Clinical Supervision And Professional Development

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Learning Objectives

This course is designed to help you:

1. Describe at least two empirically and methodologically sound approaches to effective supervision.
2. Identify and discuss at least two specific supervisory roles within the context of the supervisory relationship.
3. Explain at least two specific multi-culturally competent supervision strategies, and comparative perspectives on supervision cross-culturally.
4. Identify at least two cultural and contextual factors related to clinical supervision.
5. Discuss at least one defining characteristic of clinical supervision that makes it a distinct professional practice.
6. Describe at least two functions of clinical supervision.
7. Discuss at least two legal and ethical issues within clinical supervision.
8. Describe at least one competency-based supervision model which focuses primarily on the skills and learning needs of the supervisee.
9. Describe at least one treatment based supervision model.

Table of Contents

1. Introduction to Clinical Supervision and Professional Development

Definitions of Clinical Supervision

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

- ☑ Supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive (Powell & Brodsky).

- Supervision is an intervention provided by a senior member of a profession to a more junior member or members. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper of those who are to enter the particular professional (Bernard & Goodyear).
- Supervision is a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices(CSAT).
- Clinical supervision is an interpersonal tutorial relationship centered on the goals of skill development and professional growth via learning and practicing. Through observation, evaluation, and feedback, supervision enables the counselor to acquire the competence needed to deliver effective patient care while fulfilling professional responsibilities (Durham).
- Supervision is a process whereby a counselor with less experience learns how to better provide services with the guidance of a counselor with more experience and skill. It is distinct from teaching in that the "curriculum" is individually determined by the supervisees and their clients (Bernard and Goodyear). Although there is some variation in the literature about the therapeutic nature of the supervisory relationship, based on the supervisor's theoretical orientation in the substance abuse field, it is generally agreed that supervision is not therapy for the counselor. In fact, a clear boundary must exist between supervision and counseling. Although the supervisee's behavior is under scrutiny, therapeutic interventions are provided for the purpose of improving the supervisee's ability to provide services, not for any broader reason (Bernard and Goodyear).
- According to the NASW, "…professional supervision is defined as the relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place. The supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency, and applicable ethical content in the practice setting. The supervisor and the supervisee both share responsibility for carrying out their role in this collaborative process. Supervision encompasses several interrelated functions and responsibilities…"
- According to the APA, "Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. Henceforth,

supervision refers to clinical supervision and subsumes supervision conducted by all health service psychologists across the specialties of clinical, counseling, and school psychology." and furthermore, " Competency-based supervision is a metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/cultural clinical setting (adapted from Falender & Shafranske). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision."

(Source: American Psychological Association. (2014). Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from http://apa.org/about/policy/guidelines-supervision.pdf).

- ✦ Clinical supervision is an essential part of professional practice and clinical programs. Clinical supervision enhances staff retention and morale.
- ✦ Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision. Clinical supervision needs the full support of agency administrators.
- ✦ The supervisory relationship is the crucible in which ethical practice is developed and reinforced.
- ✦ Clinical supervision is a skill that has to be developed.
- ✦ Clinical supervision most often requires balancing administrative and clinical supervision tasks. Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence.
- ✦ Successful implementation of evidence-based practices requires ongoing supervision. Supervisors have the responsibility to be gatekeepers for the profession.
- ✦ Clinical supervision is effective when it involves direct observation methods.

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

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

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

According to the APA, "Although supervisor competency is assumed, little attention has been focused on the definition, assessment, or evaluation of supervisor competence (Bernard & Goodyear, 2014). This has diminished the perceived necessity for training in supervision. As Kitchener concluded, it has been much easier to identify the absence of competence than to define it. Articulating practices consistent with competent supervision ultimately facilitates the provision of quality services by supervisees and minimizes potential harm to supervisees and clients (Ellis et al., 2014)".

(Source: American Psychological Association. (2014). Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from http://apa.org/about/policy/guidelines-supervision.pdf).

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

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

Central Principles of Clinical Supervision

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

development are major concerns in the substance abuse treatment field. Clinical supervision is a primary means of improving workforce retention and job satisfaction.

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

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

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

- **Clinical supervision is a skill in and of itself that has to be developed.** Good counselors tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client goals and a knowledge base to complement a new set of skills. Programs need to increase their capacity to develop good supervisors.

- **Clinical supervision most often requires balancing administrative and clinical supervision tasks.** Sometimes these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the roles to promote the efficacy of the clinical supervisor. (See Part 2.)

- **Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence.** Supervisors require cultural competence at several levels. Cultural competence involves the counselor's response to clients, the supervisor's response to counselors, and the program's response to the cultural needs of the diverse community it serves. Since supervisors are in a position to serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.

- **Successful implementation of EBPs requires ongoing supervision.** Supervisors have a role in determining which specific EBPs are relevant for an organization's clients (*Lindbloom, Ten Eyck, & Gallon*). Supervisors ensure that EBPs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring counselors. Excellence in clinical supervision should provide greater adherence to the EBP model. Because State funding agencies now often require substance abuse treatment organizations to provide EBPs, supervision becomes even more important.

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

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

Practical Issues in Clinical Supervision

Distinguishing Between Supervision and Therapy

Differences Between Supervision and Counseling

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

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

	Clinical Supervision	Administrative Supervision	Counseling
Purpose	• Improved client care • Improved job performance	• Ensure compliance with agency and regulatory body's policies and procedures	• Personal growth • Behavior changes • Better self-understanding
Outcome	• Enhanced proficiency in knowledge, skills, and attitudes essential to effective job performance	• Consistent use of approved formats, policies, and procedures	• Open-ended, based on client needs
Timeframe	• Short-term and ongoing	• Short-term and ongoing	• Based on client needs
Agenda	• Based on agency mission and counselor needs	• Based on agency needs	• Based on client needs
Basic Process	• Teaching/learning specific skills, evaluating job performance, negotiating learning objectives	• Clarifying agency expectations, policies and procedures, ensuring compliance	• Behavioral, cognitive, and affective process including listening, exploring, teaching
Source: Adapted from Dixon, 2004			

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

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

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

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

- How is this client affecting you? What feelings does this client bring out in you? What is your behavior toward the client in response to these feelings? What is it about the substance abuse behavior of this client that brings out a response in you?
- What is happening now in your life, but more particularly between you and the client that might be contributing to these feelings, and how does this affect your counseling?
- In what ways can you address these issues in your counseling?
- What strategies and coping skills can assist you in your work with this client?

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

✳ The supervisee's idealization of the supervisor.

✳ Distorted reactions to the supervisor based on the supervisee's reaction to the power dynamics of the relationship.

✳ The supervisee's need for acceptance by or approval from an authority figure.

✳ The supervisee's reaction to the supervisor's establishing professional and social boundaries with the supervisee.

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

✓ The need for approval and acceptance as a knowledgeable and competent supervisor.

✓ Unresolved personal conflicts of the supervisor activated by the supervisory relationship.

✓ Reactions to individual supervisees, such as dislike or even disdain, whether the negative response is "legitimate" or not. In a similar vein, aggrandizing and idealizing some supervisees (again, whether or not warranted) in comparison to other supervisees.

✓ Sexual or romantic attraction to certain supervisees.

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

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

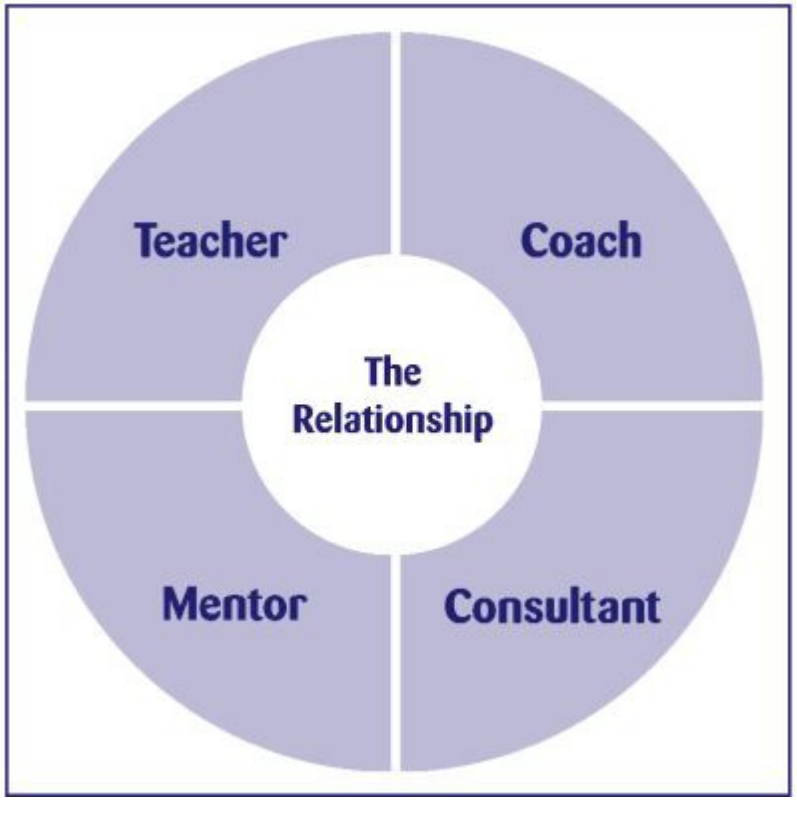
Finally, counselors will be more open to addressing difficulties such as countertransference and compassion fatigue with you if you communicate understanding and awareness that these experiences are a normal part of being a counselor. Counselors should be rewarded in performance evaluations for raising these issues in supervision and demonstrating a willingness

to work on them as part of their professional development.

2. Functions, Methods and Techniques of a Clinical Supervisor

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

Roles of the Clinical Supervisor **Figure 1**



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

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

Methods and Techniques of Clinical Supervision

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

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

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

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

the model. The majority of these models begin with articulating their treatment approach and describing their supervision model, based upon that approach.

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

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

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

- ➡ Explicitly addressing diversity of supervisees (e.g., race, ethnicity, gender, age, sexual orientation) and the specific factors associated with these types of diversity;
- ➡ Explicitly involving supervisees' concerns related to particular client diversity (e.g., those whose culture, gender, sexual orientation, and other attributes differ from those of the supervisee) and addressing specific factors associated with these types of diversity; and
- ➡ Explicitly addressing supervisees' issues related to effectively navigating services in intercultural communities and effectively networking with agencies and institutions.

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

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

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

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

leadership.

- ✓ Precise, clear, and consistent.
- ✓ Comprehensive, using current scientific and evidence-based practices.
- ✓ Operational and practical, providing specific concepts and practices in clear, useful, and measurable terms.
- ✓ Outcome-oriented to improve counselor competence; make work manageable; create a sense of mastery and growth for the counselor; and address the needs of the organization, the supervisor, the supervisee, and the client.

Finally, it is imperative to recognize that, whatever model you adopt, it needs to be rooted in the learning and developmental needs of the supervisee, the specific needs of the clients they serve, the goals of the agency in which you work, and in the ethical and legal boundaries of practice. These four variables define the context in which effective supervision can take place.

Developmental Stages of Counselors

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

This schema uses a three-stage approach. The three stages of development have different characteristics and appropriate supervisory methods. Further application of the IDM to the substance abuse field is needed. (For additional information, see Anderson, 2001.)

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

- ✦ There is a beginning but not an end point for learning clinical skills; be careful of counselors who think they "know it all."
- ✦ Take into account the individual learning styles and personalities of your supervisees and fit the supervisory approach to the developmental stage of each clinician.
- ✦ There is a logical sequence to development, although it is not always predictable or rigid; some counselors may have been in the field for years but remain at an early stage of professional development, whereas others may progress quickly through the stages.
- ✦ Clinicians at an advanced developmental level have different learning needs and require different supervisory approaches from those at Level 1; an

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

Developmental Level	Characteristics	Supervision Skills Development Needs	Techniques
Level 1	• Focuses on self • Anxious, uncertain • Preoccupied with performing the right way • Overconfident of skills • Overgeneralizes • Overuses a skill • Gap between conceptualization, goals, and interventions • Ethics underdeveloped	• Provide structure and minimize anxiety • Supportive, address strengths first, then weaknesses • Suggest approaches • Start connecting theory to treatment	• Observation • Skills training • Role playing • Readings • Group supervision • Closely monitor clients
Level 2	• Focuses less on self and more on client • Confused, frustrated with complexity of counseling • Overidentifies with client • Challenges authority • Lacks integration with theoretical base • Overburdened • Ethics better understood	• Less structure provided, more autonomy encouraged • Supportive • Periodic suggestion of approaches • Confront discrepancies • Introduce more alternative views • Process comments, highlight countertransference • Affective reactions to client and/or supervisor	• Observation • Role playing • Interpret dynamics • Group supervision • Reading
Level 3	• Focuses intently on client • High degree of empathic skill • Objective third person perspective • Integrative thinking and approach • Highly responsible and ethical counselor	• Supervisee directed • Focus on personal-professional integration and career • Supportive • Change agent	• Peer supervision • Group supervision • Reading
Source: Stoltenberg, Delworth, & McNeil, 1998			

Developmental Level	Characteristics	To Increase Supervision Competence
Level 1	• Is anxious regarding role • Is naïve about assuming the role of supervisor • Is focused on doing the "right" thing • May overly respond as an "expert" • Is uncomfortable providing direct feedback	• Follow structure and formats • Design systems to increase organization of supervision • Assign Level I counselors
Level 2	• Shows confusion and conflict • Sees supervision as complex and multidimensional • Needs support to maintain motivation • Overfocused on counselor's deficits and perceived resistance • May fall back to being a therapist with the counselor	• Provide active supervision of the supervision • Assign Level 1 counselors
Level 3	• Is highly motivated • Can provide an honest self-appraisal of strengths and weaknesses as supervisor • Is comfortable with evaluation process • Provides thorough, objective feedback	• Comfortable with all levels
Source: Stoltenberg, Delworth, & McNeil, 1998		

	Description	Advantages	Disadvantages
Verbal Reports	Verbal reports of clinical situations Group discussion of clinical situations	• Informal • Time efficient • Often spontaneous in response to clinical situation • Can hear counselor's report, what he or she includes, thus learn of the counselor's awareness and perspective, what he or she wishes to report, contrasted with supervisory observations	• Sessions seen through eyes of beholder • Nonverbal cues missed • Can drift into case management, hence it is important to focus on the clinical nature of chart reviews, reports, etc., linking to the treatment plan and EBPs
Verbatim Reports	Process recordings Verbatim written record of a session or part of session Declining method in the behavioral health field	• Helps track coordination and use of treatment plan with ongoing session • Enhances conceptualization and writing skills • Enhances recall and reflection skills • Provides written documentation of sessions	• Nonverbal cues missed • Self-report bias • Can be very tedious to write and to read
Written/File Review	Review of the progress notes, charts, documentation	• An important task of a supervisor to ensure compliance with accreditation standards for documentation • Provides a method of quality control • Ensures consistency of records and files	• Time consuming • Notes often miss the overall quality and essence of the session • Can drift into case management rather than clinical skills development

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

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

Source: Adapted from Mattel, 2007.

Developmental Stages of Supervisors

Supervisor Developmental Model

A number of methods and techniques are available for clinical supervision, regardless of the modality used. Methods include (as discussed previously) case consultation, written activities such as verbatims and process recordings, audio and videotaping, and live observation. Techniques include modeling, skill demonstrations, and role playing. (See descriptions of these and other methods and techniques in *Bernard & Goodyear,; Borders & Brown,; Campbell,; and Powell & Brodsky.*) outlines some of the methods and techniques of supervision, as well as the advantages and disadvantages of each method. The context in which supervision is provided

affects how it is carried out. A critical issue is how to manage your supervisory workload and make a reasonable effort to supervise. The contextual issues that shape the techniques and methods of supervision include:

- The allocation of time for supervision. If the 20:1 rule of client hours to supervision time is followed, you will want to allocate sufficient time for supervision each week so that it is a high priority, regularly scheduled activity.
- The unique conditions, limitations, and requirements of the agency. Some organizations may lack the physical facilities or hardware to use videotaping or to observe sessions. Some organizations may be limited by confidentiality requirements, such as working within a criminal justice system where taping may be prohibited.
- The number of supervisees reporting to a supervisor. It is difficult to provide the scope of supervision discussed in this document if a supervisor has more than ten supervisees. In such a case, another supervisor could be named or peer supervision could be used for advanced staff.
- Clinical and management responsibilities of a supervisor. Supervisors have varied responsibilities, including administrative tasks, limiting the amount of time available for clinical supervision.

3. Supervisory Problems and Resources

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

Working With Supervisees Who Are Resistant to Supervision

Some of your supervisees may have been in the field longer than you have and see no need for supervision. Other counselors, having completed their graduate training, do not believe they need further supervision, especially not from a supervisor who might have less formal academic education than they have. Other resistance might come from ageism, sexism, racism, or classism. Particular to the field of substance abuse treatment may be the tension between those who believe that recovery from substance abuse is necessary for this counseling work and those who do not believe this to be true.

In addressing resistance, you must be clear regarding what your supervision program entails and must consistently communicate your goals and expectations to staff. To resolve defensiveness and engage your supervisees, you must also honor the resistance and acknowledge their concerns. Abandon trying to push the supervisee too far, too fast. Resistance is an expression of

ambivalence about change and not a personality defect of the counselor. Instead of arguing with or exhorting staff, sympathize with their concerns, saying, “I understand this is difficult. How are we going to resolve these issues?”

When counselors respond defensively or reject directions from you, try to understand the origins of their defensiveness and to address their resistance. Self-disclosure by the supervisor about experiences as a supervisee, when appropriately used, may be helpful in dealing with defensive, anxious, fearful, or resistant staff. Work to establish a healthy, positive supervisory alliance with staff.

Things a New Supervisor Should Know

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

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

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

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

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

5. Rely first on direct observation of your counselors and give specific feedback. The best way to determine a counselor’s skills is to observe him or her and to receive input from the clients about their perceptions of the counseling relationship.

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

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

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

The following are resources for supervision:

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

Barriers to Implementing Clinical Supervision

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

(*Source: Roche, Todd, & O'Connor, p. 244; Powell & Brodsky)*

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

Models and Developmental Stages of Clinical Supervision

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

Level 1 counselors are new to the field, highly motivated, and highly anxious. Supervision for these people should include direct observation, skills training, and support. According to *Stoltenberg, McNeill, and Delworth*, a counselor with 1–5 years of experience in the field might be expected to be in Level 1. Level 2 counselors have 6–9 years' experience and are able to show empathy toward their clients, but have uneven success in practicing their skills (they are usually aware of this. In supervision, they need support, empathy, and constructive feedback but are ready to begin processing personal issues, such as self-awareness and defensiveness. At Level 3, counselors are fairly autonomous and have gained professional identity. They typically have been in the field for more than 10 years and have a high level of insight into their functioning. They benefit from supervision that is more collegial and can discuss the supervisor—supervisee relationship and countertransference. Stoltenberg et al. also indicates that supervisors go through similar stages of development, from Levels 1–3, over the course of their career.

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

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

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

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

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

- Self. Each supervisor develops an idiosyncratic style of supervision, largely based upon his or her personality profile and model of counseling.
- Philosophy of counseling. Supervisors articulate their philosophy or model of counseling, describing what they do in counseling, what models and techniques they use, and at what times and/or circumstances.
- Descriptive dimension. The blended model uses a version of Bascue and Yalof's Descriptive Dimensions.
- Stages of counselor development. This model adapts the IDM model of Stoltenberg et al. and other developmental approaches to clinical supervision.
- Contextual factors. The blended model uses the work of Holloway and other contextual models of clinical supervision, addressing factors affecting supervision, such as age, race, gender, ethnicity, recovery–non-recovery, disciplines, academic background, and the like.
- Affective–behavioral axis. The model views supervision along a continuum, blending affective and behavioral changes for the counselor in supervision.
- Spiritual dimensions. In addition to addressing cognitive, skills, affective, and latent issues in supervision, a supervisor may address "spiritual" issues. The first four components aid a counselor in understanding "how" to counsel. The spiritual dimension focuses on "why" issues: why a counselor does what he or she does.

Modalities of Supervision

Individual supervision is, historically, the typical modality of supervision most clinicians receive. It provides the supervisor the opportunity to develop a closer relationship with the supervisee and to tailor the process to the unique needs of that person. Several formats are possible in individual supervision. Live supervision includes bug-in-the-ear (where the supervisor

provides feedback via an earphone in the supervisee's ear), phone-ins, and consultation breaks. Each method is distracting to one degree or another (*Bernard & Goodyear*). Co-facilitation, where the supervisor sits in on the individual or group session led by the supervisee, allows the supervisor to share the experience of the group. In this format, the supervisor can intervene directly if the session become counter-therapeutic (*Powell & Brodsky*). For many counselors, possession debriefing is common. The supervisee brings a case or a problem that arose during a session to the supervisory session for discussion. This type of self-report, although convenient, is problematic, particularly for inexperienced counselors who may miss important details and nuances in a clinical situation (*Bernard & Goodyear, Powell & Brodsky*).

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

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

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

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

Several surveys show a limited preference among supervisees for individual supervision. No

studies of counselors' preferences for one modality were found in *Eby et al.'s* research. Ray and Altekruse compared four modalities of supervision used with master's level counseling students. Eighty-one percent ranked individual supervision the most or second most helpful experience, while 45 percent ranked group supervision equally highly. Newgent, Davis, and Farley compared group, individual, and triadic (supervisor and two supervisees) modalities of supervision for doctoral-level counselor education students (n = 15). These students preferred individual supervision in terms of their satisfaction, their perception of its effectiveness, and their belief that it better met their needs. Again, the data are sparse, with relatively small sample sizes not specific to the substance abuse field.

Supervisory Styles and Contributing Factors

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

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

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

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

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

(Source: Friedlander & Ward)

Categories of Supervisory Style

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

Cross-Cultural Supervision

One's culture is generally viewed as a strength that, during treatment or supervision, should be validated (*Garcia*). Clinical supervision must address gender, racial, ethnic, and cultural concerns. Particularly when the client and counselor (or counselor and supervisor) are of different cultures, this disparity can have a significant impact on the therapeutic alliance and the effects of treatment (*Holloway*). Supervisors can have a positive effect on their supervisees by providing a climate in which discussion of these issues is encouraged and by modeling appropriate behaviors.

Some of the skills included in cultural competence include "awareness, openness, and sincere

attention to cultural and racial factors, guidance and explicit discussion of culture-specific issues, being vulnerable and sharing [supervisors'] own struggles, and providing opportunities for multicultural activities" (*Inman, Borders and Brown*). Supervisors have a responsibility to initiate discussions on:

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

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

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

Legal and Ethical Issues in Supervision

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

Supervisors of counselors need to be familiar with the ACA's Code of Ethics, Section F,

Supervision, Training and Teaching, and for Supervisor's of Substance Abuse Counselors, the Codes of Ethics of National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the codes of ethics of the applicable certification boards for the counselors they supervise. Ethical issues for supervisors, as for counselors, vary. Supervisors are responsible for adherence to their own discipline's code of ethics and for ensuring that their supervisees adhere to theirs.

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

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

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

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

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

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

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

Supervisor Training and Supervision

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

resources in addition to the following:

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

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

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

Administrative Issues in Supervision

Organizational support for supervision is essential to instilling the belief that clinical supervision is key to staff retention and workforce development. Strategies for reducing the costs involved in a supervision program include agreements with other agencies, using retired supervisors interested in part-time employment, and group supervision (Roche, Todd, & O'Connor, 2007).

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

Elements in a Supervision Policy

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

Specific clinical arrangements	The arrangements under which supervision will take place in the organization	Group supervision by an experienced facilitator

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

4. Cultural and Contextual Factors

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

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

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

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

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

There are three levels of cultural consideration for the supervisory process: the issue of the culture of the client being served and the culture of the counselor in supervision. Holloway

emphasizes the cultural issues of the agency, the geographic environment of the organization, and many other contextual factors. Specifically, there are three important areas in which cultural and contextual factors play a key role in supervision: in building the supervisory relationship or working alliance, in addressing the specific needs of the client, and in building supervisee competence and ability. It is your responsibility to address your supervisees' beliefs, attitudes, and biases about cultural and contextual variables to advance their professional development and promote quality client care.

Continuum of Cultural Competence

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

Cultural Destructiveness
Superiority of dominant culture and inferiority of other cultures; active discrimination

Cultural Incapacity
Separate but equal treatment; passive discrimination

Cultural Blindness
Sees all cultures and people as alike and equal; discrimination by ignoring culture

Cultural Openness (Sensitivity)
Basic understanding and appreciation of importance of sociocultural factors in work with minority populations

Cultural Competence
Capacity to work with more complex issues and cultural nuances

Cultural Proficiency
Highest capacity for work with minority populations; a commitment to excellence and proactive effort

Source: Cross, 1989.

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

based on cultural or other factors. Another benefit from these discussions is that counselors will eventually achieve some level of comfort in talking about culture, race, ethnicity, and diversity issues.

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

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

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

✓ What demographic variables do you use to identify yourself?

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

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

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

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

with a male supervisor, and so on. In the reverse situations, where the supervisor is from the minority group and the supervised from the majority group, the difference should be discussed as well

5. Trauma Informed Clinical Supervision

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

Adopting an Evidence-Based Model of Clinical Supervision and Training

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

Counselor competencies:

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

Supervisor roles:

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

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

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

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

Supervision and Consultation

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

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

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working

with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

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

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

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

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author concluded that behavioral health professionals'

experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field. Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address. To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives. When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors

Risk and Protective Factors Associated With Secondary Traumatization

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

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health

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

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

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience, having specialized training in trauma informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (*Sprang, Clark, & WhittWoosley,*). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multi-method study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (*McGarrigle & Walsh*). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time

for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices. One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma related disorders and reduces the sense of hopelessness that is often a part of the work. One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (*Sprang et al.*). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (*Bober & Regehr*).

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

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their supervisors" were less likely to experience STS. Thus, it is not simply the frequency and regularity of clinical supervision, but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

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

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

Strategies for Preventing Secondary Traumatization

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

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and non trauma related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by

promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.

- ➡ Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to reduce the risk for secondary traumatization and promote counselor resilience.
- ➡ Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately. *Stamm* has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout" *(Newall & MacNeil*).
Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (*Adams, Figley, & Boscarino; Newall & MacNeil*).
This tool can be used in individual and group clinical supervision, trainings on self-care, and

team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization. The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction sub-scale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives.

Case Illustration: Arlene

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

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

Advice to Clinical Supervisors:

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

Advice to Clinical Supervisors:

Recognizing STS in Counselors Who Are In Recovery

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

Addressing Secondary Traumatization

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

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker’s individual needs (e.g., peer, group, or individual

individual sessions); if possible, these services should be offered continuously instead of just one time.

Secondary Traumatization Signs

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

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

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

Case Illustration: Gui

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

Addressing Secondary Traumatization

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

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention

should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

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

Advice to Clinical Supervisors:

Advantages and Disadvantages of Using Psychometric Measures

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

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

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.

- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

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

Advice to Clinical Supervisors:

Is it Supervision or Psychotherapy?

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

Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.

6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

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

Clinician Self-Care

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

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

Case Illustration: Carla

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

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

A Comprehensive Self-Care Plan

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

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

Activities that may help clinicians find balance and cope with the stress of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making

sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives. In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16 to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem." —Member of a Disaster Response Team at the Pentagon after September 11 (*Source: Walser*)

Essential Components of Self-Care

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

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

Comprehensive Self-Care Plan Worksheet Instructions

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

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

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

<u>Spiritual</u>
- What helps me find meaning in life?
- What helps me feel hopeful?
- What sustains me during difficult times?
- What connects me to something greater?

Burke Source: Burke, P Used with permission.

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

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

- ➡ Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
- ➡ Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

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

Commitment to Self-Care

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

Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives. Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma informed organization.

The Ethics of Self-Care

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

Standards of self-care guidelines

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

<u>PRoQOL Scale</u>

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5

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

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

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I [help].
___ 3. I get satisfaction from being able to [help] people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I [help].
___ 7. I find it difficult to separate my personal life from my life as a [helper].
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].

___ 9. I think that I might have been affected by the traumatic stress of those I [help].
___ 10. I feel trapped by my job as a [helper].
___ 11. Because of my [helping], I have felt "on edge" about various things.
___ 12. I like my work as a [helper].
___ 13. I feel depressed because of the traumatic experiences of the people I [help].
___ 14. I feel as though I am experiencing the trauma of someone I have [helped].
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a [helper].
___ 20. I have happy thoughts and feelings about those I [help] and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
___ 24. I am proud of what I can do to [help].
___ 25. As a result of my [helping], I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a [helper].
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

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

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

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

Burnout Scale
On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because

scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. “I am happy” tells us more about the effects of helping when you are not happy so you reverse the score.

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

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

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher

scores on this scale mean that you are at higher risk for burnout. The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

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

6. Legal and Ethical Considerations in Clinical Supervision

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

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

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

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

(1) Vicarious liability (or respondent superior)

(2) Dual relationships and boundary concerns

(3) Informed consent

(4) Confidentiality

(5) Supervisor ethics

Direct Versus Vicarious Liability

An important distinction needs to be made between direct and vicarious liability. Direct liability of the supervisor might include dereliction of supervisory responsibility, such as "not making a reasonable effort to supervise" (defined below). In vicarious liability, a supervisor can be held liable for damages incurred as a result of negligence in the supervision process. Examples of negligence include providing inappropriate advice to a counselor about a client (for instance, discouraging a counselor from conducting a suicide screen on a depressed client), failure to listen carefully to a supervisee's comments about a client, and the assignment of clinical tasks to inadequately trained counselors. The key legal question is: "Did the supervisor conduct him- or

or herself in a way that would be reasonable for someone in his position?" or "Did the supervisor make a reasonable effort to supervise?" A generally accepted time standard for a "reasonable effort to supervise" in the behavioral health field is 1 hour of supervision for every 20–40 hours of clinical services. Of course, other variables (such as the quality and content of clinical supervision sessions) also play a role in a reasonable effort to supervise.

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

Dual Relationships and Boundary Issues

Dual relationships can occur at two levels: between supervisors and supervisees and between counselors and clients. You have a mandate to help your supervisees recognize and manage boundary issues. A dual relationship occurs in supervision when a supervisor has a primary professional role with a supervised and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship. Examples of dual relationships in supervision include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an Alcoholics Anonymous sponsor for a former supervisee. Obviously, there are varying degrees of harm or potential harm that might occur as a result of dual relationships, and some negative effects of dual relationships might not be apparent until later.

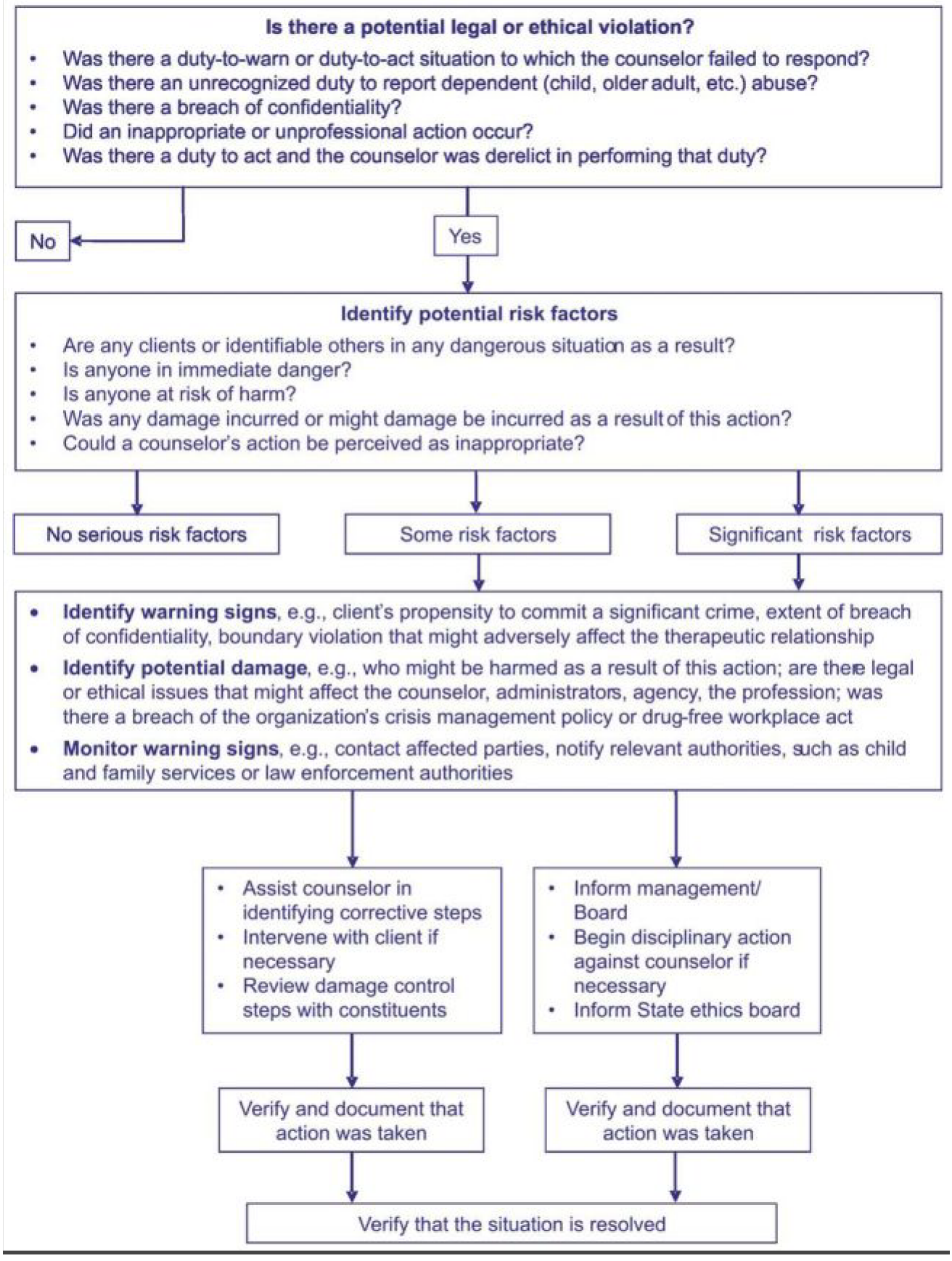
Therefore, firm, always-or-never rules aren't applicable. You have the responsibility of weighing with the counselor the anticipated and unanticipated effects of dual relationships, helping the supervisee's self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship.

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

The most common basis for legal action against counselors (20 percent of claims) and the most frequently heard complaint by certification boards against counselors (35 percent) is some form of boundary violation or sexual impropriety (See the discussion below of transference and countertransference).

Codes of ethics for most professions clearly advise that dual relationships between counselors and clients should be avoided. Dual relationships between counselors and supervisors are also a

concern and are addressed in the substance abuse counselor codes and those of other professions as well. Problematic dual relationships between supervisees and supervisors might include intimate relationships (sexual and non-sexual) and therapeutic relationships, wherein the supervisor becomes the counselor's therapist. Sexual involvement between the supervisor and supervisee can include sexual attraction, harassment, consensual (but hidden) sexual relationships, or intimate romantic relationships. Other common boundary issues include asking the supervisee to do favors, providing preferential treatment, socializing outside the work setting, and using emotional abuse to enforce power. It is imperative that all parties understand what constitutes a dual relationship between supervisor and supervisee and avoid these dual relationships. Sexual relationships between supervisors and supervisees and counselors and clients occur far more frequently than one might realize. In many States, they constitute a legal transgression as well as an ethical violation.


Is there a potential legal or ethical violation?
• Was there a duty-to-warn or duty-to-act situation to which the counselor failed to respond?
• Was there an unrecognized duty to report dependent (child, older adult, etc.) abuse?
• Was there a breach of confidentiality?
• Did an inappropriate or unprofessional action occur?
• Was there a duty to act and the counselor was derelict in performing that duty?
No
Yes
Identify potential risk factors
• Are any clients or identifiable others in any dangerous situation as a result?
• Is anyone in immediate danger?
• Is anyone at risk of harm?
• Was any damage incurred or might damage be incurred as a result of this action?
• Could a counselor's action be perceived as inappropriate?
No serious risk factors
Some risk factors
Significant risk factors
• Identify warning signs, e.g., client's propensity to commit a significant crime, extent of breach of confidentiality, boundary violation that might adversely affect the therapeutic relationship
• Identify potential damage, e.g., who might be harmed as a result of this action; are there legal or ethical issues that might affect the counselor, administrators, agency, the profession; was there a breach of the organization's crisis management policy or drug-free workplace act
• Monitor warning signs, e.g., contact affected parties, notify relevant authorities, such as child and family services or law enforcement authorities
• Assist counselor in identifying corrective steps
• Intervene with client if necessary
• Review damage control steps with constituents
• Inform management/ Board
• Begin disciplinary action against counselor if necessary
• Inform State ethics board
Verify and document that action was taken
Verify and document that action was taken
Verify that the situation is resolved

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

Informed Consent

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

Confidentiality

In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor's vicarious liability. Informed consent and concerns for confidentiality should occur at three levels: client consent to treatment, client consent to supervision of the case, and supervisee consent to supervision (*Bernard and Goodyear*). In addition, there is an implied consent and commitment to confidentiality by supervisors to assume their supervisory responsibilities and institutional consent to comply with legal and ethical parameters of supervision. (See also the Code of Ethics of the Association for Counselor Education and Supervision [ACES], available online at http://www.acesonline.net/ethical_guidelines.asp).

With informed consent and confidentiality comes a duty not to disclose certain relational communication. Limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies. Criteria for waiving client and supervisee privilege should be stated in institutional policies and discipline-specific codes of ethics and clarified by advice of legal counsel and the courts. Because standards of confidentiality are determined by State legal and legislative systems, it is prudent for supervisors to consult with an attorney to determine the State codes of confidentiality and clinical privileging.

In the substance abuse treatment field, confidentiality for clients is clearly defined by Federal law: 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA). Key information is available at http://www.hipaa.samhsa.gov. Supervisors need to train counselors in confidentiality regulations and to adequately document their supervision, including discussions and directives, especially relating to duty-to-warn situations. Supervisors need to ensure that counselors provide clients with appropriate duty-to-warn information early in the counseling process and inform clients of the limits of confidentiality as part of the agency's informed consent procedures.

Under duty-to-warn requirements (e.g., child abuse, suicidal or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may

need to be waived. Organizations should have a policy stating how clinical crises will be handled. What mechanisms are in place for responding to crises? In what timeframe will a supervisor be notified of a crisis situation? Supervisors must document all discussions with counselors concerning duty-to-warn and crises. At the onset of supervision, supervisors should ask counselors if there are any duty-to-warn issues of which the supervisor should be informed.

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

Supervisor Ethics

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

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

7. Monitoring Performance

The goal of supervision is to ensure quality care for the client, which entails monitoring the clinical performance of staff. Your first step is to educate supervisees in what to expect from clinical supervision. Once the functions of supervision are clear, you should regularly evaluate the counselor's progress in meeting organizational and clinical goals as set forth in an Individual

Development Plan (IDP) (see the section on IDPs below). As clients have an individual treatment plan, counselors also need a plan to promote skill development.

Behavioral Contracting in Supervision

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

Individual Development Plan

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

Evaluation of Clinicians

Supervision inherently involves evaluation, building on a collaborative relationship between you and the clinician. Evaluation may not be easy for some supervisors. Although everyone wants to

know how they are doing, counselors are not always comfortable asking for feedback. And, as most supervisors prefer to be liked, you may have difficulty giving clear, concise, and accurate evaluations to staff.

The two types of evaluation are formative and summative. A formative evaluation is an ongoing status report of the counselor's skill development, exploring the questions "Are we addressing the skills or competencies you want to focus on?" and "How do we assess your current knowledge and skills and areas for growth and development?"

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

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

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

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

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

Clients are often the best assessors of the skills of the counselor. Supervisors should routinely seek input from the clients as to the outcome of treatment. The method of seeking input should be discussed in the initial supervisory sessions and be part of the supervision contract. In a residential substance abuse treatment program, you might regularly meet with clients after sessions to discuss how they are doing, how effective the counseling is, and the quality of the therapeutic alliance with the counselor.

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

Addressing Burnout and Compassion Fatigue

Did you ever hear a counselor say, "I came into counseling for the right reasons. At first I loved seeing clients. But the longer I stay in the field, the harder it is to care. The joy seems to have gone out of my job. Should I get out of counseling as many of my colleagues are doing?" Most counselors come into the field with a strong sense of calling and the desire to be of service to others, with a strong pull to use their gifts and make themselves instruments of service and healing. The field risks losing many skilled and compassionate healers when the life goes out of their work. Some counselors simply withdraw, care less, or get out of the field entirely. Most just complain or suffer in silence. Given the caring and dedication that brings counselors into the field, it is important for you to help them address their questions and doubts.

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

You can help them redevelop their innate capacity for compassion, to be an openhearted presence for others. You can help counselors develop a life that does not revolve around work. This has to

be supported by the organization's culture and policies that allow for appropriate use of time off and self-care without punishment. Aid them by encouraging them to take earned leave and to take "mental health" days when they are feeling tired and burned out. Remind staff to spend time with family and friends, exercise, relax, read, or pursue other life-giving interests.

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

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

Other suggestions include:

- ✓ Help staff identify what is happening within the organization that might be contributing to their stress and learn how to address the situation in a way that is productive to the client, the counselor, and the organization.
- ✓ Get training in identifying the signs of primary stress reactions, secondary trauma, compassion fatigue, vicarious traumatization, and burnout. Help staff match up self-care tools to specifically address each of these experiences.
- ✓ Support staff in advocating for organizational change when appropriate and feasible as part of your role as liaison between administration and clinical staff.
- ✓ Assist staff in adopting lifestyle changes to increase their emotional resilience by reconnecting to their world (family, friends, sponsors, mentors), spending time alone for self-reflection, and forming habits that re-energize them.
- ✓ Help them eliminate the "what ifs" and negative self-talk. Help them let go of their idealism that they can save the world.
- ✓ If possible in the current work environment, set parameters on their work by helping them adhere to scheduled time off, keep lunch time personal, set reasonable deadlines for work completion, and keep work away from personal time.
- ✓ Teach and support generally positive work habits. Some counselors lack basic organizational, team-work, phone, and time management skills (ending sessions on time and scheduling to allow for documentation). The development of these skills helps to reduce the daily wear that erodes well- being and contributes to burnout.
- ✓ Ask them "When was the last time you had fun?" "When was the last time you felt fully alive?" Suggest they write a list of things about their job about which they are grateful. List

five people they care about and love. List five accomplishments in their professional life. Ask "Where do you want to be in your professional life in 5 years?"

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

Methods of Observation

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

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

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

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

- Simply by observing a counseling session, the dynamics will change. You may change how both the client and counselor act. You get a snapshot of the sessions. Counselors will say, "it was not a representative session." Typically, if you observe the counselor frequently, you will get a fairly accurate picture of the counselor's competencies.
- You and your supervisee must agree on procedures for observation to determine why, when, and how direct methods of observation will be used.
- The counselor should provide a context for the session.
- The client should give written consent for observation and/or taping at intake, before beginning counseling. Clients must know all the conditions of their treatment before they consent to counseling. Additionally, clients need to be notified of an upcoming observation by a supervisor before the observation occurs.
- Observations should be selected for review (including a variety of sessions and clients,

challenges, and successes) because they provide teaching moments. You should ask the supervisee to select what cases he or she wishes you to observe and explain why those cases were chosen. Direct observation should not be a weapon for criticism but a constructive tool for learning: an opportunity for the counselor to do things right and well, so that positive feedback follows.

- When observing a session, you gain a wealth of information about the counselor. Use this information wisely, and provide gradual feedback, not a litany of judgments and directives. Ask the salient question, "What is the most important issue here for us to address in supervision?"
- A supervisee might claim client resistance to direct observation, saying, "It will make the client nervous. The client does not want to be taped." However, "client resistance" is more likely to be reported when the counselor is anxious about being taped. It is important for you to gently and respectfully address the supervisee's resistance while maintaining the position that direct observation is an integral component of his or her supervision.
- Given the nature of the issues in any possible drug and alcohol counseling, you and your supervisee need to be sensitive to increased client anxiety about direct observation because of the client's fears about job or legal repercussions, legal actions, criminal behaviors, violence and abuse situations, and the like.
- Ideally, the supervisee should know at the outset of employment that observation and/or taping will be required as part of informed consent to supervision.

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

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

8. Clinical Vignettes and Application

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

Master Supervisor Notes are comments from an experienced clinical supervisor about the strategies used, what the supervisor may be thinking, how supervisors with different levels of experience and competence might have managed the situation, and information supervisors

should have. *"How-to" Notes* contain information on how to implement a specific method or strategy.

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

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

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

Vignette 1—Maintaining Focus on Job Performance

Overview

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

Background

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

Since receiving her license as a counselor, Juanita has been given new job assignments that

involve working with more complex and difficult clients. She now conducts educational and support groups by herself, does intake interviews, provides individual counseling to her caseload, and has recently increased her caseload to accommodate the increased number of clients at the agency. She is also seeing several clients with co-occurring disorders.

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

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

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

Learning Goals:

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

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

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

JUANITA: That's fine, but I think I owe you an apology about our last session. I really want to apologize for saying all those things to you about my family and how that is affecting me and all that, and I just want to apologize. I know it had nothing to do with anything work related. We

were doing supervision and should just have talked about cases, and I just want to assure you that that will never happen again.

MELISSA: Well, Juanita, I'm sorry you have to cope with all that's going on, but I don't feel you need to apologize for anything last week. I know that what's happening is stressful to you. I hope we can work out a plan to help you get the help you need and also be sure that the pressures you are experiencing don't spill over into your work with clients.

JUANITA: I appreciate that. I just want you to know that that's not me. That's not me.

MELISSA: And I appreciate that, and I want you to know that I value your work. You've worked hard. You've really worked hard in learning not only your job, but also as a professional counselor and you've made a valuable contribution to working with our clients.

JUANITA: I love my job. I love it.

MELISSA: Juanita, I want to be really clear with you that I am concerned about what is going on in your personal life, and I want to work with you to get help for that. I don't feel that it's something that we should address in supervision though, except to the extent that it affects your job performance. The goal of our supervision time is to help you to be the best counselor possible. When personal issues come up, those may keep you from being the best *person* you can be. These are important issues for you to address in your own personal counseling and therapy. I hope that distinction is clear for you. But I really want you to hear my concern for you.

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

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

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

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

JUANITA: Sure, if you have the tape there.

How To Address Personal Issues That Affect Job Performance

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

- You can help your supervisees see the relationship between their personal difficulties and work-related problems. The key question you need to return to is "How is this personal issue affecting your job performance?" This prevents you from becoming the counselor's counselor and turning supervision into therapy.
- You can clarify the boundaries of what constitutes acceptable job performance, as some counselors may be uncertain where the boundaries lie.
- You should continually focus on approaches to improve job performance, providing useful suggestions and recommendations for improvement. It is also helpful to provide measurable benchmarks by which counselors can assess their own improvement.
- You and your supervisee should develop a written work plan for how the employee will take the necessary steps to improve job performance.
- You can help the counselor examine how personal stressors might affect interactions with coworkers or clients.
- Finally, you and your supervisee can explore how you and the agency can support the employee in confronting and resolving personal issues that are affecting job performance, such as a referral to the EAP, use of personal or sick time, rescheduling the clinician's time, and the like.

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

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

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

MELISSA: I'm glad you can stand back objectively and see the relationship between your personal issues and your clinical functioning. So, what do you think you need to do now?

JUANITA: Well, first maybe I shouldn't see any more male patients?MELISSA: That is an option.

But I think we can find a better resolution. For right now, let's focus on what else needs to change.

JUANITA: Well, I just won't cancel any more appointments. I didn't realize rescheduling was such a problem. But I just won't do it anymore. And about the missed days, I think that is beyond me now. If I need a day off for personal reasons, I'll schedule them in advance from now on.

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

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

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

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

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

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

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

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

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

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

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

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

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

Vignette 2—Mentoring a Successor

Overview

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

Background

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

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

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

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

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

Learning Goals:

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

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

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

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

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

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

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

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

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

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

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

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

BETTY: What do you mean?

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

BETTY: Yes, there were many.

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

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

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

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

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

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

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

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

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

BETTY: Thanks for the vote of confidence.

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

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

MARGIE: It can be intimidating, presenting to people you work with.
BETTY: I assume you’ll help me with that?
MARGIE: Yes. I also think you have the potential to present at State and national conferences.

This would expand your repertoire of material, hone your speaking skills, build your confidence, and help you become better known outside the agency. We know you’re good. It’s time for others outside to see in you what we see.

BETTY: Really?

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

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

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

BETTY: So is this what you meant by mentorship?

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

BETTY: Sure, I want to hear.

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

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

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

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

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

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

BETTY: And you would be willing to make that kind of investment in me, Margie?
MARGIE: I sure am. The agency surely is.
BETTY: You know how exciting this is? I am fluttering inside.

MARGIE: It's exciting for me too. I enjoy seeing staff use their potential to the fullest. It's something I can leave behind when I retire that will last far beyond my years of service. It's like looking into the eyes of children and seeing the future in them that I will never realize myself. If I can help mentor you and others, that will be the icing on the cake of my career.

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

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

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

Resources on Mentorship

ATTC Leadership Institute (http://www.nattc.org/leaderInst/index.htm). After an assessment of leadership and management interests, values, and skills, participants attend a 5-day training session designed to present the necessary body of information. With their mentors, participants

develop an individualized training plan and individualized project. They then return to their organizations for 6 months of mentoring and working on their projects.

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

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

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

Unique Issues in Supervision for Substance Abuse Counselors

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

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

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

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

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

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

9. The Use of Technology in Clinical Supervision

Supervision and Training Using New Technologies

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

computers in training and supervising counselors, including such factors as use of computer- based simulations, student attitudes toward new technology, and ethical issues. Individual and group instruction can be conducted using Web-based technology; at least one study has found the latter to be an effective training platform for teaching CBT to counselors (*Weingardt, Cucciare, Bellotti, & Lai*). Different types of technology may have different specific applications to training and supervision, just as they do to counseling. Video conferencing and text-based interactions, such as using instant messaging or online chat forums, can be effective ways to improve counselor attitudes and skills (*Abbass et al.*). *Carlson-Sabelli* discussed the use of Internet forums as an adjunct to counselor training and supervision. *Coursol, Lewis, & Seymour* discussed the application of video conferencing technology to counselor training and supervision. However, not all studies have found Web-based training as effective as that delivered in person. For example, Sholomskas et al. found the effectiveness of a training Web site with written materials superior to written materials alone, but somewhat less effective than an in- person seminar with supervised casework for the teaching of CBT. The Internet can also be used to train auxiliary staff members and peer assistants. Worrall and Fruzzetti discussed the use of a Web-based training program using online videos for peer supervisors working with therapists delivering dialectical behavior therapy. Vaccaro and Lambie reviewed options for conducting computer-based training and supervision, as well as advantages and disadvantages and ethical concerns for this type of supervision/training. *Smith, Carpenter, et al.* randomly assigned 97 substance use disorder treatment counselors who were enrolled in a 2-day motivational interviewing workshop to receive live supervision conducted using video conferencing technology, supervision using videotaped practice sessions, or the workshop alone without an additional supervision component. Participants' sessions with clients were rated 1, 8, and 20 weeks after the workshop using the Motivation Interviewing Treatment Integrity Coding System. Participants who used teleconferencing for supervision had significantly better compliance compared with those who used the workshop alone, and they did a significantly better job in maintaining a proper ratio between questions and reflections than did those in either of the other groups.

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

Peer supervision and support can also be provided to counselors via Internet or phone. Yeh et al. suggested that an online peer supervision group is a viable alternative to in-person

groups, and they found that participants in an online peer supervision group for counselors felt comfortable and confident using this form of interaction. A related issue is the need to train therapists in the use of electronic media to conduct therapy. As Abbott et al. observed, training is needed to communicate effectively via computer, with attention to tasks such as communicating empathy via text instead of in person and handling ethical issues that might arise in the e-therapy situations.

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

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

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

Supervisor Competencies

There are distinct competencies that supervisors who oversee TAC must master. These competencies are generally derived from using technology in their own practice. In addition, supervisors who use technology to deliver long distance clinical supervision must have a distinct set of competencies if they are to be adequately prepared to use technology to conduct supervision effectively. Sample Telehealth Policies Policies and procedures vary based on the type of technology used, risks associated with the intervention, the organization's regulatory climate, and

the size and scope of the organization itself. The sample policies that are available at https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924 are adapted from an internal policies and procedures manual developed by The Billings Clinic in Billings, MT, and provided by TIP Consensus Panelist Thelma McClosky Armstrong, M.A. They provide a snapshot of some issues that organizations may wish to consider in developing policies for technology assisted services. Some of the sample policies clearly relate to telehealth for physical disorders or when a telehealth provider may need a close or thorough physical view of the client. Although telebehavioral health will not often require such a physical review of the client, the policies have been included to foster integrated care in case the telebehavioral health administrator wishes to share these sample policies with a general telehealth administrator.

10. References

Alderfer CJ. "The Effects of Gender on the Supervisory Process". Amherst, MA: University of Massachusetts; 1991. Video recording.

American Counseling Association. ACA Code of Ethics. Alexandria, VA: American Counseling Association; 2005. Retrieved June 8, 2007 from http://www.cacd.org/ACA_2005_Ethical_Code10405.pdf.

American Association for Marriage and Family Therapy. (2007). *AAMFT approved supervisor designation standards and responsibilities handbook*. Retrieved from: http://www.aamft.org/imis15/Documents/Approved_Supervisor_handbook.pdf

American Psychological Association. (2013a). *Guidelines for the practice of telepsychology*. APA Council of Representatives. Washington, DC: Author.

American Psychological Association. (2013b). *Guidelines for psychological practice in health care delivery systems*. Retrieved from: http://www.apa.org/practice/guidelines/delivery-systems.aspx

American Psychology Association. (2011a). *Guidelines for psychological practice with lesbian, gay and bisexual clients*. Retrieved from http://www.apa.org/pi/lgbt/resources/guidelines.aspx

American Psychological Association. (2011b). *Guidelines for assessment of and Intervention with persons with disabilities*. Retrieved from: http://www.apa.org/pi/disability/resources/assessment disabilities.aspx

American Psychological Association. (2011c). Model act for state licensure of psychologists. *American Psychologist*, 66, 214-226. doi:10.1037/a0022655.

American Psychological Association. (2011d). *Revised competency benchmarks for professional psychology*. Retrieved from: http://www.apa.org/ed/graduate/revised-competency-benchmarks.doc.

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct.* Retrieved from http://apa.org/ethics/code/index.aspx

American Psychological Association. (2008). *Report of the APA Task Force on the implementation of the* Multicultural Guidelines. Retrieved from http://www.apa.org/about/governance/council/policy/multicultural-report.pdf

American Psychological Association. (2007a). Guidelines for psychological practice with girls and women. *American Psychologist*, 62, 949-979. doi.org/10.1037/0003-066X.62.9.949.

American Psychological Association. (2007b). Record keeping guidelines. *American Psychologist*, 62, 993-1004. doi: 10.1037/0003-066X.62.9.993.

American Psychological Association. (2004a). Guidelines for psychological practice with older adults. *American Psychologist,* 59, 236-260. Doi: 10.1037/0003-066X.

American Psychological Association. (2004b). Developing and evaluating standards and guidelines related to education and training in psychology. Retrieved from http://www.apa.org/about/governance/council/policy/bea-guidelines.pdf.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402. doi: 10.1037/0003-066X.58.5.377

American Psychological Association. (1996). *Recognition of health service providers*. Approved Council Resolution. C.(17). Washington, DC: American Psychological Association.

American Psychological Association Commission on Accreditation. (2009). *Guidelines and principles for accreditation of programs in professional psychology*. Washington, DC: Author.

American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. doi: 10.1037/0003-066X.61.4.271.

Armfield, N. R., Gray, L. C., & Smith, A. C. (2012). Clinical use of Skype: A review of the evidence base. Journal of Telemedicine and Telecare, 18, 125–127.

Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Boston: Pearson.

Bledsoe, T. S., & Simmerok, B. D. (2014). A multimedia-rich platform to enhance student engagement and learning in an online environment. Journal of Asynchronous Learning Networks, 17(4), 57–66.

Burkard AW, Johnson AJ, Madson MB, Pruitt NT, Contreras-Tadych DA, Kozlowski JM. et al. Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. *Journal of Counseling Psychology.* 2006; 53: 288–301.

Campbell JM. Becoming an Effective Supervisor: A Workbook for Counselors and Psychotherapists. Philadelphia: Accelerated Development; 2000.

Carlson-Sabelli, L. (2010). Using forums to enrich counselor training and supervision. In K. Anthony, D. M. Nagel, & S. Goss (Eds.), The use of technology in mental health: Applications, ethics and practice (pp. 415–420). Springfield, IL: Charles C. Thomas

Center for Substance Abuse Treatment. Manpower Development Study. Rockville, MD: Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services; 2003.

Center for Substance Abuse Treatment. Technical Assistance Publication (TAP) Series 21 (HHS Publication No (SMA) 07-4243). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.

Center for Substance Abuse Treatment. Technical Assistance Publication (TAP) Series 21-A (HHS Publication No (SMA) 07-4243). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2007. Competencies for Substance Abuse Treatment Clinical Supervisors.

Christensen TM, Kline WB. A qualitative investigation of the process of group supervision with group counselors. *Journal for Specialists in Group Work.* 2000; 25: 376–393.

Derrig-Palumbo K, Zeine F. Online Therapy: A Therapist's Guide to Expanding Your Practice. 1st ed. New York: WW Norton & Company; 2005.

Dixon GD. Clinical supervision: A key to treatment success. Southern Coast Beacon. Tallahassee, FL: Southern Coast ATTC; 2004.

Eby LT, McCleese CS, Baranik L, Owen C. Project MERITS Year 1 Summary Report. Athens, GA: University of Georgia Institute for Behavioral Research; 2007.

Falender CA, Shafranske EP. The practice of clinical supervision. Washington, DC: American Psychological Association; *Clinical Supervision: A Competency-Based Approach.* 2004a: 3–35.

Falender CA, Shafranske EP. Clinical Supervision: A Competency-Based Approach. Washington, DC: American Psychological Association; 2004b.

Falender CA, Shafranske EP. Ethical and legal perspectives and risk management. Washington, DC: American Psychological Association; *Clinical Supervision: A Competency-Based Approach.* 2004c: 151–194.

Falender, C. A., & Shafranske, E. P. (2014). Supervision. In B.Johnson, & N. Kaslow (Eds.) *Oxford handbook of education and training in professional Psychology*. In press.

Fernando DM, Hulse-Killacky D. The relationship of supervisory styles to satisfaction with supervision and the perceived self-efficacy of master's-level counseling students. *Counselor Education and Supervision.* 2005; 44: 293–304.

Fouad, N. A. & Grus, C. G. (2014). Competency-based education and training in professional psychology. In W. B. Johnson & N. J. Kaslow (Eds.), *Oxford handbook of education and training in professional psychology* (PP. 105-119). New York: Oxford.

Forrest, L. (2012). Educators' and trainers' responsibilities when trainees' personal beliefs collide with competent practice. *Training and Education in Professional Psychology, 6*, 187-188. doi : 10.1037/a0030799.

Forrest, L., Elman, N. S., Huprich, S. K., Veilleux, J. C., Jacobs, S. C., & Kaslow, N. J. (2013). Training directors' perceptions of faculty behaviors when dealing with trainee competence problems: A mixed method pilot study. *Training and Education in Professional Psychology, 7*, 23-32.

Hoge MA, Morris JA, Daniels AS, Stuart GW, Huey LY,Adams N. An Action Plan on Behavioral Health Workforce Development. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2007.

Inman AG. Supervisor multicultural competence and its relation to supervisory process and outcome. *Journal of Marital & Family Therapy.* 2006; 32: 73–85.

Kavanagh DJ, Spence SH, Strong J, Wilson J, Sturk H, Crow N. Supervision practices in Allied Mental Health: Relationships of supervision characteristics to perceived impact and job satisfaction. *Mental Health Services Research.* 2003; 5: 187–195.

Kraus R, Zack JS, Stricker G., editors. Online Counseling: A Handbook for Mental Health Professionals. New York: Elsevier Science; 2004.

Lane, D. J., Lindemann, D. F., & Schmidt, J. A. (2012). A comparison of computer-assisted and

self-management programs for reducing alcohol use among students in first year experience courses. Journal of Drug Education, 42, 119–135.

Lucey, R. (2015). SAMHSA's Current and Future Direction for Prevention in Higher Education Rockville, MD: Substance Abuse and Mental Health Services Administration.

Minkoff K. Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. *New Directions for Mental Health Services.* 2001; 91: 17–30.

NAADAC, The Association for Addiction Professionals. NAADAC, The Association for Addiction Professionals Practitioner Services Network Year 2 Final Report: A Survey of Early Career Substance Abuse Counselors. Washington, DC: NAADAC, The Association for Addiction Professionals; 2003.

National Association of School Psychologists. (2010). *Model for comprehensive and integrated school psychological services*. Retrieved from: http://www.nasponline.org/standards/2010standards/2_PracticeModel.pdf.

National Association of Social Workers and Association of Social Work Boards. (2013). *Best practice standards in social work supervision*. Retrieved from: http://www.socialworkers.org/practice/naswstandards/supervisionstandards2013.pdf

Nelson ML, Gizara S, Hope AC, Phelps R, Steward R, Weitzman L. A feminist multicultural perspective on supervision. *Journal of Multicultural Counseling and Development.* 2006; 34: 105–115.

Newgent RA, Davis H, Farley RC. Perceptions of individual, triadic, and group models of supervision: A pilot study. *Clinical Supervisor.* 2004; 23: 65–79.

New Leadership Alliance for Student Learning and Accountability. (2012). *Committing to quality: Guidelines for assessment and accountability in higher education*. Washington, DC: New Leadership Alliance for Student Learning and Accountability.

Newman, C. F. (2013). Training cognitive behavioral therapy supervisors: Didactics, simulated practice, and 'meta-supervision.' *Journal of Cognitive Neuroscience, 25*, 5-18. doi: 10.18910889-83.91.27.1.5.

Northwest Frontier ATTC. Clinical supervision—part 1: Models of clinical supervision (Series 20). Addiction Messenger. 2005a.

Northwest Frontier ATTC. Clinical supervision—part 2: What happens in good supervision? (Series 20). Addiction Messenger. 2005b

Powell DJ. Maximizing the benefits of online therapy. *Addiction Professional.* 2006; 4: 26–32.

Powell DJ, Brodsky A. Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models, Methods. San Francisco: Jossey-Bass; 2004. (Rev ed).

Ray D, Altekruse M. Effectiveness of group supervision versus combined group and individual supervision. *Counselor Education and Supervision.* 2000; 40: 19–30.

Reamer FG. Social Work Malpractice and Liability: Strategies for Prevention. 2nd ed. New York: Columbia University Press; 2003.

Reamer FG. Social Work Values and Ethics. 3rd ed. New York: Columbia University Press; 2006.

Reeves D, Culbreth JR, Greene A. Effect of sex, age, and education level on the supervisory styles of substance abuse counselor supervisors. *Journal of Alcohol and Drug Education.* 2001; 47: 76–86.

Roche AM, Todd CL, O'Connor J. Clinical supervision in the alcohol and other drugs field: An imperative or an option. *Drug and Alcohol Review.* 2007; 26: 241–249. [PubMed]

Shulman L, Safyer A.New York: Haworth Press; *Supervision in Counseling: Interdisciplinary Issues and Research.* 2006 Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006.

Additional References

Addiction Technology Transfer Center. The Change Book: A Blueprint for Technology Transfer. 2nd ed. Kansas City, MO: Author; 2004.

American Psychological Association. Record keeping guidelines. *American Psychologist.* 2007; 62: 993–1004.

Anderson CE. Supervision of substance abuse counselors using the integrated developmental model. *Clinical Supervisor.* 2000; 19: 185–195.

Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 5th ed. New York: Oxford University Press; 2001.
Bernard JM, Goodyear RK. Fundamentals of Clinical Supervision. Boston, MA: Pearson Education; 2004.

Borders LD, Brown LL. The New Handbook of Counseling Supervision. Mahwah, NJ: Lawrence Erlbaum Associates; 2005.

Burke PA, Carruth B, Prichard D. Counselor self-care in work with traumatized, addicted people. In: Carruth B., editor. Psychological Trauma and Addiction Treatment. New York: Haworth Press; 2006. pp. 283–301.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 5 (HHS Publication No (SMA) 95-3057). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1993a . Improving Treatment for Drug-Exposed Infants.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 2 (HHS Publication No (SMA) 93-1998). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1993b. Pregnant, Substance-Using Women.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 6 (HHS Publication No (SMA) 95-3060). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1993c. Screening for Infectious Diseases Among Substance Abusers.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 11 (HHS Publication No (SMA) 94-2094). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1994. Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 16 (HHS Publication No (SMA) 95-3041). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1995a. Alcohol and Other Drug Screening of Hospitalized Trauma Patients.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 21 (HHS Publication No (SMA) 95-3051). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1995b. Combining Alcohol and Other Drug Treatment With Diversion for Juveniles in the Justice System.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 14 (HHS Publication No (SMA) 95-3031). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1995c. Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 13 (HHS Publication No (SMA) 95-3021). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1995d. The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 18 (HHS Publication No (SMA) 95-3047). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1995e. The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 23 (HHS Publication No (SMA) 96-3113). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1996. Treatment Drug Courts: Integrating Substance Abuse Treatment with Legal Case Processing.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 24 (HHS Publication No (SMA) 97-3139). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1997a. A Guide to Substance Abuse Services for Primary Care Clinicians.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 25 (HHS Publication No (SMA) 97-3163). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1997b. Substance Abuse Treatment and Domestic Violence.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No (SMA) 98-3222). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1998a. Comprehensive Case Management for Substance Abuse Treatment.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 30 (HHS Publication No (SMA) 98-3245). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1998b. Continuity of Offender Treatment for Substance Use Disorders from Institution to Community.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 28 (HHS Publication No (SMA) 98-3206). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1998c. Naltrexone and Alcoholism Treatment.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 26 (HHS Publication No (SMA) 98-3179). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1998d. Substance Abuse Among Older Adults. SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 29 (HHS Publication No (SMA) 98-3249). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1998e. Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities. SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 34 (HHS Publication No (SMA) 99-3353). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999a. Brief Interventions and Brief Therapies for Substance Abuse. SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 35 (HHS Publication No (SMA) 99-3354). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999b. Enhancing Motivation for Change in Substance Abuse Treatment. SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 31 (HHS Publication No (SMA) 99-3282). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999c. Screening and Assessing Adolescents for Substance Use Disorders.SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 32 (HHS Publication No (SMA) 99-3283). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999d. Treatment of Adolescents With Substance Use Disorders. SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 33 (HHS Publication No (SMA) 99-3296). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999e. Treatment for Stimulant Use Disorders. SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 38 (HHS Publication No (SMA) 00-3470). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2000a. Integrating Substance Abuse Treatment and Vocational Services. SAMSHA

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 36 (HHS Publication No (SMA) 00-3357). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2000b. Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 37 (HHS Publication No (SMA) 00-3459). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2000c. Substance Abuse Treatment for Persons With HIV/AIDS.

Center for Substance Abuse Treatment. Manpower Development Study. Bethesda, MD: Department of Health and Human Services; 2003.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 40 (HHS Publication No (SMA) 04-3939). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2004a. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 39 (HHS Publication No (SMA) 04-3957). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2004b. Substance Abuse Treatment and Family Therapy.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 43 (HHS Publication No SMA 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005a. Medication-Assisted Treatment for Opioid Addiction.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 44 (DHHS Publication No (SMA) 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005b. Substance Abuse Treatment for Adults in the Criminal Justice System.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 41 (HHS Publication No SMA 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005c. Substance Abuse Treatment: Group Therapy.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 42 (HHS Publication No SMA 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005d. Substance Abuse Treatment for Persons With Co-Occurring Disorders.

Center for Substance Abuse Treatment. Technical Assistance Publication (TAP) Series 21 (Rep No HHS Publication No (SMA) 07-4243). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 45 (HHS Publication No SMA 06-4131). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006a. Detoxification and Substance Abuse Treatment.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 46 (HHS Publication No SMA 06-4151). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006b. Substance Abuse: Administrative Issues in Intensive Outpatient Treatment.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 47 (HHS Publication No 06-4182). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006c. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.

Center for Substance Abuse Treatment. Technical Assistance Publication (TAP) Series 21-A(Rep No HHS Publication No (SMA) 07-4243). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2007. Competencies for Substance Abuse Treatment Clinical Supervisors.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 48. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2008. Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 50. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2009. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 49. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2009. Incorporating Alcohol Pharmacotherapies Into Medical Practice.

Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 51. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2009. Substance Abuse Treatment: Addressing the Specific Needs of Women.

Center for Substance Abuse Treatment (in development a). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Addressing Viral Hepatitis in People With Substance Use Disorders.

Center for Substance Abuse Treatment (in development b). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Improving Cultural Competence in Substance Abuse Treatment.

Center for Substance Abuse Treatment (in development c). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Management of Chronic Pain in People With or in Recovery From Substance Use Disorders.

Center for Substance Abuse Treatment (in development d). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Relapse Prevention and Recovery Promotion.

Center for Substance Abuse Treatment (in development e). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Substance Abuse Treatment for Native Americans and Alaska Natives.

Center for Substance Abuse Treatment (in development f). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Substance Abuse Treatment: Men's Issues.

Center for Substance Abuse Treatment (in development g). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Substance Abuse Treatment for People Who Are Homeless.

Center for Substance Abuse Treatment (in development h). Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration; Substance Abuse and Trauma.

Constantine MG. Multicultural competence in supervision: Issues, processes, and outcomes. In: Pope-Davis DB, Coleman HLK, Liu WM, Toporek RL., editors. Handbook of Multicultural Competencies: In Counseling & Psychology. Thousand Oaks, CA: Sage Publications; 2003. pp. 383–391.

Cross TL, Bazron BJ, Dennis KW, Isaacs MR. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Vol. 1. Washington, DC: Georgetown University; Child Development Center: 1989.

Delaney DJ. A behavioral model for the supervision of counselor candidates. *Counselor Education and Supervision.* 1972; 12: 46–50.

Dixon GD. Clinical Supervision: A Key to Treatment Success. Southern Coast Beacon Tallahassee, FL: Southern Coast ATTC; 2004. Retrieved August 14, 2007, from http://www.scattc.org/pdf_upload/Beacon004.pdf.

Falender CA, Shafranske EP. Clinical supervision: A Competency-Based Approach. Washington, DC: American Psychological Association; 2004.

Falvey JE. Documentation in Supervision: The Focused Risk Management Supervision System (FoRMSS). Pacific Grove, CA: Brooks/Cole; 2002a.

Falvey JE. Managing Clinical Supervision: Ethical Practice and Legal Risk Management. Pacific Grove, CA: Brooks/Cole-Thomson Learning; 2002b.

Fong ML, Lease SH. Cross-cultural supervision: Issues for the white supervisor. In: Pope-Davis DB, Coleman HLK., editors. Multicultural Counseling Competencies: Assessment, Education and Training and Supervision. Thousand Oaks, CA: Sage; 1997. pp. 387–405.

Glenn E, Serovich JM. Documentation of family therapy supervision: A rationale and method. *American Journal of Family Therapy.* 1994; 22: 345–355.

Herman KC. Reassessing predictors of therapist competence. *Journal of Counseling & Development.* 1993; 72: 29–32.

Hogan RA. Issues and approaches in supervision. *Psychotherapy: Theory, Research, Practice, Training.* 1964; 1: 139–141.

Holloway E. Clinical Supervision: A Systems Approach. Thousand Oaks, CA: Sage Publications; 1995.

Hubble MA, Duncan BL, Miller SD., editors. The Heart and Soul of Change: What Works in Therapy. Washington, DC: American Psychological Association; 1999.

International Certification & Reciprocity Consortium. Clinical Supervisor of Alcohol and Other Drug Abuse Counselors Role Delineation Study. Research Triangle Park NC: CASTLE Worldwide, Inc.; 2000.

Kadushin A. Supervision in Social Work. New York: Columbia University Press; 1976.

Lambie G. Burnout prevention: A humanistic perspective and structured group supervision activity. *Journal of Humanistic Counseling, Education & Development.* 2006; 45: 32–44.

Lindbloom G, Ten Eyck TG, Gallon SL. Clinical Supervision I: Building Chemical Dependency Counselor Skills: Instructor Guide. Salem, Oregon: Northwest Frontier Addiction Technology Transfer Center; 2004. Retrieved August 14, 2007, from http://www.mattc.org/_media/publications/pdf/Clinical_InstructorGuide1-05_3rd_ed.pdf.
Loganbill C, Hardy E, Delworth U. Supervision: A conceptual model. *Counseling Psychologist.* 1982; 10: 3–42.

Mattel P. *Designing and implementing clinical supervision.* 2007 Unpublished manuscript.
Munson CE. Social Work Supervision. New York: Free Press; 1979.
Munson CE. Clinical Social Work Supervision. 2nd ed. New York: Haworth Press; 1993.

NAADAC, The Association for Addiction Professionals. NAADAC, The Association for Addiction Professionals Practitioner Services Network Year 2 Final Report: A Survey of Early Career Substance Abuse Counselors. Washington, DC: NAADAC, The Association for Addiction Professionals; 2003. Retrieved August 14, 2007, from http://naadac.org/pressroom/files/Year2SurveyReport.pdf.

Nichols WC, Nichols DP, Hardy KV. Supervision in family therapy: A decade restudy. *Journal of Marital & Family Therapy.* 1990; 16: 275–285.

Pope KS, Sonne JL, Greene B. What Therapists Don't Talk About and Why: Understanding Taboos That Hurt Us and Our Clients. 2d ed. Washington, DC: American Psychological Association; 2006.

Pope-Davis DB, Coleman HLK.Thousand Oaks, CA: Sage Publications; *Multicultural Counseling Competencies: Assessment, Education and Training, and Supervision.* 1997

Porter J, Gallon SL. Clinical Supervision II: Addressing Supervisory Problems in Addictions Treatment. Salem, OR: Northwest Frontier Addiction TechnologyTransfer Center; 2006.

Powell DJ, Brodsky A. Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models, Methods. San Francisco: Jossey-Bass; 2004. (Rev ed) .

The Psychology Board of Australia's *Guidelines for supervisors and supervisor training providers* consists of a document that focuses on competency-based supervision (Psychology Board of Australia, 2013).

The National Association of Social Workers and the Association of Social Work Boards recently released a document on best practices for supervision (National Association of Social Workers and the Association of Social Work Boards, 2013), articulating five standards: context in supervision, conduct of supervision, legal and regulatory issues, ethical issues, and technology.

Reamer FG. Social Work Values and Ethics. 3rd ed. New York: Columbia University Press; 2006.
Remley TP, Herlihy B. Ethical, Legal, and Professional Issues in Counseling (Updated 2nd ed). Upper Saddle River NJ: Pearson Merrill Prentice Hall; 2007.

Rigazio-DiGilio SA. Integrative supervision: Approaches to tailoring the supervisory process. In:

Todd T, Storm C., editors. The Complete Systemic Supervisor: Context, Philosophy, and Methods. Needham Heights, MA: Allyn and Bacon; 1997. pp. 195–217.
Roche AM, Todd CL, O'Connor J. Clinical supervision in the alcohol and other drugs field: An imperative or an option. *Drug and Alcohol Review.* 2007; 26: 241–249. [PubMed]

Shoptaw S, Stein J, Rawson R. Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV. *Journal of Substance Abuse Treatment.* 2000; 19: 117–126. [PubMed]

Skovholt TM, Ronnestad MH. The Evolving Professional Self: Stages and Theories in Therapist and Counselor Development. New York: Wiley; 1992.

Spice CG Jr, Spice WH. A triadic method of supervision in the training counselors and counseling supervisors. *Counselor Education and Supervision.* 1976; 15: 251–258.

Stoltenberg CD, Delworth U. Supervising Counselors and Therapists: A Developmental Approach. San Francisco: Jossey-Bass; 1987.

Stoltenberg CD, McNeill B, Delworth U. IDM Supervision: An Integrated Developmental Model for Supervising Counselors and Therapists. 1st ed. San Francisco: Jossey-Bass Publishers; 1998.
Swenson LC. Psychology and Law for the Helping Professions. 2nd ed. Pacific Grove, CA: Brooks/Cole Pub. Co; 1997.

Tromski-Klingshirn D. Should the clinical supervisor be the administrative supervisor? The ethics versus the reality. *The Clinical Supervisor.* 2006; 25: 53–67.

U.S. Department of Health and Human Services. Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations (Rep No HHS Pub No SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2003.

White WL, Popovits RM. Critical incidents: Ethical Issues in the Prevention and Treatment of Addiction. 2nd ed. Bloomington, IL: Chestnut Health Systems; 2001.

Williams L. A tool for training supervisors: Using the supervision feedback form (SFF). *Journal of Marital and Family Therapy.* 1994; 20: 311–315.