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CLINICAL SUPERVISION FOUNDATIONS
Part Two:

Participant Workbook

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PREFACE:

Welcome! This workshop is the second part of a three-part training course covering the foundations of clinical supervision. Designed for supervisors in substance use disorder (SUD) treatment and recovery settings, the course totals 30 hours and introduces clinical supervisors (and persons preparing to become supervisors) to the knowledge and skills essential to the practice of supervision.

You have already completed the 14-hour online portion of the course. There you were introduced to theories, definitions, roles, issues and practices germane to developing supervisory skills. This workshop is also 14-hours and provides you an opportunity to deepen your understanding of key issues and actually practice supervisory skills. The third part of the course is a 2-hour worksite assignment which includes a review of clinical supervision competencies, a self-evaluation, and the creation of a personal plan to continue developing proficiency in clinical supervision. The assignment is made at the conclusion of the Part 2 workshop.

The objectives for this workshop include facilitating the development of a personal model of supervision and practicing skills helping shape the delivery of high quality, effective clinical services to those seeking assistance for substance use disorders. Each of the seven modules comprising the workshop is aimed at preparing you to observe job performance, provide feedback and coaching, prioritize learning needs, develop achievable learning objectives, and continue monitoring performance to assess effectiveness.

When you complete the workshop, including the Part 3 worksite assignment, you will receive a formal certificate for 16 hours of continuing education. The total of 30 hours for the entire course meets the minimum education requirements of several clinical supervision credentialing organizations. Our hope is that the course prepares you to implement a program of clinical supervision which is mutually beneficial to you, your supervisees, and ultimately, the clients and patients you serve.

We hope what you learn here will be valuable, challenging, and interesting. Best wishes for a great training experience!

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INTRODUCTIONS:

PURPOSE

This module provides a forum for participants and trainers to begin getting to know one another and an opportunity for participants to share expectations. The module also provides an orientation to the course, including an overview of course assumptions and a review of the agenda.

LEARNING OBJECTIVES

Participants will be able to:

1. Get to know the trainer and other participants.
2. Identify personal expectations for the course.
3. Clarify course assumptions.
4. Review the course agenda.

COURSE ASSUMPTIONS

Clinical supervision is a unique professional relationship that all counselors experience in their career. Clinical supervision is most effective when it becomes “a mutual endeavor of clinical oversight and professional development” (Durham, 2003, p. 1). Unfortunately, much of what is labeled as clinical supervision lacks this mutuality and developmental focus. We agree with the viewpoint of Bernard and Goodyear (1998) who classify supervision as “an intervention in its own right” (p. 1) and that a breadth of knowledge exists about clinical supervision among the helping professions. However, we also agree with Powell (2004) who notes supervisory training has been scarce, particularly in the substance abuse field. The primary goal of this course is to give professionals a firm foundation upon which they can learn from this breadth of knowledge and build an effective clinical supervisory practice. This foundation includes some basic assumptions about clinical supervision essential in one’s practice as a clinical supervisor. The following is a list and description of these assumptions:

1. Relational issues – The relationship between counselor and supervisor is a vital component of a counselor’s clinical work and his or her contribution to client outcome.

2. Direct observation – Supervisors who observe the work of counselors have a far better grasp of counselors’ strengths and areas for potential growth as opposed to those who do not provide direct observation.

3. Counselor self-efficacy – Counselors who develop a positive supervisory relationship tend to have higher levels of self-efficacy. A study by one of the authors showed direct observation often leads to an increased level of comfort in the supervisory relationship and hence higher self-efficacy (Durham, 2003).

INTRODUCTIONS:

COURSE ASSUMPTIONS cont.

4. Solution-based and strength-based supervision – Another contributor to self-efficacy in supervision is a solution or strength-based approach whereby the supervisor helps the counselor build on his or her successes and/or strengths such that a higher level of motivation is fostered thus further establishing a positive supervisory relationship.

5. Needs-based approach – Counselors differ in relation to culture, experiences, expertise, interests, education, and familiarity with research and best practices. As a result, clinical supervision should be tailored to individual counselor's needs and should be the result of an ongoing assessment.

6. Outcome-oriented supervision – Supervisors must offer a blend issues such as evidence-based practices, skills enhancement, and educational opportunities that focus on goals for professional growth for the counselor while pursuing outcome-oriented treatment for the client.

7. Evidence-based practices – Supervision is the ideal venue for promoting and developing clinical skills necessary to provide practices that have been shown, through research, to influence positive client outcome.

8. Individualized supervisory model – Due to differences in philosophy, culture, training and other idiosyncrasies, it is important that each supervisor develop his or her own unique model of clinical supervision.

INTRODUCTIONS:

COURSE AGENDA

TRAINING TOPIC	MODULE	DESCRIPTION
DAY ONE		
Introductions	INTRODUCTORY MODULE	Introductions, expectations, and course overview
Roles and Definitions	MODULE 1	The competing roles of the clinical supervisor
A Personal Model of Supervision	MODULE 2	Begin defining our own approach to supervision
The Supervisory Alliance	MODULE 3	Characteristics and challenges to an effective alliance
Supervisory Modalities and Methods	MODULE 4	Selecting and building support for your preferred style of clinical supervision
DAY TWO		
Assessment Resources	MODULE 5	*Addiction Counseling Competencies* and the *Performance Assessment Rubrics*
Performance Evaluation	MODULE 6	Assessing counselor proficiency; providing performance feedback; structuring supervisory interviews
Counselor Development	MODULE 7	Cultural and Contextual Consideration; Preferred Learning Styles; Negotiating a Professional Development Plan

MODULE 1: Roles and Definitions of Clinical Supervision

PURPOSE

This module provides participants the opportunity to examine their current (or anticipated) supervisory practice and preferences in terms of the definitions, responsibilities, and roles of clinical supervision covered in the online course.

LEARNING OBJECTIVES

Participants will be able to:

1. Define the primary goals of their own clinical supervision practice.
2. Identify discrepancies between their current (expected) supervisory practice and their ideal and some of the causes for these discrepancies.
3. Analyze their own supervisory practice using the definitions, responsibilities and roles of the clinical supervisor covered in the online course.
4. Identify barriers when trying to balance these roles and responsibilities.

DESCRIBE YOUR CLINICAL SUPERVISION

Write the answer to:

1. **What are you trying to accomplish in your work as a clinical supervisor?**

2. **What tasks take up (or will take up) most of your supervision time?**

3. **If you could choose how to spend your supervision time, what tasks you would spend your time on?**

4. **What discrepancy exists between your answer to #2 and #3?**

MODULE 1: Roles and Definitions of Clinical Supervision

DEFINITION OF CLINICAL SUPERVISION

SAMHSA's TAP 21-A (2007), as reviewed in the online portion of this course, defines clinical supervision as:

- A social process occurring over time in which supervisor participates with supervisees to ensure quality care

- Effective Supervisors:
  - Observe
  - Evaluate
  - Mentor
  - Coach
  - Build teams
  - Promote self-motivation, learning, professional development
  - Create Cohesion
  - Resolve conflict
  - Shape agency culture
  - Address ethical & diversity issues

- Such supervision is key to both quality improvement and the successful implimentation of consensus and evidence-based practices.

How do your responses to how you spend your time and how you wish you could spend your time as a clinical supervisor compare to the definition above?

GOALS OF CLINICAL SUPERVISION

There are four primary goals of clinical supervision:

1. Promoting professional growth and development through teaching
2. Protecting the welfare of clients through observation and mentoring
3. Monitoring counselors' performance as a "gatekeeper" through observation and evaluation
4. Empowering counselors to engage in continuous professional development

> To achieve these goals will require balancing the various responsibilities and roles of a clinical supervisor.

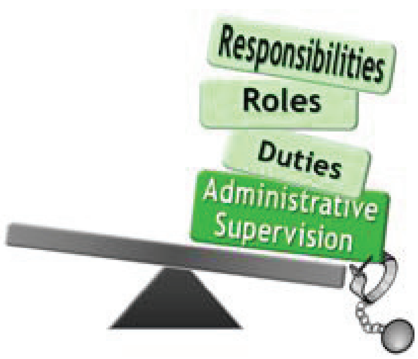
MODULE 1: Roles and Definitions of Clinical Supervision

CLINICAL, ADMINISTRATIVE, & EVALUATIVE RESPONSIBILITIES

In the online course, you reviewed the various responsibilities of clinical supervisors.

The **clinical** focus in supervision is on improving the skills and effectiveness of the supervisee as a counselor. To satisfy clinical responsibilities you:

- Identify needs
- Instruct
- Model
- Give feedback
- Consult with the counselor



The **administrative** element of clinical supervision focuses on following, and helping the counselor follow, the administrative and procedural aspects of the agency's work. Administrative supervision tasks include:

- Selecting, hiring, and firing personnel
- Structuring staff work
- Formally evaluating personnel for pay and promotions
- Planning, organizing, coordinating, and delegating work

Evaluation is central to both clinical and administrative responsibilities:

EVALUATION CLINICAL	EVALUATION ADMINISTRATIVE
Continuously evaluate the counselor's performance, knowledge and skills, strengths and deficiencies, needs, attitudes, and development.	Ensure compliance with correct formats for documentation, agency leave policies, scheduling and coverage, performance reviews, and contractual expectations.

DISCUSSION

Thinking of the seesaw graphic, in which direction does your balance tip?

What do you like doing most?

How does what you do compare to the "push" in your agency?

MODULE 1: Roles and Definitions of Clinical Supervision

CLINICAL SUPERVISOR ROLES

Clinical supervision is a complex, multi-component process. It includes a multifaceted relationship between a supervisor and a counselor. As a result, effective clinical supervisors assume multiple roles. The following roles were addressed in the online portion of the course. Included here are a few examples of the activities carried out within these roles:

TEACHER

- Provide an intensive learning experience
- Promote professional development
- Expand connections between personal interest and continual learning

COACH

- Provide non-clinical counseling
- Give support and encouragement
- Offer discrete affirmation

CONSULTANT

- Help solve problems
- Monitor ethical and legal issues
- Protect both clients' and agencies' interests

MENTOR

- Be a role model
- Provide direction and guidance
- Challenge with acceptance

EVALUATOR

- Help set goals
- Conduct performance reviews
- Promote and demonstrate excellence

Adapted from Haynes, Corey, & Moulton (2003)

ANSWER

1. **Which roles do you imagine yourself emphasizing in your supervision?**

2. **What are the barriers you face when trying to balance these roles?**

MODULE 2: A Personal Model of Supervision

PURPOSE

In this module you will review a number of models for clinical supervision and begin to articulate your own model.

LEARNING OBJECTIVES

Participants will be able to:

1. Articulate characteristics of various models that can be applied to clinical supervision
2. Describe the theoretical concepts upon which your own personal approach to clinical supervision is based
3. Begin to define your own model of supervision

THEORETICAL FOUNDATIONS

1. **How does counseling help people change?**

2. **What are the necessary ingredients for change?**

3. **What model of change are you most attracted to?**

MODULE 2: A Personal Model of Supervision

MODELS OF CLINICAL SUPERVISION

All good models are based on a specific philosophy. One of the many parallels between counseling and supervision follows the concept that what is useful in promoting change with clients will likely foster change with supervisees. As we discuss the following theories, you will likely find one or more that fits for you and your style of supervision.

The following reviews the predominant models of clinical supervision under four categories and illustrates the primary features of each model:

1. COMPETENCY-BASED MODELS

Focus on skills, learning needs and current knowledge of the supervisee. They include:

Discrimination Model (Janine Bernard)

- Developed originally as a teaching tool
- Three areas of focus: intervention, conceptualization, and personalization
- Three supervisor roles: teacher, counselor, consultant
- Choosing which area of focus and which role to utilize with each supervisee are crucial to the success of the relationship and progress of the supervisee

Skills/Behavioral Models (Alan Ivey)

- Microtraining
- Teaching skills and extinguishing inappropriate behaviors
- Modeling and reinforcement by the supervisor
- Skills monitoring and feedback
- Role-playing

Task-Oriented Model (Eugene Mead)

- Manipulation of behavioral variables
- Reinforce counselor behavior
- Not tied to a therapeutic orientation

MODELS OF CLINICAL SUPERVISION cont.

2. TREATMENT-BASED MODELS

Psychodynamic Model of Supervision

The primary focus of the psychodynamic models is on the supervisee's increase of self-awareness of his or her intrapersonal and interpersonal dynamics with the supervisor and clients (Haynes, Corey, & Moulton, 2003). This may include the examination of the dynamics of a therapeutic relationship between the supervisee and his or her client and how the counselor's own feelings may block insight and growth. Psychodynamic supervision was extensively documented by Ekstein and Wallerstein (1972) who described supervision as a learning process with an emphasis on relationship dynamics, particularly the supervisory relationship. This relational focus includes the resolution of conflict, seen as a benefit to the supervisee in preparation for future work with clients (Bernard & Goodyear, 1998). Other significant factors include:

- Focus on supervisee – the dynamics and on his or her own self-awareness of these dynamics; the supervisor's looks somewhat like that of a "therapist" who encourages insight, self-exploration and reality testing
- Transference and countertransference – help to understand one's own reactions to client and to client's transference
- Influence of client-counselor reactions on the course of therapy
- Unresolved personal conflicts – supervision is therapeutic in that issues such as internal conflicts are explored as they relate to clinical work
- Parallel process – the counselor's interaction with the supervisor that parallels the client's behavior with the counselor. By exploring parallels the counselor may gain an understanding of the role personal issues play in the supervisory relationship

Person-Centered Model of Supervision

The person-centered model is based on the assumption of self-direction in one's life and the ability to solve problems without interpretation and direction from the supervisor (Haynes, Corey, & Moulton, 2003). The originator of person-centered therapy, Carl Rogers, saw clinical supervision as a central concern and was among the first to involve tape-recording of client sessions (Bernard & Goodyear, 1998). Other significant factors include:

- Influence of the relationship – the relationship is the basis for self-understanding; outcome hinges on the quality of the relationship
- Modeling
- Personal growth and exploration – shaping behavior, nurturing feelings through a climate of safety and trust
- See-saw between experiential and didactic
- Personal issues/countertransference – "a therapeutic process of shaping counselor's personality/behaviors"

2. TREATMENT-BASED MODELS cont.

Cognitive-Behavioral Model of Supervision

This model evolved from behavior therapy. It focuses on beliefs, assumptions, and thoughts of the supervisee, and their impact on emotion and behavior (Haynes, Corey, & Moulton, 2003). Cognitive behavior supervision involves challenges to the supervisee's cognitions, but with a focus on learning in order to master the techniques to be utilized with clients (Bernard & Goodyear, 1998; Liese & Beck, 1997). To summarize:

- Challenge cognitions and misperceptions
  - Identify cognitive distortions and irrational assumptions
  - Identity self-defeating patterns that affect client care as well as the counselor's growth
  - Goal of modifying cognitions; focus of supervisee's cognitive picture of his or her skills
  - Focus on beliefs and thoughts and how they affect emotions and behavior
  - Assume that both adaptive and maladaptive behaviors are learned and maintained through their consequences
- Adult learning theory
  - Recognition of everyone's potential to learn; supervisor becomes a teacher
  - Focus on the "how" counselor's cognitive picture of his or her skills affect his or her ability as a counselor
  - Supervisee becomes familiar with cognitive-behavioral concepts and techniques and learns how to apply them with clients
- Modeling and observation – supervisor demonstrates cognitive-behavioral methods
- Assignments – supervisor gives "homework" assignments
- Supervision is structured, focused, and educational
- Supervision parallels counseling with a client

Family Therapy Model of Supervision

Clinical work based on this model typically involves the supervision of a family counselor and his or her work with a family as a system (Haynes, Corey, & Moulton, 2003). This evolved out of Murray Bowen's work and his concept of differentiation of self (the psychological separation of intellect and emotion and independence of the self from others). In the classic family therapy supervision model, the supervisory relationship is seen as a system and is much like family therapy in that it is active and collaborative (Liddle, Becker, and Diamond, 1997). This model also encourages self-examination of one's own family dynamics. Included are variations of the classic family therapy model such as those of Salvadore Minuchin and Jay Haley, both of whom play down self-examination and dwell more on teaching techniques and tactics (Powell, 2004). Haley and Minuchin differ from each other in how counselors are trained and supervised. For example, Minuchin's structural family therapy supervision includes an understanding of theory behind the techniques (Munuchin & Fishman, as cited by Powell, 2004). In the case of Haley's strategic family therapy, supervision is isomorphically like strategic family therapy itself: It is directive and outcome-oriented with pre-planned action-oriented strategies (Powell, 2004). Depending on the specific model of supervision for in family therapy, the following may be included in supervision:

MODELS OF CLINICAL SUPERVISION cont.

2. TREATMENT-BASED MODELS cont.

- Active, directive, collaborative – it is very much like family therapy itself
- Self-examination of intergenerational dynamics – examining one's own intergenerational dynamics, values, and cultures
- A dynamic supervisory relationship – supervisor relationship is seen as a system whereby the change to one person in the system brings change in others
- Counselor is encouraged to understand the development of his or her own family dynamics and identify patterns such as enmeshment, detachment, and triangulation
- Genograms, family history, and family sculpting are all utilized in this family-of-origin approach to supervision as a means to train therapists to work with families
- A philosophy that adheres to the notion that a therapist's reaction clients' stories will bring to light old patterns of familial behavior and unresolved family issues (Getz & Protinsky, 1994).
- Other techniques used: circular questioning, reframing, boundary setting, assignments, pro-actively planned strategies.

Feminist Model of Supervision

The feminist model is based on the underlying philosophy of being flexible, interactional, and lifespan-oriented. Emphasis is on the fact that gender-role expectations have a profound influence on both male and female identity from birth onward (Haynes, Corey, & Moulton, 2003). The process of supervision includes openness, egalitarianism and a clear understanding of the process of supervision. The supervisee is seen as an active partner in his or her professional growth and, as in the therapeutic relationship, puts gender and power at the core of the supervisory process (Corey, 2001).

- Presents a unique approach to supervision by acknowledging how individuals have been socialized to accept gender roles
- Questions many assumptions in the counseling profession, such as the fact that most psychotherapeutic theories were created by White men and based on Western culture
- Gender-fair – takes the position of equality between the sexes to enhance an active partnership in learning in the supervisory (as well as clinical) relationship
- Individual and social change – aims to replace the current patriarchy to create a society of interdependent, cooperative, and mutually supportive relationships
- Egalitarian relationship – strives for an equalization of the power base between supervisor and supervisee
- Empowered relationship – supervisory relationship is based on empowerment
- Collaborative spirit – a collaborative model of supervision that leads to an empowered relationship characterized by a sense of safety
- Minimization of hierarchy – by being grounded in the value of a collaborative interaction

3. DEVELOPMENTAL MODELS

The Integrated Developmental Model (IDM)

This model, based originally on the work of Cal Stoltenberg and Ursula Delworth, acknowledges that counselors go through different stages of growth in their professional development. It provides a framework for understanding the appropriate approach to take with a counselor based on his or her level of development as a counselor. This model follows a three-stage approach and acknowledges growth across eight performance domains, assessed each on three overriding structures (self and other awareness, motivation and autonomy).

4. INTEGRATED MODELS

There are multiple approaches to clinical supervision that can be characterized as integrative approaches. These include the Solution-Oriented Model, the Motivational Interviewing approach, and Powell's Blended Model of Supervision.

The Solution-Oriented Model of Supervision

The primary goal of the Solution-Oriented Model is to seek solutions by focusing on what is working and to get the supervisee to stop focusing on real or imagined deficiencies (deShazer, 1988). The solution-focused supervisor takes on a consultative and cooperative role.

- Creating narratives and visions – goal-setting through visions of future growth
- Constructing solutions – focusing on positive growth, not dwelling on the problem
- Emphasizing success – acknowledge success and encourage more success
- Cheerleading – encouragement to continue positive path
- Focusing on salient issues – the supervisor encourages success by focusing on what is working; a recognition that there is no such thing as resistance, only a difference in goals and perspective
- Identifying exceptions – a method of encouragement by refraining from focusing on problems and instead pointing to when the problem is not occurring, such as exceptions
- Future orientation – focusing on goals set for the future and devising a plan to reach them
- Externalizing the issue – reframing a problem as a means of depersonalizing it; getting the individual to look at the problem objectively and from an external position
- Goal setting – working with the counselor to develop goals as a component of a plan for professional development
- Boundary profiling – asking the individual to rate himself or herself, both now and in the future, on a scale from 1 to 10. Then set goals by identifying what steps need to be taken to move from current rating to future rating (e.g., what it will take to go from a 3 to an 8)
- The "miracle question" – asking a counselor to imagine that he or she woke up one morning and everything in his or her life was exactly how they wanted it to be. Ask him or her to describe it and set goals that would have to be reached to fulfill the vision

MODELS OF CLINICAL SUPERVISION cont.

4. INTEGRATED MODELS cont.

Motivational Interviewing (MI)

Although technically not a therapeutic model but an interdisciplinary approach (Miller & Rollnick, 2002), MI can be quite effective in developing effective supervisory relationships and in promoting self-motivation for supervisees.

Research has identified ways in which approaches can help to increase the likelihood of facilitating and enhancing motivation for adopting healthy behaviors.

- Focus on competencies. Enhancing motivation for change requires clinicians to identify, enhance, and use the supervisees' strengths and competencies. This involves supporting and strengthening their self-efficacy and encouraging their optimism that change is achievable.
- Provide person-centered interventions. Research demonstrates greatest improvement when interventions are individualized for each person and when there is an emphasis on individual choice and personal responsibility for change—by providing a menu of options.
- Establish therapeutic partnerships for change. Rather than supervisees passively receiving clinical supervision, motivational enhancement involves partnerships in which the supervisor and counselor agree on goals and work together to develop strategies designed to meet those goals.
- Use empathy not power. Research demonstrates that positive outcomes are associated with high levels of clinician empathy reflected in warm and supportive listening, and an optimism that change is possible.
- Conduct early interventions. The focus has shifted to providing interventions in early stages of problem behaviors. This includes providing motivational interventions with individuals who are not yet aware that they have a problem, meaning that interventions can be conducted while one's resources are robust.

Transtheoretical Change Theory

Motivation is best understood as a process rather than an outcome or a static state (DiClemente & Scott, 1997; DiClemente, 1999; Prochaska, DiClemente, & Norcross, 1992). The change process is a sequence of stages through which people progress as they think about, initiate, and maintain new behaviors (Prochaska & DiClemente, 1984).

You can be helpful at any point in the change process by using motivational interventions specific to the one's stage of change.

- **Precontemplation.** At this stage, individuals are not yet considering change or are unwilling or unable to change.

MODULE 2: A Personal Model of Supervision

4. INTEGRATED MODELS cont.

- **Contemplation.** At this stage, individuals may perceive that there is cause for concern and reasons to change. However, they are ambivalent and simultaneously have reasons to change and not change.

- **Preparation.** Individuals perceive the advantages of change, and perceive that the adverse consequences of certain behaviors outweigh the perceived benefits of those behaviors. The decisional balance tips in favor of change, and commitment to change emerges. Preparation involves planning for change and examining one's capabilities for change.

- **Action.** The client is actively taking steps to change but has not yet reached a stable state. Individuals in this stage choose a strategy for change and begin to pursue it.

- **Maintenance.** During this stage, individuals make efforts to sustain gains achieved during the action stage.

Powell's Blended Model of Supervision

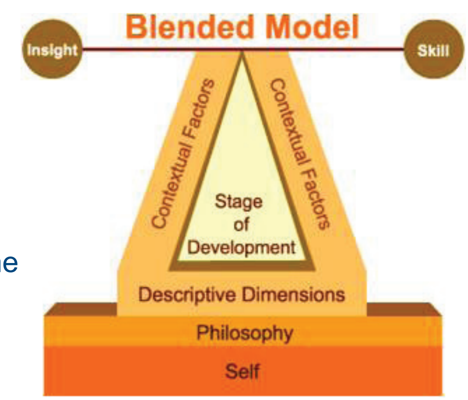
Here the emphasis is on insight and behavioral change, the change process, individual needs, and solutions (Powell and Brodsky, 2004).

- Blend of insight and behavioral change – supervision requires a blending of understanding of why something works and learning how to do it (blending of skills and theory)
- Change is constant and inevitable – everyone changes at his or her own pace, but everyone does change
- Developmental needs –acknowledgment of the stages of counselor development to build a supervisory relationship based on unique needs
- Context plays a role – when deciding an approach to take in supervision context must be taken into account
- Individualized approach – Everyone has unique needs and responds best to interventions that meet those specific needs
- Explore solutions, not causes – focus on the salient issues to avoid dwelling on the problem, resulting in higher self-efficacy and esteem

Powell's model is based on the following concepts:

- People have the ability to change with the help of a guide
- A guide concentrates on what's changeable
- People don't always know what's best for them – denial
- Change is constant
- Key is to blend insight and behavioral change in right amounts/time
- Knowledge of causes is not necessary to resolve the problem
- There are many correct ways to see the world

Adapted from Powell (2004)



MODULE 2: A Personal Model of Supervision

DEVELOPING A PERSONAL MODEL OF SUPERVISION

During the course of this course you will have an opportunity to document your beliefs and preferences regarding how you practice clinical supervision. Please answer the following questions and we will add to them as we move through the workshop.

1. **What supervisory model type are you most attracted to?**

2. **What about the model is attractive?**

3. **Some of your foundation beliefs:**

    a. **What is the purpose of supervision?**

    b. **What is the key role of the supervisor?**

    c. **What are the primary tasks of the supervisee?**

    d. **What methods do you prefer to use in supervision?**

MODULE 3: Supervisory Alliance

PURPOSE

This module introduces participants to the importance of an effective supervisory alliance, factors that influence the alliance, and methods to address weaknesses and failures in the supervisory relationship.

LEARNING OBJECTIVES

Participants will be able to:

1. Understand the value of a positive supervisory alliance.
2. Describe the concept of parallel process in relation to the supervisory alliance.
3. Identify key factors which strengthen or compromise the supervisory alliance.
4. Recognize conflict in supervision, and identify methods to minimize or resolve conflict.

SELF-INVENTORY

Choose the response that best describes your current thoughts regarding each statement using the five-point scale:

1 = Strongly agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly disagree

____ 1. A positive and productive relationship between the supervisor and supervisee is essential if supervision is to be effective.

____ 2. As a supervisor, it is acceptable to me to become socially involved with a supervisee who seems more like a colleague to me.

____ 3. I believe that I can be an effective supervisor even though I may not like my supervisee.

____ 4. A supervisor's primary responsibility is to develop an atmosphere conducive to learning.

____ 5. The methods a supervisor uses are more important to the outcomes of supervision than is the quality of the supervisory relationship.

____ 6. As a supervisor, I would rarely engage in self-disclosure with my supervisee.

____ 7. Supervision is an appropriate context for supervisees to express and explore their fears, concerns about their performance, and their self-doubts.

____ 8. I believe that many trainees have keen insights, useful reactions, and insightful intuitions that they keep to themselves because they doubt themselves.

____ 9. I think courage is not the absence of any performance anxiety; rather, courage involves identifying and challenging those fears.

____ 10. To the degree supervisees are unaware of their needs and personal dynamics, they are likely to use their work mainly to satisfy their unmet needs.

____ 11. As a supervisor, I will strive to develop collegial and collaborative relationships with my supervisees.

____ 12. As a supervisor, I would want to be personal and disclose my professional experiences with my supervisees, when appropriate.

____ 13. I believe supervisors need to take a personal interest in their supervisees as well as their cases.

Adapted from ETP, 2002

MODULE 3: Supervisory Alliance

FORMING A POSITIVE SUPERVISORY ALLIANCE

Trust

If clinical supervision is to facilitate genuine staff development, the process requires considerable trust by the supervisee and supervisor. Clinical supervision operates only within an environment of trust.

- Respect and a sense of safety must be present for trust to exist
- Trust gives the counselor confidence (respect) and freedom to take risks without fear of judgment (safety)

Increased self–efficacy

Several research studies have shown that the strength of the supervisory alliance is a source of increased self-efficacy by the supervisee (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Chen & Bernstein, 2000; and Cashwell & Dooley, 2001). These studies have all also concluded that a strong working alliance in supervision leads to:

- Increased comfort by the supervisee
- A higher level of motivation for continued growth
- Greater satisfaction with the role as a counselor
- Positive impact on counseling performance.

CHALLENGES TO THE SUPERVISORY ALLIANCE

BOUNDARY ISSUES/DUAL RELATIONSHIPS

Extending the boundary beyond supervision potentially complicates the relationship. Dual relationships occur when individuals assume two roles simultaneously or sequentially with a person seeking help (or being supervised).

EXAMPLES:

- Sponsoring a supervisee in AA
- Developing a business relationship with a supervisee
- Supervising a family member
- Supervising an intimate partner
- Allowing supervision to slip into psychotherapy. Therapeutic boundary can be inadvertently crossed due to the supervisor's experience as a therapist.

"A good clinical supervisor is a therapist doing supervision— not a supervisor doing therapy."

MODULE 3: Supervisory Alliance

POWER AND AUTHORITY

What is power? What is authority? What are their roles in clinical supervision and how do they contrast with leadership?

- **Power** is the ability to influence or control others (Kadushin, 1992).
- **Authority** is the right to control others (Kadushin, 1992)
- **Leadership** is the ability to use authority to make others powerful (Zander, R.S. & Zander, B., 2000)

THE SUPERVISORY RELATIONSHIP AS AN INTERPERSONAL PROCESS:

As is true of a therapist-client relationship, the clinical supervision relationship can give rise to transference and counter-transference. In addition, supervisor triads can develop.

- **Transference** can occur in the supervisory relationship when a counselor unconsciously shifts feelings to the supervisor which are displacements from reactions to others.
- **Counter-transference** can occur when a counselor loses objectivity with a client due to unresolved personal issues triggered by clients. It can also occur as a reaction toward the counselor by the supervisor.

What is a **parallel process?**

Parallel process describes the supervisee's interaction with the supervisor that frequently parallels the client's behavior with the supervisee in the role of counselor (Ekstein & Wallerstein, 1972). It is a common phenomenon of the dynamics in supervision replicating those that occurred or are occurring in the supervisee' relationship with a client.

- It may be helpful for supervisors to pay attention to and explore forms of parallel process in supervision
- Awareness alone does not eliminate it; supervisor can serve as a model to demonstrate how to respond to clinical issues that the supervisee is mirroring in supervision
- The counselor learns how to respond to the client as the supervisor responds to the supervisee
- Counselor gains an understanding of the client's issues as he/she becomes aware of parallels

MODULE 3: Supervisory Alliance

CONFLICTS BETWEEN SUPERVISOR AND SUPERVISEE:

Conflicts between Supervisor and Supervisee:
People have different beliefs, perceptions, and ways of thinking and behaving. Thus, conflict is part of life and will occur within clinical supervision.

- Conflict is a natural part of all relationships.
- Relationships are strengthened by “working through” conflict.
- Resolution is reached with listening, understanding, and working to clarify the ground rules of the relationship.
- Stalemates are reached when both parties act as if they are right and the other is wrong—each expecting the other to change.
- Since the supervisor has more power than the supervisee, conflicts can easily occur in supervision.

SUPERVISING THE “RESISTANT” COUNSELOR:

A common issue in clinical supervision is a counselor who is resistant to supervision. When working with counselors who appear to be resistant consider the following factors which might precipitate counselor hesitancy to participate in supervision:

- Uncertainty about the purpose of supervision
- Lack of trust in the supervisor
- Absence of structure in supervisory meetings
- Fear of criticism
- Hesitancy to take risks

MODULE 3: Supervisory Alliance

CHALLENGING SITUATION SCENARIOS EXERCISE

SCENARIO 1 - BOUNDARY ISSUES

You are now supervising someone you were close to as a peer.

1. **What are the advantages and disadvantages?**

2. **What are potential problems?**

3. **How would you manage it?**

SCENARIO 2 - POWER AND AUTHORITY

During the past year, because of staff turnover, the capacity to do periodic reviews has been mitigated. You going to be doing an annual review with a supervisee who is consistently late from hour lunch break, late in their charting, and 60% of their clients have dropped out in first 30 days of care.

1. **What would be some examples of a supervisor overusing/abusing their power and authority?**

2. **What might cause the supervisor to underutilize their power and authority?**

3. **How will the fact that the persons' compensation package for the year will be influenced?**

4. **What are healthy guidelines for managing power and authority?**

MODULE 3: Supervisory Alliance

SCENARIO 3 - INTERPERSONAL RELATIONSHIP

Imagine yourself as a 45-50 year old supervisor and your supervisee is 28-30 year old of the opposite sex.

1. **What potentially impacts the supervisory alliance?**

2. **How might a supervisor abuse his/her power and authority because of emotional reaction to supervisee?**

3. **What would your responses be if supervisor and supervisee were:**

- **Same age and same gender**

- **Same age and different gender**

- **Same age, same gender, different sexual orientation**

MODULE 3: Supervisory Alliance

SCENARIO 4 - CONFLICT

Imagine yourself in supervisory relationship where:

- Supervisor believes in empowering clients to take responsibility for their own recovery
- Supervisee believes in providing guidance to help the client avoid making mistakes that will interfere with their recovery

1. How might these differences impact the supervisory relationship?

2. What are special considerations supervisor will have to give to establish a successful supervisory alliance?

3. What guidelines would you suggest for managing these ideological differences?

SCENARIO 5 - RESISTANCE

A supervisee's former supervisor was highly critical, directive, and constantly disappointed in the supervisee's performance. Now in new supervisory relationship, the supervisee is hesitant, afraid of criticism, of taking risks, and of being observed. Even though the supervisee is achievement oriented, there seems to be a strong fear of failure. The supervisor notices the resistance to supervision and is trying to communicate that making mistakes and taking risks are a natural part of the learning process.

1. What does the supervisor have to attend to in this situation to enhance the alliance?

2. How can the supervisor reassure the supervisee?

3. How would the needs of this type of supervisee impact the supervisor's expectations and how the relationship will develop?

4. What are some guidelines for managing resistant counselors?

MODULE 4: Supervisory Modalities and Methods

PURPOSE

Next we will identify several modalities for conducting clinical supervision and discuss how to decide which is most appropriate for the supervisee. We will review methods that have application no matter which modality you choose to use, emphasizing the value of direct observation as a primary source of performance feedback.

LEARNING OBJECTIVES

Participants will be able to:

1. Define when to use each of three different modalities to establish a productive learning environment.
2. Describe at least three different methods of gathering first-hand supervisee job performance information.
3. List several methods for individual and group supervision.
4. Build enthusiasm for observation-based supervision.

MODELS OF CLINICAL SUPERVISION

In the online *Clinical Supervision Foundations* course you were introduced to four basic orientations:

Competency-based models – focused primarily on the learning needs of the supervisee and building needed skills.

Treatment-based models – limited to enhancing supervisee understanding and skill in using a specific theoretical approach to treatment.

Developmental approaches – facilitated counselor growth based on professional stage of development

Integrated models – focused on addressing skill, competency and affective needs of the counselor, often related to the implementation of evidence-based practices.

No matter which orientation you use, there are a number of methods available to you, depending on your style, personal preference, and needs of the supervisee.

MODULE 4: Supervisory Modalities and Methods

MODALITIES

The modality you choose for clinical supervision is optimally decided based on individual counselor needs. You do not need to limit the supervision you provide to one modality. A questionnaire to help you decide on the most appropriate modality was presented in the online course and is reprinted below.

Supervision Modality Decision Questionnaire

1. **Is the counselor seeking credentialing that mandates a particular modality or number of hours of clinical supervision?**

2. **Does the counselor have previous counseling experience?**

3. **Is the counselor working with an unfamiliar situation or particularly difficult case?**

4. **Could other counselors benefit from the experience (growth and learning) of this counselor regarding a similar issue?**

5. **Is the counselor part of a group of counselors you supervise that have similar needs?**

6. **Would group supervision benefit *every* counselor in the group?**

7. **Has the counselor had considerable counseling experience and clinical supervision?**

8. **Would this experienced counselor benefit from observing and collaborating with other experienced counselors?**

The decision about which modality might best serve a counselor rests on a variety of factors, including the needs of the counselor, her experience, the needs of other supervisees and the nature of the client caseload. All might be taken into account when deciding the type of supervision most appropriate to the needs of the counselor, the clients and the agency.

MODULE 4: Supervisory Modalities and Methods

Three of the most frequent modalities for providing clinical supervision are individual, group, and peer supervision.

1. **Individual:** The supervisor works one-to-one with the supervisee

- Objectives – professional skill development individualized to supervisee and agency needs.
- Frequency – labor-intensive, time-consuming method with meeting frequency determined by the needs of the supervisee, can be mixed with group supervision meetings
- Structure – individual is the most typical form of clinical supervision. First-hand observations are the basis of job performance feedback which fosters an agenda for skill development and conformity to agency standards.
- Advantages – tailor the process to individual needs, promotes a closer relationship between supervisor and supervisee
- Disadvantages – labor intensive, time consuming

2. **Group:** Supervisor meets with a group of supervisee peers

- Objectives – team building, staff development, skill practice
- Frequency – cost effective format can include weekly meetings plus periodic tutorial meetings with individual supervisees
- Structure – recommended group size is four to six supervisees; activities can include case discussion, role-playing, in-service training, and review of recorded group and individual counseling sessions.
- Advantages – multiple perspectives, team building, saves time, cost-effective
- Disadvantages – may not meet all needs, discomfort, can be competitive

3. **Peer:** Experienced counselors review each other's work in absence of supervisor

- Objectives – accountability to peers and personal development
- Frequency – determined through collaboration with peers and management
- Structure – one-to-one or group meetings featuring case presentations, review of recorded or observed counseling sessions, and literature review/discussion.
- Advantages – effective with small groups who have limited time
- Disadvantages – potential "history" or conflicts between group members

MODULE 4: Supervisory Modalities and Methods

CASE STUDIES

Referring back to the issues raised in the Supervision Modality Decision Questionnaire, decide which modality you think would be most appropriate in each of the following situations? How frequently should the counselor be involved in clinical supervision activities? What are the needs you perceive that lead you to those decisions?

1. Alex is a credentialed counselor who has worked at an outpatient agency for four years after receiving his Associates degree in human services with an emphasis in addiction counseling. He is a valued member of the treatment team and has consistently met the terms of his employment contract. He is now, together with other members of the clinical staff, preparing to implement a new cognitive-behavioral clinical protocol for DUI offenders. The protocol includes teaching, group facilitation and skill building exercises with which he is not familiar.

- **Which modality(s) of supervision might best fit for this staff member?**

- **How frequently should the counselor be engaged in supervision activities?**

- **What are the needs, either stated or implied, that lead you to make that decision?**

2. Hana is an entry-level counselor who shows great promise. She develops excellent rapport with her clients and is eager to continue her professional development. The agency encourages the use of motivational interviewing methods and Hana has requested assistance in improving her MI skills and appears open to recording her interviews.

- **Which modality(s) of supervision might best fit for this staff member?**

- **How frequently should the counselor be engaged in supervision activities?**

- **What are the needs, either stated or implied, leading you to make this decision?**

MODULE 4: Supervisory Modalities and Methods

CASE STUDIES cont.

3. Evan is a Masters level social worker who works mostly with criminal justice clients. He is part of a multi-disciplinary team working to engage and retain clients in cognitive-behavioral treatment for at least 90 days. Evan's philosophy of treatment is that clients should be expected to demonstrate a willingness to participate and a readiness to change behavior. If the client is resistant Evan is in favor of discharging the client and expresses impatience at the team's hesitancy to do so.

- **Which modality(s) of supervision might best fit for this staff member?**
- **How frequently should the counselor be engaged in supervision activities?**
- **What are the needs, either stated or implied, that lead you to make that decision?**

4. DeLynn is one of four counselors who have been with the agency over 10 years. She is an accomplished therapist who is self-motivated and enjoys working with the most difficult women clients. She is a respected member of the staff and enjoys managing or trying to resolve challenging situations. She has no interest in becoming a supervisor or manager because she much prefers direct service as compared to more administrative tasks.

- **Which modality(s) of supervision might best fit for this staff member?**
- **How frequently should the counselor be engaged in supervision activities?**
- **What are the needs, either stated or implied, leading you to make this decision?**

DISCUSSION NOTES:

METHODS IN SUPERVISION

A variety of methods are available to you as a supervisor no matter which modality you choose. The online course differentiated indirect (verbal, written, case consultation) and direct (live and recorded observation). Your preferences, experience, understanding of supervisee needs, agency policies and your familiarity with supervisory literature will all determine the choices you make. Let's consider one of the least used but increasingly important methods, direct observation.

DIRECT OBSERVATION

In general, direct observation will provide you the most accurate data about supervisee knowledge, skills and attitudes. Direct observation includes:

1. **Live observation during a clinical session can be:**
    a. In vivo – the supervisor sits in the session to observe. Rules regarding participation need to be established beforehand
    b. Co-therapy – the supervisor co-facilitates the session after having reviewed the purpose and clarifying the supervisor's role prior to the session

2. **Observation through a one-way mirror can be used to:**
    a. Provide peer or supervisor feedback during a debriefing
    b. Make observations and suggestions through an electronic bug-in-the-ear during the session

3. **Audio-Video recording can be used to facilitate:**
    a. Self-observation with or without the presence of the supervisor
    b. Peer or supervisor feedback based on observations made in reviewing the session
    c. Practice of specific skills

ANSWER

1. **Which indirect and direct method(s) do you prefer?**

2. **What are the drawbacks to the use of any of your preferred direct and indirect methods?**

3. **What hesitancies do you have about direct observation?**

MODULE 4: Supervisory Modalities and Methods

INDIVIDUAL AND GROUP SUPERVISION

Some other methods that fit within individual and group supervision:

INDIVIDUAL METHODS

When meeting one-to-one with supervisees a few methods that can be useful in addition to providing feedback based on direct observation include:

1. Role play – following instruction or mentoring the supervisor and counselor can role play as practice and an opportunity to shape counselor skill
2. Interpersonal process recall – as part of reviewing a recording, the supervisor can facilitate the counselor's recall of thoughts, feelings, or strategies employed during the session
3. Motivational interviewing – can be utilized by the supervisor to facilitate supervisee identification of professional development objectives

GROUP METHODS

When peers meet together with the supervisor multiple opportunities exist for professional development, including:

1. Case consultation – supervisees can be asked to make formal case presentations followed by collaboration with peers
2. Team or peer feedback – recordings can be reviewed and discussed, with an opportunity for supervisees to request or offer feedback based on direct behavioral observation
3. Skill practice – in-service training, counseling role-play, and group facilitation can all be practiced when supervisees meet together as a group with their supervisor.

NOTES FROM GROUP DISCUSSION

Experience with individual supervision:

Experience with group supervision:

Factors that influencing the use of individual or group supervision:

METHODS FOR BUILDING SUPPORT AND ENTHUSIASM

Several ideas for helping supervisees see the value and look forward to observation-based feedback are presented in TIP 52 (pp. 35-44). Some of those ideas and a few others are described briefly here:

1. Present the rationale for clinical supervision: Summarize these benefits:
   a. Administrative,
   b. Clinical,
   c. Professional development, and
   d. Program evaluation and research.

2. Help counselors get comfortable with live observation:
   a. Acknowledge their anxiety,
   b. Listen reflectively and attend to their concerns,
   c. State that observation is part of the way the agency does business, and
   d. Coach counselors on how to present the idea of recording or observation to clients.

3. Clarify how observations will be dealt with in supervisory sessions:
   a. Offer of behavior-based feedback,
   b. Identify clinical strengths and opportunities for continued development,
   c. Collaborate on professional development plans, and
   d. Increase self-awareness and impact of self on others.

4. Volunteer to be recorded or observed first:
   a. Take the risk of being first,
   b. Be open to feedback from staff and demonstrate vulnerability,
   c. Solicit comments and ideas from counselors, and
   d. Model acceptance by committing to trying out a suggestion

5. Acknowledge that supervision is a required condition of employment:
   a. Supervision is an ethical and legal responsibility of both agency and staff,
   b. Every counselor is evaluated and has a professional development plan,
   c. Periodic observation is the only way to gather objective first-hand information, and
   d. Job performance assessment using clear criteria is intended to help foster professional growth and continuous improvement of client services.

MODULE 4: Supervisory Modalities and Methods

DISCUSSION

1. **What might concern supervisees most about being observed and being given feedback on their counseling skills?**

2. **What assurance or clarification would be most effective in relieving supervisee anxiety or resistance to being observed directly or via a recording?**

DEMONSTRATION AND PRACTICE NOTES:

MODULE 5: Assessment Resources

PURPOSE

This module examines tools and strategies supervisors can use to help trainees improve performance as they move thought the developmental stages and emphasizes the importance of fostering an effective learning environment that facilitates individualized and continuous professional development.

LEARNING OBJECTIVES

Participants will be able to:

1. Understand the value of a developmental perspective.
2. Link *TAP 21: Addiction Counseling Competencies* to the companion *Performance Assessment Rubrics*.
3. Assess counselor performance and develop learning goals using the *TAP 21: Addiction Counseling and the Performance Assessment Rubrics*.

THE INDIVIDUAL DEVELOPMENTAL MODEL (IDM) OF CLINICAL SUPERVISION

The foundation of the developmental model of supervision is the concept that people are continuously growing and that growth is not linear but sporadic. Growth can be affected by changes such as caseload, treatment setting, supervisory relationship, and population served. Based on their experiences, people develop strengths. Clinical supervisors can help supervisees to identify areas for potential growth. And, as supervisees gain experience, supervisors and the supervisory relationship change. Thus, there are developmental trends and patterns in clinical supervision.

- Acknowledgment of development level: three levels of growth
- Multidimensional
- Continuous growth
- Focused individual

Eight growth areas

Clinical supervisors can help supervisees identify their own strengths and growth areas. Doing so helps supervisees assume an active role in their own long-term professional growth and development. Stoltenberg and McNeill (2009) identify eight growth area domains for supervisees:

1. Intervention skills competence
2. Assessment techniques
3. Interpersonal assessment
4. Client conceptualization
5. Individual differences
6. Theoretical orientation
7. Treatment plans and goals
8. Professional ethics

Three levels of supervisees

Stoltenberg and McNeill (2009) conceptualize a developmental model with three levels of supervisees: *beginning, intermediate, and advanced.* Within each level, they noted a trend to begin first in a rigid, shallow, imitative way and then move toward more competence, self-assurance, and self-reliance for each level. In particular, they identified three overriding structures for professional growth that counselors move through towards mastery:

- Self- and other awareness
- Motivation
- Autonomy

MODULE 5: Assessment Resources

USING THE RUBRICS & COUNSELING COMPETENCIES

On the next pages you will find:

- Rating scale for the Screening Competencies (*Rubrics:* Practice Dimension I - Element 1, pg. 120)
- Rubric for Competency 24 (*Rubrics:* Element 1: Screening, pg. 33)
- Knowledge, Skills, and Attitudes which comprise the foundation for Competency 24.

Think of a specific supervisee (or counselor) for whom Competency 24 has been a challenge.

1. Use the rubric for Competency 24 to assess and rate the counselor's proficiency.
2. Use the KSA breakdown from TAP 21 to identify areas issues for improvement related to knowledge, skill, or attitude.
3. Choose a partner in your small group. Have him/her pretend to be your supervise, and explain your assessment end of sentence ADD:of the counselor's proficiency in Competency 24.
4. Propose one or two learning goals for your supervisee to consider based on the KSAs.
5. Summarize the discussion.
6. Exchange roles and repeat the exercise.

PRACTICE DIMENSION I: CLINICAL EVALUATION > Element 1: Screening

Rating Scale for Screening Competencies. From *Performance Assessment Rubrics, p. 120* .

1 = AWARENESS **2** = INITIAL APPLICATION **3** = COMPETENT PRACTICE **4** = MASTERY

Practice Dimension I: **CLINICAL EVALUATION > Element 1: Screening**	RATING
★ 24. Establish rapport, including management of crisis situation and determination of need for additional professional assistance.	
25. Gather data systematically from the client and other available collateral sources, using screening instruments and other methods sensitive to age, developmental level, culture, and gender. At a minimum, data should include current and historical substance use; health, mental health, and substance-related treatment histories; mental and functional statuses; and current social, environmental, and or/economic constraints.	
26. Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and coexisting mental health problems.	
27. Assist the client in identifying the impact of substance use on his or her current life problems and the effects of continued harmful use or abuse.	
28. Determine the client's readiness for treatment and change, as well as the needs of others involved in the current situation.	
29. Review the treatment options appropriate for the client needs, characteristics, goals, and financial resources.	
30. Apply accepted criteria for diagnosis of substance use disorders in making treatment recommendations.	
31. Construct with client and appropriate others an initial action plan based on client needs, preferences, and resources available.	
32. Based on initial action plan, take specific steps to initiate an admission or referral and ensure follow-through.	

Think of a supervisee or counselor. Using the Rubrics and Competency KSA's below:

- Rate your "supervisee" on this competency.
- Identify learning goals.

Performance Assessment Rubrics

Element 1: Screening

24. Establish rapport, including management of a crisis situation and determination of need for additional professional assistance.		SUPERVISOR	COUNSELOR
AWARENESS	Describes effective methods for establishing rapport and managing the initial contact with persons who may be in crisis.	1	1
INITIAL APPLICATION	Demonstrates effective engagement skills, including the ability to recognize crisis situations.	2	2
COMPETENT PRACTICE	Effectively establishes rapport in a variety of situations including crises and potentially volatile circumstances.	3	3
MASTERY	Uses rapport building skills in managing crisis situations and establishing an effective working relationship with persons who may be in need of immediate professional assistance.	4	4

From *TAP 21: Addiction Counseling Competencies,* p.39.

COMPETENCY 24:

Establish rapport, including management of a crisis situation and determination of need for additional professional assistance.

KNOWLEDGE

- Importance and purpose of rapport bulding.
- Rapport-building methods and issues.
- The range of human emotions and feelings.
- What constitutes a crisis.
- Steps in crisis prevention and management.
- Situations and conditions for which additional professional assistance may be necessary.
- Available sources of assistance.

SKILLS

- Demonstrates effective verbal and nonverbal communication is establishing rapport.
- Accurately identifying the client's beliefs and frame of reference.
- Reflecting the client's feelings and message.
- Recognizing and defusing volatile or dangerous situations.
- Demonstrating empathy, respect, and genuineness.

ATTITUDES

- Recognition of personal biases, values, and beliefs and their effect on communication and the treatment process.
- Willingness to establish rapport.

MODULE 5: Assessment Resources

LEARNING STYLES

Chart #2 Effective Teaching Techniques for Each Learning Modality

VISUAL	AUDITORY	KINESTHETIC
Guided imagery Demonstrations Copying notes Highlighting key ideas in notes Flash cards Color coding Diagrams/Charts/Graphs/ Photos/Movies/TV Mind maps/Acronyms	Auditory tapes Reading Aloud Oral instructions Lectures Repeating ideas orally Poems/Rhymes/Word association Group discussion Music/Lyrics TV	Experiments Role play/Acting scenes out Games Problem-solving Writing notes Making lists Physical examples Associating emotions with concepts

From Northwest Frontier Addiction Technology Transfer Center. (2005, August). Counselor as educator-Part 2: Learning styles-teaching styles. *Addiction Messenger, 8* (8), p.3.

TAILORING SUPERVISION TO INDIVIDUALIZED LEARNING NEEDS

Counselors differ in relation to experiences, expertise, interests, education, and familiarity with research and best practices. As a result, clinical supervision should be tailored an individual counselor's needs, and should be the result of an ongoing assessment. To do so, effective clinical supervisors must take the time to understand the individualized needs of each counselor. To provide needs-based clinical supervision, effective supervisors do the following:

- Focused support for counselors at each level of professional development
- Continually assess counselor needs
- Facilitate mutual outcome-oriented planning and goal setting
- Recommend training opportunities for counselors
- Assist in developing a career ladder and career path for workforce development

MODULE 6: Performance Evaluation

PURPOSE

Reinforce performance evaluation as an essential component of clinical supervision. Identify issues that potentially affect evaluation, and then present and practice methods for assessing counselor proficiency, providing feedback and collaborating on a professional development plan.

LEARNING OBJECTIVES

Participants will be able to:

1. Identify importance of on-going, timely, and objective performance evaluation to both the supervisee and the agency.
2. List a number of methods for monitoring counselor job performance.
3. Provide performance-based feedback to the supervisee.
4. Structure supervisory interviews to be of most benefit to the supervisee and the agency.

ROLE OF PERFORMANCE EVALUATION

Performance evaluation serves the following functions:

1. Provides a process by which job performance and professional development can be assessed within the context of a supportive alliance between supervisor and supervisee.
   a. Supervisor authority is acknowledged and accepted.
   b. Assessment methods are clear and predictable.
   c. Supervisory relationship is marked by trust and collaboration
   d. Criteria for successful job performance and professional development are clearly defined

2. Links counselor performance with criteria and methods for evaluation.
   a. Criteria for successful performance are clarified as part of the counselor's work plan.
   b. Methods used for assessing performance and their relationship to the criteria are clear and agreed upon by both supervisor and counselor.

3. Engages supervisees in a process of continuous learning and development.
   a. Continuous professional development is a value and an ethical responsibility.
   b. Performance evaluation is an ongoing process not a periodic event
   c. Evaluation can be formative and/or summative.

4. Assures staff conformity to agency mission, delivery of quality services, and protection of client safety.
   a. Evaluation serves the client, the supervisee and the agency
   b. Observation, feedback, and the development of knowledge, skills and attitudes consistent with quality care are integral to achieving positive clinical outcomes.

MODULE 6: Performance Evaluation

CASE STUDY

Tony is a 28 year old Mexican American seeking outpatient treatment for alcohol and heroin addictions after being confronted by his girlfriend, Laura. Recently unemployed as a car salesman due to absenteeism, Tony's sole source of support is Laura. They live together with her two children. His drug and alcohol use began at age 13 prior to moving from Mexico with his mother. His mother has supported him in the past but is now refusing to have anything to do with him since he took all her jewelry and money to purchase drugs.

Laura indicated she is afraid of Tony and wants him to leave her home. He frequently becomes violent when drinking and her children, ages three and 11 are afraid of him. Tony denies any violent behavior but states a willingness to find a place of his own. Laura plans to loan Tony enough money for his first month's rent.

Tony reports being diagnosed with hepatitis-C and diabetes. He has been prescribed several medications which Laura has been paying for through her insurance. He has no resources to purchase the meds himself. His affect seems quite flat and he reports that the only positive things happening in his life are the feelings he gets from shooting dope.

Megan is the counselor who did the initial assessment of Tony, which was audio recorded as a routine procedure. In playing back the interview, the supervisor noted Megan seemed to establish good rapport early in the interview, and Tony readily acknowledged a need for help. He discussed his drug use openly. However, he could not identify any ideas for how to help himself or what he should do next. His personal goals were vague and he did not seem particularly concerned about the future.

Megan seemed uncertain about how to facilitate an exploration of Tony's current needs and any vision he might have for the future. Her inquiry about available social supports was brief and cut short when Tony became upset in describing his mother's refusal to help him. He denied the need for medical care and seemed hesitant to seek public assistance and unemployment benefits. Megan scheduled Tony for another appointment the following week, at which time she said they would develop a treatment plan. Tony left with no plans for the interim.

MODULE 6: Performance Evaluation

QUESTIONS REGARDING THE CASE STUDY

1. **As a supervisor, what concerns might you have about Tony and how the counselor managed this interview?**

2. **What positive feedback could you provide the counselor?**

3. **What feedback about your concerns would you give to the counselor?**

4. **What strategy or tactic might the supervisor use to identify alternatives for managing the situation and expanding the counselor's knowledge or skills?**

MODULE 6: Performance Evaluation

METHODS FOR MONITORING PERFORMANCE: A REVIEW

Direct Observation

In general, direct observation will provide you the most accurate data about supervisee knowledge, skills and attitudes. They can, however, be supplemented with client and peer evaluations of counselor performance. Direct observation includes:

1. **Live observation** during a clinical session can be:
   a. In vivo – the supervisor sits in the session to observe. Rules regarding participation need to be established beforehand
   b. Co-therapy – the supervisor co-facilitates the session after having reviewed the purpose and clarifying the supervisor's role prior to the session
2. **Observation through a one-way mirror** can be used to:
   a. Provide peer or supervisor feedback during a debriefing
   b. Make observations and suggestions through an electronic bug-in-the-ear during the session
3. **Audio-Video recording** can be used to facilitate:
   a. Self-observation with or without the presence of the supervisor
   b. Peer or supervisor feedback based on observations made in reviewing the session
   c. Practice of specific skills

Individual methods

When meeting one-to-one with supervisees a few methods that can be useful in addition to providing feedback based on direct observation include:

1. **Role play** – following instruction or mentoring the supervisor and counselor can role play as practice and an opportunity to shape counselor skill
2. **Interpersonal process recall** – as part of reviewing a recording, the supervisor can facilitate the counselor's recall of thoughts, feelings, or strategies employed during the session
3. **Motivational interviewing** – can be utilized by the supervisor to facilitate supervisee identification of professional development objectives

Group strategies

When peers meet together with the supervisor multiple opportunities exist for professional development, including:

1. **Case consultation** – supervisees can be asked to make formal case presentations followed by collaboration with peers
2. **Team or peer feedback** – recordings can be reviewed and discussed, with an opportunity for supervisees to request or offer feedback based on direct behavioral observation
3. **Skill practice** – in-service training, counseling role-play, and group facilitation can all be practiced when supervisees meet together as a group with their supervisor.

MODULE 6: Performance Evaluation

INTEGRATIVE ACTIVITY

Based on the information in the Case Study presented at the beginning of this module and the assumptions you make about the counselor's performance, please record your responses to these requests:

1. **Imagine giving Megan feedback on the assessment interview. What issues seem most important for discussion?**

2. **Using the *Rubrics* document, read through the rubrics for Dimension I - Screening and Assessment (p. 33-41), and Dimension II – Treatment Planning, (p. 42-49). Identify 1-3 competencies that might be targeted for improvement. Note both the number and the essence of each competency you select below.**

MODULE 6: Performance Evaluation

GIVING AND RECEIVING FEEDBACK

Basic Concepts:

1. What we observe in a counselor's work and how we interpret it is based on our own assumptions about the counselor's actions and our expectations regarding preferred job performance.

2. When we give feedback to a supervisee it is important that we be able to describe and explain our assumptions and expectations so that the supervisee can understand "where we are coming from."

3. Sharing and comparing expectations allows us to communicate effectively, to collaborate better, and to open the door to constructive, voluntary change.

4. Because feedback is often experienced as criticism, we can easily be too brief, rushing through what we want to share and not being clear, resulting in misunderstanding.

5. Clarifying and verifying mutual understanding between two parties is necessary to confirm that what was intended was received and understood. A head nod is not sufficient.

Feedback Defined:

Feedback is any overt response, verbal or nonverbal, that gives specific and subjective information to a person about how her or his behavior in a particular situation affects someone or something.

The Objective:

Transmit reliable information so that a person receiving it can establish a "data bank" from which to change behavior if she/he chooses to do so.

THE ORAL MODEL – THE 1ST STEPS IN GIVING FEEDBACK

O Observe:
Observe and record behavioral information.

R Report:
Repeat in specific, objective, behavioral terms as factually as possible what was seen and/or heard.

A Assume:
Share your assumption or belief about the behavior you just described. What did you think the person was thinking or trying to accomplish. What assumptions are you making about the person's motivation?

L Level:
Describe your feelings and how the other person's behavior affected you and others, including the "bottom line" expectations and long term consequences, if needed.

THE MODEL SOUNDS LIKE THIS:

"When I saw (heard) you...
I assumed (thought)...
and my reaction was.."

ADDING THREE MORE PARTS TO THE BASIC MODEL

- Start by asking permission to share some feedback
- Request playback of the message, either before the feedback or immediately after
- Confirm mutual understanding after accurate playback

ORAL PROCESS

1. Ask permission
2. Report behavior observed
3. Relate assumptions
4. Share your feelings and concerns
5. Report impact on clients, colleagues, agency
6. Request playback of message sent
7. Clarify misunderstandings and omissions
8. Confirm mutual understanding

FEEDBACK OBSERVATION CHECKLIST

1. **Was permission asked of supervisee?** ________ yes ________ no

2. **Did the supervisor cite specific behavior?** ________ yes ________ no

3. **Did the supervisor describe the behavior in the following terms:**

   a. **Specific and factual?** ________ yes ________ no

   b. **Observable?** ________ yes ________ no

4. **Did the supervisor share assumptions about what was observed?** ________ yes ________ no

5. **Did the supervisor describe the impact of the observed behavior?** ________ yes ________ no

6. **Did the supervisor state the potential impact of that behavior on clients, colleagues, and the agency as a whole?** ________ yes ________ no

7. **How did the supervisor ask for playback?**

8. **How do you know the supervisee and supervisor had a mutual understanding?**

MODULE 6: Performance Evaluation

PREPARING FEEDBACK

1. **What have you observed that merits providing job performance feedback? Be specific. What exactly did you hear or see that was noteworthy. Describe the who, what, when, and where of the situation.**

2. **What assumptions did you make about your observation? What did you think was going on? What do you think the person's beliefs, assumptions or motivations were in the situation?**

3. **What was the result, the potential impact or the ramification of what you observed?**

4. **What was your personal reaction, thought, feeling, belief about what you observed? How did it impact you?**

5. **Is there a change or improvement you are hoping the counselor will make? What is it?**

MODULE 6: Performance Evaluation

STRUCTURING SUPERVISORY INTERVIEWS

Definition
The Supervisory Interview is a structured communication process with a clearly definable purpose: to enable the counselor to improve job performance.

Purpose
1. To create an atmosphere and provide a structure which facilitates bi-directional feedback, teaching, learning and evaluation.
2. To improve the quality and effectiveness of client services.

Focus
The focus in clinical supervision is on the development of supervisee knowledge, skills and professional attitudes.

STEPS IN THE SUPERVISORY INTERVIEW

	OBJECTIVES	TOOLS
STEP 1: **Set Agenda**	Provide structure Decrease anxiety Foster trust, rapport, partnership	Give agenda Prioritize Set time frame
STEP 2: **Give Feedback**	Empower supervisee* Individualize supervision	ORAL model
STEP 3: **Teach and Negotiate**	Confirm common understanding of the performance issue Negotiate agreement on importance of this issue and establish a performance objective	Motivational skills Active listening Paraphrasing
STEP 4: **Secure Commitment**	Determine interest, willingness to change Clarify expectations, responsibilities Create mutual accountability	Clarification skills Asking for a commitment

* Empower means to create a relationship which elicits, guides, supports, validates and respects the other's individual and autonomous thoughts and behaviors; therefore allowing the individual *the choice* to communicate and act freely and *safely* without fear of retribution.

SUPERVISORY INTERVIEW OBSERVATIONS

	STATEMENTS/BEHAVIORS	COMMENTS
STEP 1: **Set Agenda**		
STEP 2: **Give Feedback**		
STEP 3: **Teach and Negotiate**		
STEP 4: **Secure Commitment**		

MODULE 6: Performance Evaluation

PREPARE TO CONDUCT A BRIEF SUPERVISORY INTERVIEW

1. **What is the performance issue?**

2. **What behaviors or observations do you want to cite as part of the performance issue?**

3. **What is your preferred outcome for the interview?**

MODULE 6: Performance Evaluation

DEBRIEFING A SUPERVISORY INTERVIEW

1. **How did the supervisor do following the structure?**

2. **What was the impact of the agenda setting portion of the interview?**

3. **What was the impact of providing behavioral feedback?**

4. **What are the strengths and weaknesses of the ORAL model?**

5. **What was the impact of verifying that the counselor understood the feedback as intended?**

6. **How difficult was it to achieve an understanding between the supervisor and counselor?**

7. **If the supervisor got diverted, what happened?**

8. **If you raised the issue of improving performance what happened?**

MODULE 7: Counselor Development

PURPOSE

Introduce a collaborative method for facilitating counselor professional development based on supervisor assessment of job performance and negotiation of a measurable proficiency improvement plan.

LEARNING OBJECTIVES

Participants will be able to:

1. Verbalize a process for facilitating professional growth of supervisees.
2. Appreciate the cultural and contextual factors which impact the supervisory relationship.
3. Utilize a Professional Development Plan to negotiate and document an agreement to improve counselor job performance.
4. Plan to implement selected strategies from this workshop in the workplace.

MODULE 7: Counselor Development

KEY STEPS IN THE PROCESS OF PROMOTING COUNSELOR GROWTH

1. Both the supervisor and counselor understand one purpose of supervision is to assist the supervisee in building the knowledge, skills and attitudes essential to effective practice.
2. The context for professional counselor development is a collaborative alliance with the supervisor taking into account the unique individual characteristics and perspectives of the supervisee.
3. First hand observation is essential to developing an understanding of the counselor's knowledge, skills and attitudes.
4. An assessment of job performance helps identify both strengths and priorities for professional improvement.
5. Feedback and coaching help improve the counselor's self-awareness and understanding of agency expectations related to job performance.
6. A professional development plan negotiated between supervisor and supervisee can guide a process of knowledge and skill acquisition.
7. Establishing how progress or achievement will be measured helps determine the success of the process and make clear the criteria by which performance will be judged.

RELATIONSHIP, CULTURE AND CONTEXTUAL FACTORS IN FACILITATING COUNSELOR DEVELOPMENT

Guidelines for building and demonstrating cultural sensitivity include:

- Become self-aware – of your identity, as well as biases
- Engage a supervisee-centered relationship – know supervisees' individualized needs
- Be culturally responsive – learn and use the supervisee's cultural knowledge, experience, and learning styles to tailor your supervision

VARIABLES THAT CAN IMPACT THE RELATIONSHIP

- Age
- Disability
- Education
- Ethnicity
- Gender
- Race
- Recovery Status
- Religion
- Sexual Orientation

MODULE 7: Counselor Development

STRATEGIES FOR BUILDING A RELATIONSHIP

- Recognize own biases and assumptions
- Explore and discuss differences openly
- Increase personal sensitivity
- Value differences
- Promote contextual understanding
- Use context to strengthen relationships
- Create collaboration
- Promote learning and growth
- Provide proactive staff training
- Create an open environment for multicultural communication

SIMPLE STEPS TO FOLLOW

- Avoid generalizations
- Remember, many factors affect how people think, perceive, and act.
- Ask questions rather than assume.
- Do not imagine that you know all there is to know. There is more to learn about every culture-including your own.

NOTES:

COUNSELOR PROFESSIONAL DEVELOPMENT PLAN

Professional Development Plan

Staff name: ______________________ Supervisor: ______________________ Date: ____________

Foundation/Practice Dimension: ______________________ Element: ______________________

Competency to be addressed and page number from TAP 21: ______________________

Strengths: ______________________

____

Challenges/Concerns: ______________________

____

Present level of proficiency from rating forms 1 2 3 4	Level of proficiency to be achieved with this learning plan 1 2 3 4	Target date to complete the plan:

What is the issue to be addressed?	**Goal** What is to be accomplished? (measurable/behavioral)	**Activities necessary to achieve the goal** What will be done?	**Metrics** How will progress be measured?	**Target Completion Date**
Knowledge:				
Skill:				
Attitude:				

COUNSELOR PROFESSIONAL DEVELOPMENT PLAN cont.

Additional comments: ____

Supervisor signature: ______________________ Counselor: ______________________

Date for “re-observation” to assess performance: ______________________

Results:

SUPERVISORY INTERVIEW OBSERVATIONS

	STATEMENTS/BEHAVIORS	COMMENTS
STEP 1: **Set Agenda**		
STEP 2: **Give O-R-A-L Feedback**		
STEP 3: **Teach and Negotiate**		
STEP 4: **Secure Commitment**		

MODULE 7: Counselor Development

WORKSITE ASSIGNMENT

The goal of the assignment is for you to use *TAP 21-A* in conducting a limited self-assessment of your supervisory knowledge and skills and then develop a Supervisor Professional Development Plan for yourself. Specifically, here is the assignment:

1. Read Section I: Introduction and Section II: Implementation Guidelines in *Competencies for Substance Abuse Treatment Clinical Supervisors (TAP 21-A)*.

2. Review or scan Section III: Foundations Areas and Section IV: Performance Domains in *TAP 21-A*.

3. Select one Foundation Area or one Performance Domain and do a self-assessment of your proficiency on each of the competencies in the Foundation or Performance Domain you select. Suggestions include:
   a. FA3: Supervisory Alliance
   b. PD1: Counselor Development
   c. PD4: Performance Evaluation

4. Select one (and only one) competency from the Foundation or Performance Domain you selected that you would like to improve.

5. Complete a Supervisor Professional Development Plan, using the form appearing in on the following pages, for the competency you selected.
   Be specific with regard to what Knowledge, Skill or Attitude you want to develop, what activities you will undertake to accomplish your goal, and how you will measure your progress/ success. Because *TAP 21-A* does not include KSAs for each competency, you will need to develop your own KSA objectives based on the competency you choose to further develop or enhance. The bibliography at the conclusion of each Foundation Area and Practice Dimension may be helpful.

6. Mail the completed Supervisor PDP to your trainer(s) for their review. Fill in the address provided by the trainer(s):

   Mailing Address: E-mail Address:

7. Upon satisfactory completion of the assignment you will receive a Continuing Education Certificate by return mail.

SUPERVISOR PROFESSIONAL DEVELOPMENT PLAN

Supervisor's Professional Development Plan

Name: ________________________ Date: ______________

Foundation Area /Performance Domain: ________________________

Competency to be addressed and page number from TAP 21-A: ________________________

____

Strengths: ________________________

Challenges/Concerns: ________________________

____

Present level of proficiency 1 2 3 4	Level of proficiency to be achieved with this PDP 1 2 3 4	Target date to complete the plan:

What is the issue to be addressed?	**Goal** What is to be accomplished? (measurable/behavioral)	**Activities necessary to achieve the goal** What will be done?	**Metrics** How will progress be measured?	**Target Completion Date**
Knowledge:				
Skill:				
Attitude:				

MODULE 7: Counselor Development

SUPERVISOR PROFESSIONAL DEVELOPMENT PLAN cont.

Additional comments: ____________________

Supervisor signature: ____________________ Counselor: ____________________

Date for “re-observation” to assess performance: ____________________

Results:

REFERENCES:

ATTC-New England (2006). The clinical supervisor: *Supporting the faithful use of evidence-based practice.* Unpublished presentation.

Bascue, L. O. & Yalof, J. A. (1991). Descriptive dimensions of psychotherapy supervision. *The Clinical Supervisor,* 9(2), 19-30.

Beauchamp, T. & Childress, J. (2001). *Principles of biomedical ethics* (5th ed.). New York: Oxford University Press.

Bernard, J. M. & Goodyear, R. K. (1998). *Fundamentals of clinical supervision* (2nd ed.). Boston: Allyn and Bacon.

Bissel, L. & Royce, J. (1994). *Ethics for addiction professionals.* Center City, MN: Hazelden Information/Education.

Brizendine, L. (2006). *The female brain.* New York: Morgan Road Books.

Borders, L. D. & Leddick, G. R. (1988). A nationwide survey of supervisory training. *Counselor Education and Supervision,* 27(3), 271-283.

Carifio, M. S. & Hess, A. K. (1987). Who is the ideal supervisor? *Professional Psychology: Research and Practice,* 18(3), 244-250.

Cashwell, T. H. & Dooley, K. (2001). The impact of supervision on counselor self-efficacy. *The Clinical Supervisor,* 20, 39-48.

Chen, E. C. & Bernstein, B. L. (2000). Relations of complimentary and supervisory issues to supervisory working alliance: A comparative analysis of two cases. *Journal of Counseling Psychology,* 47(4), 485-497.

Chung, Y. B., Marshall, J. A., & Gordon, L. L. (2001). Racial and gender biases in supervisory evaluation and feedback. *The Clinical Supervisor,* 20(1), 99-111.

Collins, J. (2002). *Built to last.* New York: HarperCollins.

Collins, J. (2001). *Good to great.* New York: HarperCollins.

Constantine, M. (2001). Multiculturally-focused counseling supervision: Its relationship to trainees' multicultural counseling self-efficacy. *The Clinical Supervisor,* 20(1), 87-98.

Corey, G. (2001). *Theory and practice of psychotherapy and counseling* (6th ed.). Belmont, CA: Brooks/Cole Thomson Learning.

Covey, S. (2004). *Seven habits of highly effective people.* New York: Simon and Shuster

Covey, S. (1994). *First things first.* New York: Simon and Shuster.

DePree, M. (1989). *Leadership is an art.* New York: Dell.

DePree, M. (1992). *Leadership jazz.* New York: Doubleday.

deShazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: W. W. Norton.

DiClemente, C. C. & Scott, C. W. (1997). Stages of change: Interactions with treatment compliance and involvement. In L. S. Onken, J. D. Blaine, & J. J. Boren (Eds.), *Beyond the Therapeutic Alliance: Keeping the Drug Dependent Individual in Treatment.* NIDA Research Monograph Series, Number 165. DHHS Pub. No. (ADM) 97-4142. Rockville, MD: National Institute on Drug Abuse, 131-156.

Disney, M. J. & Stevens, A. M. (1994). *Legal issues in clinical supervision.* Alexandria, VA: American Counseling Association.

Durham, T. G. (2001). *Clinical supervision: An independent study course.* East Hartford, CT: ETP Inc.

Durham, T. G. (2003). The relationship between live supervision, counselor development, and self efficacy for substance abuse counselors in the U.S. Navy. *Dissertation Abstracts International,* 64, 2913. (UMI No. 3094924).

Durham, T.G. & Landry, M. (2004). *Clinical supervision: A five day course – Participant workbook.* Silver Spring, MD: Danya International.

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology,* 37(3), 322-329.

REFERENCES:

Ekstein, R. & Wallerstein, R. S. (1972). *The teaching and learning of psychotherapy* (2nd ed.). New York: International University Press.

ETP, Inc. (2002). *Clinical supervision participant handbook.* East Hartford, CT: Author.

Falvey, J. (2002). *Managing clinical supervision: Ethical practice and legal risk management.* Pacific Grove, CA: Brooks/Cole.

Gabriel, R.M., & Knudsen, J (2003). *Advancing the current state of addiction treatment: A regional assessment of substance abuse treatment professionals in the Pacific Northwest and Hawai'i*. Portland, OR: RMC Research Corporation.

Gallon, S.L., Gabriel, R.M., & Knudsen, J (2003). The toughest job you'll ever love: A Pacific Northwest treatment workforce survey. *Journal of Substance Abuse Treatment, 24*,183-196.

Gallon, S.L., Gabriel, R.M., & Knudsen, J (2006). *The current state of addiction treatment: Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey – State of Hawai'i.* Portland, OR: Northwest Frontier Addiction Technology Transfer Center.

Gay, G. (2000). *Culturally responsive teaching: Theory, research, & practice.* New York: Teachers College Press.

Getz, J. G., & Protinsky, H. O. (1994). Training marriage and family counselors: A family-of-origin approach. *Counselor Education and Supervision,* 33(3), 183-200.

Goleman, D. (2006). *Social intelligence.* New York: Bantam Books.

Goleman, D. (2005). *Emotional intelligence.* New York: Bantam Books.

Goleman, D. (2002). *Primal leadership.* New York: Bantam Books.

Goleman, D. (2000). Leadership that gets results. *Harvard Business Review*

Haley, J. (1988). Reflections on supervision. In H. A. Liddle, D. C. Bruenlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision.* New York: Guilford Press, 358-367.

Haynes, R., Corey, G., & Moulton, P. (2003). *Clinical supervision in the helping professions: A practical guide.* Pacific Grove, CA: Thomson-Brooks/Cole.

Herdman, J. W. (2001). *Global criteria: The 12 core functions of the substance abuse counselor.* Holmes Beach, FL: Learning Publications.

Inscape Publishing. (2001). *DiSC classic profile.* Minneapolis: Inscape Publishing.

International Certification and Reciprocity Consortium. (2001). *Clinical supervisor of alcohol and other drug abuse counseling: Role delineation study.* Research Triangle Park, NC: IC&RC.

Ivey, A. E., Normington, C., Miller, C., Morill, E., & Haase, R. (1968). Microcounseling and attending behavior: An approach to pre-practicum counselor training. *Journal of Counseling Psychology,* 15(2), 1-12.

Kagan, N. (1980). Influencing human interaction: Eighteen years with IPR. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research and practice.* New York: wiley, 262-286.

Kadushin, A. & Harkness, D. (2002). *Supervision in social work* (4th ed.). New York: Columbia University Press.

Kadushin, A. (1992). *Supervision in social work* (3rd ed.). New York: Columbia University Press.

Keller, J. F., Protinsky, H. O., Lichtman, M., & Allen, K. (1996). The process of clinical supervision: Direct observation research. *The Clinical Supervisor,* 14(1), 51-63.

Ladany, N., Brittan-Powell, C. S., & Pannu, R. K. (1997). The influence of supervisory racial identity interaction and racial matching on the supervisory working alliance and supervisee multicultural competence. *Counselor Education and Supervision,* 36, 285-305.

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development,* 77(4), 447-455.

Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B., (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist,* 27(3), 443-475.

REFERENCES:

Ladany, N., Walker, J. A., & Melincoff, D. S. (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure. *Counselor Education and Supervision,* 40(4), 263-275.

Landry, M. (1995). *Overview of addiction treatment effectiveness.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Larson, L. M., Clark, M. P., Wesely, L. H., Koraleski, S. F., Daniels, J. A., & Smith, P. L. (1999). Videos versus role plays to increase counseling self-efficacy in prepractica trainees. *Counselor Education and Supervision,* 38, 237-248.

Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist,* 26(2), 179-218.

Larson, L. M., Suzuki, L. A., Gillespie, K. M., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology,* 39(1), 105-120.

Leach, M. M., Stoltenberg, C. D., McNeill, B. W., & Eichenfield, G. A. (1997). Self-efficacy and counselor development: Testing the integrated developmental model. *Counselor Education and Supervision,* 37(2), 115.

Liddle, H. A., Becker, D., & Diamond, G. M. (1997). Family therapy supervision. In C. E. Watkins, Jr. (ed.), *Handbook of psychotherapy supervision.* New York: Wiley, 400-421.

Liese, B. S., & Beck, J. S. (1997). Cognitive therapy supervision. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision.* New York: Wiley, 114-133.

Lindbloom, G., Ten Eyck, T. G., & Gallon, S. L. (2005). *Clinical supervision I: Building clinical supervision skills* (3rd ed.). Salem, OR: Northwest Frontier ATTC.

Linehan, M. M., & McGhee, D. E. (1994). A cognitive-behavioral model of supervision with individual and group components. In S. E. Greben & R. R. Ruskin, (Eds.), *Clinical perspectives on psychotherapy supervision* (pp. 165-188). Washington, DC: American Psychiatric Press.

Locke, L. D. & McCollum, E. E. (2001). Clients' view of live supervision and satisfaction with therapy. *Journal of Marriage and Family Therapy,* 27(1), 129-133.

Magnuson, S., Wilcoxon, S. A., & Norem, K. (1999). A profile of lousy supervision: Experienced counselors' perspectives. *Counselor Education and Supervision,* 39(3), 189-202.

Martino, C. (2001). *Secrets of successful supervision: Graduate students' preferences and experiences with effective and ineffective supervision.* Symposium conducted at the meeting of the American Psychological Association, San Francisco, CA.

Mauzey, E. & Erdman, P. (1997). Trainee perceptions of live supervision phone-ins: A phenomenological inquiry. *The Clinical Supervisor,* 15(2), 115-128.

Mauzey, E., Colvin Harris, M. B., & Trusty, J. (2000). Comparing the effects of live supervision interventions on novice trainee anxiety and anger. *The Clinical Supervisor,* 19(2), 109-122.

Mead, D. E. (1990). *Effective supervision.* New York: Bruner/Mazel.

Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing models of counselor development with a measure of counseling self-efficacy. *Journal of Counseling and Development,* 74, 640-644.

Miller, W. R. & Rollnick, S. (2002). *Motivational interviewing* (2nd ed.). New York: Guilford Publications.

Minuchin, S. & Fishman, H. C. (1990). *Family therapy techniques.* Cambridge, MA: Harvard University Press.

Moorhouse, A. & Carr, A. (1999). The correlates of phone-in frequency, duration, and the number of suggestions made in live supervision. *Journal of Marital & Family Therapy,* 21, 407-418.

Moorhouse, A. & Carr, A. (2001). A study of live supervisory phone-ins in collaborative family therapy: Correlates of client cooperation. *Journal of Marital & Family Therapy,* 27(2), 241-249.

Munson, C. (2001) *Clinical social work supervision.* Binghamton, New York: Haworth Press.

REFERENCES:

Nichols, M. & Schwartz, R. (2005) *Family therapy: Concepts and methods.* Upper Saddle River, NJ: Pearson Education.

NIDA-SAMHSA. (2006). *Motivational interviewing assessment: Supervisory tools for enhancing proficiency.* Salem, OR: Northwest Frontier ATTC.

Pope-Davis, d. B. & Dings, J. G. (1995). The assessment of multicultural counseling competencies. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 287-311). Thousand Oaks, CA: Sage.

Powell, D. J. (2004). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods* (2nd ed.). San Francisco: Jossey-Bass.

Powell, D. J. (2006, May). *How to define and assess competencies.* Presentation at the Annual Clinical Preceptorship Program Conference, Norfolk, VA.

Prochaska, J. O. & DiClimente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy.* Homewood, IL: Dow Jones-Irwin.

Prochaska, J. O., DiClimente, C. C., & Norcross, J. C. (1992). *In search of how people change: Applications to addictive behaviors. American Psychologist.* 47:1102-1114.

Prochaska, J. O. & Norcross, J. C. (2002). *Systems of psychotherapy: A transtheoretical analysis* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Ramos-Sanchez, L., Esnil, G., Goodwin, A., Riggs, S., Touster, L., Wright, L., Ratanasiripong, P., & Rodolfa, E. (2002). Negative supervisory events: Effects on supervision satisfaction ad supervisory alliance. *Professional Psychology: Research and Practice,* 33(2), 197-202.

Ray, M. & Rinzler, A. (1993). *The new paradigm in business.* New York: Putnam.

Schmidt, W. & Tannenbaum, R. (May-June, 1973). How to choose a leadership pattern. *Harvard Business Review.* 51, p. 162.

Schmidt, W. & Tannenbaum, R. (July-August, 1986). How to choose a leadership pattern. *Harvard Business Review.* 64, p. 129

Smith, R. C., Mead, D. E., & Kinsella, J. A. (1998). Direct supervision: Adding computer-assisted feedback and data capture to live supervision. *Journal of Marital & Family Therapy,* 24(1), 113-125.

Steward, R. J. (1998). Connecting counselor self-efficacy and supervisor self-efficacy: The continued search for counseling competence. *The Counseling Psychologist,* 26(2), 285-294.

Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists.* San Francisco: Jossey-Bass.

Sue, D. W. & Sue, D. (2002). *Counseling the culturally different* (4th ed.). New York: Wiley and Sons.

Wheatley, M. (2006). *Leadership and the new science: Discovering order in a chaotic world.* San Fransisco: Berret-Koehler.

White, W. (1993). *Critical incidents: Ethical issues in substance abuse prevention and treatment.* Bloomington, IL: Lighthouse Institute.

White, W. & Popovits, R. (2001). *Ethical issues in the prevention and treatment of addiction.* Bloomington, IL: Lighthouse Institute.

Zander, R. & Zander, B. (2000). *The art of possibility.* Boston: Harvard Business School Press.