

Clinical Supervision:
We Are More Than Bosses... We Are Leaders

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This home study course has been approved by the Ohio Counselor, Social Worker and Marriage and Family Therapist Board for 6 hours of Clinical Supervision (approval # MCST041009)

Learning Objectives

The following course is designed to facilitate the continued growth and development of a mental health professional that is doing clinical supervision. The information contained in this course serves to add to the competency of the clinical supervisor. After completing this course the mental health clinician will be able to:

- Explain the historical background of clinical supervision
- Define what a clinical supervisor is and the roles of a clinical supervisor
- Identify the difference between an administrative supervisor and a clinical supervisor
- Detail the legal and ethical implications of practicing as a clinical supervisor
- Outline the nationally defined skills required for competent clinical supervision
- Explain three models of supervision and begin incorporating these models into the clinical supervisor's own integrative model
- Articulate how art and science play a vital role in clinical work
- Define four clinical supervision styles
- Identify various attributes that lead to relationship and alliance building
- Discuss the needed elements in writing a clinical supervisory contract
- Articulate the different tasks and functions that occur in the assessment, engagement and work stages of clinical supervision
- Define the advantages and disadvantages of group clinical supervision and individual clinical supervision
- Incorporate several strategies to facilitate in the reduction and avoidance of stress and burnout
- Define the pitfalls and games that can occur in clinical supervision

Introduction

It is the scope of this course to assist supervisors and clinical supervisors at familiarizing themselves with the role of a clinical supervisor, and to broaden their knowledge base in order to perform their roles and tasks more efficiently, effectively and competently. The overall goal of this course is to help clinical supervisors in making a shift from seeing themselves as a boss to seeing themselves as a leader. This will be accomplished by defining what the tasks and functions of a clinical supervisor are, and by defining how a clinical and administrative supervisor are different.

This program is strength based and will address the importance of relationship building in the clinical supervisor role. The course will move the reader through a brief history of clinical supervision, including a working definition of clinical supervision, and outlining what to do and when to do it. We will discuss four clinical supervision models.

Clinical supervision is a complex practice. This process becomes less complex when the clinical supervisor and clinical supervisee build an alliance that maximizes both persons abilities. To insure this alliance is constructed, this course will look at the art and science of clinical work and look at the relationship skills that are needed for building a positive clinical supervisory alliance. Now lets look at a brief historical background of clinical supervision, and then move on to defining what a clinical supervisor is, and what a clinical supervisor does.

What Is Supervision?

Haynes, Cory, and Moulton (2003) state that “A primary aim of supervision is to create a context in which the supervisee can acquire the experience needed to become an independent professional.” Haynes, et. al also state that supervision is “artful, but it is an emerging formal arrangement with specific expectations, roles, responsibilities, and skills.” (2003, pg. 3) Holloway (1995, pg 1) defines supervision as, “To oversee, to view another’s work with the eye of the experienced clinician, the sensitive teacher, the discriminating professional. Holloway also states, “Supervision provides an opportunity for a student to capture the essence of the psychotherapeutic process as articulated, and modeled by the supervisor, and subsequently, to recreate this process in an actual counseling relationship.”

Supervision is the arena where one's work is overseen. Supervision is artful as well as technical. Supervision is the place where the unknown is transformed into the known. Supervision is where a supervisor keeps a watchful eye on the learner. Supervision is where a person has responsibility over another. Based on what these authors write it can be stated that supervision is the context in which supervisees can gain the knowledge and experience to become a competent mental health professional.

What Is A Clinical Supervisor?

A clinical supervisor is a staff person who is assigned so the supervisee can acquire the experience needed to become an independent professional. Cohen (2004) writes, "A clinical supervisor is a person in a supervisory role who facilitates the professional growth of one or more designated supervisees to help them attain knowledge, improve their skills, strengthen their professional attitude, and values as they provide clinical services to their clients." Haynes et. al, 2003 conclude that a clinical supervisor is a trained, skilled clinician who provides consistent observation and evaluation of the supervisee's clinical work with clients.

The writers on the subject of clinical supervision agree that the four main goals of the clinical supervisor are:

- To provide for the professional growth, and development of the clinical supervisee
- To provide protection for the welfare of the client so they are not harmed by the training supervisee
- To keep a watchful eye on the supervisee's performance to insure the supervisee is practicing within the guidelines of the profession. This means the clinical supervisor is the gatekeeper for the profession
- Teach, train, and empower the supervisee so they can become competent, independent clinicians who can carry out their goals, and be a positive influence on their clients

Clinical supervision is a unique professional relationship between a supervisor, a supervisee, and the client served. It is the arena where the clinical supervisor and supervisee separate the known, and familiar from the unknown, and unfamiliar. Through their collaborative work, the clinical supervisor and the supervisee can add depth to what is known, and bring clarity to what is unknown.

Historical Background

Prior to the 1900, boards, associations, state legislation, and charities governed clinical practices. It was not until the 1900s that individual supervision was defined, and formalized. It was after this time that training schools were developed specifically for the training of clinicians. After some time, group supervision was added to broaden the training of clinicians. The introduction of group supervision made it possible to train more supervisees, and reduce the need for as many supervisors.

In 1935, Freudian therapy was the major focus of supervision. Clinical supervision spent most of its time training supervisees on this new theory and practice. As time went on other theories were added to the clinical supervision arena. It was not until 1950, that supervision took on the role of the supervisor as the teacher and the supervisee as the learner. Clinical supervision became the training ground to further the skills of supervisees. It was believed at that time that being a good clinician with sufficient experience was all that was needed for developing trainees into good therapists. During the time following the 1960s, supervision followed a psychotherapy model.

Today, supervision requires supervisors to have a multitude of skills and procedural knowledge. These skills include: the ability to initiate and maintain a positive supervisory relationship, the ability to be competent and demonstrate competence, the ability to assess the needs of both the supervisees and all the clients they will serve and practicing multiple modes of direct observation of the supervisee's work. The procedural knowledge includes; formalized knowledge of supervision, knowledge of formal contracts and agreements, knowledge of policies and procedures for practice, knowledge of proper documentation methods, good risk management practices, excellent communication skills, and evaluation plans.

Clinical Supervisor's Roles

A clinical supervisor will play many roles each, and every day. The primary role of a clinical supervisor is that of a teacher. It is through the teaching role that the clinical supervisor can pass along the needed knowledge, guidance, and skill base that supervisees need in order to become competent. It is this writer's opinion that the teaching role is the most important role a supervisor can perform. This is especially true for the novice supervisee.

Next to teaching, the second most important role is that of the mentor. Learning to be effective with clients is always an ongoing process that truly never stops in the helping profession. Clinical supervisors can mentor a supervisee by sharing their knowledge, and helping the supervisee know what to do, and what not to do. In this mentoring process the supervisee can gain valuable information and technical training that will lead to their mastering their trade. Part of the mentoring process involves relationship building. Without a quality, healthy relationship, the mentoring process, and the advancement of the supervisees skills will be compromised.

Beginning supervisees as well as advanced clinicians need support. Being a support system is another role the clinical supervisor must perform. Human beings grow, and develop through support and the same is true for supervisees. The clinical supervisor can be supportive by being available to the clinical supervisee, by encouraging, and positively pointing out what the supervisee does well. Finally, the clinical supervisor can be supportive by pointing out mistakes in a manner that does not demoralize the supervisee. Effective clinical supervision leaves supervisee challenged to perform their tasks correctly. The supportive role is one that must be performed throughout the supervisory process.

The clinical supervisor is responsible for the work of the supervisee. Therefore, the clinical supervisor must evaluate the work the supervisee does to insure it is of the highest quality, and meets the standards of the agency, and the profession as a whole. In order to do the evaluation process effectively; the clinical supervisor should spell out how the supervisee will be evaluated. A thorough evaluation will include the methods used, how often the evaluation process will take place, and what role the supervisee has in this process. This evaluation process should also address the goals and learning objectives for the supervisee. A written copy of the evaluation process is recommended to be given to the supervisee so they are aware of

all of the attributes of the evaluative process. A written copy will reduce much of the conflict and disagreements that can occur in supervision. By creating an evaluative process that all the parties can agree to, and have a vested interest in, the process will lend itself to a positive supervisory relationship.

Being an advisor, and providing consultation is another role the clinical supervisor performs. It is through the consultation processes that the education of the supervisee can occur. This is the place where the supervisee can ask questions, get advice, and receive guidance as they learn the different aspects of clinical work. Advising provides the supervisee with support, and information that can decrease feelings of inadequacy and insecurity that arise throughout a day's work of the supervisee. The clinical supervisor must balance the amount of advice and consultation being shared. If the clinical supervisor provides too much help too often, the supervisee will not learn how to think through the difficulty they are encountering. On the other hand, if the supervisor provides too little advice and consultation the supervisee may end up feeling like they are sinking in quicksand without any lifeline. If this occurs, the supervisory relationship will be compromised.

As it was stated earlier, the clinical supervisor is responsible for the work the supervisee does. Since this is the case, another role of the clinical supervisor is to oversee the supervisee's work. The purpose of this role is to protect the client, protect the supervisee, and to protect the profession. To enhance the overseeing process, the supervisor should maintain written documentation of each interaction. This can be extremely difficult when a clinical supervisor has the responsibility of supervising many supervisees. It would be wise to include in the documentation: when the supervision meeting was held, the content of the presenting problem, what options were explored and the final disposition.

There are times when the clinical supervisor will need to counsel with the supervisee. This role is to address any transference that may be going on with the work between the clinical supervisor and the supervisee as well as between the supervisee, and the client. This counseling role should not go beyond addressing issues that impede effective work with clients. Any counseling that goes beyond what is in the best interest of the client should be referred to an outside therapist. Clinical supervision should avoid any therapeutic counseling with supervisees due to the ethical problems and boundary crossings that will occur.

Clinical Supervision Is Different Than Administrative Supervision

Clinical supervision is different than administrative supervision for several reasons. Clinical supervision focuses on the professional development of the supervisee with the goal to develop a competent and effective professional. Administrative supervision's major focus is maintaining the organization, and building on its integrity. Clinical supervision focuses on the evaluation of the individual skills of the clinician, which includes the supervisees training needs, goals, and objectives. Administrative supervision focuses on the mission of the organization, its goals, and objectives. Administrative supervision maintains the organizational functions, and accounts for the needs of the agency. Both the clinical supervisor and the administrative supervisor must look out for the well being of the client, however it is the clinical supervisor's ethical responsibility to look out after the well being of the supervisee. It is in the organization's best interest to look out after the well being of its workers, but this is not always the case. When clinical supervisors do not look out after the well being of the supervisee, the supervisor/supervisee relationship can turn toxic and end up with both parties being sued by the client they serve.

Legalities of Supervision

Many clinical supervisors are not aware of the legal and ethical risks that come with being the clinical supervisor. Falender and Shafranske (2004) would support this statement, and go on to add, "An increased attention has recently been paid to supervisor liability and malpractice. Pivotal to the concern is the principle of respondeat superior, or vicarious liability." This term refers to the legal doctrine which holds that "one who occupies a position of authority or direct control over another (such as a master and servant, employer and employee, or supervisor and supervisee) can be held legally liable for the damages of another suffered as a result of the negligence of the subordinate". (Falender 2004)

By reviewing the NASW codes, the ACA, and the AAMFT codes of ethics, one will see that they all indicate directly and indirectly that the clinical supervisor has final responsibility. Generally speaking, the supervisor **is** legally and ethically responsible for all of the professional activities of the supervisee as well as his or her own actions as a supervisor. (Haynes, et al

2003) Keep in mind that when it comes to lawsuits, ignorance is not a valid defense, nor is being too busy to know what the supervisee is doing a good defense. Do not take this section lightly. This is serious business. Keep in mind that as the clinical supervisor you may also have to defend your supervisory actions to the board even if it is your clinical supervisee who is the one who made the error. Why, because the clinical supervisor is responsible for the actions of the supervisee when it pertains to the treatment of clients.

The ethical codes for all mental health professionals address the ethical issues in clinical supervision. For example the NASW code of ethics state in section 3.01 Supervision and Consultation,

(a) Social workers who provide supervision or consultation should have the necessary knowledge, and skill to supervise or consult appropriately, and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

The ACA Code of Ethics states in section

- F.1.a A primary obligation of counseling supervisor is to monitor the services provided by other counselors or counselors in-training.
- Section F.1.b, Counseling supervisors work to ensure that clients are aware of the qualifications of the supervisees who render services to the clients.
- Section F. 3.a, Counseling supervisors clearly define and maintain ethical, professional, personal and social relationships.
- Section F.4.a, Supervisors are responsible for incorporating into their supervision the principals of informed consent and participation.
- Section F.4.d, Supervisors or supervisees have the right to terminate the supervisory relationship with adequate notice.

The AAMFT Codes of Ethics address supervision ethics in Principle IV Responsibility to Students and Supervisees. This section of the AAMFT Codes states: “Marriage and family therapists do not exploit the trust and dependency of students and supervisees.” The AAMFT all so states:

- 4.1 Marriage and family therapists are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons.
- 4.2 Marriage and family therapists do not provide therapy to current students or supervisees.
- 4.3 Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee.
- 4.4 Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience.
- 4.5 Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.
- 4.7 Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver or permitted by law.

Although the lists above are not complete, one can clearly see that the clinical supervisor is bound by these standards. For a more through review of the ethical codes pertaining to clinical supervision the reader is instructed to review their professions ethic codes. These can be obtained by going on to the profession's website or calling them directly. It is strongly recommended that the clinical supervisor keep the ethic guidelines in the fore front of their minds and review these entire code of ethics at least once a year. Failure to do so can only lead the supervisor down a path they would regret wholeheartedly.

Supervisory Actions to Reduce or Prevent Ethical, and Legal Problems

A basic premise that the clinical supervisor can maintain which lowers the risk of legal and/or ethical problems is to recognize that the supervisor is ultimately responsible, both legally and ethically for the actions of the supervisee. Therefore, it would be prudent to act wisely, read and understand all the codes of ethics, make no assumptions and be aware of what the

supervisee is doing. This also implies having knowledge of every case/client with whom the supervisee is working. This can be quite a cumbersome task, particularly if you are the supervisor who is supervising a number of supervisees. It is recommended to supervise no more than six to eight supervisees in order to do a thorough job. It is very difficult to monitor the competency of each supervisee if the supervisor has too many staff members to oversee. Monitoring the actions and decisions of the supervisee can aid in the prevention of legal and ethical problems.

An equally important practice to perform in order to prevent legal and ethical problems is for the clinical supervisor to only work within the scope of their expertise, and refer out for additional supervision as necessary. When a supervisor attempts to supervise beyond their own competencies it can only lead to disaster both for the clinical supervisor, and the supervisee. Saying “no” to cases that the supervisor is not competent to see is wise and ethically responsible.

Documentation is a requirement for all clinicians. This also applies to the clinical supervisor. It is through the documentation process that the clinical supervisor can gain some protection. Documentation is practicing Ryan’s law. When I was in graduate school at The Ohio State University, I was taught Ryan’s law. Dr. Ryan taught social policy and his law stated, “*If it is written it is so and if it is not written it is not so.*” So, when a clinical supervisor fails to document what directions, advice, and recommendations were given to the supervisee; there is no record and therefore, “it is not so.” When directions and recommendations are clearly written down it shows the legal and ethical communities that the directions given have a factual base with evidence that supervision occurred.

What should the clinical supervisor document? This is a good question that has varying opinions; The basic items to cover in the documentation should include:

- The time and date the supervisor/supervisee met
- What was discussed
- What action plan was formulated
- How the decision was made
- How the action plan is going
- Potential complications of problematic cases.

- Any difficult cases that was problematic and needed extra attention and feedback

One of the major complaints that supervisees have about their supervisor is that supervisors are not available. So, if you are a wise, competent, clinical supervisor, and you want to reduce any risk factors, it would be prudent to be available as much as possible for your supervisees. By doing so, you may ward off any potential problems before they become crises for the both of you.

Allowing incompetent supervisees to continue to practice could lead the clinical supervisor down the path of legal/ethical problems. This can be avoided by having an evaluation process in place. Many agencies do evaluations, but they are only once a year. Too much time goes by, and mistakes can be magnified under this plan. A more thorough and useful evaluation process to be carried out is one that is done every 90 to 120 days. This will give both the clinical supervisor and the supervisees target goals to work on, and a follow up process to see how effective the supervisee has become. More frequency will also give the supervisor and the supervisee more opportunities to build skills, develop their relationship, and solve problems together. We will cover in more detail what the evaluation process should include later in the program.

Supervisees can file a lawsuit against their clinical supervisors as well as filing a complaint with the board. There is no foolproof plan to prevent these adverse actions. The clinical supervisor can take some proactive steps to avoid these kinds of nightmares. One common sense step is to develop a positive working relationship. People are less likely to take legal action against someone they like verse someone they don't.

Providing supervisees with information about clear expectations for performance requirements can reduce many conflicts that occur between the supervisee and the supervisor. Outlining procedures for dealing with adverse actions such as suspensions, reprimands, unresolved conflicts can also reduce friction and tension between both parties and can provide solutions for how to resolve these conflicts. Explaining to supervisees their rights to appeal an adverse action should also be included in this process. A good explanation of the rules and requirements informs all parties how the "game" is played.

There are other strategies to take that can reduce legal and ethical conflicts in the supervisor/supervisee relationship. These include:

- Having a written contract between the supervisor, and supervisee regarding the scope and expectations in supervision
- Monitoring the personal development of the supervisee as it affects the practice of counseling
- Modeling effective problem-solving skills for supervisees, and helping supervisees develop problem-solving capabilities
- Promoting the supervisee's ethical knowledge and behavior
- Educating supervisees to critical ethical issues involved when working within a managed care environment

National Standards For Clinical Supervision

The national standards for supervisors are discussed in the ethical codes for social worker, counselors and marriage, and family therapist. These standards state the supervisor should be:

- Skilled
- Professionally trained
- Experienced and knowledgeable
- Demonstrate characteristic and personal traits that are consistent with the role of the clinical supervisor
- Possess knowledge and understandings of ethical and legal matters
- Show expertise in the development and management of professional relationships
- Have knowledge in methods and techniques of counseling, understand how supervisee's growth, and development occurs
- Supervisors must be experts in case management and be able to show expertise in client and supervisee assessment and evaluation
- Must be able to communicate effectively in oral and written formats, and to be able to back up their knowledge with sound research, and to make research part of the supervisor, and supervisee relationship

Clinical Supervision is Complex

It was once believed that if you were a good clinician you would make a good clinical supervisor. This was the practice for many years. This trend is no longer the case due to an increase in academic training, postgraduate study, and professional development conferences. Governing bodies, like the State of Ohio Counselor, Social Work, and Marriage and Family Therapist Board now require counselors, and social workers to complete continuing education units specific to the subject of clinical supervision.

As the knowledge base grows so does the complexity of clinical supervision. Haynes, et al (2003) writes, “ The body of knowledge needed to practice supervision now includes, but is certainly not limited to, roles and responsibilities, relationship dynamics, counseling skills, instructional skills, legal and ethical decision-making skills, multicultural competencies, and evaluative skills.”

The complexity of supervision can be reduced for the clinical supervisor by getting advanced training which looks at the models of supervision, the art and science of supervision, and knowing what to do and when to do it. The following pages will examine those elements that can take the bite of the complexity of supervision.

Seven Elements That Make Clinical Supervision Complex

Any professional who has done clinical supervision will have experienced the complexity of this practice. The following seven elements are additional factors to be considered in clinical supervision. These include:

- Philosophy of life
- Philosophy of practice
- Theory in use
- Espoused theory
- Technique
- Understanding of the treatment process
- Random acts

Let's take a brief look at each of these elements to clinical supervision. These elements may be different for each supervisor, and each supervisee. By having a clear understanding of each of these elements the task of clinical supervision will be easier.

Philosophy Of Life

Philosophy of life refers to the beliefs, values and morals that the supervisor and supervisee possess and maintain. If you have watched the television show entitled *House* you will recall that House's philosophy of life is, "All people lie." The way House manages his patients is predicated by this belief. Supervisors/supervisee life philosophies will need to be recognized because of the impact on clinical work. It is not essential that the supervisor adhere to the same philosophy of life as a supervisee. What is essential for making clinical supervision effective is the differences need to be in the forefront and managed.

Included in the philosophy of life the supervisor needs to identify and manage the supervisee's ideas about how the world works and how people behave in the world. Again, the supervisor must manage the differences that come up, manage how each problem is sorted out and manage the different ways to solve a problem. As we all know, what works for one client may not work for another. We must work with differences in clinical supervision.

Philosophy of life also includes the frame of reference, i.e. past, present, and future orientation of where the supervisee works. Most of this writer's work is focused on today, and how history has influenced current behavior. There are others who feel for work to be effective we must resolve the past conflicts. We can argue for days who is right, but the point here is for the clinical supervisor to be effective, the supervisor must recognize that supervisee's hold many different perspectives. The key is to be able to manage these differences in such a way that the supervisee grows, develops, and the client benefits from their work.

Philosophy Of Practice

Philosophy of practice refers to the manner in which the supervisor and the supervisee conceptualize clinical practice. This includes orientation of problems. For example, are you a psychoanalytical clinician, a system theorist, a behaviorist or a cognitive therapist? Philosophy of practice looks at what each party, thinks works, and what does not work. Supervisors may need to help supervisees build a language to describe, and articulate their practice philosophy. It is not the supervisor's job to dictate the practice methods supervisees employ. Effective supervisors again manage the differences that exist between both parties, and to facilitate the development of a positive learning environment.

Theory In Use

Theory in use needs to be one of the tasks that the supervisor and the supervisee examine. It is in the theory discussion the science side of clinical work is brought into play. What the supervisee does in face to face contact with clients can be connected to the science side of clinical work. A discussion of the theory behind what we do serves to expand, and broaden the competency of the supervisee.

Espoused Theory

Espoused theory is similar to theory in use, but it attempts to explain what the clinician does during a session. It recognizes theory from the literature, and examines what strategies are being utilized in every day practice. It is safe to say that when we are talking about espoused theory we are looking at science and art and how they are balanced. Combining art and science provides us with the accumulation of practice wisdom. Thus, supervision is needed to insure the clinician does not get confused or lost in data collected resulting in ineffective treatment.

Technique

Clinical supervision needs to focus on techniques. How the clinician works has an impact on the benefit clients gain from treatment. When discussing techniques we can look at all the elements of style, the artistic and scientific perspectives, and how to apply a particular intervention. When clinical

supervision focuses on techniques it aids the supervisee to know what to do and when to do it, and to know how to apply a particular intervention.

Understanding Of The Treatment Process

Clinical supervision is the place for the supervisor to expand the supervisee's understanding of the treatment process. It goes beyond knowing that treatment has a beginning, middle and an end. Clinical supervision is the training ground to assist supervisee so they understand how clients, and therapist react to treatment, understand how trust is developed, and understand how resistance is developed. Clinical supervision looks at client behavior patterns, and makes recommendations on how to assist at reframing these patterns.

With the addition of EAP services and managed care the clinical supervisor needs to educate the supervisee on what differentiates brief treatment from long term treatment. In sum, the clinical supervisor needs to ensure supervisees acquire knowledge of what makes for good clinical work.

Random Acts

Random acts are events that occur causing change for the client, but have no roots in the treatment. These changes can occur for any reason and may include things like, the therapist's casual conversation or an outside life event on part of client. For instance, Aunt Millie coming to town and the client responds in a brighter more positive affect, and the client makes the necessary change, may be an example of a random act. Change is attributed to Aunt Millie not counseling.

Random acts are important for the clinical supervisor and the supervisee to discuss because it shows that the client's life events have an impact on growth. Discussing these events suggest that our work with clients is only one means for change, and that change for clients can come in many forms. This in a manner of speaking can be a more realistic perspective on the helping process by showing its strengths and limitations.

Clinical Supervision Models

There are a variety of models of supervision. In this program, four models will be discussed. Models are intended to aid in interpreting, and

understanding complex phenomena. For example, by having a model explaining how to construct a chair increases the likelihood the chair building process will generate common features such as how far off the floor should the seat be, and how many legs should it have. Without models we could have a whole host of variations and differences.

What else do models do? Models also help in learning complex skills. We have models to show how cognitive behavior therapy and systematic desensitization is conducted. Models put words and meaning to concepts that would not be understood without them. Models provide a framework for clinicians to practice, and communicate. Finally, models show us the protocols, and the steps to take to make an intervention beneficial.

The four clinical models of supervision to be covered in this program include the:

- Development model
- Social role model
- System model
- Integrative model

Development Model Of Clinical Supervision

This model advocates that supervisors match the structure, and style of supervision to the clinicians level of development. As the supervisee grows, and develops, the supervisory methods are adjusted to fit the skill level, and confidence of supervisee. As the supervisee grows, and develops, the supervisor brings in additional information needed to widen the knowledge base of the supervisor, which in turn leads to independence.

The developmental milestones that will be overcome in this model include: fear, anxiety, uncertainty, feelings of inadequacy, transference, counter transference, enmeshment, over identification with clients, conflicts in values, remaining unbiased, and being nonjudgmental. These milestones will move the novice supervisee from a place of dependency to a place of independency.

Social Role Model

The social role model specifies that the supervisor act and perform certain roles, tasks, and functions that take into account behaviors, beliefs, and

attitudes that the supervisee is expected to follow. It is through this modeling of behaviors, attitudes, and tasks that the supervisee learns what is required in order to achieve independent status. The supervisor is expected to imitate these roles. Competency occurs when these roles are entrenched in the supervisee.

System Model

The system model emphasizes a learning alliance between the supervisor, and the supervisee. This alliance is based the relationship that is developed between the supervisor, and the supervisee. In this model the supervisor and the supervisee are in the growth process together. The growth and development of the supervisee is brought about through the interconnectedness of the two parties that is built through a relationship.

In the system model of supervision the goal of supervision is for the supervisee to learn a broad spectrum of skills, attitudes, and knowledge. The system model states, “successful supervision occurs when a professional relationship that is ongoing and mutually involving develops.” (Holloway,1995) It is the professional relationship that is the primary context for the facilitation of the supervisee’s learning process. The system model includes the content, the process of each interaction between the supervisor and the supervisee and the supervisor and the client. These interactions become the instructional process that enables the supervisee to grow and develop. In the system model the supervisee gains empowerment, skill, and knowledge as the supervisor teaches and articulates information in an interpersonal exchange of ideas and practices.

Integrative Model

The integrative model is eclectic. This means that this model is a mixture of all the other models described above. It also includes the supervisor’s own style, demeanor and philosophy of effective supervision.

Developing Your Own Integrative Model Of Supervision

It is strongly recommended that supervisors develop their own model of supervision. This model incorporates theoretical knowledge, practice wisdom, and personal wisdom, which is based on applied knowledge. In

order to be able to develop ones own integrative model, several factors need to exist. The factors the clinical supervisor must possess are:

- Having advanced knowledge of a variety of clinical methods and techniques
- Being able to reflect on one's own supervising experience
- Identifying what works and what did not work
- Being able to incorporate what was learned from early supervision experiences
- Identifying what was hoped to be learned in early supervision experiences and what prevented it from occurring
- Show consistent master of a variety of theories that fit ones beliefs about human behavior
- Be a student of supervision, and read, study supervision methods, and research
- Be open minded to supervisory weaknesses, and consult with other supervisors
- Modify ones integrative supervisory model to fit one's own changing needs as well as the changing needs of the supervisee

Clinical Supervision Manages Both Art And Science

A well-rounded clinical supervision practice manages both the science side of practice as well as the art side of clinical practice. Art is defined in the dictionary as: a skill acquired through experience, study, or observation. Science is defined as an orderly presentation of facts, reasonings, doctrines, or beliefs concerning a subject. Art and science must be combined to create practice style that is comprehensive, effective, and complete. One without the other leads to incompetent work, which short changes the client. It is through art, and science we can differentiate clinicians from the normal population. It is the clinical supervisor's responsibility to build, manage, and maximize the clinician abilities to utilize art and science in their work with clients.

Science Side Of Clinical Work

When talking about the science side of clinical work, we are referring to the technical side of clinical artistry and craftsmanship. The technical side consists of the scientific data that is backed up with empirical studies. It is not good enough in the technical side to say, "I think this is effective". The

technical side has the empirical data to support the work. The data takes us beyond thinking, and moves toward proving.

The supervisor must ensure that the science backs up the art of clinical work because without the technical side we are practicing like lay people. The assurance of technical support is acquired by sharing new bodies of knowledge that comes through research, and empirical study. This acquired research is the blueprint of knowledge that tells what works and what does not work. As a result of the emphasis of the technical side the supervisee is moved beyond self-knowledge to scientific knowledge. Furthermore, the science side of clinical work dictates the questions to ask. Supervision must incorporate the science side to assure that the clinician has a set of theoretical perspectives to operate from. When science is added the clinician is no longer just shooting from the hip.

The Art Side of Clinical Work

The art side of clinical work is just as important as the technical side and deserves equal attention. Many practitioners find the art side of clinical work to be the most creative, and satisfying. What does the art side consist of? The art side includes the style, clinical demeanor of the clinician, the creative capabilities of supervisee/supervisor, techniques the clinician uses to engage the dysfunction presented by clients, their words, phrases, and interpretations.

If the science side of clinical supervision dictates what we ask our clients, then the art side dictates how the questions are asked. It is in this area that supportive clinical supervisor and supervisee can create, and play around with various possibilities with the hopes of finding the most effective way to ask meaningful questions to clients. Without this exploration process our work can become dull, ineffective and meaningless to clients. Supportive supervisors can enhance practitioners' artistic style by focusing on the elements of art which we will discuss in our next section. It is important for the practicing clinical supervisor to guard against using too much criticism. Overly critical supervisors can hamper practitioners' artistic style by shutting down the practitioners' creative capacities.

Elements Of Art

Five elements of art that the clinical supervisor, and supervisee can focus on are:

- Creation
- Curiosity
- Discipline
- Rehearsal
- Critic

Each of these elements helps the clinical worker develop skills that make it possible to engage clients in a personable manner rather than a machine like manner. In doing so, this allows the client to be more human, open, personable, and able to create a synergy with the clinician. This in turn brings out traits, ideas and possibilities that would ordinarily lie dormant in the client. In other words, art helps to bring out the best in all of us. Let us now look at these elements and see how they can assist us all.

Supervisors Are Sources Of Creation

Clinical supervisors are sources of creation by assisting their supervisees at being creative during the treatment process. This can be done in a variety of ways. The first way to assist at creation is by getting to the heart of what we do, which is to ask meaningful questions. By looking at what questions to ask and how to ask these questions opens up the clinical environment, and can take the work to many different levels. When we discuss how questions are asked, the supervisee, and the supervisor can practice and anticipate how clients may respond to the different questions. This questioning process can look at insight orientation, or rational based possibilities. The study of how questions are asked can lead the clinical supervisee to realize that different people respond to different questions, and being able to vary one's questions makes for a more effective helper.

A second way the clinical supervisor can work on creation with the supervisee is to analyze the phrases used by the clinician and the client. Like questions, the phrases used by both parties can provide many clues to how the client frames the problem. Many times a simple phrase can lead a client to a new discovery. Phrases give meaning to our work and can short circuit or by bypass complex defense mechanisms. When this happens, the door to growth is open.

We were all taught in counseling/social work school 101 that you engage the client where the client is. Keeping this in mind, a third way for the supervisor and the supervisee to work on creation is by discussing how to engage clients. We can engage clients in a variety of ways from being direct, being passive, sharing of one self or not sharing of one self, to using confrontation directly or caringly, to using metaphors, and story telling. All of these techniques are useful for engaging the client. When the supervisee and the supervisor analyze, practice, and rehearse engagement skills, the clinician learns to use them correctly. This is similar to the precision of a skilled surgeon. In doing so, the client benefits from the work.

Knowing how to apply techniques and theory is the fourth way the supervisor and the supervisee can work on creation in the clinical setting. This is accomplished by looking at different theories different techniques, and learning how to use them. This is similar to what a woodworker does when he invests in a new tool. The tool is studied so the craftsman knows its functions, and capabilities. Then the craftsman practices with the tool on scrape wood to learn how the tool handles, what can the tool do and in what circumstances should the woodworker use the tool. The more the woodworker practices, studies, and explores the tool, the better he can use the tool and gain better results. You would not see a woodworker take the new tool out of the box and go straight to the final machining process on an \$3000 desk he was building. Like wise, you would not be a competent clinician if you did practice, and study the new tools you have to work with. It is in the clinical supervision process that we build on theory and develop techniques with the tools we have to work with. These tools should be used by skilled craftsman with skilled hands.

Clinical Supervision Includes Curiosity

Curiosity is an art element that the clinical supervisor is responsible for creating. Curiosity lets the supervisor/supervisee look deeper into a case that looks like the same case that has been seen over and over again. Curiosity by either party can be inspiring because it brings new light to dull, and confusing situations. Curiosity expands our thinking about the other possibilities. Curiosity asks the question, what if?

Curiosity can be the tool that moves the practitioner toward more in-depth intervention and leads the client to “their promise land”. Curiosity can

motivate clients to change their behaviors, and it opens up avenues and possibilities for them that they have never considered before. Curiosity offers a new direction to travel in.

Criticism although useful must be handled delicately. If the clinical supervisor uses too much criticism it is likely that the supervisee will shut down, and go into a defensive posture rather than operate from a position of curiosity. The clinical supervisor can guard against this by being positive, supportive, and encourage the supervisee to stretch their thinking in a safe, secure, and non-judgmental environment.

Clinical Supervision Teaches Discipline

Artistic creativity requires discipline. Without discipline we have chaos. Discipline balances art, and science. It acts like a traffic light telling people when to go, when to stop, and when to go cautiously.

The clinical supervisor can teach discipline by teaching clinical techniques and monitoring whether or not the supervisee is learning them. Learning the fundamentals insures both parties that each knows what to do and when to do it.

Discipline must also be taught, and requires knowing how, when, and why to use technical skills. Discipline follows an orderly path. When the clinical supervisor and supervisee discuss, and outline an orderly pattern, it insures that interactions will go more smoothly when working with clients.

Rehearsal, Practicing Before We Perform

Rehearsal and practice are also elements of art. Without rehearsal, and practice our skills will not advance. Just imagine what a marching band would look and sound like if they never practiced. Clinical supervision can be the place to try out new techniques and ideas before the actual session. To make clinical supervision a proactive field, the clinical supervisor can encourage rehearsal and practice, and be willing to be an active member of this process rather than a Monday morning quarterback.

There are a variety of means of rehearsing. These include:

- Role playing
- Script writing
- Audio taping
- Video taping

Role-playing, audio and video taping really need no explanation. When suggesting script writing, what we are referring to is for the clinical supervisor, and the supervisee to work together by writing a client script similar to a movie script where each spell out different dialogues. This gives the supervisee an opportunity to look at the "what if " questions. It is importance to get signed releases of consent for taping the client to stay compliant with confidentiality. This should go without saying.

Audience And Critics

Who is the audience, who is the critic, and how do these have an impact on the art side of clinical work? The audience and the critics are the observers of our work. They include the patient, the supervisor and the clinician. It is the feedback from these parties that determine if what is being done is effective or not. The audience and critics provide feedback that can be sifted through. It is this feedback that the supervisor, and supervisee use to adjust the many sides of the clinical work. Without this information it is hard to say what is working and what is not. Feedback can guide the supervisor to instruct the supervisee. The feedback received from the supervisor can help empower the clinician by affirming what is being experienced and encountered. The feedback from the audience can tell the clinician to move faster, slower, be more or less challenging, supporting or stop altogether. Without the feedback, it would be hard to determine if the art that is being created has any value or worth.

What Do Good Supervisors Do?

Any helping professional can go back and review their clinical supervisory experience. In doing so identifies what those attributes are that lead the clinician to conclude that the supervision they received was “good.” The following are some of those positive characteristics that lead to good clinical supervision. These include:

- Supervisors who integrate theory and practice and have been helpful at assisting their supervisees to be able to do this as well
- Supervisors who used teaching as the principle role the clinical supervisor practiced
- Clinical supervisors who participate in the professional education and development of clinical staff members.
- Supervisor who created a learning environment to enhance the supervisee’s clinical skills
- Clinical supervisor was non-judgmental, created a safe, trusting, and supportive relationship
- The Supervisor who monitored the quality of the supervisee’s work, and was available to provide the feedback that the supervisee could use
- Supervisor who used education, and empowerment
- Clinical supervisor who provided an optimum level of challenge, and support by teaching, advising, mentoring, consulting, coaching, and acting as a sounding board for the clinical supervisee.

Structure And Process Of Supervision

There is a structure and a process in clinical work that the clinical supervisor must focus on. Structure refers to the rules, the guidelines that govern the agency, the supervision role, and the relationships between supervisee, and supervisor. Structure is the science side of supervision.

Process on the other hand, has to do with the task and functions that the clinical supervisor needs to manage. The process also has to do with how the procedures are implemented, and includes factors such as style, artistry and craftsmanship.

Supervisor Functions

There are a variety of functions the clinical supervisor must attend to. These include:

- Monitoring the skills being learned by the supervisee, and the impact on the client
- Evaluating assessing the degree to which the supervisee is able to grasp the skills, and bring those skills into the work with clients
- Advising to provide direction, and feedback to the supervisee
- Instructing to teach effective helping skills
- Modeling to model appropriate behavior that supervisees need to conduct themselves
- Consulting to help supervisees separate their personal issues that may be in the way. The purpose of counseling is for the betterment of the client and should not be for treatment for the supervisee
- Supporting to provide the emotional support, encouragement and feedback that communicates to the supervisee that they are moving in the right direction of growth and development
- Sharing to provide enough personal/profession information that leads to the development of a positive professional relationship

The above lists are relatively straightforward except for the evaluation process. The evaluation process is a function that needs to be spelled out for the supervisee.

The Evaluation Process

Questions for consideration in the evaluation process may include:

- 1) What are the essential features to include in the evaluation process?
- 2) How will the supervisee's performance be measured?
- 3) How often should the supervisee be evaluated?
- 4) Does the supervisee has the option of evaluating the supervisor
- 5) How will the concerns of the supervisee, and the supervisor be handled?
- 6) Should this be a formal or informal process?

The evaluation process as described here in not used to mean judging the outcome or effectiveness of treatment. Nor is the evaluation done for administrative benefit. The purpose of the evaluation process is outlined by Munson, (1997). He writes, "The evaluation process used here is related to

the supervisor, and practitioner jointly evaluating the practitioner's practice to enhance learning, and therefore, effectiveness." Haynes, et al., (2003) says the report of the Association of State and Provincial Psychology Boards, captures the requirements for evaluation in supervision. This Board stated, " Evaluations provide objective assessment and direct feedback about the supervisee's competence in order to facilitate skill acquisition, and professional growth. They are necessary to ensure that supervisees achieve identified objectives. At the outset of the supervisory period each supervisor together with the supervisee shall establish a written contract that specifies a) the competencies to be evaluated, and the goals to be attained; b) the standards for measuring performance; c) the time frame for goal attainment. Direct feedback should be ongoing with written evaluations provided at least quarterly. Written evaluation of the supervisor by the supervisee should be allowed at the end of the training" (Haynes et al., (2003)

If we were to accept the recommendation made by the above Psychology Board we can say the following elements should be included in the evaluation process: These elements are:

1. A written contract
2. Identified objectives
3. Competencies to be acquired
4. Goals to be reached
5. The standard of measuring learning
6. The time frame for reaching the goals
7. The review dates

In order to make the evaluation process less intimidating the supervisor can inform the supervisee that the evaluation process is for growth not judgement. It is important for the supervisee to know that the supervisor will not be bringing up any surprises. The groundwork to lay is to ensure the supervisee knows that both are in this together.

Being clear in the feedback given is essential in making the evaluation process effective. The last thing the supervisee needs is to have to read between the lines. Providing ongoing supportive feedback can make the supervision evaluation process less threatening.

There are two main methods of conducting a supervisory evaluation. The first and most common occurring method is the evaluative feedback method. This, method is done one to one or sometimes with a group. This method is

subjective, and is based on the supervisee presenting cases for discussion with the clinical supervisor. Direct observation of the supervisee's work is another subjective method. In this method the supervisor has a first hand look at the work of the supervisees. These observations and interpretations of the supervisee can be shared and discussed. A group method can also be used both directly and indirectly; therefore, the supervisee can benefit from the various interpretations that the group members observe.

A written format can also be used in the evaluation process. In this format, the supervisor prepares a detailed form pertaining to the goals, learning objectives, skill building activities, and competency levels outlined in the written contract. The supervisee answers the items on the written format, and together the supervisee and supervisor can analyze the responses.

Objective or standardized evaluative tools are also available to the clinical supervisory. One such tool is the Minnesota Supervisory Inventory. The MSI has been empirically derived and uses an anchored scale for supervisors to evaluate the clinical work of supervisees in eight domains. (Haynes, 2003) Worthen and Isakson (2000) developed the Supervision Outcome Scale that is another evaluative tool that the clinical supervisor can utilize.

It is worth restating the evaluation process is required by the ethics codes of NASW, AAMFT, and the ACA and the clinical supervisor who fails to comply with these standards are putting themselves in harms way. By combining the indirect, direct method, the written format, and a objective tool, the clinical supervisor will be able to provide a comprehensive, and through evaluation process that will insure the supervisee develops the competencies required to perform independently, and will satisfy the ethical requirements.

Non Clinical Issues Supervisors Must Address

There are times that the clinical supervisor needs to assist their supervisee in non-clinical areas. These include:

- Preparation for licensing

- Managing the bureaucracy of the organization
- Working with burnout
- Project priorities
- Working with other professionals
- Managing conflicts with other employees
- Time management

Clinical Supervisors Styles

Clinical supervisors come in many shapes and sizes and they have many different styles. The four styles discussed here are authority, laissez-faire, bureaucrat and facilitator. The first three styles, authority, laissez-faire, and the bureaucrat are not styles recommended because they do not lead to the development of a positive mutual working relationship between the supervisee and the supervisor.

In the **Authority** style the supervisor takes on the superior position and dictates. This leaves no room for independent thinking, and can create a passive aggressive reaction as a means of equalizing the power structure.

The **Laissez-faire** style breeds distrust, uncertainty and lack of support because the supervisor is acting in a passive “whatever” manner, and does not provide the confidence that supervisees need. This style lacks direction, goals, objectives, and leaves supervisees wondering what is the “right” thing to do.

The **Bureaucrat** style can lead to distrust and uncertainty because the supervisee may not experience the supervisor backing them up. When supervisees do not feel like the supervisor has their backs, little risk taking will take place, and creativity are put on the back burner. Fear that if a mistake is made the supervisee will be “thrown under the bus” is increased. Under the Bureaucratic style the supervisor is only looking after itself. This is a violation of supervisory ethical codes that state the clinical supervisor is responsible for taking care of the wellbeing of the supervisee.

The **Facilitator** style is the style that is recommended because this style of clinical supervision utilizes teaching, coaching, counseling, and discipline in the training of a competent supervisee. This style creates a safe non-judgmental environment that supervisees need. This style of supervision leads to building effective supervisory relationships where supervisees are

free to explore, and develop their science side and art side of clinical work. The above three mentioned styles fall short of these aspects of clinical supervision.

Clinical Supervisors Play Many Rolls

Clinical supervision would be a less stressful task if all the clinical supervisor had to do were provide supervision. The demands agencies, and organizations are under require the clinical supervisor to play many roles besides being the clinical supervisor. These roles the clinical supervisor also need to balance are:

- Clinician
- Manager
- Staff Member
- Facilitator of professional growth
- Leader

Role As Clinician

Many clinical supervisors have to carry their own clinical caseloads, which includes providing clinical services to clients. Maintaining their own practice gives the clinical supervisor an opportunity to continue to build skills, and remain aware of the every day challenges of clinical practice. It is also in this role that the clinical supervisor can model effective practice, which the clinical supervisee can observe and imitate. This role is not the place where the clinical supervisor can practice “don’t do as I do, do as I say”. This is a prescription for disaster because it leads to distrust and decreased credibility.

Role As Manager

At times clinical supervisors have administrative duties. These duties focus on the accounting needs of the agency, and staff, carrying out the mission of the agency, and attending to legal, and ethical issues. Additional duties include: managing the fit between the agency’s needs, and staff’s needs, providing feedback up and down the organizational table, and explaining the evaluation process, the formal, and the informal parts.

The clinical supervisor needs to balance these roles. If the supervisor spends too much time as a manager, and not enough time as a clinical supervisor the supervisees can start to feel they are out on a limb on their own. It is difficult to serve two masters and the clinical supervisor is wise to remember their primary responsibility is to the supervisee. The agency needs come second. This is a balancing act many clinical supervisors struggle with, and leads to stress for them. By remembering what master comes first will reduce some of this stress.

Role As Staff Member

Being the clinical supervisor should not give the supervisor special status. The supervisor is bound to utilize the agencies policies, and procedures as any other member of the organization. The supervisor is not exempt from following the basic nuts, and bolts of agency practice, and procedures. Furthermore, the supervisor must make certain all supervisee's are knowledgeable of the policies, and procedures that govern the agency, the profession, and the board.

Facilitator Of Professional Growth

The clinical supervisor can be a source of professional growth for all the members of an agency. This is done by behaving in a professional manner at all times. This can also be orchestrated by creating, and maintaining a safe, and supportive learning environment. In other words, the clinical supervisor is a team player who is willing to share his expertise to any staff member who asks.

Professional growth can also be obtained when the clinical supervisor engages in activities that increase knowledge, skill, attitudes, and values. Defining the goals and path of the supervisor/supervisee relationship are part of the activities the supervisor can engage in.

Role As A Leader

People want to be lead, not bossed around. Clinical supervisees are no different. The clinical supervisor behaves as a leader by:

- Showing integrity
- Being honesty

- Empowering others
- Using the strengths of wisdom
- Demonstrating the strength of character

Effective Techniques For Good Supervisors

As I go around the tri-state area doing this clinical supervision workshop, I have compiled a list of what participants have said are the top behaviors that good clinical supervisor demonstrates. These are not scientifically tested, but they come from the hearts of those participants who have experienced good clinical supervision. The list is not inclusive, but is as follows:

- Knowledgeable
- Supervise confidently
- Knows what the professional goals of each supervisee
- Has the supervisee's back
- Behaves decisive
- Allow for differences
- Takes nothing personally
- Allow room for discussion
- Compromises when appropriate
- Does not sweat the small stuff
- Handles problems as they come up
- Provide the three A's of supervision
 1. Acceptance
 2. Approval
 3. Affirmation
- Practice Steven Covey "Seek first to understand in order to be understood" rule (Covey 1989)

Challenging supervisee knowledge, skill, attitudes, and behavior in a positive helpful manner for the purpose of bringing out blind spots, ineffective clinical behavior.

Clinical Supervision Is About Relationship Building

For clinical supervision to be worthwhile for all parties involved a healthy professional relationship is necessary. Watkins, 1999; Kaiser, 1997; Yontef, 1997). Corey, Corey, and Callanan (2003) put it this way:

– “ *We believe that the most important element in the supervisory process is the kind of person the supervisor is. The methods and techniques supervisors use are more likely to be helpful if an effective and collaborative working relationship with supervisees has been established.*”

The above quote tells us that the relationship between the supervisee and the supervisor is more important than the methods and techniques used by the clinical supervisor. Therefore, a discussion of how to build a professional relationship would add to the competency of any clinical supervisor because a positive relationship is needed for the learning process to occur.

Elements To Incorporate For Building a Successful Supervisory Relationship

As clinical workers, we know that for clinical work to flourish a relationship is needed. The elements we use as clinical professionals to build effective therapeutic relationships are the same that are needed for building professional supervisory relationships. Here are the necessary elements which are not in hierarchy order:

- Mutual involvement
- Recognize that both parties bring vital information to the relationship
- Trust
- Self-disclosure
- Diversity awareness
- Boundary management
- Using power and authority in an appropriate manner

- Acceptance and /or unconditional positive regard
- Genuineness
- Congruence
- Availability
- Validation of strengths
- Warmth and caring
- Support
- Advocacy
- Thoughtfulness
- Empathy
- Attending
- Active listening
- Caring confrontation
- Tune into their supervisees' fears, struggles, and hopes
- Have a clear understanding of the purpose and the limits of the supervisory relationship
- Be fully present
- Seek consultation when you are unfamiliar with the topic

Phases Of The Supervisory Relationship

The establishment of a healthy clinical supervisory relationship has three phases. Each of these phases has specific tasks to be performed. These phases are:

- The beginning phase
- The mature phase
- The termination phase

The Beginning Phase

The beginning phase of the clinical supervision relationship is the starting point of this relationship. It is the time when the supervisor and the

supervisee meet for the first time. It is in the beginning phase that the supervisor and supervisee clarify what this working relationship will be.

The establishing of a supervision contract is started, in the beginning phase. Both parties outline their part to play, and what is expected of each player. The rules are defined as well as the goals, and objectives. Supporting measures will be established. Specific educational teaching interventions to be used will be detailed in this phase as well.

The two parties will work out when, where and how frequent they will meet and how to handle emergencies if and when they arise. This phase is ended when all the details are worked out and both parties are satisfied with this arrangement.

Mature Phase

This phase works on increasing individual autonomy. The relationship exists without much effort. The parties' involvement becomes less role bound and a peer like supervisory relationship is established. It is at this time that the supervisee has developed sufficient skills and expertise that they can operate more confidently and needs less direction from the supervisor. The main focus of the clinical relationship is support, coaching, encouragement, and any tweaking that may arise.

Terminating Phase

In theory the supervisory relationship has a beginning, and an end. It is the terminating phase where individual competency on the part of the supervisee has occurred. The purpose for meeting has been satisfied. The supervisee demonstrates an understanding of the connections between theory and practice in relation to particular clients. No further needs are required to perform the duties of clinical work and this relationship now ends. It may move into a less structured style like peer supervision.

Contracts

One way to insure the clinical supervision process is satisfying to both parties involved is to spell out all the necessary details in a written contract.

By writing out a formal contract we can satisfy Ryan's law. Clinical supervision can get pretty messy when the rules are not spelled out. Imagine playing Monopoly with a group of friends and no one reads the rules. There would be a lot of confusion about how the game is played and sure enough someone would get their feelings hurt. The same thing can happen in the clinical supervision process if the rules are not spelled out.

So, the question to ask is what do you put in the written contract? The following list should serve as a guide to help you put together a useful supervisory contract. The contract is a mutual agreement between supervisor and supervisee that both parties sign. The contract is dynamic in that it must change over the life cycle of the supervisory relationship, and includes the following:

- Reviewed every 90 days thus allowing ample time to identify and resolve problem areas
- What is expected of each person
- Who is responsible for what
- What are the necessary requirements
- Explain how the evaluation of the supervisor will be done
- Explain how the supervisee will be evaluated
- Specify how problems between the two parties will be dealt with
- Spell out how long the supervisory relationship will last

Benefits Of The Contract

Written contracts satisfy Ryan's law. A written contract between the supervisee, and the supervisor reduces the misconceptions about the supervision process. A written contract minimizes covert agendas because what is expected is spelled out, and is right up front. The written contract can aid in the orientation of the supervisee by spelling out the details of supervision and what can be expected. Power can be a problem in clinical supervision. The written contract can serve as a vehicle to balance out this power. In short, the written contract serves to tie the supervisee and supervisor together by providing instructions for how to play the game.

Breaking Through Impasses & Overcoming Difficulties

From time to time problems arise in the clinical supervision process. Most of these problems can be resolved by following these suggestions. The first suggestion is not to take things personally. When we take things personally we can become defensive which stimulates the flight or fight response. Remain objective, and work together to define the problem. Bring all the issues out on the table and talk about them rationally. The second suggestion is to identify and investigate an issue to arrive at a common ground. Allow time for differences, and disagreements, but avoid becoming disagreeable. Thirdly, work toward mutual agreements by integrating both parties' ideas, and come up with a joint decision. The fourth suggestion is to exchange accurate information, not opinions. The fifth suggestion is to negotiate and be willing to give, and take. The sixth suggestion says, as the supervisor, you are the leader, your role is to educate, and to facilitate growth. Your role is not to control, dominant, and win.

If things are not working follow the seventh suggestion that says do something different. This is what the brief therapy experts would suggest. The eighth suggestion is to take a time out, sleep on the problem, and give you time to ponder. The final suggestion is to seek consultation. If that does not work, bring a mediator in to assist both parties at coming to a mutually satisfying agreement.

Some Obstacle Don'ts

There are a couple of things that are recommend the clinical supervisor not do. If you do these, you are making the clinical supervisor's job far more difficult than it has to be.

- Do not ignore a vital problem. When we ignore a problem the problem will get bigger, and bigger, then much harder to correct. Address the problem when it is small. It usually requires less effort, time, and money to fix it.
- Do not procrastinate addressing a problem because this will make you look inadequate and indecisive to the supervisee.
- Do not minimize a problem. When clinical supervisors minimize problems the supervisee can start to feel shortchanged, not heard, and feel like the supervisor does not have their back. Do not overly criticize, this only serves to limit the creative endeavors of supervisees.
- Do not loose your cool with your supervisee. Loosing your cool, yelling and screaming only makes you look like a jerk, and who respects a jerk?

Putting it All Together: What to do and When to Do It as A Clinical Supervisor

Up to this point we have been talking about what clinical supervision is, what are the tasks, and functions of the clinical supervisor, and what elements are needed to establish healthy relationships. Contracting, and some suggested don'ts were also covered. In this section, we will be discussing what to do, and when to do it as the clinical supervisor. What to do and when to do it fall in three stages: Assessment stage, Engagement stage, and the Work stage.

The Assessment Stage

The purpose of the assessment stage is to figure out what the supervisee has to work with, their strengths, and weaknesses. In the assessment stage, the clinical supervisor will determine what the supervisee needs to learn and wants to learn. In addition, this assessment will determine how equipped the supervisor is to meeting the supervisee's needs.

During the initial weeks of clinical supervision, the clinical supervisor will be assessing the supervisee's knowledge base, skill level, professional values, and ethics. The assessment process also looks at professional and personal attitudes the supervisee brings to the supervisory relationship.

The goal of the assessment stage is for the clinical supervisor to have the clearest possible understanding of who is being supervised. The clinical supervisor should assess how effective the supervisee has been with their clients, and how able the supervisee is to take directions or caring criticism. This also includes assessing how well has the supervisee worked with other supervisors. One question to ask the supervisee is, when you worked with other supervisors, what worked for you, and what did not work? The assessment of the clinical supervisee can include a determination of the supervisee is development level, multicultural level and learning style. The developmental level refers to where the supervisee falls on a developmental continuum where dependent is at the left side of the continuum, independent is some where in the middle of this continuum, and interdependent is the far right side of the developmental continuum. Interdependent refers to the ability and to work within a group. Knowing this information will tell the supervisor how to utilize its time, efforts, and resources.

Multicultural levels also need to be assessed particularly when the supervisee works in a diverse clinical population. The supervisor needs to know how effective the supervisee is at working with different cultures. This information will tell the supervisor what deficiencies exist, and how to correct them.

We all learn at different rates and in different means. The assessment process should also include an assessment of the supervisee's learning style. The assessment questions to answer are how does the supervisee learn, does the supervisee learn best from practice or from reading, is this a person who learns by observing then doing or visa versa. Knowing how a supervisee learns dictates the kind of feedback that is given to each supervisee. This could vary greatly from supervisee to supervisee. To assist the learning process, the supervisor would be wise to know adult learning principles.

Adult Learning Principles

Core's Adult Learning Principles (Knowles, 1998) say that adults learn differently than children. Adult learning is dependent on:

- The need to know for the benefit of learning a new skill
- The learner's self concept due to a need to be seen as being capable of self-direction
- The role of learner's experiences both professional, and personal
- Readiness to learn i.e. is the supervisee ready to learn a new skill
- Motivation referring to what drives the person to want to grow
- Is this an internal process or and external one
- Orientation to learning means the time orientation needs to be in present context if it is to achieve maximum potential

Direct & Indirect Assessment Methods

The assessment of a clinical supervisee can be maximized by using direct, and indirect assessment methods. Each of these methods provides the supervisor with valuable information in order to develop an effective learning program for the supervisee.

Direct Methods of Assessment

- Audio/Videotape
- Live observation
- Two way mirrors
- Telephone call ins
- In room consultant

Indirect Methods of Assessment

- Verbal report
- Process recording
- Case study review
- Role playing

The Engagement Stage

The Engagement stage is similar to the engagement period before marriage. This is the beginning or introduction to supervisor/supervision based on all the data that was collected during the assessment stage. The engagement stage is the foundation where all the other clinical supervision work is based on. The tasks to accomplish include orienting the supervisee to the process of supervision, and orienting the supervisee to the structure, and how clinical supervision will be conducted.

The development of a safe and trusting environment that outlines each party's respective roles is another task to complete in the engagement stage. A task that also needs to be completed is defining what the supervisor, and the supervisee will be doing. How they will be working together also must be defined. Relationship building will also need to be explored. Contract negotiating, goal setting, and objective writing that lead to a formal contract must also be completed during the engagement stage.

There is other less concrete areas to establish in the engagement stage. These are:

- Use of power
- Use of self
- Dual relationships/Boundaries

Use of Power

Power in the clinical supervision arena needs to be used lightly so as not to come off looking authoritative or dictatorial. When formalized power is used too frequently, safety and trust will be eroded. We do not want to use power over some one because power over refers to controlling with authority behavior. If power is to be used, it is best used as power with. Power with refers to collaboration, sharing of power and cooperation. Power with decreases the chances of power struggles.

Use of Self

There are differing opinions about what to share, and what not to share. However, a discussion with the supervisor on this subject would be fruitful. This discussion can explore the rationality of what is shared in the supervisory meetings, and when working with clients. It would be wise to

identify the comfort level, and the degree or depths of what is shared. The discussion of the use of self can do a lot to maximize the usefulness of what is shared, and what is not.

Dual Relationships and Boundary Decisions

At times dual relationship and boundaries can blur. Sitting on the same committee, working together on a community event, a work-sponsored activity can all lead to dual relationship issues, and some boundary crossing. There are safeguards to utilize for managing when dual relationship and boundary crossing occur. An initial safeguard is for the supervisor to be clear in their boundaries as they switch from one function to another. Another safeguard is for the supervisor to be clear about the appropriateness of the use of their power. The supervisor should never employ a covert agenda. Covert agenda's only look out for the supervisor's needs and objectives. By using overt agendas, the supervisor is providing safeguard because overt agendas are above board where all involved know what to expect. Overt agendas look out after the needs of the supervisee. Putting the needs of the supervisee first, and practicing ethically will insure the safety and trust in the working relationship. A comprehensive discussion with the supervisees about the times when boundary crossing occur will serve to keep the relationship true.

The Work Stage

The Work stage builds on the engagement stage and focuses on the supervisee's work. It is in the work stage that the supervisee learns how to hone their clinical skills. It is this stage that the supervisee learns how to dance. The supervisor's main focus is on teaching the supervisee all there is to know about the dance. There is secondary work taking place while this dance is going on. The secondary work consists of maintenance of the supervision relationships, problem solving, conflict resolution, collaboration, and consultation. The final outcome of the work stage is the competency training, continued growth, and development of the supervisee so the supervisee can practice independently. Independent practice is the ultimate goal of supervision.

Working Through Stress and Burnout

Any helping professional who has done clinical work knows that clinical work can lead to stress, and burnout. The factors that lead to stress and burnout include, but are not limited to: heavy workloads/caseloads, high unrealistic expectation that come from an internal or external source, barriers to achieving goals, poor and uncomfortable work environments, incompatible demands, ambiguous role expectations, unavailable and incompetent supervisors.

Supervisors can help reduce stress, and burnout by supporting supervisee's. Being available for questions, and having an open door policy can help to reduce stress, and burnout. Supervising in a consistent fashion and responding to supervisee's inquires in a straightforward manner can also help. Knowing, and understanding the stress response, and addressing these conditions when they are observed can also reduce stress, and burnout. The supervisor can role model healthy stress practices in hopes that the supervisee will imitate those responses. Recognizing each supervisee's unique way of dealing with stress, and providing the appropriate feedback to the supervisee will have a positive impact at reducing stress, and burnout. Comparing a workers performance to his past performance rather than comparing it to someone else's performance will eliminate competitions among workers, thus reducing stress and burnout. Facilitate insight by encouraging a discussion of problems, creating the best possible work environment, promoting, encouraging education, and knowledge advancement can play a profound impact on reducing stress, and burnout.

Leading the clinical supervisee through the ebb, and flow of agency and personnel changes will also help the supervisee avoid stress, and burnout. This is done by educating the supervisee that change is a constant reality. Providing accurate information, and not participating in the rumor mill will aid the supervisee. The clinical supervisor can be sensitive to the emotional distress that change brings to the supervisee, and allow time for venting and readjustment.

When the clinical supervisor practices as a leader not a follower will also reduce stress, and burnout. Being a leader provides the clinical supervisee someone to follow and provides a consistent reality center. Lastly,

professionally welcome and integrate new personnel into your supervision group can help all to manage change and reduce stress, and burnout.

Group Clinical Supervision vs. Individual Clinical Supervision

Our discussion would not be complete without the comparing and contrasting group supervision, and individual clinical supervision. The tasks to accomplish in clinical group supervision are similar to clinical individual supervision. There are some advantages for doing group clinical supervision. One of these advantages is that groups allow for a greater economy of time, money, effort, and expertise. A wider range of client situations can be exposed under a group supervision practice. There is an increase in vicarious learning from peers that takes place in group work. Feedback from other supervisees can generate a variety, and diversity of perspectives that can not be acquired in individual clinical supervision. Groups can act as a source of emotional support for the clinical supervisee when the clinical supervisor is not available. Group clinical supervision can provide an increased amount of encouragement. Groups can provide a sense of belonging. Other group members can fill the voids that are not addressed in individual supervision.

There are disadvantages of group supervision. The supervisor may not be an expert in group work resulting in a less effective clinical supervision experience. Group supervision may not provide the individual time needed for personal learning and processing time. The diversity in skill levels, interests, and case relevance can limit the usefulness of group clinical supervision. Another disadvantage of group supervision is the dysfunctional dynamics such as scapegoating, competition, and power hungry group members may be increased in a group setting, This can render the groups ineffective. The complexity of meeting the learning styles and developmental demands of a diverse group can also make clinical group supervision less effective. The problem maintaining confidentiality of clients, and supervisee arises more frequently in the group supervision format.

Individual clinical supervision has its advantages. The ability to have a detailed look at the supervisee's work is a clear advantage. Individual time to be able to discuss all of the supervisee's cases is another significant advantage. Individual attention is provided more consistently in individual

clinical supervision. The clinical supervisee may feel more comfortable sharing their work within an individual setting than in a group setting.

The disadvantages of individual clinical supervision are the advantages of clinical group supervision. The experts in clinical supervision suggest that the clinical supervisory process be a mixture of both individual and group. This way the supervisee gets the best of both worlds.

Pitfalls in Clinical Supervision

There are a couple of supervisory pitfalls to mention before concluding this course. The first pitfall is supervisory enabling. This occurs when the clinical supervisor does not hold the supervisee accountable. Enabling occurs when the clinical supervisor does the work for the supervisee or makes excuses for why the supervisee has not performed at a professional level. Another example of clinical supervisory enabling occurs when the supervisor fails to address the dysfunctional behavior of the supervisee, and the supervisee is allowed to continue to perform incompetently.

Supervisory enabling devalues the supervision relationship and it erodes trust. It also promotes inequality of work that has a drastic effect on client care. Enabling also reinforces dysfunctional behavior, and this also compromises patient care. Enabling compromises the morale of any agency, and leads to other staff members wondering why they are following the rules.

Performing therapy with a supervisee is another major pitfall, and is an ethical violation because it crosses boundaries. This is a dual relationship. Treatment of the supervisee should be avoided at all times. The clinical supervisor's function is to make the supervisee a better worker, not a better person. The supervisor does not have the right to intrude on the supervisee's personal life. Trust and credibility are lost if treatment occurs in the clinical supervision setting. Supervisory roles become blurred and confused when the supervisee becomes the patient. A way of avoiding this pitfall is for us to remember that we ask the supervisee, "How can I help you do your work better" and we ask clients, "How can I help you in your life". If a clinical supervisee presents behaviors that would suggest some sort of pathology a referral to the agency EAP or outside counseling is recommended.

When Problems/Conflicts Surface

There are times when the clinical supervisory process becomes problematic. Falender (2007) points out that there are red flags that surface that warn the clinical supervisor that there are difficulties in the supervision process. This list includes:

- Change in supervisee behavior
- Withdrawal, aloofness
- Decreased verbal behavior, not forthcoming quality of interaction
- Change in interaction
- Over-compliance with supervisor suggestions
- Supervisee appearing preoccupied
- Supervisee seeming distant or annoyed
- Supervisee seeming stressed or nervous
- Supervisee confusion

It is the supervisor's responsibility to read these warning signs and address them as they surface. Failure to address these will only serve to further erode the clinical supervisory process. In addition to the red flags, and warning signs that occur in supervision, game playing between the clinical supervisor and the supervisee also occurs.

Gamesmanship was reported to be occurring in the clinical supervision process some thirty years ago. (Munson, 1979). She defines a game as, "An ongoing series of complementary ulterior transactions-superficially plausible, but with a concealed motivation." These same games are still being played out in the clinical supervision arena by both the supervisee, and the supervisor.

Although very dysfunctional, the purpose for the game is to achieve some objective or purpose. Munson, (1979) wrote, "The purpose of engaging in the game, of using the maneuvers, snares, gimmicks, and ploys that are, in essence, the art of gamesmanship, lies in the payoff." One or both of the parties in the clinical supervision relationship choose a strategy to maximize their chances to achieve their payoff, while at the same time minimizing any penalties. Winning as much as possible without losing one's stake is the objective. Munson adds, "Games people play in supervision are concerned with the kinds of recurrent interaction incidents between supervisor and supervisee that have a payoff for one of the parties in the transaction."

To reduce the amount of games played in supervision, it would be beneficial to outline some of these games. In doing so, the clinical supervisor has a greater chance of not falling prey to them. Awareness, understanding, and short-circuiting the game is the supervisor's best line of defense. Below are some of the games played.

Us Against Them - In this game the supervisee is attempting to form an alliance with the supervisor against the agency. The supervisee is attempting to gain power against the agency as a way to carry out its own beliefs and agendas. The goal is to achieve the supervisee mission rather than the mission of the agency. The clinical supervisor is wise to maintain the balance of power between the agency, the supervisee, and supervisor. It would be helpful to redirect the efforts of the supervisee to work within the organizational level.

You Are The Best Supervisor Ever - This is a game of emotional blackmail in which the supervisee showers the supervisor with flattery in hopes of rendering the supervisor helpless or powerless. In this game, the supervisor needs to beware that the ploy is to stroke the supervisor's ego in hopes that the supervisor will respond in like kind, and not present any criticism to the supervisee. Maintaining good boundaries, and staying focused to goal attainment can keep the supervisor from taking the "nice" bait.

A Little Therapy Please – In this game the supervisee manipulates the supervisor in solving his personal problems in order to not expose his professional work. If the supervisor plays this game supervisee enabling will occur. The prudent action on the part of the supervisor is to reframe the personal problem back to the clinical work and to refer the supervisee for professional counseling outside of the supervision domain.

But We Are Friends – This is the game where the supervisee has defined the supervisory relationship in terms of friends rather than clinical work. The friend card is a manipulative interaction pattern to move the supervisor off course, and the supervisee is no longer held accountable because "we are friends". The supervisor can stay clear of this game by remembering the roles that were agreed upon in the written contract and being friends was not one of those roles.

I Am Big Like You – In this game the supervisory relationship is reduced to peer-peer, and democratic participation is the major focus. The payoff for the supervisee in this game is the acquisition of power. When the supervisee sees the relationship as equal, he/she is free to do what they want to do rather than what the supervisor wants them to do. The correct move for the supervisor to take in this game is to be aware of the need of the supervisee to have more power, and to remind the supervisee that your responsibility is to evaluate the supervisee's performance.

You Do Not Have All The Answers - The supervisee in this game attempts to put the supervisor down by emphasizing he knows more than the supervisor in a particular area. Rather than getting into an argument over who knows more, the supervisor can allow the supervisee to shine in the areas of competence and share the platform on expertise when it is appropriate. There is no point in arguing who has the best basketball when the goal is for us to mutually play basketball together.

I Have An Agenda – The gimmick of this game is for the supervisee to control the meeting with a deluge of questions. The questions are designed to prevent the supervisor from addressing areas of weakness. If the supervisor allows this behavior to occur the supervisee will continue to use it which will have a negative impact on goal and skill attainment. The counter move for the supervisor is to use time wisely, interrupt the supervisee, and spell out the supervisor's agenda. The supervisee and the supervisor can negotiate which questions will be addressed during the session.

Supervisor's Games

Unfortunately, clinical supervisors also involve themselves in gamesmanship. Supervisors play games for a variety of reasons which include, fear of losing control, anxiety about their own competency, perceived threats in the hierarchy, wanting to be liked, approval seeking, and a passive way for the supervisor to express hostility. The following describes some of the games supervisors play.

They Won't Let Me – Because of the desired to be liked, the supervisor blames his superiors for why an action could not be taken, but he never consulted his superiors. In playing this game the supervisor avoids appearing to be like the other authority figures in the agency. If the

supervisor moves past the desire to be liked and focuses on the objective of clinical supervision this game would not need to be played.

Poor Me – The supervisor uses this game to abdicate her authority by claiming to be too busy to meet, and discuss the problem that the supervisee is encountering. One motive for this game may be to avoid looking less competent to the supervisee. The truth be told, this behavior sends a message to the supervisee that the supervisor is aloof and does not care. A better game to play for the clinical supervisor is be honest, and when a question is asked that the supervisor does not know, admit it, and be willing to seek out the answer for the supervisee.

One Good Question Deserves Another - Here the supervisor deliberately passes the question back to the supervisee in an attempt to not be discovered that he may not be on top of the latest knowledge, to keep from having to make a decision, and be wrong. In doing so the supervisor can feel superior. The supervisor rationalizes by returning the question back to the supervisee it is for the supervisee's growth and development. The simplest move the supervisor can make is just not to play this game in the first place and just answer the question.

Remember Whose Boss – Employing this game, the supervisor defines his role as one of absolute power and permits no contradictions, disagreements or negotiations. Supervisor's who play this game need to remember, "those who live by the sword, die by the sword." If the supervisor wants an easier day, she would be wise to focus on building a professional relationship. If the supervisor wants to have supreme control, he should be on the look out for a caudate.

Father/Mother Knows Best – In this game, control is maintained by the supervisor behaving parentally. "This has always worked for me so it will work for you." is the operating belief on the part of the supervisor. This game does not let the supervisee learn by their mistakes and hampers growth and development. This game if played is an ethical violation. This game can be avoided by the supervisor being the teacher and allowing its students to learn by doing and learn by making mistakes.

Conclusion

In this program we have look at a wide range of information about clinical supervision. We have explored the historical background of clinical supervision, and can see that clinical supervision is evolving into its own specialty. We looked at the legal and ethical considerations of clinical supervision. Now we know that the clinical supervisor is responsible for the work of the supervisee, and may have to respond to ethical and legal problems that arise.

This program explored the assessment, engagement and work stages in the clinical supervision process. Each of these stages has tasks the clinical supervisor must accomplish. One of those tasks is to write a comprehensive contract that spells out the duties, expectations, responsibilities, and the evaluation process to be use by both parties in the relationship. Relationship building is a major task to be completed in the clinical supervision process. How to build a successful professional relationship was covered. It is important to remember that it is the kind of person the supervisor is that is most important to relationship building. The techniques take second place.

Stress and burnout are emotions that can not be ignored by the clinical supervisor. Several strategies were discussed. The supervisor can reduce stress and burnout by modeling effective behavior.

In the program we pointed out the pros and cons of group, and individual clinical supervision. It was suggested that the best clinical practice is to use of combination of group, and individual supervision so the supervisee gets the best of both worlds. We also compared clinical supervision with administrative supervision, and described how they are different. One difference is the clinical supervisor looks out for the well being of the supervisee, and the administrative supervisor looks after the organization first.

We talked about the two pitfalls of clinical supervision, enabling, and doing counseling with a supervisee. Neither of these pitfalls is recommended, and the clinical supervisor should be on watch that he does not fall in them. Conflict areas do occur in clinical supervision, and we presented some red flags as well as games that the supervisee, and the supervisor play.

The writer would like to congratulate you on the completion of this home study course, and to encourage you to continue to study, and develop your

clinical supervisory skills for your benefit, the benefit of the supervisee, and the benefit of the clients that are served.

Clinical Supervision Home Study Course

Exam

Directions: Respond to each question using the answer sheet provided. You must obtain a score of 75% in order to complete the course and receive your certificate. When finished with the exam, please fax, or mail the answer sheet along with your payment.

1. Clinical Supervision is a complex practice that can be enhanced through, study, collaboration and consultation.
True False
2. A supervisor is?
 - a. A well known authority in an organization
 - b. Is a person that is assigned or designated by an organization or agency to oversee another employee's work
 - c. A postgraduate who is brought to an agency to consult with staff members
 - d. A staff member who is assigned by the agency director to be in charge
3. What's the primary aim of clinical supervision?
 - a. To make the lives of every clinical supervisee full of joy and prosperous
 - b. To ensure that the clinical supervisee does not get the organization involved in a legal conflict
 - c. To create a context in which the supervisee can acquire the experience needed to perform independently
 - d. All of the above
4. What is a clinical supervisor?
 - a. A person who is assigned to oversee the work of a staff person who is providing clinical services
 - b. A well trained and knowledgeable person who is in a supervisory role to facilitate the growth of another clinical worker
 - c. A supervisor who's primary purpose is to help supervisee's attain the knowledge needed to perform services to clients in such a manner that no harm comes to the client or the profession
 - d. All the above

5. Clinical supervision is a unique professional relationship between a supervisor, a supervisee and the clients they serve.
True False
6. The clinical supervisor plays many roles. Which of the following roles is the primary role of the clinical supervisor?
a. Gardener
b. Gatekeeper
c. Mentor
d. Teacher
e. Consultant
7. Prior to the 1900s, clinical supervision was conducted within an agency and the emphasis was on system theory which was later replaced by Freudian psychodynamic theories.
True False
8. Clinical supervision is different than administrative supervision because
a. Clinical supervision focuses on the individual development and competency building of the supervisee
b. Administrative supervision's primary aim is to the wellbeing of the agency and then the clients served
c. Administrative supervision focus mainly on accountability and judging supervisee's performance for the purpose of advancement and raises
d. It is the clinical supervisor's responsibility to ensure that those the supervisor supervises are knowledgeable and are following proper ethical codes outlined by their given profession
e. None of the above
f. All the above
9. The clinical supervisor can not be brought into a malpractice suit brought about by the action of one of his/her supervisee's nor can the clinical supervisor be held responsible if a supervisee's client files a complaint with the Counselor, Social Work, and Marriage and Family Board.
True False

10. Which of the following is not an action the clinical supervisor can take to avoid or reduce legal or ethical problems within their supervisory role?
- To recognize that the supervisor is ultimately responsible for the actions of his/her supervisee and should work competently and wisely
 - Let clinical supervisees work independently and autonomously without monitoring
 - Have knowledge of every case the clinical supervisee is providing services to
 - The clinical supervisor can work within the scope and competency of his or her practice and refer those cases that are outside of that practice
11. National standards now exist that add to the quality of clinical supervision. Which one of the following is not a standard?
- Skilled
 - Professionally trained
 - Knowledgeable
 - Having a great sense of humor and can tell a good story
 - Has the ability to establish a professional relationship
12. Which of the following models were discussed in this home study course?
- Developmental model
 - Social role model
 - System model
 - Integrative model
 - All were discussed
 - None were discussed
13. It is recommended that the inexperienced clinical supervisor ignore already proven models of supervision and use his/her own integrative approach.
- True False

14. The clinical supervisor balances the art side and the science side of clinical practice. Which of the following is not an aspect of the science side?
- Research
 - Empirical data
 - Curiosity and creativity
 - Sound information that goes beyond thinking and moves toward proving
15. Which of the following is associated with the art side of clinical work?
- The types of dress the clinician wears
 - The clinical style and demeanor of the clinician
 - The treatment method chosen by the clinician
 - All the above
16. The elements of art consist of the critic, rehearsal, discipline, curiosity and creation.
True False
17. Without discipline in the manner in which a supervisee works with clients creates?
- Chaos
 - Happy customers
 - Happy supervisees
 - A safe place to work in
 - A better learning environment
18. Random acts are factors the supervisee and supervisor need to address. What are random acts?
- Acts that occurred out of the many hours of clinical work
 - Acts that occurred because God is humorous and he wanted to see what would happen
 - Acts that occurred that had little to do with the work the client was doing in treatment, but was profound enough to bring about the desired change for the client
 - Random acts don't exist, all things occur for a reason

19. A good supervisor is one who is described as:
- A wise fellow who brings cookies to staff meetings and encourages nap time after lunch
 - A supervisor who insisted that all paperwork needed to be completed regardless of patient care
 - A supervisor who creates a safe, secure learning environment and is available when the supervisee is in need of help
 - Is knowledgeable in one theory and is consistent in only talking about that theory of practice
20. The clinical supervisor has many functions to perform. These functions do not include which of the following?
- Monitoring supervisees
 - Evaluating supervisees
 - Advising supervisees
 - Modeling for supervisees
 - Treating supervisees
21. The evaluation process described in this course has to do with judgement of performance, accountability of effort, effectiveness of treatment and conducted on an annual basis.
- True False
22. Of the four clinical supervisor styles detailed in this course which of the following is not one of those styles?
- Authoritative
 - Bureaucrat
 - Laissez-faire
 - Facilitator
 - Mediator
23. Clinical supervision is about relationship building. In the quote by Watkins et al, which of the following do the authors believe is the most important element needed in the supervisory process?
- The kind of person the supervisor is
 - The methods and techniques used by the clinical supervisor
 - The attitudes about what makes for resistant clients
 - All the above

24. The clinical supervision process is one that is always changing, dynamic, and moves through three phases and never ends.

True False

25. Written contracts are important because they?

- a. Satisfy Ryan's Law
- b. Reduce confusion
- c. Inform the supervisee of what is expect
- d. Keep the process above board
- e. Non of the above
- f. All the above

26. Stress and burnout are emotions that all supervisees will encounter and there is nothing the clinical supervisor can do to reduce stress and burnout. The only recourse the clinician has is to help him or her self.

True False

27. Which of the following is not something the clinical supervisor needs to address during the assessment stage?

- a. The supervisee's developmental level
- b. The supervisee's skill level
- c. The development of the supervisory contract
- d. The professional values and ethics of the supervisee

28. Direct methods to employ during the assessment stage include?

- a. Live observation
- b. Videotape
- c. In room consultation
- d. Verbal report

29. In the assessment stage the clinical supervisor wants to know as much about the supervisee as possible, the engagement stage addresses and defines the use of power, boundaries, and relationship building. The work stage focuses on the actual work the supervisee is performing.

True False

30. When problems develop between the supervisee and the supervisor, the supervisor is directed to?
- a. Quickly start psychotherapy with the supervisee
 - b. Have a direct, open, and non-judgmental discussion with the supervisee and seek consultation
 - c. Enable the behavior by ignoring the problem
 - d. Get into game playing responses
 - e. Stand out on the roof of your office and scream very loud, “ Take this job and shove it “

Thank you very much for choosing one of my Home Study courses. Please provide me some feedback on the attached form.

I hope you choose another one of my Home Study courses or come see me live at one of my workshops.

Bill Malone, MSW, LISW-S

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This page has all the information you will need to tell us who you are, and how you will be paying for the course. The answer sheet and evaluation questions are also on this form. You will need to completed the following:

1. Participant’s demographic information
2. Payment method **\$70.00** for the course, if using check mail to above address, credit card can be faxed to above fax number
3. Test answer sheet (you must get a 75% to pass this test and receive your CEU certificate)
4. Evaluation questions

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Payment method for the course \$70.00

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| 2 | A | B | C | D | | |
| 3 | A | B | C | D | | |
| 4 | A | B | C | D | | |
| 5 | TRUE | | FALSE | | | |
| 6 | A | B | C | D | E | |
| 7 | TRUE | | FALSE | | | |
| 8 | A | B | C | D | E | F |
| 9 | TRUE | | FALSE | | | |
| 10 | A | B | C | D | | |
| 11 | A | B | C | D | E | |
| 12 | A | B | C | D | E | F |
| 13 | TRUE | | FALSE | | | |
| 14 | A | B | C | D | | |
| 15 | A | B | C | D | | |
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| 28 | A | B | C | D | | |
| 29 | TRUE | | FALSE | | | |
| 30 | A | B | C | D | E | |

Evaluation questions:

Your opinion is important to us. Please share with us your thoughts about this home study course you just completed. Please circle the number you feel answers the question. 1- disagree completely to 10 – agree completely

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| A. What is your overall evaluation of this home study course? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| B. The material was interesting and informative. It held my interest. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| C. I feel like I learned something useful to add to my work | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| D. Was the process of using our website, downloading the test and sending in the test easy? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| E. I would recommend this homestudy course to a colleague? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| F. Comments | | | | | | | | | | |
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