CLINICAL SUPERVISION:
BEST PRACTICES

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WWW.CFALENDER.COM
Clinical Supervision: A Competency-Based Approach (APA, 2004)
Carol A. Falender & Edward P. Shafranske

Casebook for Clinical Supervision: A Competency-Based Approach (APA, 2008)
Carol A. Falender & Edward P. Shafranske (Eds.)

Getting the Most Out of Clinical Supervision: A Practical Guide for Interns and Trainees (APA, 2012)
Carol A. Falender & Edward P. Shafranske

Diversity and Multiculturalism in Clinical Supervision: Foundation and Praxis
Carol A. Falender, Edward P. Shafranske, & Celia Falicov (Eds.) (APA, 2014)
2019:
- Consultation in Psychology: A Competency-based Approach
  Carol A. Falender, & Edward P. Shafranske (Eds.)

In Development
- Clinical Supervision: A Competency-based Approach (2nd ed.)
  Carol A. Falender & Edward P. Shafranske

Supervision Essentials for the Practice of Competency-Based Supervision.
Carol A. Falender & Edward P. Shafranske (APA, 2017)
Outline of the two day training

Identifying take-away plans, Transforming

Definitions: State of the Field, Competence, Metacompetence, Competency-based Supervision

Effective Practice Components: Guidelines/Best Practices

Alliance Formation and Repair and Maintenance as a Competence

Skills/Modalities Supervision Contract

Feedback Group Supervision

Multicultural Competence

Competence in Managing Personal Factors in Supervision

Legal and Ethical Competence

Supervisees who do not meet Competence Standards

Self-Care Leadership Exercises and Examples
TRANSFORMING SKILL SETS: SUPERVISOR AS LEADER

- Transactional versus transformational leadership
  - Application to clinical supervision
  - International phenomenon (Gonsalvez & Calvert, 2014)

- Identify ways you currently supervise and think throughout this workshop of ideas you can incorporate to enhance your supervision experience and that of your supervisees!

- Supervision is fun, creative, and fosters development and productivity

- Creates environment of caring, shared objectives, and productivity
TAKE-AWAY PLANS

- Identify specific competencies to bring to your setting
- Consider your own “model of supervision”
- Identify steps to motivate change towards competency-based clinical supervision and to enact it!
- Develop a “frame” for your particular setting to enhance life-long learning
- Identify “bright spots”—successful indications of readiness for change or exemplars of effective supervision
- Skill development for implementation
QUESTIONS

• What questions do you have about clinical supervision from your practice and experience?
• What are you hopeful we will address in this two day training?
• If you think of more questions later, do not hesitate to ask.
REGULATIONS FOR THE DISCIPLINES (BBS/BOP)
FAQS FOR THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, 42CFR

- 42 CFR Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). Most drug and alcohol treatment programs are federally assisted. For-profit programs and private practitioners that do not receive federal assistance of any kind would not be subject to the requirements of 42 CFR Part 2 unless the State licensing or certification agency requires them to comply. However, any clinician who uses a controlled substance for detoxification or maintenance treatment of a substance use disorder requires a federal DEA registration and becomes subject to the regulations through the DEA license.
42CFR REGULATIONS

• The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that “would identify a patient as an alcohol or drug abuser …” (42 CFR §2.12(a) (1)). In laymen’s terms, the information protected by 42 CFR Part 2 is any information disclosed by a covered program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program.

• With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.

• --The Legal Action Center
THE PRACTICE OF CLINICAL SUPERVISION

• Previously viewed as a process of osmosis, or internalizing or absorbing one’s experience of having been supervised—we are now in a new era of clinical supervision
  • Falender & Shafranske, 2004; 2017
• The magnitude of this change has caught many by surprise
  • Gonsalvez & Calvert, 2014
SELF-ASSESSMENT

- Think of particular issues you have experienced as a supervisor or supervisee that guide you and how these create a lens through which conduct supervision? What stands out for you?

- What factors determine your practice of supervision?
  - Personal experience
  - Theoretical orientation
  - Supervision training/literature/study including CE

- What is your history of supervision?
  - How does that impact your practice?
REFLECTION:
ARE ALL SUPERVISORS COMPETENT?

☐ An unspoken premise in supervision
☐ No attention to competence of the supervisor
☐ Concern raised by inadequate, and even harmful supervision
  ☐ Bernard & Goodyear, 2014; Ellis et al., 2014; Ladany, 2014; Ellis et al., 2017
☐ Harmful and inadequate supervision as supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee and client
  ☐ Ellis et al., 2014 (Ireland, U.S.); Entire issue The Clinical Supervisor, 2017
☐ Counterproductive supervision and ethical infractions of supervisors (rated by doctoral students, interns, and supervisors)
  ☐ Pepperdine studies, 2009-present
WHY? HARMFUL SUPERVISION (36.2% REPORTED HAD RECEIVED)

- Threatened me physically
- Have a sexual relationship
- Have been sexually intimate
- Is aggressive and abusive
- Sharing drugs with supervisee
- Harmed by supervisor’s actions
- Traumatized by supervision
- Dual relationship was harmful
- Supervisor sexually inappropriate
  - Ellis et al., 2013
HARMFUL SUPERVISION NARRATIVES

Instances recounted by Ellis (2017) represented:

- failure to recognize the importance of power, privilege, and multicultural differences
- poor supervisory boundaries—multiple relationships
- unresolved and unrecognized difficulties in the supervisory alliance including strains and ruptures
- Supervisor failure to provide ongoing formative feedback
- Failure to provide feedback and documentation that is accurate and consistent regarding competence development and competence/performance problems as perceived by the supervisor
  - Ellis, 2017; Reiser & Milne, 2017
- We add failure to work within a format or structure of clinical supervision—systematic and intentional; failure to have standards of practice for supervisors and explicit training to criteria of competence
Four Studies on Counterproductive Supervision that frame essential need for change in clinical supervision (Grayson, Lucas, Kakavand & Incledon in Pepperdine Lab)

- i. Q-sort by current graduate students
- ii. Q-sort by experts in clinical supervision
- iii. Q-sort by practicing supervisors

Studies (Wall, 2009) found high frequency of non-adherence to ethical practices affected alliance; high frequencies generally (Hansell, 2017—33%)

Four studies on impact of supervisory alliance on supervisee disclosure
CURRENT GRADUATE STUDENTS (RANK ORDER)

- Cultural Insensitivity
- Inadequate Understanding of Performance Expectations for Supervisee and Supervisor/Role Conflict
- Failure to Address Needs of Supervisee
- Supervisor Supervision Approach and Supervisee Learning Approach Mismatch
- Additional Counterproductive Experiences
- Inadequate Attention to Ethics, Ethical Lapses, and Unethical Behavior
- Boundary Crossings/Violations
- Supervisor/Supervisee Theoretical Orientation Mismatch
- Inappropriate Supervisor Self-Disclosure
SUPERVISOR PROBLEMS OF PROFESSIONAL COMPETENCE

Over half the participants reported that their supervisors have had problems of professional competency

- unprofessional behavior (39.9%),
- educators being culturally insensitive or culturally incompetent (39.6%),
- educator’s inadequate supervision skills (35.8%),
- educators displaying inappropriate boundaries (31.6%),
- educator’s inability to regulate emotions (30.4%),
- educators with inadequate clinical skills (27.4%)

Furr & Brown-Rice, 2016
• Individuals who have not had formal supervision training do not value supervision compared to those who have (Rings et al., 2009)

• The majority of supervisors are still practicing through “osmosis” or conducting supervision the way they were supervised in their training—with variable levels of supervisor competency

• There is little formal training in social work or psychology
WHAT’S WRONG WITH THIS PICTURE?

- Metacompetence
- Systematic, intentional process
- Supervision Relationship
- Supervision Contract
- Diversity and Multiculturalism
- Professionalism
- Managing Countertransference or Reactivity
- Legal and Ethical Issues and Professionalism
- Knowledge, skill sets, and attitudes associated with effective supervision
METACOMPETENCE

- Ability to assess what one knows and what one doesn’t know
  - Introspection about one’s personal cognitive processes and products
  - Dependent on self-awareness, self-reflection, and self-assessment
    - Weinert, 2001

- Supervision guides development of metacompetence through encouraging and reinforcing the supervisee’s development of skills, knowledge, and attitudes in self-assessment
  - Falender & Shafranske, 2007
WE ARE VERY POOR AT SELF-ASSESSMENT

- Self-assessment bias
- 25% of mental health professionals viewed their skill to be at the 90th percentile when compared to their peers, and none viewed themselves as below average (defying statistical probabilities)
- Review of therapist lack of skill in identifying clients who got worse
  - Walfish, McAlister, O’Donnell, & Lambert, 2012
- Hannan et al. (2005) and Walfish et al. (2012) found clinicians tend to remain optimistic about treatment effect and treatment outcome, even when clients report negative progress--clinicians tend to be biased when interpreting observed progress, at least when they lack access to empirically sound counterfactual models.
  - Expert performers actively sought more feedback than moderate performers (Sonnentag, 2000)
VIDEO CLIP

This is a supervisee-client session

Consider the strengths you observe AND the areas needing improvement
• What is called “supervision” ranges from
  – “Usual care” or osmosis-driven
  – Psychotherapy theory-driven
  – Evidence-based theory driven
  – Developmental theory-driven (Harvey & Struzziero, 2009; Stoltenberg & McNeil, 2010)
  – Supervision theory-driven (Westefeld, 2009)
  – Combinations of above
DEFINITIONS OF CLINICAL SUPERVISION

- Agreement -- or lack of such -- on definition
  - Hierarchical vs. collaborative relationship
  - Developmental frame
  - Power differential and evaluative function
  - Relationship of administrative to clinical
  - Theoretically driven
  - Valence and value of clinical supervision
ACROSS DISCIPLINES

- Agreement on essential components and practices of clinical supervision across mental health and educational disciplines
  
  - Kavanagh et al., 2008; Bernard & Goodyear, 2018
COMPETENCY-BASED CLINICAL SUPERVISION: A TRANSTHEORETICAL FRAMEWORK

- An explicit orientation to competence—intentional, systematic

- Can be applied across the range of clinical services (e.g., psychotherapy, psychological testing, neuropsychological assessment, consultation), settings (e.g., CMH, medical forensic) and theoretical orientations.

- Quality clinical supervision as a protective factor
  - Knudsen, Roman, & Abraham, 2013
CLINICAL SUPERVISION DEFINITION

Supervision is a distinct professional activity
In which education and training aimed at developing science-informed practice are facilitated through
A collaborative interpersonal process
It involves observation, evaluation, feedback, facilitation of supervisee self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving.
Building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy.
Supervision ensures that clinical (supervision) is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large.

* (p. 3)

Plus Superordinate Values and Pillars of Supervision
SUPERORDINATE VALUES

- Integrity-in-Relationship
- Ethical, Values-based Practice
- Appreciation of Diversity
- Science-informed, Evidence-based Practice
  - Falender & Shafranske, 2004
PILLARS OF SUPERVISION

• Supervisory relationship
  • Foundation for alliance shared by supervisor and supervisee

• Inquiry
  • Processes facilitating understanding of therapeutic process AND awareness of professional and personal contributions

• Educational praxis
  • Learning strategies, tailored to enhance supervisee’s knowledge and develop technical skills
    • Falender & Shafranske, 2004
Collaboration is developmental

- Meaning changes as does elucidation with experience and enhanced competence
  - Underlying principles:
    - Respect for presenting competencies of supervisee
      - Knowledge
      - Skills
      - Values and attitudes
    - Transparency regarding competencies of supervisor and supervisee
    - Transparency in feedback
    - Respect for process and contributions of each

-Falender, 2010
SUPERVISION DISTINGUISHED FROM:

- Consultation *(Duty of Care to Distinguish)*
- Psychotherapy
- Mentoring

Critical Components
- Evaluation
- Power
- *Responsibility* and Liability
- Imperative vs. choice
- Depth and breadth of case knowledge
Competence and Self-Assessment
WHAT ARE THE COMPONENTS OF COMPETENCE?

• Knowledge
• Skills
• Attitudes or Values

What Are the Knowledge, Skills and Attitudes you assume a supervisee will have entering your program-- in therapeutic engagement?
PROFESSIONAL COMPETENCE

• Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflections, in daily practice for the benefit of the individual and community being served”
  • Epstein & Hundert, 2002, p. 226

• “Competence depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence”
  • Epstein & Hundert, 2002, p. 226
LATEST GUIDELINES: PSYCHOLOGY AND SOCIAL WORK

- Approval by APA Council of the Guidelines for Clinical Supervision in Health Service Psychology so they are now American Psychological Association Policy (2014, 2015)

- Best Practice Standards in Social Work Supervision
BEST PRACTICE STANDARDS IN SOCIAL WORK SUPERVISION

- Overview of Supervision
  - Administrative
  - Educational
  - Supportive
  - Qualifications

Competency-based and meta-theoretical refers to working within any theoretical or practice modality, systematically considering the growth of specific competencies in the development of competence.
ASSUMPTIONS ABOUT SUPERVISION

- A distinct professional competency that requires formal education and training
- Prioritizes the care of the client and the protection of the public
- Focuses on the acquisition of competence by and the professional development of the supervisee
- Requires supervisor competence in services being supervised
- Is anchored in the evidence base related to supervision and the services being supervised
- Occurs within a respectful and collaborative supervisory relationship
- Entails responsibilities on the part of the supervisor and supervisee
ASSUMPTIONS (2)

- Intentionally infuses and integrates diversity in all aspects of professional practice
- Is influenced by both professional and personal factors
- Is conducted in adherence to ethical and legal standards
- Uses a developmental and strengths based approach
- Requires reflective practice and self assessment by the supervisor and supervisee
- Incorporates bidirectional feedback
- Includes evaluation of the supervisee’s acquisition of competencies
- Serves a gatekeeping function for the profession
- Is distinct from consultation, personal psychotherapy, and mentoring
BEST PRACTICE STANDARDS IN SOCIAL WORK SUPERVISION

• Overview of Supervision
  – Administrative
  – Educational
  – Supportive
  – Qualifications

– http://www.naswdc.org/practice/naswstandards/supervisionstandards2013.pdf for this and next 5 slides
• Standard 1. Context in Supervision
  • Understanding Scope of Practice
  • Communities of Practice
  • Interdisciplinary Supervision
  • Cultural Awareness and Cross-cultural Supervision
  • Dual Supervision and Conflict Resolution
Standard 2. Conduct of Supervision

- Confidentiality
- Contracting for Supervision
- Leadership and Role Model
- Competency
- Supervisory Signing Off
- Self-Care
• Standard 3. Legal and Regulatory Issues
  • Liability
  • Regulations
  • Documentation
  • Other Legal Concerns
• **Standard 4. Ethical Issues**

  • Ethical Decision-Making
  • Boundaries
  • Self-Disclosure
  • Attending to Safety
  • Alternative Practice
To maintain objectivity in supervision, it is important to negotiate a supervision contract with mutually agreeable goals, responsibilities, and time frames,

- provide regular feedback to supervisees on their progress toward these goals,
- establish a method for resolving communication and other problems in the supervision sessions so that they can be addressed,
- identify feelings supervisees have about their clients that can interfere with or limit the process of professional services.

SUPERVISORY COMPETENCIES
GROUPED BY DOMAIN

• Supervisory Relationship and Process
  – Conduct self-assessment-supervisor
  – Establish the supervisory relationship
    • Develop contract
    • Develop an environment that enhances communication and reflects supervisory working alliance
    • Establish/maintain boundaries
    • Monitor and address impact of relational dynamics
    • Address parallel processes
    • Address thoughts, feelings and behavior
    • Manage conflict-disagreement
- Manage power and authority
- Provide constructive feedback
- Solicit/respond appropriately to feedback from supervisee
- Manage termination process
- Supervision of supervisee's practice
  - Use reflection, analysis and contextual attributes
  - Facilitate acquisition of advanced social work knowledge
  - Follow-up on case planning
  - Direct/guide to ensure ethical practices within regulations and laws
  - Resolve professional ethical dilemmas
  - Assist supervisee in appropriate use of advocacy across systems
  - Develop and follow-up on learning plans
  - Address personal safety and risk
- Professional Relationships
  - Supervisees and colleagues-to develop collaborative relationships
  - Recognize and respect socio-cultural differences
  - Relationship with other settings
- Work Context
- Evaluation
- Life-long learning and professional responsibility
  - (Excerpted from “An analysis of supervision for social work licensure”)
SUPERVISOR SELF-ASSESSMENT

Complete self-assessment and plan
What practices, theories, models shape your supervision practice?

Consider aspects of planful, intentional, systematic practice.

WHAT IS YOUR SUPERVISION MODEL?
Competence and Competency-Based Supervision Implementation
COMPETENCY-BASED MODEL

- Transition from input model
  - Education and training to examinations to application of knowledge
- To output model (still using input!)
  - Competency-based with competency redefined at each level of training
    - Bartram & Roe, 2005
Competency-based supervision is a metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/cultural clinical setting (adapted from Falender & Shafranske, 2007). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision. (APA, 2014)
STEPS IN COMPETENCY-BASED IMPLEMENTATION

1. Orientation to the competency-based approach
2. Collaborative identification of competencies which will be training focus
3. Collaborative identification of requisite knowledge, skills, and values to define focus of supervision
4. Collaborative identification of individual areas of strength and areas for enhancing knowledge and skills
5. Development of supervision contract

Note: Developmental levels should not be assumed (Self-assessment, self-report, and observation should be used)
(a) The supervisor examines his or her own clinical and supervision expertise and competency;

(b) the supervisor delineates supervisory expectations, including standards, rules, and general practice;

(c) the supervisor identifies setting-specific competencies the trainee must attain for successful completion of the supervised experience;

(d) the supervisor collaborates with the trainee in developing a supervisory agreement or contract for informed consent, ensuring clear communication in establishing competencies and goals, tasks to achieve them, and logistics; and

(e) the supervisor models and engages the trainee in self-assessment and development of metacompetence (i.e., self-awareness of competencies) from the onset of supervision and throughout.

Falender & Shafranske, 2007, p. 238
SUPERVISEE COMPETENCIES
COMPETENCY DOCUMENTS

- Competency Benchmarks

- Interprofessional Collaborative Practice, 2011
  - www.aacn.nche.edu/education-resources/IPECReport.pdf
  - (APA, 2013)

- CCPTP—Counseling Psychology Competencies (M.A. Psych Competencies)
  - http://www.ccptp.org/assets/docs/copsy%20competencies%20final2.pdf


CalSWEC II Competencies for Social Work

https://calswec.berkeley.edu/sites/default/files/2017_calswec_curriculum_competencies_0.pdf

MFT Competencies

https://www.coamfte.org/Documents/COAMFTE/Accreditation%20Resources/MFT%20Core%20Competencies%20(December%202004).pdf
• Competencies for Psychology Practice in Primary Care
  • McDaniel et al., 2014 (American Psychologist)
  • SAMHSA/HRSA Core Competencies for Integrated Behavioral Health and Primary Care

• Social Work – Council on Social Work Education
COMPETENCIES

☐ Pediatric Psychology Competencies
  - Internship Competencies: Jerson, Cardona, Lewallen, Coleman, & Goyette-Ewing, (2015); Boshkoff, Wilson, Harris, and Freeman (2015)
  - Postdoctoral Competencies: Talmi et al., 2015
  - Best Practices: Palmero et al., 2015

☐ Neuropsychology
  - Nelson et al., 2015, Guidelines for Practicum Training in Neuropsychology (AACN)
  - Rey-Casserly, Roper, & Bauer, 2012
  - Lamberty & Nelson, 2012
COMPETENCIES IN SUBSTANCE ABUSE TREATMENT

- Substance Abuse Treatment Clinical Supervisors: TAP 21A
  http://www.nattc.org/resPubs/tap21/TAP21a.pdf
- Substance Abuse Counselor Supervision: TIP 52
- ATTC: Performance Assessment Rubrics for the Addiction Counseling Competencies (2011)
• ATTC Supervision
  • TIP 52 part 3  https://store.samhsa.gov/shin/content//SMA14-4435/SMA14-4435_TIP52_LitRevblk.pdf
  • Substance Use Disorder Peer Supervisor Competencies
PROFESSIONAL COMPETENCIES

• National Panel for Psychiatric-Mental Health Nurse Practitioner Competencies
  – http://www.aacn.nche.edu/Accreditation/psychiatricmentalhealthnursepractitionercopetencies/FINAL03.pdf

• Board of Registered Nursing
  – http://www.rn.ca.gov/regulations/npa.shtml

• School Psychology
  – http://www.nasponline.org/standards/FinalStandards.pdf
  – Also Tharinger, Pryzwansky, & Miller, 2008

• Case Management Competencies
  • https://bphc.hrsa.gov/archive/technicalassistance/resourcecenter/clinicalservices/casemanagercompetencytool.pdf

• Peer Specialists Competencies
  • http://file.lacounty.gov/dmh/cms1_194804.pdf
SPECIALTY AREAS

Health Psychology and Primary Care
- Kerns et al., 2009
- Kaslow, Dunn, & Smith, 2008
- France et al., 2008
- SAMHSA/HRSA Core Competencies for Integrated Behavioral Health and Primary Care

Forensics including Corrections
- Varela & Conroy, 2012
- Specialty Guidelines for Forensic Psychology

Gerontology
- Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010
- APA Guidelines for Psychological Practice with Older Adults
FEEDBACK EXERCISE

- Think of a supervisee you have worked with
- Using Competencies documents that correspond to your SUPERVISEE’s discipline (Social Work, Marriage and Family Therapy, Nursing) consider *specific* competencies from the document and how you would frame the SPECIFIC feedback to your supervisee.
- Think about how you would prepare the supervisee for feedback early in your relationship—what you could do to ensure openness to feedback
- Be sure to use the competency document stated items as the content of your feedback!
REFLECTIVE PRACTICE

Creating a habit, structure or routine to step back and devote serious thought, deliberation as well as attention to emotional impact/response attached to experience
The Learning Cycle (Falender & Shafranske, 2016) adapted from Kolb, 1984

**The Learning Cycle**

- **Performance**
  - Supervisee performs psychological service
  - Supervisee Self-assessment

- **Planning**
  - Identifies interventions/procedures to be performed
  - Instruction and experiential learning activities

- **Observation**
  - Direct Observation (live supervision and/or review of recorded sessions)
  - Review of client feedback

- **Feedback/Evaluation**
  - Supervisor encourages supervisee self-assessment and provides formative evaluation/feedback and summative evaluation factoring in client outcome assessment

- **Reflection**
  - Supervisor and supervisee individually and together reflect on observations
OVERVIEW OF COMPETENCY-BASED SUPERVISION COMPONENT PARTS**

- Supervisor Self-assessment—including assessment, interventions, multicultural intersections
- Supervisory Relationship Contract—Identifying goals/tasks
- Assessing relationship strength, strains, ruptures and repairing
- Infusion of multicultural competence of triad/worldviews
- Professionalism
- Client outcomes (Routine Outcome Monitoring) and infusion into supervision process
- Attending to and managing personal factors and reactivity
- Assessment, competency-anchored feedback, feedback from supervisee and evaluation
- Ethical, legal, and regulatory issues/standards
- Self-care
- Ongoing self and system assessment to move to culture of communitarian competence
REFLECTIVE SUPERVISION

- Developing relationship
- Inviting curiosity, welcoming and responding respectfully to supervisee input
- Inviting exploration of emotional impact
  - Reactive versus responsive
- Inviting reflection on and discussion of attitudes of client/supervisee-therapist/supervisor
- Integrating routine client outcome monitoring in supervision
- Helping to integrate these into planning for intervention in the best interests of the client(s)
REFLECTION-ON-ACTION TO REFLECTION-IN-ACTION AND BEYOND

- Essential component of self-monitoring or regulating our attentiveness and motivation
  - Attention to choice of data we attend to
  - Meta-awareness – of our own state and of our openness and curiosity
    - Openness easier if self-concept and self-efficacy are strong
    - Increased emotional arousal regulation with experience
  - Epstein, Siegel, & Silberman, 2008
TASK—IDENTIFYING COMPETENCIES

- Select a partner
- Select clinical competences associated with
- ASSESSMENT of Self-Harm or Danger to Self in your contextual setting
- For each competence identify context-specific
  - Knowledge
  - Skills
  - Attitudes/Values
<table>
<thead>
<tr>
<th></th>
<th>Core Competencies in Suicide Assessment</th>
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<tbody>
<tr>
<td>1.</td>
<td>Know and manage your attitude and reactions toward suicide</td>
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<td>2.</td>
<td>Maintain a collaborative, empathetic stance toward the client</td>
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<td>3.</td>
<td>Know and elicit evidence-based risk and protective factors</td>
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<td>4.</td>
<td>Focus on current plan and intent of suicidal ideation</td>
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<td>5.</td>
<td>Determine level of risk</td>
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<td>6.</td>
<td>Develop and enact collaborative evidence-based treatment plan</td>
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<td>7.</td>
<td>Notify and involve other persons</td>
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<tr>
<td>8.</td>
<td>Document risk, plan, and reasoning for clinical decisions</td>
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<td>9.</td>
<td>Know the law concerning suicide</td>
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<td>10.</td>
<td>Engage in debriefing and self-care</td>
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DIVERSITY: A CORE COMPETENCE

MULTICULTURAL COMPETENCIES
FOCUS ON DIVERSITY AMONG CLIENT, SUPERVISEE, SUPERVISOR: WORLDVIEWS
• Significant difference between endorsement as appropriate strategies of multiculturally competent practices and likelihood of actual use of them in practice—licensed psychologists endorsed and used multicultural competent counseling practices more than graduate students—but there was significant difference for both between endorsement and implementing in practice.

• Importance of assessing supervisees’ USE of practices—not just identification or knowledge
  – (Sehgal et al., 2011)

• What is the hardest? Training in knowledge, skills, or attitudes?
DIVERSITY FACTORS

- Gender
- Sexual orientation
- Gender identity
- Gender non-conforming
- Age-generation
- Race
- Ethnicity
- Language
- Country of origin
- Immigration/status
- Political affiliation/party
- Acculturation
- Indigenous heritage
- Culture
- Social class, socioeconomic
- Religion & spirituality
- Disability or Ableness
- Urban vs. rural
- Body size
- Military experience
- Other factors including worldview
Focus on Diversity among Client, Supervisee, Supervisor: Worldviews

An Ethical Imperative
DIVERSITY IN SUPERVISION

• Low rates of actual discussion of ethnicity, gender, sexual orientation in supervision
  - Duan & Roehlke, 2001

• Topics simply does not come up i.e., religion
  - Shafranske, 2014 (In Falender, Shafranske, & Falicov, 2014)

• Depth of discussion of identities (more frequent with ethnic minority supervisees, and LGBT), correlated with alliance, multicultural self-efficacy, and counseling self-efficacy
  - Phillips, Parent, Dozier, & Jackson, 2017

• Higher levels of role conflict associated with less lower perceived depth of discussion of identities
  - Phillips et al., 2017

• Pain inflicted on supervisees (and worry re: client welfare) by culturally insensitive supervisors
  - (Jernigan et al., 2010; Singh & Chun, 2010) by misunderstanding
MULTICULTURAL COMPETENCIES

- Non-judgmental, supportive environment attending to self-awareness and potential biases
- Demonstration of respect for or interest in culture or worldviews of supervisee/therapist in relation to client
- Attention to the multiple identities of client, supervisee/therapist, supervisor and impact of these on assessment/treatment
- Discussion of cultural/worldviews of client, supervisee/therapist, supervisor and their relevance to assessment, treatment planning and decisions, and processes
- Supervisor modeling reflection, openness to alternative perspectives, increasing understanding and empathy towards clients
The generic ecosystemic parameters,

- Migration/acculturation
- Ecological context,
- Family organization
- Family life cycle

Apply to diverse cultural groups, incorporating cultural diversity and social justice lenses. Within a postmodern position of not-knowing and curiosity
• The constellation of beliefs about health, illness, religion, spirituality, and magic are relevant for understanding the client’s preferred avenues and attitudes toward mainstream health care, psychotherapy, and complementary folk medicine.

• Personal responsibility, cultural styles of coping

• (Falicov in F, S, & F, 2014)
• Supervisee and supervisor work from cultural maps
  • Theoretical perspective and professional subculture
  • Personal values, preferences derived from family of origin and other life influences
  • In context of “cultural humility” — client is expert
  • Culture as background and foreground — attitudinal factor in supervision

• Falicov in F, S, & F, 2014)
ECOLOGICAL NICHES AND BORDERLANDS

- Shared worldviews, meanings, adaptive behaviors, derived from simultaneous membership and participation in multiple contexts
  - language; rural, urban or suburban setting; race, ethnicity, and socioeconomic status; age, gender, sexual orientation, gender identity religion, spirituality, disability, nationality; employment, education and occupation, political ideology, stage of migration/acculturation, partaking of similar historical moments and ideologies (Falender, Shafranske, & Falicov, 2014)

- Or exclusion from

- Each person has a series of collective identities--groups of belonging, participation, and identification that comprise ecological niche

- Each individual’s ecological niche shares "cultural borderlands" or zones of overlap of similarity and difference with others
• Cultural aspects of presenting problem(s) in this frame
• Holistic assessment of family—contexts to which they belong, resources, strengths, constraints and cultural dilemmas
  ◦ However, knowing the context is NOT knowing the family
• Do ask, don’t assume
• Exploring health, religious resources that may be helpful—how those work adopting a “not-knowing” approach…curiosity and respect
SUCCESSFUL SUPERVISOR MULTICULTURAL BEHAVIOR

- Delphi poll identified successful and unsuccessful supervisor multicultural behaviors. Top rated:
- Creating a safe, (nonjudgmental, supportive) environment for discussion of multicultural issues, values, and ideas.
- Developing my own self-awareness about cultural/ethnic identity, biases, and limitations.
- Communicating acceptance of and respect for supervisees' culture and perspectives.
- Listening to and demonstrating genuine respect (for) supervisees’ ideas about how culture influences the clinical interaction
- Providing openness, genuineness, empathy, warmth, and nonjudgmental stance.
  - Dressel, Consoli, Kim, & Atkinson’s (2007)
SUPERVISORY ALLIANCE
• The mutually defined goals and tasks of clinical training,
• the knowledge, skills, and values, which will be assembled to form specific clinical competencies, and
• the learning strategies and evaluation procedures involved in developing the competencies should be articulated in the supervision contract.

Clarity in the training goals and the collaborative identification of the means to achieve the goals establish a context for the development of an alliance out of which an emotional bond will develop and the training goals will be achieved.
ALLIANCE

- An emotional bond, characterized by trust, respect and caring, develops through a confluence of factors as the process of supervision unfolds. In our view, the development of the bond and the effectiveness of supervision, more generally, will be shaped by the degree to which the superordinate values are expressed . . .
KEYS TO ALLIANCE

- Clarity—including difference and feedback
- Transparency and No Surprises
- Definition of All Power Differentials Including Administrative
- Integrity
- Safety
- Continuous Constructive Feedback Given Sensitively and Welcomed as well
HOW DO YOU ESTABLISH THE SUPERVISORY ALLIANCE?

• Role play establishing the alliance
  • Identifying two goals and two tasks each based on supervisee self-assessment (refer to competencies documents)
    • Consider knowledge, skills, and attitudes
    • Emotional tone—respect, (multicultural) cultural humility
ASSESSING YOUR SUPERVISORY ALLIANCE: EXERCISE—RECENT SUPERVISION

- Feeling comfortable
- Agreement about things needing to be done
- Worried about supervision outcomes
- Supervision provides new way of looking at myself
- Understanding each other
- Finding what we do in supervision confusing
- Finding what we do in supervision confusing
- Wish we could clarify purpose of sessions
- Disagree about what I should get out of supervision
- Believe time is not spent efficiently
- Clear what responsibilities are in supervision
- Goals of sessions are important
  - Excerpted from Bahrick (in Appendix of Falender & Shafranske, 2004)
ALLIANCE STRAINS AND RUPTURES
ALLIANCE STRAINS

- Strains can be brought about by the challenges inherent in clinical practice/clinical training, conflicts in the goals and/or tasks, inadequate attention to the superordinate values, inadequacies in technical competence (inquiry & educational praxis), and particularly, in boundary crossings and violations, in problematic supervisee behavior, and through negative reactions and the enactment of transference, countertransference and parallel process phenomena.

- Think of strains have occurred in your setting or previous settings
ALLIANCE STRAINS

- Frustrations in treatment/supervision process and outcome may activate negative personal reactions and defensives, e.g., increasingly controlling, rigid, critical, etc., further straining the collaboration.
INDICATORS OF STRAIN

- Withdrawal
- Paucity of disclosure
- Direct expression of criticism/hostility
- Noncompliance/passive responding
- Acting in/acting out
SUPERVISOR RESPONSE

- Frustrations in treatment/supervision process and outcome may activate negative personal reactions and defensives, e.g., increasingly controlling, rigid, critical, etc., further straining the collaboration.
LEADING TO DOUBLE OR TRIPLE TRAUMATIZATION

• Presence of previous exposure to trauma
• Strains
• Ruptures

• Resulting in:
  • Failure to Disclose
  • Spurious Compliance

• When conflict arises between supervisor and supervisee and is not resolved, it compounds supervisee exposure to trauma from clients—trauma-informed supervision aspects are important
NONDISCLOSURE: IS IT RELATED TO STRAIN?

- Positive correlation between positive supervisory alliance and supervisee disclosure
- Nondisclosure—topics in supervision
  - Negative reactions to supervisor (90% who failed to disclose)
  - Personal issues (60%)
  - Clinical mistakes (44%)
  - Evaluation concerns (44%)
  - General observations about client (43%)
  - Negative (critical, disapproving, unpleasant) reactions to client (36%)
    - Ladany, Hill et al. 1996; Supported by Wall, 2009
• Negative reactions to clients, supervisee, or supervisor interfere with working alliance and client outcome
  • They need to be dealt with and contained
  • Relationship must be safe
  • Disclosures must be accepted, not ridiculed
• Supervisee reinforces negative patterns of interaction with little awareness of personal involvement
  • Adopting stance of inquiry, stepping back from defensive mode of reacting interrupts cycle of misattunement
    • Frame feeling states and attributions being made
    • Attempting to gain insight through understanding what feelings are being warded off
COLLABORATIVE APPROACH TO RESOLVING STRAINS AND RUPTURES

• Noticing/attending to rupture or strain marker
• Internal review—consider intensity/significance of marker
• Make decision to act on observed marker (or not)
• Acknowledge/reflect on rupture/strain with supervisee and precipitating event
• Supervisor acknowledges own contribution and validates supervisee experience
• Exploration of links to other occurrences and client treatment
• Collaboratively agree on action—consider revising formulation/monitoring/making revisions

Based on Aspland, Llewelyn, Hardy, Barkham, & Stiles. 2008; applied to supervision in Falender & Shafranske (2012)
SUPERVISION CONTRACT—
informed consent
SUPERVISORY CONTRACT AND THE ALLIANCE

- Development of the supervision contract is an essential component of the supervisory process and serves as the basis for the supervisory alliance, enhanced articulation of expectations, informed consent, and definition of parameters of the relationship and the process and content of supervision.
SUPERVISION CONTRACT (APA, 2014)

a. Content, method, and context of supervision—logistics, roles, and processes
b. Highest duties of the supervisor: protection of the client(s) and gatekeeping for the profession
c. Roles and expectations of the supervisee and the supervisor, and supervisee goals and tasks
d. Criteria for successful completion and processes of evaluation with sample evaluation instruments and competency documents (APA, 2010, 2.06)
d. Criteria for successful completion and processes of evaluation with sample evaluation instruments and competency documents (APA, 2010, 2.06)

e. Processes and procedures when the supervisee does not meet performance criteria or reference to such if they exist in other documents

f. Expectations for supervisee preparation for supervision sessions (e.g., video review, case notes, agenda preparation) and informing supervisor of clinical work and risk situations
g. Limits of confidentiality of supervisee disclosures, behavior necessary to meet ethical and legal requirements for client/patient protection, and methods of communicating with training programs regarding supervisee performance

h. Expectations for supervisee disclosures including personal factors and emotional reactivity (previously described, and worldviews (APA, 2010, 7.04))

i. Legal and ethical parameters and compliance, such as informed consent, multiple relationships, limits of confidentiality, duty to protect and warn, and emergent situation procedures

j. Processes for ethical problem-solving in the case of ethical dilemmas (e.g., boundaries, multiple relationships)
SUPERVISORY CONTRACT—OTHER ASPECTS (FALENDER & SHAFRANSKE, 2004; 2016)

- Logistics of setting

- Roles and Expectations of supervisee and Supervisor
  - Learning activities, competence self-assessment, feedback, mutually defined goals and tasks, diversity-multicultural competence
SUPERVISORY CONTRACT—OTHER ASPECTS (FALENDER & SHAFRANSKE, 2004; 2017)

• Legal/Ethical Parameters
  • Setting-specific boundary expectations
  • Specific reference to ethical codes, regulations, and laws
  • Handling electronic information—e.g., informed consent, confidentiality
  • Social media guidelines
  • Reference agency/site personnel practices
  • Normative management of countertransference, reactivity, strains or ruptures to alliance
  • Limits of supervision
    • Not personal psychotherapy
SELF-ASSESS

- Do you use a supervision contract?
- Does it include the relevant informed consent aspects?
- Does it correspond to supervision actually practiced?—all all staff on the same page?
- What could be added?
- Consider how carefully you have described limits of confidentiality in supervision contract/program description
- Spend a few minutes considering aspects you should add to your supervision contract
SUPERVISION CONTRACT EXAMPLES

- www.cfalender.com
- Falender & Shafranske, 2017
GIVING ACCURATE POSITIVE AND CORRECTIVE FEEDBACK

ANCHOR FEEDBACK IN COMPETENCIES AND IN LIVE OBSERVATION (OR VIDEO)
FEEDBACK—ESSENTIAL COMPONENTS

- Self-assessment is not accurate and highly skewed and not taught in graduate school
- A trusting relationship is essential in which there is safety
- Goals are translated into working tasks; feedback is anchored in tasks derived from mutually determined goals—behavior does not change if the supervisee does not agree with the feedback
- Groundwork is laid by discussion of worldviews, perspectives, diversity lens
- Feedback is specific and targeted—ideally from live observation or video review
- Feedback should reflect transparency in evaluation
- Feedback is ongoing, occurring in every supervisory session and be two-way
FEEDBACK ISSUES

- Too little and too late
- Forgetting law of no surprises
- Not specific or targeted to competencies—strengths and those in development
- Strictly negative with no acknowledgement or attention to strengths—or listening to the other’s perspective
- Balancing respect for culture values of client and supervisee while upholding ethics of profession and gatekeeping responsibility
- Reticence on the part of supervisors to engage in difficult conversations providing feedback, competency and clinical monitoring, and evaluation
- What are reasons supervisors do not give feedback?
Think of a time you were reluctant to give feedback, especially about a difficult feedback subject (intersecting with multicultural/personal/personal-professional)
  • What are keys to “difficult feedback conversations”

Conduct a difficult conversation
  ◦ Determine a competence problem area with supervisee in your experience
  ◦ Role play the conversation
  ◦ Reflect on the process, difficulty, impact, and result
EFFECTIVE FEEDBACK

• First, invite supervisee self-reflection and self-assessment and reinforce metacompetence.
• Provide a framework for the feedback you will give that communicates the importance of the competence issue to be addressed and the developmental level, e.g., “normative” developmental challenge, doesn’t meet performance expectations, exceeds expectations.
• Feedback given should be formative and continuous, which will contribute to the summative evaluation.
The most effective feedback is that which is:

- Specific (behaviorally anchored)
- Delineates the knowledge, skills, attitudes/values that require attention
- Frames competence with a developmental orientation
- Acknowledge strengths on which competence will be enhanced
- Invites reflection and articulation of specific area for development
- Leads to discussion of learning strategies, including learning in the supervision session
FEEDBACK

• In study of feedback: supervisors gave easily, reluctantly (with difficulty), or not at all
  – Easily was generally about clinical problems in the case, given directly and well-received, positive effects
  – Difficult was clinical, personal or professional issues, given indirectly, with mixed effects, characterized by lack of supervisee openness
  – Not given was about personal or professional concerns, hindered by lack of supervisee openness

• Supervisors reported negative effects of not giving feedback and wishing they had in retrospect
  » Hoffman, Hill, Holmes, & Freitas, 2005
WHAT FACILITATED FEEDBACK?

- **Mediating factors**
  - Supervisee response
  - Supervisor competence in feedback related area (e.g., religion, spirituality, EBPs)
  - Strong alliance and trust; previous discussions of cultural shared and differing factors
  - Timing in terms of supervisee readiness—or in response to collaborative video review that illustrated
  - Supervisor received collegial support to give
    - Hoffman et al., 2005
• This Implementing Regulation is intended to clarify the expectations of the CoA with regard to “direct observation” as described in doctoral APA Standards of Accreditation (SOA) as follows:

• Standard II.B.3.d (APA CoA –Accreditation, 2017)

• “As part of a program’s ongoing commitment to ensure the quality of its graduates, each practicum evaluation must be based in part on direct observation of the practicum student and her/his developing skills (either live or electronically).”
FEEDBACK EXERCISE

- Role play a supervision session in which you and the supervisee observe a video (to be shown to the group), and both supervisee and supervisor use—2 opportunities to role play

- Techniques of “Give me 5 (or 2-3)”
  - Supervisor and Supervisee list 2-3 (and no more) aspects of the session—highlights, salient issues, key patterns—a wide angle lens approach to emergent themes and competency domains (without prior assumptions)
    - Target strengths and weaknesses; emotional reactivity
    - Stuck points, turning points, insights, preoccupying factors

- adapted from Gonsalvez, Brockman, & Hill, 2016
The therapist is 30, is the mother of a 2-year-old son, is White/European Descent, solidly upper middle class; in her first year in the post-Master’s doctoral program. She is in her first year practicum placement. The therapist feels frustrated with the client because the therapist has had to coordinate childcare with the client’s therapy time, and the client does not seem to value their designated therapy time. The therapist decides to confront the client with the goal of helping the client be more on time to appointments (perhaps so that client can also maintain a job in the future).
BACKGROUND

• Supervisee goals

• Goal I: Basic mindfulness and self-awareness; basic reflectivity regarding professional practice (reflection-on-action) specifically addressing intellectual curiosity and flexibility

• Goal II: Professionalism: Concern for the welfare of others—empathic engagement

• Goal III: Knowledge, awareness, and understanding of one’s own dimensions of diversity and attitudes towards diverse others
The client is a first-generation Thai American woman from Thailand, 40 years old.

Her presenting problems are Persistent Depressive Disorder/Social Anxiety Disorder; low self-esteem; isolation as a self-protective strategy, blunted affect. She is struggling financially because she has been unemployed for the past 6 months and has to take the bus to therapy; has attended 15 sessions, but has been late for the past 5 sessions, generally about 15-20 minutes late. The client has felt embarrassed about sharing her financial challenges with the therapist (who is very affluent), so the therapist is unaware client has been taking the bus to therapy.
Video Clips and Discussion/Reflection
EFFECTIVE FEEDBACK

- Competency-based (knowledge, skills, attitudes) and anchored to competency behavioral anchors
- Based on behavioral observations and previously self-assessed behaviors
  - Administered close in time to behavior observed/enacted
  - Critical aspect is the impact on recipient—how it is understood and used going forward
  - Accepting and incorporating feedback is a competency
SMALL GROUP REFLECTION

- Think of a difficult situation you have encountered with a supervisee to whom you wished to give feedback.
- What kept you from giving feedback?
- What do you wish you had done?
- What did you do?
- Anything you learned about how to approach such situations in the future?
TRAUMA-INFORMED SUPERVISION
SUPERVISORY CHALLENGES

- Complexity of client presentations/situations
- Involvement of clients with multitude of systems that do not employ a trauma-informed lens (e.g., legal, children’s services when mandatory reports are made)
- Limited resources precluding ability to obtain essential/needed services
- Failure to see immediate client improvement; symptoms/situations growing more complex over time; need for very long-term treatment
- Supervisee pain hearing trauma recounting, difficulty not being judgmental; understanding client reticence to recall trauma; restraining supervisee tendency to find a quick fix; client recounting of trauma triggers supervisee memories, past life experience and they want to disclose that to clients
  - Collen & Cohen, 2013; Berger & Quiros, 2016
• Normality of errors – shame, anxiety or incompetence are normative and supervisors need to address feelings elicited by trauma client (and all client) work

• Problem of “impression management”—wanting supervisor to see supervisee as super-confident and competent—actually this is a deterrent to effective supervision—and can be addressed in competence model
EFFECTIVE PRACTICE

• Empowering of supervisee
  • Encourage supervisees to develop supervision agendas in advance with focus on goals previously determined collaboratively through self-assessment—instilling hope
  • Parallel process of empowering supervisee to choose interventions to empower client

• Strong relational component
  • Addressing countertransference, “overflow” into their personal lives, modeling strategies to deal with that; ensuring they are not staying too late, taking on extra clients, exhibiting continuum of over-involvement to avoidance of clients
• Helping supervisees feel safe and supported in supervision One supervisor said, being “attentive, gentle, supportive, and nurturing, while also nudging workers to challenge themselves, hold them accountable, and yet create a safe space to struggle toward professional growth”
• Comfort discussing clients AND their own response/reactions/emotional impact
• How to handle disclosures of their own trauma history?
  • As a means to address their emotional availability to client, the boundaries between own experience and client’s, impact on their work, their client of their own experience, responsivity versus reactivity as a response
• Avoidance of discussion of personal impact of trauma on supervisee can lead to detrimental effects – management of self of the therapist
  • Inappropriate behavior, multiple/dual inappropriate relationships
  • Need to help supervisee process issues, gain insight into emotions raised and how to manage them, use insights, empathy with supervisee (feeling stuck),
ESSENTIAL COMPONENTS

- Strong Supervisory relationship marked trust, collaboration, safety, discussion about power – of supervisor and of therapist
- Factors: transparency and clear boundaries (in supervision and in psychotherapy)
- Self-care alone is not enough of a protective factor although it was previously thought to be—maintenance of emotional regulation is essential—and other strategies we will discuss
  - Sense of humor, work-life balance, social support, spirituality, maintenance of realistic optimism, sense of meaning in work
  - Also, reminding clinicians of what worked, successes, learning from and drawing upon those
PROCESSES

• Integrity
• Collaboration and Informed Consent (Supervision Contract/Plan) Disclosure (and receipt of disclosure with reflective process)
• Use best evidence for treatment Clarity about informed consent, limits of supervisor confidentiality regarding supervisee disclosures
• Strength-based (across client-supervisee-supervisor)
• Attention to assumptions, biases, worldviews and impact- and discussion of those
• Ethical – Values Based Practice
• Rule 1: Clinical supervision is critical – a priority and an ethical and legal imperative
• Preserving the sanctity of clinical supervision
• In high pressure organizations, clinical supervision is often sacrificed—it can happen insidiously.
• Consistency and predictability of supervision times
Rule 2: Creation of a physically and emotionally safe supervision environment for a reflective process of supervision—with goal to enhance personal and professional development of the supervisee and optimal outcomes for the clients—and to evaluate stress level and address that

- Identify personal and professional issues that may interfere with/impact client work and identify strategies to deal with them to ensure protection of the client while fostering the growth of the supervisee
- Addressing knowledge, skills, and attitudes
- Empathy
• Rule 3: Supervision is a Protective Factor
  • Containment
  • Co-construction of knowledge and experience
  • Mutual process of meaning-making—(within evaluative structure)
  • Increasing self-awareness
  • Supervisors may partially relinquish “expert” role and adopt more open, vulnerable stance—some professional self-disclosure is helpful—maintaining ethical standards and boundaries
SUPERVISION ASSUMPTIONS

• Safety
• Trusting and trustworthy environment
• Collaboration
• Empowerment within context

• Includes
• Modeling clear and appropriate boundaries
• Modeling and abiding by confidentiality standards/ policies
• Providing clarity in supervision interventions
• Being consistent and predictable
• Being available for supervision as needed
TRAUMA-INFORMED ENVIRONMENT

- Offers clients choice—empowerment
- Treatment is collaborative, culturally sensitive
• The supervisor’s role is educative, supportive, and administrative
  • Educative: Population, setting, context, intervention strategies and skills, theoretical orientation(s)
  • Supportive: emotional support, trauma trigger management, personal factors or issues that impact client treatment and management of those, self-forgiveness, self-care; effective boundaries
  • Administrative: Intersection of agency policies, supervisee adherence, management of treatment/case load; evaluation of clinical e and administrative performance/compliance
TRAUMA-INFORMED SUPERVISION

• Essential Components
  • Understanding of “self of the therapist” in complex relationship of working with trauma-affected clients
  • The immediate “visceral” clinical encounter and impact on therapist of hearing client’s trauma experience/narrative
  • Personal or family (multi-generational) experience of trauma
  • Trauma embedded in the culture and the community
  • Experiential supervision—through role-play, modeling, and reflection
SELF OF THE THERAPIST

- Matched self or self identification—when therapist feels the same feelings as trauma survivor
- Complementary self of therapist: therapist takes on role predicated by the client
- Therapist feels intense empathy, sadness, even horror and ruminates on this
- STRONG consideration of appropriate therapist-client boundaries with trauma survivor
- How to empathically engage with trauma history/recounting without immersion—emotional or action—and without blame
- Additional complexity in family trauma cases with multiple individuals, therapist identification and empathy for each or several or only one
EVIDENCE-BASED PRACTICE
PROCESS OF SUPERVISION SESSION

• Use of formatted supervision
  • 50% used agenda
  • About 20% or less used role play, or active techniques
  • Only 5% used direct observation
    • Reiser & Milne, 2012

• How to increase experiential learning?
  • Observation with feedback, modeling, targeted feedback guided by standardized competencies
Supervisees and supervisors alike reported too little time spent on client and supervisory alliance and on supervisory relationship/process.

- Accurso et al., 2011

Practice elements were not discussed in each session and not necessarily thoroughly.

- Accurso et al., 2011

¼ to 1/5 reviewed video or audio tapes of session in supervision (Schoenwald et al., 2008)

Frequency was even less in Accurso et al. (2011)—12% and .8%

Administrative matters take up significant time in clinical supervision.

- (Garland et al., 2006) but may not be an issue generally
PROACTIVE STEPS

- Follow competency-based supervision – all components
- Establish a supervisory alliance and be proactive regarding strains
- Ensure practice elements are not simply addressed but that supervisee has competence in these and that supervisor tracks specific use of elements
- Engage in experiential learning, role-play with supervisee
- Observe or conduct co-therapy with your supervisee at least once
- Monitor attention to administrative issues to ensure adequate time in clinical supervision – highest duty of supervisor is protection of the client
ASSESSMENT OF CLIENT OR SUPERVISION OUTCOME

Client outcome in supervision
- Feedback loop with client to supervision
- Lambert OQ or other behavioral checklist
- Associated with greater supervisee satisfaction
  - Grossl et al., 2014
- An increasing trend is towards routine outcome monitoring
  - Peterson & Fagan, 2017
- An excellent practice—although unfavorable outcomes may not relate directly to therapist competence—use ethical problem solving frame
  - Pinner & Kivlighan, 2018
- Outcome monitoring is complex and tools are new, in development and may deliver less than some evidence suggests
  - Langkass, Wampold, & Hoffart, 2018
GROUP SUPERVISION
WHY GROUP SUPERVISION?

- Support of peers facing similar anxieties, fears and understand others face similar issues.
- Input and feedback comes from peers and the supervisor—group challenges collusion between supervisor and one group member.
- Supervisor or supervisees can check out intuitive or emotional responses to material—do others have same response?
- Exploration of “paralleling” phenomena.
- Group can provide a wider range of life experience, empathy,
- More opportunities to use action techniques
  - Hawkins & Shohet, 2000
- Richness of multicultural perspectives and approaches, reflective process
  - Falender & Shafranske, 2016
GROUP SUPERVISION RULES?

- Respectful process; Mutual respect
- Cultural humility
- No cross talk
- No cellphones or devices
- Maintaining confidentiality (by supervisees)
- Fostering safety while gently pushing on certain things—learning and growth
- Respect silence—no obligation to talk all the time
- Time allocation/management
- Starting and ending on time
EFFECTIVE GROUP SUPERVISION

- Establish clear group rules
  - Confidentiality among group members (clarify supervisor confidentiality)
  - Balanced time allotment
  - Respectful interaction including respect for multicultural/worldviews
  - Difficult conversations
- Most effective if process oriented and respect-driven
- Affords vicarious learning opportunities and breadth of experience
- Supervisees receive feedback and support from peers
- Attending to parallel process (isomorphism) is a rare and special opportunity in group supervision
- Strengths in process: openness, sense of humor, enhancing comfort and communication through respect
  - Riva & Cornish, 1995; Ogren, Jonsson, & Sundin, 2005; Smith et al., 2012
HELPFUL AND HINDERING MULTICULTURAL EVENTS IN GROUP SUPERVISION

• Helpful—supervisors who integrated multicultural issues and were involved, proactive in multicultural discussion, a validating group climate, supporting peer vicarious learning, supervisors’ response to multicultural event

• Hindering—misapplication of multicultural theory or misunderstanding, multicultural conflicts with supervisors, avoidance of multicultural issues that arise or of differing viewpoints even when conflict arises in group supervision
  • Kaduvettoor, O’Shaughnessy, Mori, Beverly, Weatherford, & Ladany, 2009
RESULTS

• More focus on process contributes significantly to perceived skills

• Supervision groups where more focus is put on theoretical matters experience less ability to handle emotional issues

• Supervisees may not discriminate between different foci of supervision as supervisors do.
  • Ogren, Jonsson, & Sundin, 2005)
LEGAL UPDATE FROM:

KEATON VS. ANDERSON WILEY
AND
WARD V. EASTERN MICHIGAN U. (WARD V. POLITE)
Jennifer Keaton, a student in a master’s program in school counseling at August State, a Georgia state school told peers and faculty that since gender is fixed, and that her Christian faith viewed “homosexuality” an immoral lifestyle choice, she advocated client change through conversion therapy.

Faculty proposed a remediation plan: ethical aspects (American Counseling Association and American School Counselor Association ethics codes), her need for multicultural competence, understanding and empathy, and issues with her writing: attending three workshops, reading ten articles in peer reviewed journals regarding LGBTQ, gaining familiarity with LGBT guidelines, exposure and interaction with gay populations perhaps attending a gay pride parade, and progress report reflecting on the impact of these upon her attitudes.
She initially agreed to the remediation plan, but upon reflection concluded that the choice was to conform her conduct to either the Bible or professional behavioral standards. The faculty clarified that she could not impose her personal belief structure on others.

- She refused the remediation plan and filed suit against faculty and the university.

- She was ultimately dismissed from the program due to noncompliance with the remediation plan.
• The federal judge ruled that Keeton’s constitutional rights were not violated. A graduate counseling program is not an open forum for all types of speech, but is a nonpublic forum especially for the purpose of supervised learning experience. Ms. Keaton was not asked to change her beliefs but simply to be aware of them and not impose them on the client.
• The ruling concluded that, “… when affairs of the conscience ripen into action – either speech or conduct – government is granted leave to regulate in behalf of certain public interests, including education and professional fitness.”

U.S.: WARD V. EASTERN MICHIGAN U. (WARD V. POLITE)

- Julea Ward, student in M.A. counseling program at Eastern Michigan University* held “orthodox Christian beliefs” and believed “homosexuality” is “morally wrong” She stated her “Christian faith prohibited her from affirming homosexual behavior”, which she believed was immoral and a choice (as it would from treating a heterosexual engaged in adultery or relating to abortion). {Bold added}

- In practicum was referred a client—upon reviewing the chart prior to seeing, learned client was homosexual. Told supervisor she would treat client for any issue but homosexual relationships

- Client was reassigned, Ms. Ward had informal review (not disciplinary)—concluded remediation plan not feasible given strength of Ms. Ward’s beliefs. She had stated “I answer to a higher power and am not going to sell out god” (Dugger & Francis, 2014)
A formal review (disciplinary) resulted in her expulsion for unwillingness to change her behavior. She brought a lawsuit against the school for infringing her First Amendment rights under the U.S. Constitution (Ward v. Wilbanks, 2010). Citing the deference courts give to academic institutions to establish academic standards and formulate curricula, the U.S. district court granted summary judgment to the school for applying a neutral policy of nondiscrimination based on a professional association’s code of ethics and a neutral referral policy. (italics added)
However upon appeal, the court concluded that if the facts were viewed in Ms. Ward’s favor, a reasonable jury could decide that Ms. Ward—not the university—should prevail. For this reason the appeals court concluded that summary judgment was not appropriate. The case should go to a jury (Ward v. Wilbanks, 2010; Behnke, 2012).

The decision stated “a reasonable jury could conclude that Ward’s professors ejected her from the counseling program because of hostility toward her speech and faith, not due to a policy against referrals.” (Julea Ward Vs. Polite, U.S. Court of Appeals).
Further, the court concluded that the ACA Code of Ethics does not prohibit values-based referrals. The Appeals court determined whether a university policy, designed and adopted to further a legitimate educational goal, is applied equally to all students regardless of their religion.

- Case was settled and Ward received a monetary settlement and it was removed from her record.
CONCLUSIONS

- Tolerance is a two way street: school must be respectful of her religious beliefs and practices as it requires her to be of her clients’ statuses.
- Referral policy should be clear
- Issue of religion in disciplinary hearings
  - Behnke, 2012
- “How should programs handle situations in which students want to operate in the professional arena in accordance with their personal values when these values are in conflict with the mandates and standards of professional ethics and behavior?”
“Being explicit that trainees do not need to give up their personal and/or religious values; and being explicit that trainees are expected to attain both demographic competency and demonstrate the competency of dynamic worldview inclusivity.”

STEPS IN DIFFICULT CONVERSATIONS...

- Consider stages of change, readiness to change—change talk by the supervisee

- Also remember that supervisees are vulnerable to our power—and are generally very sensitive to feedback

- Remember strength of supervisory alliance is associated with more supervisee disclosure, satisfaction

- Do not enter a difficult conversation when you are in a reactive state (or the supervisee is) – take time to be reflective and adopt a respectful tone

- Generally it is important to be open to the supervisee's perspective, listen, and reflect
CONDUCTING DIFFICULT CONVERSATIONS

• Topics of difficult conversations
  ◦ Diversity
  ◦ Respect
  ◦ Evaluation and Power Differential

Exercise 1: Role play supervisor-supervisee interaction with supervisee who has stated, “I cannot work with the (diversity category ____)(client)______ because of my own personal values and belief structures.
WHY NOT HAVE A DIFFICULT CONVERSATION?

- The belief that if we are a good enough supervisor, we can fix it, so no need to discuss
- Jumping to diagnosis and then treatment ... especially in the face of really difficult situations we do not know how to deal with
- We forget to use our competency-based frame—the supervisee’s self-assessment, our appraisal and small increments of feedback, and generally the Competencies Benchmarks or our own competency ratings: Use of that language translates to professionalism
- We may not know the personnel or setting practices to deal with supervisees who do not meet competence standards.
- We may not feel comfortable discussing our concerns with colleagues or training directors or administrators as we worry it is our personal failure
- Consider Conscience Clause in your jurisdiction:
Michael, your supervisee had told you before he entered the placement he was “value-driven” and very committed to his faith. You have viewed that as a strength and he has been a very strong trainee, has a strong supervisory alliance, and has done extremely well for the past 7 months under your supervision of a wide range of cases. This week he was assigned a new case, a lesbian couple raising a boy, and he came to you with heartfelt sincerity told you that he simply cannot see this case, generally because he is not competent to do so, but also it is against his belief system. How could you proceed with this supervisee, how could you help him…and what standard do you set for his competence—his adequate performance in the placement?
PERSONAL FACTORS AND REACTIVITY
INITIATION INTO ROLE OF PERSONAL FACTORS

• Personal and professional sources influence conduct of psychological treatment and become intertwined
  • Conscious beliefs
  • Culturally-embedded values reflecting individual differences and diversity
  • Unresolved conflicts

• Supervision is subject to these influences as well
ROLE OF PERSONAL INFLUENCE

• Countertransference
  – Supervisor and clinician’s understanding is always perspectival: influenced by personal interests, commitments, and cultures out of which personal meanings are constructed
  – Countertransference in the broadest sense takes into consideration that ---in the final analysis all understanding is self-understanding (Gadamer, 1962)
COUNTERTRANSFERENCE MANAGEMENT

• Relationship must exist before countertransference exploration
• Countertransference approached as important informers of the therapeutic process
• Countertransference includes both positive and negative forms of personal influence
• Countertransference informs the therapeutic process
• Countertransference may elicit positive and/or negative responses in the therapist and take forms of distinctly unusual, idiosyncratic, or uncharacteristic acts or patterns of therapist experience and/or actions towards clients, including enactments and parallel processes involving the supervisory relationship
  • Shafranske & Falender, 2008
COUNTERTRANSFERENCE MANAGEMENT

- Inquiry into supervisee subjective states (boredom, confusion, irritation) when departures from usual clinical conduct arise or when treatment is not progressing
- Critical to maintain boundary between supervision and psychotherapy
COUNTERTRANSFERENCE MANAGEMENT

• How supervisees treat countertransference and ruptures is more important than the fact they occur.

• Clinical competence includes the awareness of personal factors which influence the therapeutic process as well as skills in effectively bringing countertransference reactions into the service of the treatment.
STAGES IN ADDRESSING PERSONAL FACTORS AND COUNTERTRANSFERENCE

• Preface
  • Supervisory contract
  • Explicit orientation to personal factors
  • Modeling
  • Exploration of positive contributions of personal factors and strength-based aspects

• Collaborative Identification of CT

• Reinforcement of Identification of CT as a Competency
RESPONSIVENESS VS. REACTIVITY
(SHAFRANSKE & FALENDER, 2008)

• Emotional responsiveness fosters engagement and empathy.
• Emotional reactivity involves over-arousal and can lead to loss of psychological contact with the client.
ADDRESSING COUNTERTRANSFERENCE
(DERIVED FROM GELSO & HAYES, 2001)

- Self-insight
- Self-integration—(differentiation)
- Anxiety experience and management
- Empathy
- Conceptualization ability
  - Elaborated in Shafranske & Falender, 2008 (In Falender & Shafranske, 2008)
- Management enhanced by meditation, mindfulness, self-differentiation
  - Fatter & Hayes, 2013
TECHNIQUES/APPLICATIONS
FEEDBACK TO SUPERVISOR

- Addressed my goals
- Addressed diversity/multicultural identities of client(s), supervisee, or supervisor or interaction
- Engaged in experiential supervision (e.g., active problem solving, role-play, Modeling)
- Addressed to my feelings, reactivity towards client
- Monitored patient progress
  - Falender & Shafranske, 2016
SKILL: USING AN AGENDA TO STRUCTURE THE SUPERVISION SESSION

- Checking in
- Setting the supervision agenda
- Bridge from previous supervision session
- Inquiry about previously supervised therapy cases
- Reviewing homework since previous supervision session
  - Case conceptualizations, reading)
- Prioritizing and discussion of agenda items
- Assignment of new homework
- Supervisor's capsule summaries (throughout session and at end)
- Elicit feedback from therapist (throughout session and at end)
  - Adapted from Liese & Beck, 1997; p. 121
STAGES OF CHANGE – HOW DO THEY MATTER? SUPERVISORS AND SUPERVISEES

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

(Relapse)—or return to Precontemplation

Prochaska, Levesque, Prochaska, Dewart & Wing, 2001
READINESS TO CHANGE

- Percentage of employees ready to change?
  - (i.e., in implementing short term treatment interventions?)
    - 20 to 30%
      - Prochaska, Levesque, Prochaska, Dewart & Wing, 2001

- How does readiness impact supervision?
  - Aten, Strain, & Gillespie, 2008
ENHANCING REFLECTION AND SELF-ASSESSMENT

- Motivational interviewing derived technique
  - Aten et al., 2008
- Supervisees self assess their recordings and supervisors respond to enhance reflection and self-critiquing
  - Sobell, Manor, Sobell, & Dunn, 2008
Motivational Interviewing and Feedback

- Supervisor might say “Tell me a bit about what you heard on your tape and how might you phrase things differently in a similar situation next time?”
- “What other things might you do differently?” or “What do we need to work on in supervision to get you to a higher level?”
- Open-ended questions allow trainees to reflect on their own progress, encourages trainees to decide to make changes (i.e., talk or interact differently with patients).

  - Sobell, Manor, Sobell, & Dunn, 2008
PROFESSIONAL PRACTICE, ETHICS AND LAW
FORMS OF LIABILITY

• Direct Liability
  • Negligent supervision
    • Supervisor’s own negligent acts
      • Not knowing what supervisee is doing
      • Instructing supervisee to do something contraindicated
      • Knowing of supervisee error but failing to take corrective action
      • Carelessness in monitoring supervisee’s work
VICARIOUS LIABILITY: RESPONDEAT SUPERIOR

Supervisor is liable by virtue of relationship with supervisee

- To prove liability and recover against the supervisor, a client must satisfy a number of factors:
  - Supervisees voluntarily agree to work under direction and control of supervisor and act in ways that benefit the supervisor
  - Supervisees were acting within the defined scope of tasks permitted by supervisor
  - Supervisor has power to control and direct the supervisee’s work
    - Disney & Stephens, 1994
ADDITIONAL FACTORS

- It must be established whether an action fell within the scope of the supervisory relationship
  - Time, Place, Purpose of the act
  - Motivation of supervisee
  - Whether supervisor could have reasonably expected the supervisee to commit the act
    - Disney & Stephens, 1994

- Financial relationship
  - Enterprise liability if supervisor has economic gain from work of supervisee
    - If supervisor is employed by hospital, etc. vicarious liability may attach to institution as institution benefits directly from supervision
      - Recupero & Rainey, 2007
MALPRACTICE ELEMENTS

- Fiduciary relationship with therapist or supervisor—supervisor is working in best interests of supervisee and clients
- Supervisor’s (or therapist’s) conduct was improper or negligent and fell below standard of care
- Supervisee (or client) suffered harm or injury which is demonstrated
- Causal relationship demonstrated between injury and negligence or improper conduct
  - Disney & Stephens, 1994
LAWSUITS BROUGHT BY CLIENTS

• Sexual misconduct
  • Negligent supervision in mishandling of transference/countertransference
    • Sexual relations between psychologist and client is a well-known hazard—Minnesota Supreme Court
      • Prudent supervisor watches carefully for signs of boundary issues
    • Mishandled transference of social work supervisee
      • 9th Circuit: Simmons vs. U.S.
ETHICAL STANDARDS

• APA Code of Ethics (2017)
  • http://www.apa.org/ethics/code/

• NASW Code of Ethics (2017)

• AAMFT Code of Ethics (2015)
  • http://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx

• CAMFT Code of Ethics (2011)

• ANA Code of Ethics for Nursing
  • http://ana.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.aspx
ETHICS OF SOCIAL MEDIA
CLIENTS AND INTERNET: CLIENTS SEARCHING FOR THERAPIST INFORMATION

- **Motivation (top 7)**
  - Curiosity
  - Seeing web presence
  - One-sided relationship
  - Other: feel closer, connection
  - Marital status
  - Whether they had children
  - Friends in common

- **Nature of Information Discovered (top 7)**
  - Family
  - Age/birthdate
  - Education
  - Home address
  - Photos
  - Hobbies/interest
  - Dating/relationships

- Kolmes & Taube, 2015
  -

**Kolmes & Taube, 2015**
THE INTERNET AND ETHICS

• Relationship of therapist to Facebook and social networking including client blogs

• Scenarios: (consider your own scenarios)
  – Client (child) invites therapist to friend him/her
  – Client (child) invites therapist to view Facebook page
  – Therapist is worried about client and looks at client’s Facebook page
    • Discovers he is being bullied
    • Discovers he has suicidal ideation
    • What is her professional obligation? Ethical obligation?

• Clinician has significant social network presence and is not mindful that clients can access her sites—and see unprofessional behavior
  – Criteria of thoughtfulness and intentionality
    • Tunick, Mednick, & Conroy, 2011
INTERNET AND CHILD CLIENTS

- Do supervisees seek out information about clients through internet?
  - Googling client?
  - Inform client before or after?
  - Engage in thoughtful process weighing risks and benefits
  - Ideally read together
  - Educate youth about internet risks
  - Provide guidance to parents about how to discuss
    - Tunick, Mednick, & Conroy, 2011
SUPERVISEE USE OF INTERNET WITH CLIENTS

- Over 75% of respondents maintained their own social network page
- 66.9% of respondents reported searching for information about clients using search engines was always or usually unacceptable;
- 76.8% of respondents reported searching for information about clients on social networks was always or usually unacceptable
- 97.8% reported they used a search engine in past year for at least one client; 94.4% used social network to search for client information
- 82% reported clients were aware of searches
- Overall searched for over 16% of clients in past year
- Decision making—client consent

DeLillo & Gale, 2011
SUPERVISEES GOOGLING?

- 90.8% uncomfortable if client contacted them via social network
- 89.7% changed privacy setting; 74% changed content of their social networking sites, 61% modified pictures since starting grad school
- About ¼ had googled clients; ½ had googled supervisors
- Generally no discussion of social networking with clients (74%) and not generally discussed in training sites
- Over half (54.5%) were concerned about making an ethical decision about contact via their social networking account-- or about contact (40.3%)
  - Asay & Lal, 2014
- Controversial multiple relationships are more likely to occur.
  - Pham, 2014
Internet data should be categorized as collateral information

Consider conducting Internet searches in evaluations case-by-case, weighing the potential utility versus the potentially prejudicial effects of such data.

With rare exceptions, forensic practitioners who gather or rely on Internet-based data should discuss this practice during informed-consent process.

With rare exceptions, forensic practitioners should provide examinees with data gathered via the Internet and allow them to address it.

Forensic practitioners should be explicit about their use of and reliance upon any data gathered via the Internet in their reports and testimony.

From Pirelli, Otto, & Estoup, 2016, p. 14-15
A supervisee/therapist tweeted after a difficult therapy session the previous night “Child a bear named Tigger and parents…horrendous poor me” One of his followers, a fellow supervisee, was taking her morning walk with her neighbor, mentioned the tweet in passing to the neighbor. The neighbor whose child’s nickname within the family was “Tigger” realized that that was HER child’s therapist, withdrew from treatment, and filed a complaint to the licensing board.
Supervisee posted a picture on Facebook of her apparent drunken behavior at a party stating that she drank all night to get over her fear that she is close to being placed on probation at her site. A peer shared the picture with their supervisor, as the peer was worried about her friend’s drinking in the spirit of professionalism.
Dr. S. is receiving multiple requests to “friend” past and current students he has (or is) supervising. How should he respond?
As you were reading a listserv for a local mental health association you saw a request from your supervisee for consultation on a case you are supervising her on with a large number of details of the case much so that it appeared to be identifiable.
DIGITAL ISSUES

- Consider that younger supervisees and clients are more comfortable with digital and other electronic communications.
- Individuals who are not Facebook friends have access to searchers information on social networking site—also sending emails (in cited case, poems therapist had written) can be misconstrued.
- Sending emails from personal account, late at night—in one case, intimate and sexually suggestive.
  - Subpoenas can include digital and electronic communications.

Reamer, 2017
• Cognizance that email, text messaging, and online posts on social networks leave digital trail, are prone to misunderstanding, and can be used as formal evidence in malpractice suits, licensing board actions, courts, and other queries

• Remote video and telephone counseling; avatars; email therapy—possibility of a 3rd person involved; or recording of sessions —lack of clarity about confidentiality

• Therapist’s friend considering a career in telemental health counseling; therapist invited him to view a recorded session without any consent

• Therapist (or client) conducts online search, discovers client (therapist) religious affiliation and stalks client

• Connecting on Facebook using pseudonym
  • Reamer, 2017
GUIDELINES

- Connect with clients digitally only for professional purposes and only with consent
- Maintain separate professional and personal social media and website
- Avoid posting personal information on professional websites or blogs
- Be aware of shared cultural identities, that may create boundary confusion
- Beware of blog or friend requests
- Avoid providing electronic services to person with whom one has had a personal relationship
- Obtain client consent before electronically searching—except in emergencies— informed consent  Reamer, 2017
QUESTIONS FOR INTERNET SEARCHING

1. Why do I want to conduct this search? (Motivation, Rationale)

2. Would my search advance or compromise the treatment? Harm my client or our relationship? Potentially benefit client?

3. Should I obtain informed consent from the client? If not, why not?

4. Should I share the results of the search with the client? How will I use the information? How will I deal with undisclosed duty to warn if it arises?

5. Should I document the findings of the search in the medical record?

6. How do I monitor my motivations and the ongoing risk/benefit profile regarding searching?

- Modified from Clinton, Silverman, & Brendel, pp. 105–107
EXAMPLES?
LEGAL CONSIDERATIONS

- Informed consent—implied by posting
- Critical questions
- Should social network or search engine info be used:
  - Was there a reasonable expectation of privacy?
  - Is the information credible and reliable?
  - Was the information hearsay? (No ability to assess or ascertain trustworthiness)
- Heightened scrutiny under 14th Amendment Equal Protection and anti-discrimination laws
  - Strict scrutiny for “suspect classifications”
    • E.g., race, national origin, religion

(Zohn, personal communication; Wester et al., 2013)
RECOMMENDATIONS FOR MEDICINE AND HEALTH CARE—A REFRAKE

- (1) Maintain professionalism at all times,
- (2) Be authentic, have fun, and do not be afraid,
- (3) Ask for help
- (4) Focus, grab attention, and engage.
  - Grajales et al., 2015
  - access to educational resources by clinicians, supervisees and clients including blogging
  - generation of content rich reference resources (eg, Wikipedia),
  - evaluation and reporting of real-time disease/mental health trends
  - catalyzing outreach during (public) health campaigns
SUPERVISORY BOUNDARIES

- Boundary Crossing: Deviation from strictest professional role, sometimes part of well-constructed treatment plan
- Boundary Violation: Therapist misuses his/her power to exploit or harm a client
- In internet era, disclosure is redefined
- Lines between personal and professional are blurred
MULTIPLE RELATIONSHIPS (ZUR, 2017)

Military—embedded military psychologists

Unavoidable multiple relationships and conflicts of interest—forensic and administrative roles

Faith, spiritual, and religious communities

Rural communities

Recovery and 12-step
EXAMPLES OF SUPERVISION BOUNDARY CROSSINGS

- Gifts
- Social events
- Lunch
- Touch
- Multiple roles
SEXUAL FEELINGS

• Feeling sexual attraction to client is normative: 88% of psychologists reported feeling at least once in their career Rodolfa et al., 1994; Pope, Sonne, & Greene, 2006

• However, training or supervision not adequate 9%
  • Pope, Keith-Spiegel & Tabachnick, 1986

• Sexual attraction manifested in greater attention to client, distance, distraction, and loss of objectivity

• Only half of supervisees discussed with supervisors; supervisors did not raise
  • Ladany, O’Brien, Hill, Melinoff, Knox, & Petersen, 1997

• Is it “developmentally inappropriate” to discuss countertransference and transference with beginning supervisees?
HIGH RISK BEHAVIORS

- Therapist response to client
- Therapist needs
- Session characteristics
- Accountability

Hamilton & Spruill, 1999
SEXUAL BEHAVIOR

• Sexual advances, seductions, and/or harassment experienced by 3.6 to 48% of psychology and mental health-related students

• 80% or more of mental health educators believe it is unethical/poor practice to engage in sexual contact with a supervisee or student, especially during the working relationship

• 13% of all participants said they would engage in sexual conduct if they knew no one would find out
  • Zakrzewski, 2006
SURVEY OF STUDENTS AND ETHICS

- Many students (53% --n of 223) would not feel safe to pursue action if they had firsthand knowledge of a sexual contact occurring
  - Feared anonymity would not be protected
  - Concerned about repercussions
    - Zakrzewski, 2006
DEALING WITH SEXUALLY INAPPROPRIATE BEHAVIOR

• What to do if supervisee tells you client asked her for a date?
• What if supervisee tells you client told her she was “hot”?
• What if supervisee tells you client told him he wanted to “hook up”?
  • Hartl, Zeiss, Marino, Zeiss, Regev, & Leontis, 2007
RESPONSE TO SEXUALLY INAPPROPRIATE BEHAVIORS

- Discussion with supervisor
- Internal emotional response and self-assessment
  - Feelings, dress, demeanor, boundary setting
- Responses when risk (i.e., to safety) is involved
- Direct responses
  - Conceptualize as
    - Lack of awareness of appropriate social interaction
  - Teach supervisee to respond in ways to teach or shape more appropriate behavior, maintaining collaborative working alliance, responding in a way that does not shame client but encourages more appropriate interactions and reaffirms therapeutic boundaries and is proportionate to the risk represented by the behavior
    - Hartl et al., 2007
QUESTIONS TO ASK IN MULTIPLE RELATIONSHIPS IN SUPERVISION

• Is entering into a relationship in addition to the supervisory one necessary or should the supervisor avoid it?
• Can the additional relationship potentially cause harm to the supervisee?
• If harm seems unlikely or avoidable, would the additional relationship prove beneficial?
• Is there a risk the additional relationship could disrupt the supervisory relationship?
• Can the supervisor evaluate the matter objectively?
  • Adapted from Gottlieb, Robinson, & Younggren, 2007
DECISION TREE SPECIFIC TO INTERNSHIP

• Professional benefit to each
• Personal benefit to each
• Present professional role
• Location of social relationship
  ❑ Intern’s ability to leave social relationship/activity without repercussion
  ❑ Probable impact on uninvolved interns
  ❑ Probable impact on uninvolved staff members
    ❑ Burian & Slimp, 2000
ETHICAL PROBLEM SOLVING

- Additional factors to add
  - Personal responses to ethical issue (first step)—Barret, Kitchener, & Burrus, 2001
  - Role of cultural/ diversity considerations
  - Evaluate the outcome (last step)
ETHICAL DECISION MAKING MODELS

• Determine that the matter is an ethical one.
• Consult available ethical guidelines that might apply to provide a possible mechanism for resolution.
• Consider all sources that might influence the kind of decision you will make.
• Locate and consult with a trusted colleague
• Evaluate the rights, responsibilities, and vulnerability of all affected parties
• Generate alternative decisions
• Enumerate the consequences of making each decision.
• Make the decision.
• Implement the decision.

(Koocher & Keith-Spiegel, 1998, 12-15)
NOT MEETING PROFESSIONAL COMPETENCE STANDARDS
UNPROFESSIONAL BEHAVIOR

• Unprofessional behavior in medical school related to subsequent disciplinary action by state medical boards

• 235 graduates of 3 medical schools disciplined by a state medical board between 1990 and 2003 and 469 control physicians matched by med school and graduation year
  • Use of drugs or alcohol (about 15% of violations)
  • Severe irresponsibility in 8.5% of physicians disciplined by medical boards (0.9 by controls)
Disciplinary action by medical board was strongly associated with prior unprofessional behavior in medical school

- **Severe irresponsibility**
  - Unreliable attendance at clinic
  - Not following up on activities related to patient care

- **Severely diminished capacity for self improvement**
  - Failure to accept constructive criticism
  - Argumentativeness
  - Display of a poor attitude
  - (This and previous slide from Papadakis, Teherani, Banach, Knettler, Rattner, Stern, et al., 2005)
SECOND STUDY

• Two performance measures independently predicted disciplinary action:
  • Low professionalism on Residents’ Annual Evaluation Summary
  • High performance on certification exam predicted decreased risk for disciplinary action

• Both behavioral and cognitive measures during residency associated with greater risk for state licensing board actions
  • Papadakis, Arnold, Blank, Holmboe, & Lipner, 2008
PROFESSIONAL COMPETENCY PROBLEMS

• Ethical imperative to address them—
  • If because of their incompetence or lack of ethical sensitivity—they would inflict harm on consumers they have agreed to help
  • Kitchener, 2000
DEFINITION OF SUPERVISEE WITH PROFESSIONAL COMPETENCY PROBLEMS*—POST REMEDIATION PLANS

- Exhibit interference in their professional functioning as reflected in one or more of the following ways:
  - Inability or unwillingness to acquire and integrate professional standards into professional behavior
  - Inability to acquire professional skills to reach acceptable level of competence.
  - Inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning.

  - Lamb et al., 1987
  - * Elman & Forrest, 2007
SUPERVISEES WITH PROFESSIONAL COMPETENCY PROBLEMS

- Does not acknowledge, understand, or address problem even when addressed
- Problem is not merely skill deficit rectifiable through academic/didactic training
- Quality of services delivered is adversely affected
- *F & S add that a critical dimension is how responsive supervisees are to feedback in general*
SUPERVISEES WITH PROFESSIONAL COMPETENCY PROBLEMS**

- Problem not restricted to one area of functioning
- Disproportionate amount of attention by training personnel required
- Behavior does not change through feedback, remediation, or time
  - Lamb et al., 1987 (includes this and 2 previous slides)

**Trainees with professional competency problems (TPPC)
  » Forrest, Miller, & Elman, 2008
FAILURE TO MEET PERFORMANCE CRITERIA: THINK COMPETENCY-FRAME

• Identify performance not meeting criteria
  – Knowledge
  – Skills
  – Values/Attitudes
  – Intersection of several

  – This will guide you in developing remediation plan
  – Remember that remediation/ actions plans can be a vital part of training
TRAINEEs WITH PROBLEMS OF PROFESSIONAL COMPETENCE (TppC)

• Trainees with problems of professional competence (TPPC) demonstrate behaviors, attitudes, and/or skills that are not consistent with expected ethical or professional standards given their stage of training
  – Elman & Forrest, 2007

• Issues of balancing gatekeeping with educational and training responsibilities contextualizing diversity factors (individual or institutional), ensure diversity competence IS a part of competence
  – Shen Miller, Forrest, & Burt, 2012
COMPETENCY PROBLEMS: EFFECTIVE STRATEGIES

- **Supervisee not meeting competency standards?**
- Early identification, informing supervisee of specific competency areas
- Early documentation: Define behavior and ensure good/specific feedback as early as possible on performance areas
- Consult and collaborate with school, Training Director/Administrative Head, Personnel or Human Resources Department to ensure due process and compliance with all personnel practices
- Propose early remediation plan: develop plan to enhance competencies (consider knowledge, skills, attitude components to improve)
- Develop specific steps to assist development as possible
- Engage in difficult conversations regarding contextual or other issues
- Monitor and track performance ongoing on a time line with *multiple* and ongoing check-ins (use Competency Remediation Plan template [http://www.apa.org/ed/graduate/competency.aspx](http://www.apa.org/ed/graduate/competency.aspx) — (Falender, Collins, & Shafranske, 2009; Forrest et al., 2013)
USE OF PERFORMANCE CRITERIA VERSUS “IMPAIRMENT”.

- Behavior not meeting performance criteria and the ADA Amendments Act (effective January 1, 2009)
- Use of the word “impairment” has been appropriated by the Americans With Disabilities Amendments Act to refer to Individuals with Mental or Physical Disabilities and implies the supervisor regards supervisee as disabled and has initiated an adverse employment action on that basis
- Initiate an interactive process following the supervisee’s voluntary disclosure of disability (ADA now applies). Reasonable accommodations and performance expectations are established.
- A full description and flow chart describing procedure is available in Falender, Collins, & Shafranske (2009).
• A proper course of action when a supervisor or the supervisee and supervisor collaboratively identify areas of substandard performance, that does not appear on track to be meeting performance criteria
  – Communicate the performance areas not meeting criteria to the supervisee with as much specificity as possible, identifying areas of deficit and strength in knowledge, skills, attitudes/values, professionalism, and metacompetence
  – Proceed to differentiate between a normative developmental challenge and need to assess problematic performance
    – Falender, Collins, Shafranske, 2009, p. 243
COMPETENCY PROBLEMS: EFFECTIVE STRATEGIES

- Supervisee not meeting competency standards?
- Identify as part of ongoing monitoring, tracking of competence: notice and process
- *Early documentation: Define behavior (using competencies) and ensure good/specific feedback as early as possible on performance areas
- *Propose early remediation plan: develop plan to enhance competencies (consider knowledge, skills, attitude components to improve)
- Develop specific steps to assist development as possible
- Engage in difficult conversations regarding contextual or other issues
- *Consult and collaborate with school, Training Director/Administrative Head, Personnel or Human Resources Department to ensure due process and compliance with all personnel practices
  - (Falender, Collins, & Shafranske, 2009; Forrest et al., 2013)
REMEDIATION PLANS: STEPS

• Clarity about competencies expected, remediation, confidential limits and protections
  • Competency-based, collaborative with supervisee, legally informed, with collaboration across levels of training (e.g., grad school to internship, internship to post-doc)—instilling meaning, direction, and hope
  • Use of behavioral indicators and clear behavioral objectives, strength-based, building on existing competencies (knowledge, skills, and attitudes parsed)—behavioral clarity of what “remediated” behavior would entail, support for progress
  • Clarity of time frame, frequent check-ins to address progress, and clarity on confidentiality of plan
    • Falender & Shafranske, 2017; Vacha-Haas et al., 2018
POSSIBLE INTERVENTIONS

- Collaborate with graduate program
- Increase supervision with same or other supervisors
- Change format, emphasis and/or focus of supervision
- Recommend personal therapy
- Reduce or shift trainee workload
- Require academic coursework
- Recommend, if appropriate, leave of absence or second internship or traineeship
NEXT STEPS

- Probation (in writing)
- Stipulate how role/function changes during probation
- Review due process
- Formal Action
- Termination

  - Lamb et al., 1987
SELF-CARE
SELF-CARE AS ETHICAL IMPERATIVE

- “Pursuit of technical competency has much to recommend it, but it might inadvertently subordinate the value of the personal formation and maturation of the psychologist”
  - Norcross & Guy, 2007, p. 5

- Distress can lead to decreases in functioning—burnout—depersonalization, emotional exhaustion and lack feelings of satisfaction/accomplishment

- Clinical work with victims of trauma or violence leads to vicarious traumatization or compassion fatigue
  - Barnett, 2007

- When supervisors model self-care supervisees report more positive quality of life
  - Goncher et al., 2013
SELF-CARE—VALIDATED NEW SELF-CARE SCALE

• Three factor scale
  • Cognitive-emotional-relational aspect of self-care (allow self to laugh; meaningful connections with others)
  • Physical aspect of self-care (taking time away from work, daily behaviors like diet and exercise)
  • Spiritual aspect of self-care, mindfulness, activities for greater good
    • Santana & Fouad, 2017
SELF CARE

- Monitor self feeling states—feeling overwhelmed—pay attention
- Take a breather
- Ensure supervisees feel comfortable disclosing personal responses to supervisors – safety and space to address and reflect on how it is impacting their clinical work, relationships with clients
- Supervisors modeling self-care (for example, taking time for lunch)
  - Berger & Quiros, 2015
- Self-reflection regarding response to client trauma and self-compassion (Use Neff Self Compassion Scale)
- Self-monitoring evoking self-criticism—prevents self-compassion
HIGH RISK AREAS

- Supervisees and suicide of clients
  - Rates—
    - 40% of psych trainees experienced client suicide or serious attempt (Kleespies et al., 1993)
    - The earlier in training, the more severe impact, enduring consequences

- Other risks
  - Half of all psychotherapists are threatened, harassed or physically attached by a client at some point in one’s career
    - Leading to greater vulnerability, decrease in emotional well-being
      - Summarized in Norcross & Guy, 2007

- Supervisee perspective: “Don’t forget about me”
  - Spiegelman & Werth, 2005
SURVIVAL VS. FLOURISHING?

- Survival—focus on status-quo and preventing negative vs. Flourishing—resilience-building attitudes and positive mindset
- Intentionality and flexibility to change—establish self-care practices with overarching positive orientation
- Reciprocity—generalizes to client – and we add to supervision process—dynamic exchange of beneficial lifestyle attitudes
- Self-care strategies integrated into rather than added on! Mindfulness based practices and principles
  - Wise, Hersh & Gibson, 2012
Self-compassion has been defined as, “being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one’s inadequacies and failures, and recognizing that one’s experience is part of the common human experience” (Neff, 2003, p. 224).

- From Johnson et al., 2014
RECOMMENDATIONS
(DERIVED FROM JOHNSON ET AL., 2011; 2014)

• See oneself as vulnerable to distress, impairment, and reduced competence (Johnson et al. 2008)

• Emphasize self-awareness, self-care, and the utter normalcy of periods of diminished competence and model self-assessment, vigilance for personal and professional dysfunction

• Provide models for help-seeking, and peer support and consultation

• Engagement in collegial discussions buffer impact—in context of competence constellation
  – Warning signs of difficulty concentrating on client, strong antipathy to clients, missing sessions, sleep difficulty
FACILITATING FACTORS

- Faculty value for self-care and modeling—directly and indirectly related to graduate trainee quality of life...creating a culture of self-care--promoting management of distress and potential interference with functioning of supervisee.

- Effective: valuing the person of the psychotherapist, refocusing rewards of the, recognizing occupational hazards, attending to the body, supportive relationships, setting boundaries, cognitive restructuring, healthy escapes, creating a flourishing environment, personal psychotherapy, cultivating spirituality and mission, and fostering creativity and growth.

  - Norcross & Guy, 2007; Goncher et al., 2013
DEALING WITH FEELINGS IN TRAUMA WORK

- Risk for vicarious traumatization—experiencing PTSD symptoms similar to those of victimized clients
  - Somatic, nausea, headaches, intrusive thoughts, sleep disturbance, emotional numbing, personal vulnerability)
- Such reactions more frequent for less experienced clinicians
- Risk of therapist who are parents of young children
- Chronic exposure leads to hopelessness and helplessness
- To address:
  - Time off
  - Ability to talk about experiences
  - Support from peers and colleagues
  - Supervision related to difficult and painful encounters
  - Recognition of quality of therapist work
    - Osofsky, 2004
COMPASSION FATIGUE

- Component of vicarious traumatization and burnout
  - Requires self-care of managing caseload, limiting compassion stress, dealing with traumatic memories
  - Empathic strains include
    - Over-identification and avoidance
    - Stories told by children are so painful therapist wish to prematurely solve problems and bring closure which may result in limited success, failure or early termination of therapy
    - Rescuing the family—interferes with effectiveness of interventions—and as therapist feels overwhelmed and helpless, leads to withdrawal from client, limited treatment success, failure, premature termination
    - Burnout more likely when therapist is isolate, overwhelmed with work, has little supervision, and experiences little progress or success with the work—and this can work cyclically

- Osofsky, 2004
PREVENTING VICARIOUS TRAUMATIZATION

• Countering isolation (personally, professionally, spiritually)
• Developing mindful self-awareness
• Consciously expanding perspective to embrace complexity
• **Empathic engagement**
• Active optimism
• Holistic self-care
• Maintaining clear boundaries
• Exquisite empathy
• Professional satisfaction
• Creating meaning
  – Harrison & Westwood, 2009

Master therapists—how they sustain personal and professional well-being
SPIRALS OF POSITIVE AND NEGATIVE DEVELOPMENT

+ POSITIVE

• Currently experienced growth
• Overall career development
• Healing involvement
  • Effective, constructive, affirming relationships
• Professional development resources

- Negative

• Currently experienced depletion
• Limited overall career development
• Stressful Involvement
  • Difficulties in tx, avoidance coping, anxiety & boredom
• Lack of work setting support & satisfaction

Orlinsky & Ronnestad, 2005
<table>
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<tr>
<th>+</th>
<th>POSITIVE</th>
<th>-</th>
<th>Negative</th>
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<tr>
<td></td>
<td>Breadth and Depth of case experience</td>
<td>Narrow range of case experience</td>
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<td>Continuous professional reflection</td>
<td>Premature “closure” to experience</td>
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<td></td>
<td>Multiple theoretical perspectives</td>
<td>Scant sense of therapeutic mastery</td>
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<td>Sense of assurance, resourcefulness, flexibility</td>
<td>Sense of awkwardness, insecurity, defensive rigidity</td>
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Orlinsky & Ronnestad, 2005
CAREER-SUSTAINING STRATEGIES

• Higher satisfaction respondents
  • Vary work responsibility
  • Use positive self-talk
  • Maintain balance between personal and professional lives
  • Spend time with partner/family
  • Take regular vacations
  • Maintain professional identity
  • Turn to spiritual beliefs
  • Participate in CE activities
  • Read literature to keep up to date
  • Maintain sense of control over work responsibilities
    • Stevanovic & Rupert, 2004
JOYS OF PRACTICE/SUPERVISION

- Hitting a bulls-eye of success with supervisee/client
- Promoting growth in client/supervisee
- Enjoyment of work
- Challenge and continuing to learn
- Professional autonomy/independence
- Increased self-knowledge
- Personal growth
- Being a role model and mentor
  - Derived from Kramen-Kahn & Hansen, 1998; Skovolt, 2001
CREATING A CULTURE/COMPETENCE
FOUNDATIONAL COMPETENCIES OF EFFECTIVE CONSTELLATION COLLEAGUES

- Authenticity and self-awareness. The ability to access and express one’s thoughts and feelings.
- Other-oriented empathy. The ability to understand others’ experiences and perspectives and a genuine concern for the welfare of others.
- Vulnerability and nondefensiveness. The ability to admit the limitations of one’s knowledge, skill, and attitudes combined with an openness to help and to feedback without marked loss of self-esteem.
- Self-care. The ability to model personal health and emotional wellbeing (Norcross & Guy 2007).
- Fluid expertise. The ability to transition easily from expert to learner to allow mutual influence and maximize collaboration.
- Collegial assertiveness. The ability to initiate difficult conversations as an expression of care, a desire to deepen the relationship, and a commitment to promote self and colleague competence (Jacobs et al., 2011)
  — Johnson, Barnett, Elman, Forrest, & Kaslow, 2013
EFFICACY OF A COMPETENCE CONSTELLATION

- Constellation Diversity
- Strength of ties
- Initiatory behaviors

- Most important is the inner core—small nucleus of mentors and colleagues
- Collegial competencies authenticity and self-awareness, other-oriented empathy, vulnerability and nondefensiveness, self-care, fluid (reciprocal) expertise, and collegial assertiveness
  - Johnson et al., 2014
TRANSFORMATIONAL LEADERSHIP
TRANSFORMING TO COMPETENCY-BASED SUPERVISION

- A process entailing transformational leadership
  - Committed leadership team develops a vision
  - Training occurs to enhance knowledge, skills, and attitudes of competency-based supervision
  - Intensive team building sessions to enhance competencies and foster and support change
  - Ensuring use of competency-based supervision at all levels, reinforcement at meetings, in supervision, etc. with ongoing feedback, anchored in competencies, support and reinforcement of positive examples for implementation

  - Kaslow, Falender, & Grus, 2012
What steps do you have to take to move towards competency-based clinical supervision?
TRANSFORMING SKILL SETS: SUPERVISOR AS LEADER

- Transactional versus transformational leadership
  - Application to clinical supervision

- Identify ways you currently supervise and think of ideas you learned you can incorporate to enhance your supervision experience and that of your supervisees!

- Supervision is fun, creative, and fosters development and productivity

- Creates environment of caring, shared objectives, and productivity
Thank You! And Happy Supervising!