. Wider boundary
 - More engaging
 - More self-disclosure
 - Empathy and warmth
 - Humor
 - Supportive
 - Nurturing / caring / giving
 - No romantic / sexual encounter of any kind
2. Use of supervisors own case material through modeling / role-play / psychodrama
3. Didactic learning
4. Trial and error learning
5. Emphasis on counter-transference issues
6. Referral for psychotherapy
7. Therapeutic elements of diminishing anxiety, building competence and self-esteem, and sorting out professional direction
8. Assessment of developmental level of supervisee form (See 'Outcome' Section/Figure 6)
9. Assessment of personality, personal qualities, life circumstances
10. Assess clinical strengths and weaknesses
11. Process of Supervision
 - Building / reinforcing strengths before more critical input
 - What supervisory style, educational techniques work for the supervisee as an individual
 - All input from supervisee highly valued/ strong positive reinforcement and encouragement
 - Parallel process for supervisee-client and supervisor-supervisee
 - Confrontation/ Evaluation of supervisee performance at a very measured pace
 - Careful monitoring of the growth process — being sure the supervisee isn't trying to move too fast or go too slow



12. Determining motivation of the supervisee to achieve high standards / Being sure this is the work they really want to do
13. Utilization of field liaison, executive director, consultants and therapists in addressing problem areas which are not resolving themselves
14. Contracting for improvement in problem areas

15. Termination Process - On-going affiliations

Relationship and Subjectivity

According to Brown (1996), the supervisor must engage the supervisee personally by modeling and providing practice in relationship skills through metaprocessing. Metaprocessing consists of metacommunication, self-disclosure and feedback, and enhances not only the supervisor-supervisee relationship but the therapist-client relationship.

These interactions focus on the human relationship — it focuses on the current experience which includes the ability to remove oneself from the subject matter and attend to the experience. By attending to the human encounter in the training and supervisory process, supervisors deal explicitly with presence and responsiveness, both prerequisites of supervision and therapy. By dealing with relationship, presence, and personal response, the supervisor uses themselves as the instrument thereby bringing themselves to the present moment. The ultimate achievement deals with what is actual, in the present moment, and being genuinely responsive.

The human relationship between supervisor and supervisee is the ultimate arena for the therapist to be initiated into the practice of reaching deeper into themselves. The supervisor sets the tone by prompting supervisees - not at the expense of clinical learning but as an integral part of it. Supervisors facilitate this process and provide their supervisee the opportunity to open themselves to their experiences and to recognize their emotions. Engagement and expression replace talking about what is often a static and stale interaction. At the same time, they learn how to genuinely engage and affirm their clients as human beings worthy of spending time with rather than as problems that need to be fixed.

The usual focus of supervisors resides in the domain of analyzing, matching, judging, comparing facts and ideas, diagnosing and composing treatment plans, and describing the symptoms of psychopathology. But relating in a caring and creative way is not learned, at least not from reading books, but from many years of life experience and self-scrutiny. The following is an example of metaprocessing between a supervisor and supervisee:

Supervisor: “this is what is going on for me right now. I sense we are on different wave-lengths. I realize I want more engagement from you. And I wonder what is going on for you now. You have been talking about your concerns for your clients but I am speaking to what is happening between us now.

Supervisee: “I have mixed feelings about what you just said. Uum, I’ve picked up some



hints that you are not satisfied with me. I guess I've been protecting myself in here. So I am caught. How much can I trust? I'm afraid you want something of me I can't give." Avoid slipping into the therapist role and work to keep the interaction on the more personal level. For example, one response could be: "What you have just told me is important for me to know. I appreciate very much that you trust me enough to say what you did. It seems we've put some juicy topics on the table. In terms of my wanting more engagement from you, you are giving me this right now. I'm open to hearing whatever else you may want to say."

Family therapy Supervision

There are a multitude of family therapy approaches and they increase day by day: Supervision of conjoint / family therapy is typically provided in institutes with a particular school of thought. Supervision is provided by seasoned practitioners and educators in clinics, agencies and in private practice. The practitioner in training will hopefully have exposure to many different approaches and with different supervisors. The more one learns, the better one is able to apply techniques that work best with their specific client populations.

Family Systems Approach (Lattman)

1. At-risk factors
2. Legal and ethical issues
3. Assessment
 - Presenting issues
 - History of presenting problems
 - Attempted solutions and previous therapy experiences
 - Family history
 - Impact of multi-cultural / human diversity issues on the family system
 - Specific stressors on the system
 - Strengths in the system — actual and potential
 - Client support system
 - Motivation for therapy - motivated and resistant family members
4. Systemic Diagnosis: incorporating:
 - Intergenerational issues
 - Flexibility versus rigidity of the system
 - Core problems
 - Potential for change
5. Goals & Objectives, therapeutic Strategies and Collaborative Systems
 - Goals and objectives: what needs changing? How will the system change? (be specific)
 - Strategies for change: compliance or defiance-based techniques
 - Who will attend and why? Working with less than desired family members
 - Utilization of adjunctive professionals and resources
 - Multimodal approaches to family treatment



6. Countertransference Issues and Personal Concerns
 - Countertransference issues of supervisee
 - How to help supervisee with personalized reactions Countertransference issues of supervisor
 - When supervisor may lose objectivity in feedback to supervisee due to own counter-transference reactions

7. Specific Assistance Requested
 - What does the intern want from the supervisor?
 - What supervisory techniques work best with the given intern / supervisee?
 - What collaborative professionals and educational forums and research compliment the individual or group supervision?

Structural family therapy supervision commonly has a format of live supervision where the supervisee is selected to treat a case and the rest of the group is behind a two-way mirror. The therapist conducting the session is receiving calls from the other therapists behind the two-way mirror the session is video-taped and the supervisee along with the group and group leader will review the tape. Then the group alternates in terms of a given supervisee being the one conducting the session. In this approach everyone participates, offers suggestions, as well as integrates theory with the practice (Watkins, 1997).

It is well advised that the supervisee has taken courses where theory is taught, that there is the viewing of educational tapes, and to have training in marital therapy from the briefer intensive model where the approach is very active and dramatic in nature. The therapist is trained to take a very strong intervention role to keep up the intensity, to establish focus, and use techniques that are meant to produce change in the session by basic techniques of confrontation, refraining, competence building, and restructuring the hierarchy of the family or couple versus using insight-oriented techniques. A real training program consists of basically a two-year program, although lesser periods of training are still valuable (Watkins. 1997).

Structural Summary:

- Change results from experience
- Action-enactment
- Here and now + some past, selectively
- Faster pace
- Less time joining
- Bypass defenses
- Spontaneous use of self
- Bolding confronting
- Refraining transactions to highlight interpersonal binding
- Uses intensity / paradox, authority, manipulation
- Explicit
- Dramatic
- Focused on changing family structure
- Also deals with defenses



- Uses mapping
- Family therapy techniques (Minuchin)

Dynamic Family therapy (Watkins, 1997)

Dynamic family therapy is a model that has been the cornerstone to the Cedars Sinai thalians post-masters training program in family therapy in Los Angeles. In this approach the differences are that there is a slower process that in not as intense or confrontational as the structural model. There is more building of therapeutic alliance and attention to defenses. Families / couples are seen over longer periods of time, often with adjunctive, therapeutic interventions such as group and individual therapy. the therapist is trained in trying to do a more psychosocial a profile of the system that while change of course is the goal, is consistent with dynamic therapies at large which look at process over a period of a minimum of six months to a year

Live supervision behind a two-way mirror is commonly used although more so a seasoned practitioner is conducting the therapy and the supervisees are observing. there also is a much broader based training experience where there are more formal year long classes in family therapy that incorporate the many schools including structural family therapy. It is therefore less of a rigid theoretical model complimenting the above discussion. There are assignments to child therapy programs, therapeutic nursery schools, and exposure to educational forums such as grand rounds and interdisciplinary approaches to family therapy. The therapist in training is assigned their own cases and has an individual supervisor. There is more attention given to the supervisee as far as their countertransference issues and personal traits that potentially may lead to recommendation to personal therapy.

Dynamic Summary

- Change results from insight
- Reflection / interpretation
- There and then + here and now
- Slower pace
More time forming therapeutic alliance
- Attentive to defenses
- Monitored use of self
- Tactfully confronting
- Interpretation of unconscious conflicts being acted out in present transactions
- Non-intense, non-paradoxical, non-authoritative
- Implicit
- Easy-going
- Focused on fostering insight into motivation

Bowenian theory (Watkins, 1997)

Bowenian theory revolves around the principle of differentiation. This concept incorporates the central principle of individuating from your family of origin in the central developmental goal. Those individuals that come into their marriages and family life with a background of enmeshment are low on the scale of differentiation. Those who have established strong individuality are high on the scale of differentiation. It is good to incorporate strong separation /



individuation from their family of origin. Differentiation is self addressed in supervision and there is commonly more of a component of therapy for the supervisee than compared to most other training methodologies. Co-therapy is commonly used. Didactic education as well as other approaches also uses video material.

There are obvious limitations and concerns in regard to Bowenian theory in that many cultures are not given to the more idealized differentiation model. This is consistent with similar concerns about the structural family therapy model as regards notions of a healthy family structure where extended family is given strong boundaries in relation to the nuclear family.

The *Bowen Approach* to training revolves around the concept of self and there is a lack of emphasis on technique. Supervisors are less concerned with what a supervisee says in reviewing a tape than with his or her personal level of functioning. Clinical ability comes directly from effort with one's own family of origin and training in the long-term focuses more on the therapist's personal growth. Differentiation of self is assessed in the trainee's clinical work and is monitored during supervision. This approach seems indistinguishable from personal therapy for the therapist as little emphasis is placed on skills or training objectives.

Supervisors are seen as equally needing to work on their own level of differentiation in the supervision relationship. This will model appropriate behavior for their trainees. Little role playing and no live supervision are used in this approach. This process takes a very long time and can be considered a lifelong quest. The most realistic outcome of training is the cognitive understanding of the concept of systems thinking. True differentiation of self is too ambitious a goal of training and a deep understanding of theory is more important than technique.

Integrative Psychodynamic and Systems Approach (Watkins, 1997) states that it is important to broaden the range within which training is defined. Training should include the education and career development of the therapist. In this approach, theoretical content comes first and is followed by the core of the training, practical clinical experience, under supervision. A variety in supervision is suggested in order to keep the trainee and the supervisor in peak performance. Here, the focus of training is not the personal growth of the trainees, but the acquisition of technique, content and a professional demeanor. Training should influence clinicians to pursue a lifelong process of professional learning and improvement. The supervisor's role is instilling values about continuing professional education.

Communication theorists (Watkins, 1997)

Communication theorists evolve from the Palo Alto School (Jackson, Satir, Bateson, Weakland). The basic assumptions of communication theory are that human behavior is contextual, that the human context in relationship, and that communication is the vehicle of observable manifestations of relationships. Importantly, this view stresses the impossibility of not communicating, for all behavior is communication.

Palo Alto theorists postulate two levels of communication. One level is the *report level*, which is purely informational, content-communication, such as, "it's a sunny day." the second level is called *metacommunication*, structures and adds meaning to what is said at the report or content



level. To use the previous example, when a person says, “it’s a sunny day,” the person is also defining what will be talked about other examples of metacommunication might be a nonverbal nod, wink, or smile that qualifies a verbal message. Problems may arise when a message at the first level is contradicted or confused by a facial expression or voice tone which communications at the second level. Such feedback occurs via metacommunication, which implicitly involves self-definition and other-definition: “I see myself this way’ and “I see you as that sort of person.” While we all need confirmation, there are three possible responses to another person’s statement of self- definition. Two of them, affirmation and negation, are potentially health-promoting, for even negation implies one” awareness of the other person’s self-view. The third possibility, disconfirmation, is inherently pathogenic, because it communicates to the other that he does not exist.

The communications theorists see two types of patterns as typically interplaying in human relationships. These are complementary and symmetry. Symmetry represents equality and similarity of behavior between individuals, complementary suggests that differences between individuals and emphasized and are needed to balance each other’s roles, as with parent and child or teacher and learner. It is important to recognize that neither of these patterns is good or bad. Both can represent valid and healthy ways of relating if they involve mutual respect of the individuals involved.

The notion of the family attempting to maintain a homeostatic balance is also central to communication theory. Healthy families, according to these theorists, have built into their communication patterns rules for the change of rules. Such flexibility seems to be necessary for families to respond adaptively to the inevitable life transitions that face both individual members and the family group. The problems of rigidity and refusal to change are basic to the Palo Alto group’s approach to pathology, which is seen as contextual. They assert that “crazy” behavior and communication may be the only possible reaction to an absurd or untenable communication context.

Clinical Practice

In the communications model, the task of the therapist is to determine what is going on, here and now in the family system that produces the behavior that is seen as a problem. After the initial family interview, the therapist formulates the main presenting problems and identifies which behaviors are central in maintaining them. The therapist then decides on a goal of treatment and considers which interventions will be most effective in changing the communications patterns of the family. The therapist’s role is active and manipulative, with the clear intention of confronting and altering destructive modes of interaction.

Refraining is one of the major techniques used by therapists of the communications school of thought, and it is based on the assumption that any opinion is “meta” to the object of the opinion. To reframe is to assume that it is not the things themselves that trouble individuals; but rather, their opinions and attitudes about these things. What changes as a result of the therapist refraining is the meaning attributed to a situation and, therefore, often, its consequences. According to the Palo Alto group, refraining can help a client experience small changes and believes that such changes tend to generate further self-induced changes in other areas of the



clients life.

Another important area of focus is that of family rules. A task of the therapist is to openly define the family's covert rules as well as rule makers, thus, hopefully, breaking up the covert leadership and its power. The therapist may also position him or herself as the third person in a two-person conflict and break family rules by exposing their complementary relationship. A third type of intervention may be to give directives such as "Do this" or "Say that," which requires a family member to break certain family rules, again providing experiences of behavior and communication change.

This approach to change stresses that if the therapist believes change will take a long time, chances are it will — the proverbial self-fulfilling prophecy. They reinterpret the traditional concept of the transference, claiming that when the context of the therapy relationship is considered, the client's so-called "regressive" behavior is actually a reasonable response to a non-adult situation — i.e., lying on the couch, being told to free associate. Because of the emphasis on the here-and-now behavior of the family as well as the relatively active role of the therapist transference, in the classical sense, is not a core issue for this group. In addition, insight is not seen as an agent of change, but, rather, as a result.

Supervision for Communications therapists

Total attention in training is put on listening to communication and changing communication in the here-and-now. In this regard, it is closely affiliated with structural and strategic models of intervention. The therapist tends to be very active and intervenes to change communication patterns and offers strong affirmation for positive changes. The theory and supervised practice of the Satiran approach emphasizes the keeping the self-esteem of each family member; there is a lot of physical positioning of family members, molding, sculpting, all designed to give the couple or family the experience of relating to one another in a more positive and productive manner.

The supervisee is given a lot of modeling by the trainer / supervisor. Also, there is a lot of use of videotape and live supervision. In larger training forums there is commonly an experienced practitioner working with a real family that the supervisees observe. Like all other approaches to supervision, there is a strong didactic component that is basically taught through educational forums with a small group size consistent with related brief-term models. This again, like other training models, asks that the supervisees set aside previous training practice. The most professional trainers / supervisors want their supervisee to experience the approach and then leave it or integrate it into their practice unless they choose to follow the more purist model of practice that are endemic to institute training.

Jay Haley — Theory (Watkins, 1997)

Haley, like many of his colleagues in the Palo Alto group, underlines the struggle for power and control in every relationship through the messages that sender and receiver exchange with each other. Who will define the relationship? Will that person turn into a symmetrical or complementary one? Who decides? Haley believes that all symptoms are strategies for controlling a relationship when other strategies have failed. The person with the symptom generally denies any intentional wish to control, claiming that the symptom is involuntary. As



an example, he cites the case of a woman who insisted that her husband be home every night because she suffered anxiety attacks if left alone. She refused to acknowledge controlling his behavior in this way, but, rather, blamed it on the anxiety attacks, over which she presumably had no control. The husband faces a dilemma: he cannot acknowledge that she is controlling his behavior (it is, after all, her anxiety that is doing so), but he also cannot refuse to let her control his behavior, for the same reason. He is in a double-bind situation. A double-bind situation is one in which a person receives contradictory messages from the same individual. He or she is called upon to make some response, but is doomed to failure whatever response he or she chooses. Haley and his colleagues believe that double-bind situations occur with great regularity in some families. They frequently involve real but not always readily apparent contradictions between what is said aloud and what is simultaneously communicated by gesture or tone.

In conclusion, Haley is concerned with the power alliances and coalitions within a family as well as with the meta-communicative aspects of family relationships. He sees family therapy as going through formal stages during which a problem in the present situation is defined and new behavior is encouraged or suggested to solve the problem, changing family relationships in the process. According to Haley, brief, intensive intervention with a family followed by rapid disengagement is preferable to long-term involvement.

Strategic Supervision Supervisory Methods (Practical Applications in Supervision, 1999)

- The supervisor is deemed the “consultant” on cases, emphasizing the greater expertise and the expectations that he or she will observe the treatment and intervene only at points where problems are occurring. Just as theory states that people can get stuck in trying to solve their problems, so, can therapists become stuck and the consultant functions to deal with the stuck points / resistance between the therapist and the family.
- Training is oriented to technique and theory, with no emphasis on the trainee’s internal experience. The consultant uses a one-way mirror giving directives by telephone or by entering the therapy room. The goal of training is for the trainee to help clients resolve their problems in relatively brief therapy. This technique-oriented training is usually supplemented by seminars and reading.

Sequence of Supervisory Orientations (Practical Applications in Supervision, 1999)

- At the beginning level of family therapy, we recommend structural supervision with its approach to teaching of family structure theory, the application of basic and concrete techniques, and a supervisory relationship in which the supervisor serves as a director in actively guiding the supervisee.
- Once a supervisee has been trained to apply theory, it is important for the supervisor to help the supervisee to work directly at integrating the “self” experience with these therapy techniques. This alleviates the risk the trainee becoming too mechanical and relying too heavily on techniques which can arise from being trained exclusively in structural-strategic therapy.

Purist vs. Multiple Model Programs (Practical Applications in Supervision, 1999)



- Should a supervisee be trained in a purist program in which only one model is taught or is a multimodal training program more desirable? The answer depends upon the training experience of the supervisee. Prior to family therapy training, the supervisee should be trained in a diversified curriculum of individual and group supervision with children and adults, using a variety of conceptual approaches, including an introduction to family therapy.
- After the initial training, a purist family therapy model is recommended. The supervisor gives the supervisee an opportunity to learn the straightforward model and forces the supervisee to take a position (“What do I think?”) about the model.
- Advanced supervisees should be trained in several different theoretical orientations by different supervisors helping to enrich the supervisee’s skills beyond what can be provided by just one model. This framework also helps to sharpen, through contrast, the supervisee’s knowledge of each model. With the use of different supervisors, there is less chance that the supervisee will become a strict adherent of any one model. The goal of which is to allow the supervisee to individuate and integrate the models in such a manner that permits a unique style to emerge.
- The risks are that the supervisee will get triangulated between different supervisors or models. Another danger is the possibility of increased confusion in the supervisee who scurries from the supervisor to supervisor without having the opportunity to discuss the similarities and differences between models. these risks can be minimized by: (a) ensuring only one supervisor is responsible for supervising each case; (b) when supervisors of differing models have a regular, open forum with supervisees to discuss their contrasting approaches; (c) when supervisors acknowledge wanting to learn from each other and (d) when the supervisee is advanced and mature enough to deal with ambiguity and conflict and can take the primary initiative.

Training Models (Practical Applications in Supervision, 1999)

- The ***Brief Therapy*** training model offers a minimalist approach to training and is facilitated in small group settings. The emphasis here is on supervision rather than on didactics. And learning this model occurs best by doing treatment, under guidance, with ongoing cases. While didactic explanation does exist, most of the training involves direct supervision. This process relies on two key processes: (1) unlearning one’s previous model; and (2) learning new and different principles. Evaluation is accomplished by the supervisor’s judgment of the supervisee’s incorporation of the model’s key elements.
- In the ***Milan Systemic*** (MS) training model theory is the critical aspect and conceptualization along system lines is acquired via observation and participation on a therapy team. Supervisees are taught to use system thinking on their families and also in the agency structure in which the treatment exists and theory acquisition is maximized by observation, role playing and seeing families. Little regard is given for the acquisition of specific therapeutic skills and the idiosyncrasies of the therapist style and the MS trainers attend to macro levels of in-session interaction. The group becomes a thinking machine, a group



mind, where matters of personality, personal style and the modification of that style for therapeutic purposes becomes secondary or nonexistent. Initial reactions of high satisfaction with the process are typically followed by several reactions including disaffection with the model itself, its apparent lack of transferability to a wide range of clinical settings, the few actual number of families that get seen, and the insufficient focus on skill development, it is suggested that strategic therapists in training should be mature and possess life experiences and be intelligent with wide range of good interpersonal skills. It is advised that trainees should be cut off from other supervisors and sources of therapeutic influence during training in strategic therapy.

- This training philosophy contains several key ingredients. It is the *supervisor's responsibility* to protect clients from the inadequacies of beginning therapists as well as to assist the trainee to develop problem solving skills. Live supervision methods are essential ingredients. Video supervision is also a key component. Learning by doing is paramount and one primary goal of training is to expand the range of therapist skills and behaviors available in clinical situations. It is important to teach a wide variety of therapy techniques as well as ways of crafting them to each case that comes along. Lastly, evaluation is essential. If the cases do not improve, training and supervision cannot be considered successful.
- ***Structural Family Therapy*** focuses on training and supervision issues. This treatment model has been taught extensively at pre-professional and continuing education levels. Video teaching tapes should be considered along with live supervision. This approach is attentive to the dangers of over-focusing on technique. It is balanced with an equal emphasis on the therapist "self" and expands the therapist's range of skill and technical mastery. Inherent to this particular approach are the disruptive aspects of the transitional period of training in which new skills are practiced and the self of the therapist is emphasized. A good training relationship is vital during these times. Imperative to this approach are direct observation and live supervision, an ongoing theory/didactic seminar to integrate theoretical ideas with practice, and the need to take the long view of training and therapist development. The trainee develops ways of transforming insights into operations and in this process of achieving wisdom beyond knowledge; the therapist discovers that she has a repertoire of spontaneous operations.
- The ***Symbolic-Experimental Approach*** occurs in three stages. The first is learning about family therapy which is best done in seminars and workshops. The second is learning to do family therapy in direct clinical experience. Lastly, it consists of a reorientation in which the therapist comes to believe in families rather than individuals. Co-therapy is one of the most powerful and central methods here. Teaching involves a continuous dialogue in which the teacher and trainee discuss assumptions, belief, values, fantasies, and notions about what might be best to do in therapy.
- ***Functional Family Therapy*** (FFT) is a model that integrates principles of learning theory, systems theory and cognitive theory and is tied closely to social learning and family systems. Four elements are emphasized: (1) didactic and modeling are primary training methods and



emphasize intellectual capacities; (2) the emotional element of training which refers to the trainee's ability to work with families under real life conditions and appreciates how therapist distress can lead to poor clinical outcome; (3) the technical aspect concerns the skills necessary to conduct a thorough assessment and to engage in therapy and education; and (4) the relational which refers to the trainee's capacity to develop and use a relationship with the supervisor to learn the skills of the approach. The first phase of training does not include direct clinical experience with families. Trainees learn the theoretical content of FFT. The second phase in where clinical work begins and happens through a variety of supervisory formats including live supervision, team supervision, videotape and individual supervision which is done with pairs of trainees.

The most common trainee problems include the demand characteristics of the setting (fear of evaluation, competition with peers, loss of status in learning a new approach); aspects of trainee style (emotional aspects of learning and its impact on the developing clinician); features of the model itself (difficulties with learning the logic or mechanics of refraining); and characteristics of trainer-trainee relationship including excessive dependence or an inability to understand the supervisor (i.e., poor communication in the supervisory relationship).



VIGNETTE EXERCISES
FOR SUPERVISION TRAINING
(Lattman, 1996)

VIGNETTE 1

A 32-year old male tells you he is HIV positive. He is very depressed. He hasn't told his lover yet. He is in a quandary as to how to stop sexual relations without informing to the reason. He has begun to use a multitude of drugs — marijuana, alcohol, valium, and cocaine, to cope with his agony. He verbalizes that he is afraid of dying a horrible death in a year He wants to quit his job. He says he can't face anyone. He doesn't want to tell his family or any friends. He was referred to you by a friend who is an ex-client of yours. Your ex-client calls later to inquire about your patient.

1. After treating this man for his acute drug problem and severe depression, how might you help him in the middle phase with talking to his family and friends about it?
2. What would be the crucial information you would like to have in regard to his family before intervening?
3. What would be your approach to helping him deal with the vital issues in regard to his lover?
4. What personal issues are you in touch with as you think through this vignette?
5. What legal/ethical issues come into play in this vignette?
6. What community resources might you be working with in this case?
7. What is your overall treatment plan for this case?
8. What intervention approach do you feel most confident in employing?



9. What are the key questions and concerns you have over his drug abuse?



VIGNETTE 2

A 38-year old Hispanic woman was brought by police to the emergency room with a deep gash over her eye, a broken arm and bruises all over her body. Her eight-year old daughter was with her, crying hysterically. You ask the mother what happened as you visit her in the hospital room. She is reluctant to talk. Her daughter blurts out that her father pushed her and hit her. She said that the police came and all of the neighbors were out watching. The mother angrily tells the daughter to “shut up”.

1. What are the red flag, “at-risk” factors in this vignette?
2. What are your most likely scenarios of what has led up to this violent episode?
3. What speculations do you have about why this woman is reluctant to talk?
4. What are your primary concerns in regard to the daughter?
5. What are you mandated to report, if anything, if you are a medical social worker?
6. What cross-cultural factors, most particular in regard to ethnicity and gender, do you see?
7. What are your diagnostic impressions in regard to the mother? To the daughter?
8. What would be your treatment goals?
9. What intervention approaches would you most likely employ? What is the rationale behind your choices?
10. What assumptions have you made about the father / husband?
11. How would the father most likely be brought into the treatment process?
12. What personal issues would you have to contend with in treating the father in couple, family or individual therapy?
13. What approach would you take in treatment of the spousal dyad?



14. What approach would you take in family therapy sessions with the daughter and possibly to other siblings?
15. What adjunctive professionals and community resources could you potentially utilize?
16. What resources in particular would you seek out in regard to the alleged domestic violence?
17. What macro level factors could be prominent in this case? For example, could the father be experiencing job loss related to the economy, lack of opportunity, discrimination, etc.?
18. What would you want to know about the family support system? Do they have a more traditional Hispanic family structure where extended family is prominent? Am I perhaps making a false presumption that the father is Hispanic? Be careful about such issues as you formulate your diagnostic impressions and responses to the other questions.
19. What are your primary concerns in regard to the socioeconomic factors in this case?
20. How might the church play a prominent role in this case?



VIGNETTE 3

A 40-year old, African-American male and his family (wife and four children) presents for therapy. The children include a 17-year old son who is the wife's by a previous marriage and three other children (14-year old, 10-year old, and a baby) that they had together the children have all been removed from the home by DCS for almost a year now.

The father has six other children. Four of these children are from a previous marriage and are now adults. The remaining two children were conceived during a separation from his current wife and are now 2 and 3 years old. The father feels great remorse over the separation and for subjecting the family to his absence (abandonment). Justin (the 14-year old son) felt injured by his father's abandonment as well as by the separation due to the DOS removal and has bitterly complained that his father never has time for him.

The removal of the children by DOS was for child abuse. Justin's father caught him in a masturbatory fantasy wearing women's panties and began whipping him. Justin's bruises were discovered by his school teacher who made the call to DCS. Consequently, all of the children were removed from the home.

In the initial phase of treatment Justin expressed strong negative feelings about things ever improving between him and his father. He also stated he did not want to return home and felt more love at the group home. He is experiencing symptoms of bedwetting and nightmares of his father attacking him. He is failing his course work and says he is beset by sad and anxious feelings. He cannot concentrate on school and has learning difficulties he is still struggling with. It was found that Justin has been wearing women's panties on a daily basis for quite some time and has allegedly approached other boys at school and at the group home for sex.

The father appears to have a very modest level of insight and has serious problems with the notion that his son could be gay. Further, both father and mother are fundamentalist "born again" Christians.

The initial DOS treatment plan included: (a) the father completes an anger management program of 52 week's duration; and (b) that both mother and father complete parenting classes. The parents have completed this court mandate, but DOS has demanded additional requirements of family and individual therapy. The father feels that both the DOS worker and the supervisor are against them and both parents feel anguish in regards to being unfairly treated by the system and feel they are being asked to jump through too many hoops.



II. ***COMMON PROBLEMS ENCOUNTERED SUPERVISION***

Anxiety

A few words about anxiety are appropriate and are especially pertinent to keep in mind before reading the preceding paragraphs. “Anxiety is a fact of life for the supervisee” (Case, 1995). The relationship between the supervisor and the supervisee can do much to either increase or decrease this anxiety. The more one knows about what is going on with the other, the less one relies on imagination.

Metaprocessing is deliberate and helps to make clear what is happening at the relationship level. There are many advantages to this process. It is an excellent indicator of their abilities to be aware of themselves and another person, and to be able to listen and respond appropriately to any situation. The use of metaprocessing provides supervisors with feedback on both the content and the process of their sessions and will carry over into the therapeutic session. According to Lipchik (in Case, 1995), “techniques by themselves are not enough. The same goes for the supervisory experience. Supervisees have to feel safe in their relationship with supervisors in order to profit from them.

1. ***PROBLEM***

- A recent supervisee in my agency was conducting therapy with a severe borderline personality disordered client. The beginning phase of therapy was successful in that rapport was developed and goals were mutually agreed upon. When the client failed to achieve the goals and in fact never made any attempt to achieve the goals, the supervisee felt this was due to a lack of experience and inadequacy on her part. the supervisee stated she had “tried everything” she knew of to try with this client and was having a hard time coping with the client’s resistance to change and the slow pace of the therapeutic process. She became more and more frustrated with her client and in fact felt like she was developing high enough levels of countertransference to warrant transferring the client to another therapist.
- In these cases, the supervisee takes it personally when the client does not respond as expected. the supervisee wants to be successful with the client goals in order to prove their competence, and steps up his or her efforts soon becoming frustrated with the client and their lack of goal attainment A common complaint is ‘I feel like I’m doing all the work’ and ‘I’m trying too hard.’

1. ***Supervisory’ Response***

- Here the supervisor normalizes the supervisee experience at their particular stage of development and utilizes their own developmental process of empathy to identify with the supervisee.
- The supervisor helps the supervisee with the process of therapy by helping them set *more realistic* goals for both client and themselves while educating the supervisee regarding client motivation.



- A review of the psychosocial assessment looking for clues, treatment goals and techniques will help the supervisee rethink their treatment approach

2. **PROBLEM**

- The supervisee feels inadequate and states they lack requisite knowledge about theory and clinical experience.

2. **Supervisory Response**

- The supervisory response is, in part, didactic, filling in knowledge gaps which may include assignment of readings. Concurrently, using the strengths perspective, the supervisor reassures the supervisee that they have more knowledge than they are allowing themselves to believe and attempts to bring that out and reinforce their ability.
- In these cases, the supervisor commonly stresses the impact and value of the supervisee's life experience as an integral component of the therapist's knowledge base. Reassure the supervisee their natural qualities such as empathy, ability to listen, compassion, and insight into their clients' problems are valuable tools in their repertoire of techniques.
- Use guidance in supervision via modeling and role playing.
- If the supervisee continues to have serious difficulties with their feelings of adequacy, then referral or recommendation for therapy is in order.

3. **PROBLEM**

- Problems are often encountered with supervisees who come into supervision at mid-life and are making a transition back to the student role. This older student may also have ten to twenty years' experience in another professional arena, perhaps as supervisor themselves, which may cause high levels of anxiety and discomfort as well as intense power struggles between themselves and the supervisor during this transition back to the entry level *I* notice role. These supervisees often feel regression to an earlier state of autonomous development.

3. **Supervisory Response**

- The supervisor must take responsibility to ensure that the trainee understands their developmental level through the open and honest exploration of their issues. Empathic verbalization of the problem will bring the issue into the open and allow the supervisee a safe place to communicate their discomfort.
- Reinforce the importance of learning new life material and affirm autonomous efforts that are viable (strengths perspective).
- By showing respect for the supervisee the supervisor parallels the process of what goes on between client and trainee.
- Give the supervisee space and time to think about their attitudes and behaviors.
- treat each supervisee as an individual noting that some trainees do require less hands-on supervision than others. Those supervisees that bring high levels of expertise and/or life experience empathic to clinical problems need to be acknowledged as such.



4. **PROBLEM**

- the disorganized intern has difficulty in following agency policies and procedures, but generally not out of true resistance or passive aggressive behavior

4. **Supervisory Response**

- This is a lot more work for the supervisor as it requires extensive monitoring due to liability issues. The supervisor must help the supervisee by facilitating the learning of organizational skills which is analogous to brief, task-centered therapy.
- The supervisor must go into detail about how to approach organizational tasks focusing on specific issues such as appropriate use of calendars, regular review of policies and procedures with supervisors and technical staff, and helping the supervisee with time management using examples, and as a last resort, the use of checklists as a double-check.

5. **PROBLEM**

- Common to supervision is the overwhelmed supervisee. Often supervisees have to balance the rigors of a graduate program with a job and family responsibilities. Often, these supervisees suffer from fatigue, excessive anxiety, depression, and vulnerabilities owing to inadequacy and thoughts of having made the right decision to enter graduate school or employment.

5. **Supervisory Response**

- Facilitation of supervisee ventilation and clarification of distress. Help the supervisee with priority setting and how to “lessen their load” as much as possible (consistent with problem solving therapy approaches).
- Thoughtful, empathic response via appropriate reduction of supervisee load”, i.e., let a process recording or journal go at a point where supervisee is particularly overloaded (multiple deadlines intern/student has due).

6. **PROBLEM**

- Reliance upon intuition may be a problem. Therapists who rely too heavily upon intuition may see their patents getting belier, but may not be able to articulate why. Therefore, learning is limited if they have not consciously increased their skills.

6. **Supervisory Response**

- It is up to the supervisor to help the therapist reflect on and express what is taking place in therapy. This is done by asking, “What did you have in mind with that intervention” or “Where do you see the therapy headed?” It is also very helpful to utilize forms such as the “Psychosocial / Treatment Goals” form (See “Outcome” Section, Figure 7) to help structure and focus the supervisee’s clinical thinking.



MORE SERIOUS SUPERVISEE PROBLEMS

1. PROBLEM

- Severe counter-transference issues - supervisee is commonly having very strong reactions to client presentation related to unresolved issues within themselves, i.e., a female therapist who has experienced abusive relationships with men may have great difficulty treating certain male clients or couples.

1. Supervisory Response

- Supervisor needs to address these issues making it clear that therapy with the supervisee is not being conducted but that the supervisor is trying to understand what is interfering in the therapeutic relationship between supervisee and client.
- Educate / enlighten supervisee how counter-transference impacts the client and the therapeutic relationship. Supervisor raises the question as to whether the supervisee should continue with training or needs to take a leave of absence and may recommend personal therapy.
- the field liaison may have to intervene and consideration would then be given as to whether the intern would be less frustrated and more productive in another placement where the caseload would be less clinical.

2. PROBLEM

- Personality disordered supervisees are prevalent in our population. Most commonly seen and predominate is narcissistic personality disorder, often seen with traits of borderline, dependent and schizoid. Passive aggressive behaviors, once listed under personality disorders, are likewise a very common behavioral pattern.
- Narcissistic vulnerability and need is evident when supervisees are submissive to authority. This can often be viewed by the supervisor as a pleasure rather than a problem, but an overly cooperative therapist in supervision may be learning through imitation rather than through his or her own struggle (Burka, J., 1999).
- Narcissistically impaired supervisees tend to be overly reactive to perceived criticism, are self-absorbed, are empathetically impaired, and have difficulty with clients and staff in regard to feeling injured or slighted they are given to a level of grandiosity in that they are invested in "their way of doing things." they are commonly very competitive with other supervisees and/or staff and try to aggrandize their self-worth. They commonly have difficulty in following agency policies and procedures. They are also commonly given to passive aggressive behaviors and have fears of losing strengths that they are holding onto as the foundation of their self-esteem. There is often a struggle in the therapist about wanting to know more and at the same time wanting to protect them and feel competent, which can lead to resistance to change (Surka, 1999).

2. Supervisory Response

- This kind of supervisee is extremely difficult for both the supervisor and the Executive Director to successfully manage. The issue has to be confronted and the supervisor must be very clear about the impact the given behaviors and attendant attitudes are having on



clients, the staff, and the agency setting as a whole. Referral for personal therapy is recommended.

- This kind of supervisee is often extremely defensive and one has to approach the trainee in an extremely tactful manner. Creation of written conditions for continuing employment or field placement, signed by the supervisee, the supervisor and the Executive Director, is recommended. Close monitoring of the supervisee's clinical work, case records and conduct, both within the agency setting and outreach to the community, is appropriate.
- 3. **PROBLEM**
 - The supervisee who has great difficulty with confrontation, appropriate assertiveness and constructive use of authority.
 - These supervisees are commonly only comfortable in the empathic mode. They commonly come across as weak to both their clients and the supervisor and staff at large. These individuals tend to have backgrounds where assertiveness and confrontation were severely repressed.
- 3. **Supervisory Response**
 - It is obviously crucial that a clinician must have a healthy balance between both empathic and confrontationally-based interventions. This must be conveyed to the supervisee with a focused supervisory contract delineating what constitutes sufficient growth for the supervisee.
 - The focus should be on building confrontation skills. Supervisory methods may include modeling, role playing, use of video presentations by skilled professionals, reading of theory and practice, and direct observation. The supervisee needs to be offered strong, positive reinforcement for efforts they are making consistent with treating each supervisee as an individual and determining their comfort level so that they don't have to live up to abilities of more advanced clinicians. In situations where the trainee is not making progress, a very tactful recommendation for personal therapy is recommended if the given supervisee is motivated to continue working as a clinician.

Teaching and Learning Problems in Supervision (Burka, U. in CAMFT Handout, Teaching Problems)

- Supervision is not just didactic, but *triadic*. The triad consists of: (1) therapist / patient; (2) therapist / supervisor and (3) supervisor / patient, i.e., the *unseen* relationship with the patient through the information presented from the supervisee.
- Ways of considering supervision:
 - (1) The *traditional model* occurs when the supervisor monitors the therapy by teaching the supervisee on how to create and maintain a stable framework, how to recognize unconscious material, how to utilize and understand the patient's history, transference / countertransference issues, and how to set limits.
 - (2) The *therapist's developmental level* takes into account where the therapist is at relating to his or her experience. With a supervisee with little experience, care must be taken to create a safe space where the trainee can bring up problems and tolerate



feedback and criticism. With more experienced therapists, the focus changes to improving therapeutic ability.

(3) Relies on the concept of organizational environment in which supervision takes place. The supervisor must consider if an evaluation is being made that will go back to a school or if the evaluation will determine the therapist's progress in an advanced program.

(4) Supervision must be viewed as a relationship which is not static and does not always go smoothly.

Problems About Learning (Burka, U. in CAMFT Handout teaching Problems)

- May result as the therapist's own issues arise during the conduct of therapy. For example, a therapist worries every time a patient talks about leaving that the patient is in fact going to quit. New therapists may simply need the experience of living through clients' threats to quit to see that it doesn't always happen and the therapist's own issues of abandonment will have to be investigated. The supervisor's role is then to bring to light what the therapist is exaggerating or overlooking in response to a patient.
- The therapist does not feel competent enough and may feel her ideas have no value. The supervisor can help the trainee to communicate her ideas to the client.
- The therapist lacks knowledge about theory or technique. The supervisor can fill in knowledge and theory gaps.
- The therapist feels pulled into power struggles suggesting tentativeness on the part of the therapist; this is difficult for the supervisor because this is a characteristic response which is likely repeated in supervision, but the supervision can give different points of view.
- The therapist's use of self is restricted in his or her work with the patient (full range of emotions is limited). The supervisor can point out the overlooked aggressive elements in the patient, giving permission to the therapist to become more assertive.
- The therapist has a fear of getting inside the patient's internal world. The supervisor can help the therapist understand what the client's internal experience might be that creates his or her needs.
- Learning is a transitional state which means shifting from a place of knowing to a place of knowing something else. In supervision, this can cause realignment.
- There is an unavoidable struggle in the therapist about wanting to know more and at the same time wanting to protect oneself and to feel competent which can lead to a resistance to change.
- Conflicts about learning may also occur within the specific supervisory relationship.
- The therapist blames herself for her mistakes before she can be accused of making



mistakes. In this mode, preoccupation with mistakes makes the therapist spend more time talking about her psychology than about the patient and the therapy. In these cases, it may be the supervisors own internal experience, that is, the supervisory countertransference, which will offer a clue as to how guilt is to be used.

III. OUTCOMES & EVALUATION

Not surprisingly, studies comparing supervision to no supervision, found that supervision produces greater personal adjustment and increased skill development. Additionally, systematic training that utilizes procedures that teach specific interpersonal / counseling skills were found to be superior to traditional training that involves the use of only audiotapes. Essentially, supervisees who received no training in empathic responding, confrontation, attending behavior, and similar skills, made much slower progress in developing these skills than the trainees who were involved in a systematic training program. Major conclusions drawn from these findings indicate that “simple behavioral skills can be quickly learned through instruction without modeling, feedback, and rehearsal; more complex skills require more time and more components of the training package; and the teachability of microskills hits a ceiling in the acquisition of simple tasks and is useful primarily for beginning trainees ... is unnecessary with more experienced therapists” (Watkins, 1997).

Other studies have shown that good supervision is typically associated with live or video review and inferior supervision utilizes note review or group supervision. The most common trainee complaints included: (a) supervisors were physically or emotionally inaccessible; (b) held infrequent sessions; (c) interrupted supervision for phone calls; (d) emphasized evaluation of shortcomings instead of helpful suggestions; and (e) insisted that trainees follow the supervisor’s style and orientation. the best supervisors “fit a Rogerian checklist’ and include: (a) the exploration of new ideas and techniques; (b) respect for divergent values; (c) a focus on the students’ personal and professional growth; (d) easy accessibility; (e), immediate and straightforward feedback; and (f) and clear conceptual frameworks. According to study author Stephen Anderson, “the most surprising finding was that less than one-third of the trainees had ever been in therapy themselves” (Cooper, 2000).

Not only should outcome measures be utilized to review supervisee performance, but also to assess supervisor effectiveness. Instruments in this area generally investigate either the trainees’ perception of the supervisor, or supervisors’ self-perception of their roles and behaviors in supervision. These instruments have the advantage of helping supervisors improve their performance while allowing trainees to express their satisfaction with the process (Cooper, 2000).

In order to measure results, *reliable* procedures that indicate changes occurring in the trainee must be used. This *requires* clear specification of goals and methods of supervision in order to measure the outcomes. One of the most important factors of criterion measures is the degree to which tests and ratings of trainee behavior are actually based on their behavior while in counseling sessions (as opposed to merely generalizing performance). According to Watkins



(1997), the most ambitious designs have involved the measurement of trainee behavior such as empathy and confrontation during therapy with actual clients. Less ambitious but still rigorous have been studies that measured trainee behavior with persons invited to act as patients. A step further has been the use of a coached client who plays a designed role. Another method is to videotape sessions)

In sum, review of training outcome measures indicate (Watkins, 1997):

- The most useful measures focus on specific and observable trainee behavior in therapy;
- The Barrett-Lennard Relationship Inventory is one of the best measures and has been shown to have at least a modest relationship to psychotherapy outcome (in spite of its shortcomings);
- Evaluation of training through criteria from several sources is absolutely necessary. Frequency counts of therapist behaviors are valuable as is the collection of data about the therapist from clients, the supervisor, and the trainees themselves; and
- Instruments based on simulation psychotherapy are not acceptable or convincing criteria, and have only limited value even when no inferences are made from the results.



FIGURE 3
Supervisor Evaluation by Supervisee (Cox, 1992)

Date: _____

Please rate each item using the following code:

1 = never 2 = sometimes 3 = usually 4 = often 5 = always

- _____ 1. My supervisor is on time.
 - _____ 2. Time is structured in a useful way.
 - _____ 3. Given the time limitations, my supervisor was available to discuss cases.
 - _____ 4. If I ask for additional supervision, I receive it readily.
 - _____ 5. My supervisor was open to my concerns and problems.
 - _____ 6. My supervisor offers feedback in a supportive manner,
 - _____ 7. My supervision is useful in that I can apply it.
 - _____ 8. My supervisor uses different methods of learning.
 - _____ 9. My supervision is educational and teaching oriented.
 - _____ 10. My supervision is geared toward personal growth.
 - _____ 11. My supervision is geared toward professional growth.
 - _____ 12. My supervisor helps create an atmosphere of mutual respect.
 - _____ 13. My supervisor encourages discussion of contextual issues.
 - _____ 14. My supervisor helps me to stay focused on my goals.
 - _____ 15. My supervisor helps me to develop and maintain a clear, theoretical direction.
 - _____ 16. My supervisor helps me to know the rationale behind interventions.
 - _____ 17. My supervisor allows room for me to develop my own ideas.
 - _____ 18. My supervisor helps me to develop my personal counseling theory.
 - _____ 19. My supervisor models professionalism and follows a consistent code of ethics.
 - _____ 20. My supervisor provides an atmosphere of trust and respect which enable me to discuss sensitive issues such as countertransference.
 - _____ 21. My supervisor is capable of helping me to appropriately stretch my limits.
 - _____ 22. My supervisor helps me to build confidence in my competence.
 - _____ 23. My supervisor believes in my ability to become a good therapist,
 - _____ 24. My supervisor has knowledge of different theories of therapy.
 - _____ 25. My supervisor has knowledge of community resources.
- A. What would you like from supervision and/or your supervisor that you did not get?
- B. What do you consider to be the strengths of your supervision experience?
- C. Please write any additional comments:



FIGURE 6
Assessment of Developmental Level of Supervisee (Lattman)

	NOVICE / INTERN		INTERMEDIATE		ADVANCED	
	1	2	3	4	5	6
Self-esteem						
Self-composure						
Life / Maturity Level						
Prior professional / academic background						
Natural qualities						
Ability to define learning / training needs						
Relates cooperatively with supervisor						
Consideration of transference issues						
Consideration of counter-transference issues						
Prior therapy / level of self-awareness						
Environmental factors / Personal life stress and its potential for impacting therapeutic relationships						
Ability to use confrontation						
Ability to receive constructive criticism						





REQUIRED CLINICAL SUPERVISION HOME STUDY QUESTIONS

1. True/False: Parallel Process often results in anxiety and defense.
2. True/False: One of the difficulties in supervisory teaching is the student's narcissistic need to keep his/her image in tact, consequently both desiring and resisting learning.
3. Which of the following incorporates the specific traits described by Dr. Brodsky as part of sex related countertransference?
 - A. Power control and approval.
 - B. Power, developmental stage of clinician and nurturance needs.
 - C. Empathy, power, nurturance and seduction.
 - D. Control, empathy, fear of rejection.
 - F. Both A & B.
4. True/False: The novice supervisor will primarily focus their fears on the supervisee.
5. True/False: It is important to have conflict resolution procedures in place to address termination of the problem intern.
6. True/False: The focus of competency remains the constant as the supervisee goes through his/her developmental stages of becoming a clinician.
7. True/False: Formal supervision should be geared by the supervisor to the interns/supervisee's ambition level.
8. Which of the following best describes the intermediate stage of a supervisee (according to Laurel Cox, Ph. D.)?
 - A. Belief that everything they say/do hinges upon the survival of the client.
 - B. To be able to work with the client without knowing the exact outcome.
 - C. Learning how to use self effectively in therapy sessions.
 - D. Every client brings up the supervisee's issues of countertransference
 - F. Both B & C.



9. Which of the following are functions of the supervisor when addressing supervisee's issues of autonomy?
 - A. Monitoring client welfare.
 - B. Enhancing growth within stages.
 - C. Addressing regression.
 - D. Presenting in a detached and reserved manner.
 - E. Both A, & B only.

10. In describing the Feminist Model regarding gender issues in supervision which of the following would not be accurate?
 - A. Maximization of the patriarchal hierarchy.
 - B. Use of social analysis.
 - C. Socialization perspective of gender expectations.
 - D. Understanding power differentials in supervision.
 - E. Both A & B, only.

11. True/False: When expressing cultural sensitivity it is best to under-pathologize and assume that some of the more unique elements of the client are culturally based.

12. True/False: "Reasonable Care" in hiring supervisees can be an issue in regard to charging the supervisor with direct liability in a mal practice case.

13. Which of the following are critical functions of supervision?
 - A. Provides feedback to supervisee.
 - B. Quality control function.
 - C. Helps form a therapist's identity.
 - D. Helps to calm anxiety regarding psychotherapy.
 - E. Provides alternative perspectives on issues raised.
 - F. A, B, & C
 - G. A, D, & C
 - H. All of the above.

14. Foci, according to Rodenhauer refers to the factors or processes that receive primary attention during the supervision. Which of the following is not one of his focal points?
 - A. Assessment/planning practices.
 - B. Personal factors
 - C. Psychotherapy
 - D. Professional, organizational factors



15. True/False: According to Butler, appropriate operationalization of therapist characteristics is crucial because the goal of supervision is to make the supervisee a more effective therapist.
16. In a humanistic approach to supervision according to Lattman, which of the following are involved in a process of supervision?
- A. Building/reinforcing before more critical input.
 - B. Confrontation/evaluation of supervisee performance at a very measured pace.
 - C. Careful monitoring of the growth process.
 - D. Parallel process for supervisee-client, and supervisor-supervisee.
 - E. Emphasis on counter-transference issues.
 - F. A, B, C & D
 - C. All of the above.
17. According to Brown, metaprocessing consists of all but which of the following?
- A. Metacommunication
 - B. Self disclosure
 - C. Relaxation exercises
 - D. Feedback
18. True/False: The Bowenian approach to training revolves around the concept of self and there is a lack of emphasis on technique.
19. Supervision for Communications therapists incorporates which of the following?
- A. Modeling by the supervisor.
 - B. Strong didactic component.
 - C. Use of small group supervision.
 - D. A supervisee works with a real family that the supervisor observes.
 - F. A, B & C
 - F. All of the above.
20. In the Milan system of training/supervision, all but which one of the options below is true?
- A. Emphasis on supervision vs. didactics.
 - B. Little regard is given for the acquisition of specific therapeutic skills.
 - C. the group mind over personal style is emphasized.
 - D. Brief intervention is discouraged.
21. True/False: In a purist model, advanced supervisees are limited to only one mentor?
22. The most common trainee problems include all but one of the following:



- A. Loss of status in learning a new approach.
 - B. Features of the model itself,
 - C. Sexual transgressions by supervisor.
 - D. Competition with peers.
23. According to Lattman, a sound supervisory response to feelings of inadequacy on the part of the supervisee incorporates:
- A. Filling in knowledge gaps which may include assignment of readings.
 - B. Emphasize strengths and life experience of supervisee.
 - C. Natural qualities are highly valued and should be emphasized in supervision.
 - D. Role play/modeling.
 - E. All of the above.
24. In helping the supervisee with difficult clients such as borderline personality disorders, which of the following apply?
- A. Normalize the difficulties in counter-transference issues.
 - B. Set more realistic, modest goals.
 - C. Review psycho-social assessment/treatment goals and techniques.
 - D. Assign the intern several more such cases to gain experience.
 - F. A, B & C
 - F. All of the above.
25. True/False: Personality disordered supervisees are rare in our field.
26. True/False: According to Burka (1999) supervision is triadic, consisting of all of the following:
- Therapist/Patient
 - Therapist/Supervisor
 - Supervisor/Patient
27. True/False: According to a study by author, Stephen Anderson “the most surprising finding was less than one third of the trainees have ever been in therapy themselves”.





CEU Course Evaluation Form

Date: _____

Name: _____

License Number: _____ Expiration Date: _____ State: _____

Why did you select this course?

What did you find most helpful about the course?

Indicate each category below using the following rating:

"1" = superior "2" = good "3" = average "4" = sub-average "5" = poor

- 1. Course was consistent with stated objectives _____
- 2. Relevance of materials to your profession _____
- 3. Was the course taught at the stated skill level? _____
- 4. Would you enroll in another course by this group? _____
- 5. Overall rating of this course _____

Specific suggestions for changing or improving the format or content

Any additional comments, including recommendations you would make to clinicians seeking a course on this topic?

List other courses you would be interested in attending, or having in a home study course

Permission to use comments for advertising purposes yes no

If yes, please print your name _____

Thank you for choosing the Carol Cole Center for Advanced Training!