Clinical Supervision and Professional Development Continuing Education Course
(6 Hours/Units)

Course Objectives: This course is designed to help you:

- Identify the central principles of clinical supervision
- Become aware of the functions of clinical supervision
- Improve standard of practice within your given field
- Increase awareness of clinical supervision problems and resources
- Increase ability to consider cultural and contextual factors
- Increase awareness of legal and ethical issues within clinical supervision
- Implement clinical supervision methods and techniques

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1. Introduction

- Clinical supervision is an essential part of all 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 should involve direct observation methods.

2. Clinical Supervision and Professional Development Introduction

Clinical supervision is emerging as the crucible in which counselors acquire knowledge and skills for the profession, providing a bridge between the classroom and the clinic. 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 counselor and 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 staff while addressing an array of psychological, interpersonal, physical, and spiritual issues of clients. Ultimately, effective clinical supervision ensures that clients are competently served. Supervision ensures that counselors continue to increase their skills, which in turn increases treatment effectiveness, client retention, and staff satisfaction. The clinical supervisor also serves as liaison between administrative and clinical staff.

This TIP 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.
Definitions

The following are definitions of supervision:

- “Supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive” (Powell & Brodsky, 2004, p. 11). “Supervision is an intervention provided by a senior member of a profession to a more junior member or members. . . . This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper of those who are to enter the particular profession” (Bernard & Goodyear, 2004, p. 8).
- Supervision is “a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices” (CSAT, 2007, p. 3).

As a supervisor to the client, counselor, and organization, the significance of your position is apparent in the following statements:

- Organizations have an obligation to ensure quality care and quality improvement of all personnel. The first aim of clinical supervision is to ensure quality services and to protect the welfare of clients.
- Supervision is the right of all employees and has a direct impact on workforce development and staff and client retention.
• You oversee the clinical functions of staff and have a legal and ethical responsibility to ensure quality care to clients, the professional development of counselors, and maintenance of program policies and procedures.

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

3. Functions 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, 1997).
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:** Bernard and Goodyear (2004) incorporate 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.

### 4. Central Principles of Clinical Supervision

The central principles identified by the Consensus Panel are:

1. **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.

2. **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 (see, for example, Roche, Todd, & O’Connor, 2007).

3. **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.

4. **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.

5. **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.

6. **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.

7. **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.)

8. **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.
9. **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, 2005). 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.

10. **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.

11. **Clinical supervision should involve 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).

5. **Problems and Resources**

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

Working With Staff Who Are Resistant to Supervision

Some of your supervisees may have been in the field longer than you have and see no need for supervision. Other 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 TIP, 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 (e.g., Holloway, 1995) 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.

6. Models of Clinical Supervision
You may never have thought about your model of supervision. However, it is a fundamental premise of this TIP 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., microtraining, the Discrimination Model [Bernard & Goodyear, 2004], and the Task-Oriented Model [Mead, 1990], focus primarily on the skills and learning needs of the supervisee and on setting goals that are specific, measurable, attainable, realistic, and timely (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 (1987), 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? (Campbell, 2000)

According to Bernard and Goodyear (2004) and Powell and Brodsky (2004), 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.

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

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 counselor.
- 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.
- Counselors at an advanced developmental level have different learning needs and require different supervisory approaches from those at Level 1; and
- The developmental level can be applied for different aspects of a counselor’s overall competence (e.g., Level 2 mastery for individual counseling and Level 1 for couples counseling).

Developmental Stages of Supervisors

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<tr>
<th>Developmental Level</th>
<th>Characteristics</th>
<th>To Increase Supervision Competence</th>
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</table>
| Level 1             | • Is anxious regarding role  
                      • Is naive 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 1 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
7. 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 (1995) and Constantine’s Multicultural Model (2003).

The competencies listed in TAP 21-A reflect the importance of culture in supervision (CSAT, 2007). 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, 2003, p. 12). 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 (1995) 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. Cross (1989) has identified several stages on a continuum of becoming culturally competent.

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<th>Cultural Destructiveness</th>
<th>Superiority of dominant culture and inferiority of other cultures; active discrimination</th>
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<tr>
<td>Cultural Incapacity</td>
<td>Separate but equal treatment; passive discrimination</td>
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<tr>
<td>Cultural Blindness</td>
<td>Sees all cultures and people as alike and equal; discrimination by ignoring culture</td>
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<tr>
<td>Cultural Openness (Sensitivity)</td>
<td>Basic understanding and appreciation of importance of sociocultural factors in work with minority populations</td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>Capacity to work with more complex issues and cultural nuances</td>
</tr>
<tr>
<td>Cultural Proficiency</td>
<td>Highest capacity for work with minority populations; a commitment to excellence and proactive effort</td>
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</table>

Source: Cross, 1989.

Although you may never have had specialized training in multicultural counseling, some of your supervisees may have (see Constantine, 2003). 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 dialog 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 (2003) suggests that supervisors can use the following questions with supervisees:

- What demographic variables do you use to identify yourself?
- What worldviews (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 supervisee from the majority group, the difference should be discussed as well.

8. Ethical and Legal Issues

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 Beuchamp and Childress (2001); Falvey (2002b); Gutheil and Brodsky (2008); Pope, Sonne, and Greene (2006); and Reamer (2006).

Legal and ethical issues that are critical to clinical supervisors include (1) vicarious liability (or respondeat superior), (2) dual relationships and boundary concerns, (4) informed consent, (5) confidentiality, and (6) 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 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 “respondeat 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 supervisee and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship. Examples of dual relationships in supervision include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an Alchoholics 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 countertransference 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 (see vignette 3 in chapter 2).

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 (Falvey, 2002b). (See the discussion of transference and countertransference on pp. 25–26.)

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 (Falvey,
2002b). 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?

[Diagram]

Yes

No

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 these 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

[Diagram]

Significant risk factors

Inform management/Board
- Begin disciplinary action against counselor if necessary
- Inform State ethics board

No serious risk factors

Assist counselor in identifying corrective steps
- Intervene with client if necessary
- Review damage control steps with constituents

Significant risk factors

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). A sample template for informed consent is provided in Part 2, chapter 2 (p. 106).

Confidentiality

In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor’s vicarious liability. Informed consent and concerns for confidentiality should occur at three levels: client consent to treatment, client consent to supervision of the case, and supervisee consent to supervision (Bernard & Goodyear, 2004). 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 (Falvey, 2002b). 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.

9. 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. An example of an IDP is provided in Part 2, chapter 2 (p. 122).

As a supervisor, you should have your own IDP, based on the supervisory competencies listed in TAP 21-A (CSAT, 2007), that addresses your training goals. This IDP can be developed in cooperation with your supervisor, or in external supervision, peer input, academic advisement, or mentorship.

Evaluation of Counselors

Supervision inherently involves evaluation, building on a collaborative relationship between you and the counselor. 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, 2004).
- Ratings of skills are highly variable between supervisors, and often the supervisor’s and supervisee’s ratings differ or conflict (Eby, 2007).
- Good feedback is provided frequently, clearly, and consistently and is SMART (specific, measurable, attainable, realistic, and timely) (Powell & Brodsky, 2004).

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, 2004).

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. (For examples of client satisfaction or input forms, search for Client-Directed Outcome-Informed Treatment and Training Materials at http://www.talkingcure.com.)

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 (2004), Powell and Brodsky (2004), and Campbell (2000). 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. (See Lambie, 2006, and Shoptaw, Stein, & Rawson, 2000.)

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. (See Burke, Carruth, & Prichard, 2006.)

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.

### 10. Practical Issues in Clinical Supervision

#### Distinguishing Between Supervision and Therapy

#### Differences Between Supervision and Counseling

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

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 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 countertransference 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.

11. Methods and Techniques of Clinical Supervision
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<tr>
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<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td><strong>Verbal Reports</strong></td>
<td>• Informal</td>
<td>• Sessions seen through eyes of beholder</td>
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<td></td>
<td>• Time efficient</td>
<td>• Nonverbal cues missed</td>
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<td></td>
<td>• Often spontaneous in response to clinical situation</td>
<td>• 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</td>
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<td></td>
<td>• 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</td>
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<td></td>
<td>Group discussion of clinical situations</td>
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<td></td>
<td>Declining method in the behavioral health field</td>
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<tr>
<td><strong>Verbatim Reports</strong></td>
<td>• Helps track coordination and use of treatment plan with ongoing session</td>
<td>• Nonverbal cues missed</td>
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<td></td>
<td>• Enhances conceptualization and writing skills</td>
<td>• Self-report bias</td>
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<td></td>
<td>• Enhances recall and reflection skills</td>
<td>• Can be very tedious to write and to read</td>
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<td></td>
<td>• Provides written documentation of sessions</td>
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<tr>
<td><strong>Written/File Review</strong></td>
<td>• An important task of a supervisor to ensure compliance with accreditation standards for documentation</td>
<td>• Time consuming</td>
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<tr>
<td></td>
<td>• Provides a method of quality control</td>
<td>• Notes often miss the overall quality and essence of the session</td>
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<tr>
<td></td>
<td>• Ensures consistency of records and files</td>
<td>• Can drift into case management rather than clinical skills development</td>
</tr>
<tr>
<td></td>
<td>Process recordings</td>
<td></td>
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<tr>
<td></td>
<td>Verbatim written record of a session or part of session</td>
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<tr>
<td></td>
<td>Declining method in the behavioral health field</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of the progress notes, charts, documentation</td>
<td></td>
</tr>
<tr>
<td><strong>Case Consultation/Case Management</strong></td>
<td><strong>Description</strong></td>
<td><strong>Advantages</strong></td>
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<tr>
<td>-------------------------------------</td>
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<tr>
<td></td>
<td>Discussion of cases Brief case reviews</td>
<td>Helps organize information, conceptualize problems, and decide on clinical interventions</td>
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<td></td>
<td></td>
<td>Examines issues (e.g., cross-cultural issues), integrates theory and technique, and promotes greater self-awareness</td>
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<td></td>
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<td>An essential component of treatment planning</td>
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<tr>
<td><strong>Direct Observation</strong></td>
<td>The supervisor watches the session and may provide periodic but limited comments and/or suggestions to the clinician</td>
<td>Allows teaching of basic skills while protecting quality of care</td>
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<td></td>
<td>Counselor can see and experience positive change in session direction in the moment</td>
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<td></td>
<td></td>
<td>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</td>
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<tr>
<td><strong>Audiotaping</strong></td>
<td>Audiotaping and review of a counseling session</td>
<td>Technically easy and inexpensive</td>
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<tr>
<td></td>
<td></td>
<td>Can explore general rapport, pace, and interventions</td>
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<tr>
<td></td>
<td></td>
<td>Examines important relationship issues</td>
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<tr>
<td></td>
<td></td>
<td>Unobtrusive medium</td>
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<td></td>
<td></td>
<td>Can be listened to in clinical or team meetings</td>
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<tr>
<td><strong>Videotaping</strong></td>
<td>Videotaping and review of a counseling session</td>
<td>A rich medium to review verbal and nonverbal information</td>
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<td></td>
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<td>Provides documentation of clinical skills</td>
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<td></td>
<td></td>
<td>Can be viewed by the treatment team during group clinical supervision session</td>
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<td></td>
<td></td>
<td>Uses time efficiently</td>
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<td></td>
<td></td>
<td>Can be used in conjunction with direct observation</td>
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<td></td>
<td></td>
<td>Can be used to suggest different interventions</td>
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<td></td>
<td></td>
<td>Allows for review of content, affective and cognitive aspects, process relationship issues in the present</td>
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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, 2004; Borders & Brown, 2005; Campbell, 2000; and Powell & Brodsky, 2004.) 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

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Webcam</td>
<td>Internet supervision, synchronistic and asynchronistic Teleconferencing</td>
<td>• 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</td>
<td>• 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</td>
</tr>
<tr>
<td>Cofacilitation and Modeling</td>
<td>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</td>
<td>• 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</td>
<td>• 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</td>
</tr>
<tr>
<td>Role Playing</td>
<td>Role play a clinical situation</td>
<td>• 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</td>
<td>• Counselor can be anxious • Supervisor must be mindful of not overwhelming the counselor with information</td>
</tr>
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</table>

Source: Adapted from Mattel, 2007.
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 TIP 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.

12. Resources

The following are resources for supervision:

- Code of Ethics from the Association of Addictions Professionals (NAADAC; [http://naadac.org](http://naadac.org)).
- International Certification & Reciprocity Consortium’s Code of Ethics ([http://www.icrcaoda.org](http://www.icrcaoda.org)).
- Codes of ethics from professional groups such as the American Association for Marriage and Family Therapy ([http://www.aamft.org](http://www.aamft.org)), the American Counseling Association ([http://www.counseling.org](http://www.counseling.org)), the Association for Counselor Education and Supervision ([http://www.acesonline.net](http://www.acesonline.net)), the American Psychological Association ([http://www.apa.org](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.

13. Clinical Scenarios Showing How to Apply the Information

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 hesitantly 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

1. To illustrate how work-related stresses and personal problems can interact and affect one another.
2. To demonstrate the boundary between clinical supervision and personal counseling.
3. To demonstrate how to help an employee get the help necessary to address personal (non–work-related) life problems that affect the work environment.
4. To illustrate how to monitor and maintain adequate clinical performance when an employee is facing difficult personal dilemmas that affect job performance.
5. 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.

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:

1. 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.
2. You can clarify the boundaries of what constitutes acceptable job performance, as some counselors may be uncertain where the boundaries lie.

3. 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.

4. You and your supervisee should develop a written work plan for how the employee will take the necessary steps to improve job performance.

5. You can help the counselor examine how personal stressors might affect interactions with coworkers or clients.

6. 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 of the counselor’s time, and the like.

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.
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.

<table>
<thead>
<tr>
<th>Personal Counseling</th>
<th>Supervision</th>
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<tbody>
<tr>
<td>1. The goal is personal growth and development, self-exploration, becoming a better person.</td>
<td>1. The goal is to make the counselor a better counselor.</td>
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<tr>
<td>2. Requires exploration of personal issues.</td>
<td>2. Requires monitoring of client care and facilitating professional training.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
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To help the counselor and the supervisor differentiate between therapy and supervision, the supervisor needs to continually ask him- or herself, “What does this have to do with your counseling functions? How is this affecting your relationship with clients?”

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.

[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 countertransferential 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 Juanita recognizes 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.

**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.

[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.]

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

1. 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.
2. To illustrate the process of establishing a supervisory alliance that incorporates principles of mentorship and training.
3. 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.

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.

**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: 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](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](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.

Definitions of Clinical Supervision

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

A social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality 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, 2007, p. 3).

Clinical supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive (Powell & Brodsky, 2004, p. 11).

Supervision is an intervention that is provided by a senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper of those who are to enter the particular profession (Bernard & Goodyear, 2004, p. 8).

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, 2001).

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 & Goodyear, 2004). 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 & Goodyear, 2004).

Unique Issues in Supervision for Substance Abuse Counselors

Clinical supervision for substance abuse counselors differs from supervision for other healthcare providers 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., 2007). 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 also recovering from substance use disorders, relapse could be an issue that a supervisor would need to monitor (Culbreth & Borders, 1999). In a survey, one study compared recovering with nonrecovering counselors. There were no between-group differences in satisfaction with supervision; however, both recovering and nonrecovering counselors were significantly more satisfied with supervision when their supervisors had the same recovery status.
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). Nonrecovering counselors say they have significantly lower professional commitment, but believe they have better employment options in other counseling fields.

2. Eby et al. (2007) 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 (CSAT, 2003). 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 (Eby et al., 2007).

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, 2002). 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, 2001).

5. Finally, Eby et al. (2007) states that the “quality of the clinical supervisory relationship is clearly important to counselors. . . . [A]s the clinical supervisory relationship is viewed more favorably by counselors, job satisfaction, organizational commitment, and perceived organizational support increase” (p. 6).

14. 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, 2007, p. 244; Powell & Brodsky, 2004, xxiii, 320

Research on these issues is extremely complex, which has doubtless 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, 2004).

Models 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 (see Delaney, 1972; Hess, 1986; Hogan, 1964; Loganbill, Hardy, Delworth, 1982; Skovholt & Rønnestad, 1992). The Integrated Developmental Model (IDM) was developed by Stoltenberg, McNeil, and Delworth (1998) and is not specific to substance abuse counselors. It 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 (Falender & Shafranske, 2004a; Northwest Frontier ATTC, 2005a; Powell & Brodsky, 2004).

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 (1998), 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 (Falender & Shafranske, 2004a; Northwest Frontier ATTC, 2005a; Powell & Brodsky, 2004; Stoltenberg et al., 1998). Stoltenberg et al. also indicate that supervisors go through similar stages of development, from Levels 1–3, over the course of their career.

In their review, Falender and Shafranske (2004a) 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 (1993), 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, 2004; Campbell, 2000; Watkins, 1993).

**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 (Ekstein & Wallerstein, 1972; Greben & Ruskin, 1994), psychoanalytic (Caligor, Bromberg, & Meltzer, 1984; Kugler, 1995; Lane, 1990; Nelson, Gizara, Hope, Phelps, Steward, & Weitzman, 2006), and client-centered approaches. Most models begin with a specific psychotherapeutic model or philosophy of treatment, especially in the marriage and family therapy field (Liddle, Breunlin, & Schwartz, 1988; Minuchin & Fishman, 1981). It has been estimated that 90 percent of the literature on clinical supervision grows out of a specific psychotherapeutic model (Powell & Brodsky, 2004).
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, 2004). 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 (Bernard & Goodyear, 2004). Although social role models may provide a useful tool for supervisors, empirical evidence does not support their “adequacy,” according to Falender and Shafranske (2004a, p. 18). 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, 2004b), the Contextual Model (Holloway, 1995), the Task-Oriented Model (Mead, 1990) and the Interactional Model (Shulman, 1993).

The Blended Model (Powell & Brodsky, 2004) is the only model specific to substance abuse supervisors. The model has a number of essential elements:

1. Self. Each supervisor develops an idiosyncratic style of supervision, largely based upon his or her personality profile and model of counseling.
2. 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.
4. Stages of counselor development. This model adapts the IDM model of Stoltenberg et al. (1998) and other developmental approaches to clinical supervision.
5. Contextual factors. The blended model uses the work of Holloway (1995) and other contextual models of clinical supervision, addressing factors affecting supervision, such as age, race, gender, ethnicity, recovery–nonrecovery, disciplines, academic background, and the like.
6. Affective–behavioral axis. The model views supervision along a continuum, blending affective and behavioral changes for the counselor in supervision.

7. 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. Culbreth’s survey (1999) found that over 50 percent of substance abuse counselors who responded received primarily individual supervision, although their ideal preference would be a combination of individual and group supervision.

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, 2004). 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 countertherapeutic (Powell & Brodsky, 2004). For substance abuse counselors, possession debriefing is most 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, 2004; Powell & Brodsky, 2004).

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, 2005; Powell, 2006; Kraus, Zack, & Stricker, 2004).

**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, 2004). These modalities furnish more opportunities for team-building, role-playing, and simulations (Powell & Brodsky, 2004). 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, 2004).

Research has generally supported the effectiveness of group supervision (e.g., Wilbur, Wilbur-Roberts, Hart, Morris, & Betz, 1994). In tracking a six-person group, interviews by Christiansen and Kline (2000) 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 (2007). Ray and Altekruse (2000) 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 (2004) 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, 1984), 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 (2005) 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, 1999). 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, & Melinoff, 2001). 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., 1998). 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 countertransferential issues, for example, might benefit from an interpersonally sensitive style (Powell & Brodsky, 2004). 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, 1984).

**Categories of Supervisory Style**

<table>
<thead>
<tr>
<th>Category</th>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attractive</td>
<td>Consultant</td>
<td>• Open &lt;br&gt;• Warm &lt;br&gt;• Friendly &lt;br&gt;• Flexible &lt;br&gt;• Supportive</td>
</tr>
<tr>
<td>Interpersonally sensitive</td>
<td>Counselor</td>
<td>• Invested &lt;br&gt;• Therapeutic &lt;br&gt;• Committed &lt;br&gt;• Perceptive</td>
</tr>
<tr>
<td>Task oriented</td>
<td>Teacher</td>
<td>• Goal oriented &lt;br&gt;• Practical &lt;br&gt;• Focused &lt;br&gt;• Structured</td>
</tr>
</tbody>
</table>

Source: Friedlander & Ward, 1984

Finally, in a survey of supervisors of counselors, no gender differences were found for how supervisors report working with male and female supervisees (Reeves, Culbreth, & Greene, 2001). 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., 2001).

Cross-Cultural Supervision

One’s culture is generally viewed as a strength that, during treatment or supervision, should be validated (Garcia, 1998). 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, 1995). 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, 2006, p. 74; see also Borders and Brown, 2005). 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, & Soo, 1999).

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., 2006, pp. 288–289).

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., 2006).

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, 2004). Thorough discussions of legal issues are in most supervision texts (Falvey, 2002; Reamer, 2001, 2003).

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 2005 Code of Ethics (ACA, 2005, p. 14; see also Falvey, 2002).

**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, 2004c). 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 (1998) 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, 2002.)

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, 1999). 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 (2004c). (See also Falvey, *Clinical Supervision: Ethical Practice and Legal Risk Management*, ...)

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, 2004; Campbell, 2000; Northwest Frontier ATTC, 2005b).

**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.
- Thomas Durham, Clinical Supervision: A 5-Day Course.
- New England ATTC, Evidence-Based Practices and Clinical Supervision.
- Mid-Atlantic ATTC, Motivational Interviewing and Clinical Supervision.
- David Powell, The Blended Model of Clinical Supervision: A 5-Day Course.
- Distance Learning Center for Addiction Studies (www.DLCAS.com), various courses on 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 single State Addiction Authority and the State credentialing body.
- Is specific to substance abuse clinical supervision, wherever possible, given the unique issues in the substance abuse field.
- 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**

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

Source: Roche, Todd, & O’Connor, 2007

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