



Rehabilitation Psychology

Life fully realized

**Early Career Psychologist Special Interest Group
2019 Spring Webinar Series**

**Navigating the Supervision Process as an
Advanced Trainee or ECP within Rehabilitation
Psychology and Counseling**

Part I: May 1st

Part II: May 8th

Webinar Housekeeping

- This webinar is being **recorded**. A recording will be posted to the Division 22 website.
- **If you are not hearing the audio**, use the **telephone icon** in your FreeConfereCall.com menu to connect by phone or computer speakers. Instructions:
<https://tinyurl.com/ecpwebinarinstructions>
- Please ensure that your mic is **muted**.
- Use the **chat feature** if you are having technical difficulties. An ECP SIG member will respond.
- We will have time for Q&A at the end.

ECP SIG

- Purpose
 - The Division 22 Early Career Psychologist Special Interest Group (ECP SIG) brings together rehabilitation psychologists who are early career members and/or those who work with and mentor early career rehabilitation psychologists to represent and advocate for the professional development and interests of this highly diverse group.
- Who we are
 - Chair: **Leah Adams, PhD**
 - ECP Representative to the Division 22 Executive Committee: **Ferzeen Patel, PsyD**
 - Webinar Coordinator: **Lauren Golla, PsyD**
 - 10-15 active members serving roles of secretary, social media liaisons, job/career liaisons, membership, special practice topics
- Opportunities for leadership
 - Contact us! Our Division is always looking for organized, motivated ECPs to take on key projects and initiatives within the Division.
 - Visit the ECP SIG page on the Division 22 website: <http://www.div22.org/early-career-psychologists>

Gloria K. Lee, PhD

Dr. Lee is an associate professor and program director of the Master's of Arts in Rehabilitation Counseling program at Michigan State University. She obtained her doctorate in Rehabilitation Psychology.

She has served as a faculty in training a variety of master's and doctoral level students in the disciplines of rehabilitation counseling, mental health counseling, school counseling, counseling psychology and school psychology.

She has taught classes for doctoral students in clinical supervision, and has supervised master's and doctoral students in clinical supervision.



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Part 2: Clinical Supervision

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Agenda

- Day 1:
 - Roles and Types
 - Clinical Supervision Models
 - Process and Ingredients
 - Techniques
- Day 2:
 - Supervision Relationship – the Therapeutic Alliance
 - Supervisor Factors, Supervisee Factors, Process and Outcomes
 - Evaluative Aspects of Supervision
 - Scenarios and Discussions
 - Concluding Tips and Resources

THE THERAPEUTIC ALLIANCE



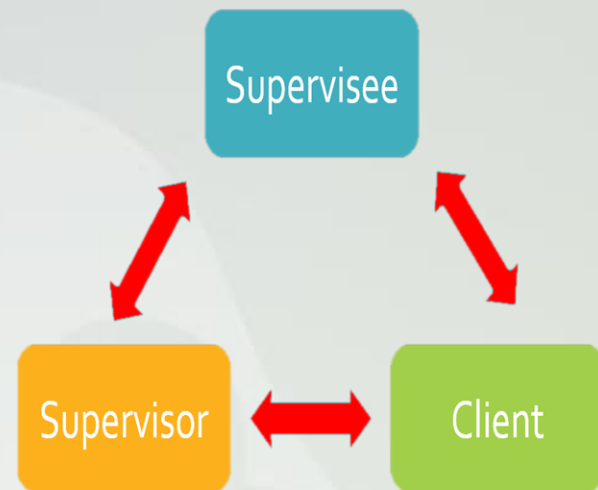
Working Alliance

Supervisee is the pivot point in the system (Frawley-O'Dea & Sarnat, 2001)

Working alliance (WA) =therapeutic relationship=therapeutic alliance
=working relationship

Key elements (Bordin, 1983):

- Agreement on goals
- Agreement on tasks
- Bonds



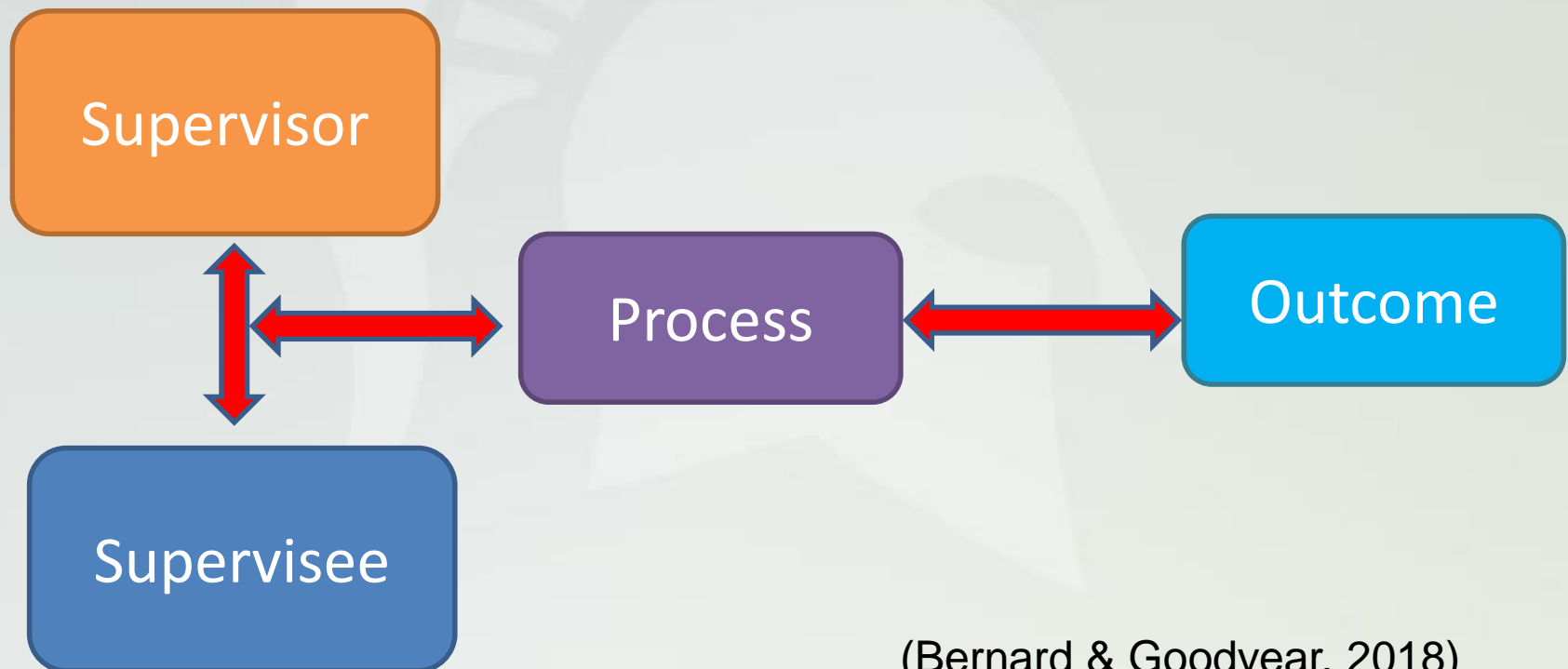
[Supervisory Working Alliance - Supervisee Form](#)

[The Brief Supervisory Alliance Scale - Supervisor Form](#)

[The Brief Supervisory Alliance Scale - Trainee Form](#)

Factors

- Contributing factors to successful supervisory and client outcomes



(Bernard & Goodyear, 2018)



SUPERVISOR FACTORS

Toolbox

As a supervisor, the use of measures to help conceptualizing pertinent supervisory constructs (and through self reflection) can be a helpful first step to know “where you stand”. Below are additional measures that can help supervisors/supervisees to know where they are in various aspects of clinical supervision.

- Knowledge/Competency:
 - [Supervisor Competency Self-Assessment](#)
 - [Multicultural Supervision Competencies Questionnaire](#)
- Self-Efficacy:
 - [Supervisory Self-Efficacy Scale](#)
- General Satisfaction, Outcome, and Process (completed by supervisees):
 - [Supervisory Satisfaction Questionnaire](#)
 - [Supervision Outcome Scale](#)
 - [Evaluation Process Within Supervision Inventory](#)
- Complete package of forms in a practice setting:
 - <https://www.sccgov.org/sites/bhd-p/QI/PQIC/Pages/TOOLKIT-For-Clinical-Supervision.aspx>

Supervisor Factors

- [Supervisory Styles Inventory](#) (Friedlander & Ward, 1984)
 - Task-oriented style not correlated with WA
 - Interpersonal style (consultant) consistently predicted WA and supervisee satisfaction
 - Attractive style mixed results
- Attachment style and emotional intelligence
 - Positive-affiliated attachment predicts strength of alliance

Supervisor Factors

- Use of expert and reference power
 - More credible source and more power
 - Social influence interpersonally
 - Being powerful also means being more flexible in how supervisors respond to supervisees
 - Power as one's personality and cultural power (being a member of the dominant culture)
- Types of interpersonal power:
 - expertness, attractiveness, trustworthiness
 - coercion (evaluative) – less comfortable for those who identifies supervisory role as counselors
- Central (involves effortful elaboration of information) and peripheral (greater reliance on cues or simple rules)
- Status – complimentary (unequal amount of status) vs. symmetrical (equal status)
- Be careful not to minimize or abuse the use of power!

Supervisor Factors

- Use of self-disclosure
 - Similar to therapeutic relationship in counseling
 - Moderate degree of disclosure relate to positive WA
 - When/how to use self-disclosure?
 - Not immediate
 - Professional role model
 - Appropriate amount of information that relate to supervisee
 - Similar experience of interest to supervisee, supervisor's past, current experiences, successful and unsuccessful experiences
 - Gauge reactions and check in with supervisee
- Ethical behavior
 - Supervisor unethical behavior → lower supervisory working alliance and satisfaction

Supervisor Factors

- Countertransference: Unconscious and exaggerated reactions stemming from a supervisory interaction related to the supervisor's unresolved personal issues or internal conflicts
- Cues: particularly strong positive or negative feelings when interacting with supervisee, experience feelings uniquely different than towards other supervisees, gradual change in feelings, discussion with colleagues
- Most literature showed harmful effects than not
- Source:
 - External stress from work, disappointment that supervisee not taking work seriously, over-identification with being a beginning counselor, wanting supervisee to be better counselors
 - Triggered by interpersonal styles, e.g., defensiveness, assertiveness, passivity, shyness, vulnerability or positive such as warmth and being engaging
 - Own personal issues
- Sexual or romantic attraction, cultural countertransference
 - What to do: Consult with colleague, discuss with supervisee as seen appropriate, personal therapy, self reflection, referral
 - Video Example: <https://www.youtube.com/watch?v=y-X7JT3NkDY>



SUPERVISEE FACTORS

Supervisee Factors

- **Supervisee resistance** (supervisor's influence, supervisory experience, noncompliant with task or mutually agreed plans)
- Why triggers resistance?
 - 1) level of trust
 - 2) level of agreement – identify disagree (if any) and resolve early
 - 3) supervisee developmental level: [Supervisee Levels Questionnaire Revised](#)
 - 4) supervisee countertransference – mirroring of client's attitudes and behaviors
 - 5) supervisor style
 - must versus can intervention
 - Consultant – least threatening, using subtle messages, discovery-oriented approach learning
 - 6) supervisor focus – least vulnerable regarding client dynamic, most vulnerable on supervisee's personhood
- Tips to address resistance:
 - Avoid labeling
 - Avoid “power struggles”
 - Reframe information
 - Emphasize personal choice
 - Recognize level of self-confidence
 - Elicit self-motivating statements
- Video Example: <https://www.youtube.com/watch?v=wfWvWDymehY>
- [Supervisee Needs Index](#)

Supervisee Factors

- Supervisee's attachment style and emotional intelligence
 - Attachment – form of behavior that results in a person attaining or retaining proximity to some other differentiated and preferred individual who is usually conceived as strong and/or wiser
 - Anxious attachment
 - Compulsive self-reliance
 - Compulsive caregiving
- Counter-transference – positive and negative
 - Video example: <https://www.youtube.com/watch?v=z8L5Nwa0nxc>
- Supervisee's experience of negative supervision
 - Affects counselor-client relationship too
- Supervisee stress and coping as predictors of alliance
 - Not necessarily supervision related stress

Supervisee Factors

- Supervisee **shame** – little research done
 - Common responses: withdrawal, avoidance, attack on others, attack on self
 - Create a climate of trust and respect, normalize the feeling, offer consistent support, provide performance feedback that is least shame-involving, self disclosure
- Supervisee **anxiety** – impression management, evaluative
 - Affects learning and performance (important but not affecting relationship)
 - Affects quality of engagement with supervisor
 - Normalizing, giving permission to make mistake (balance being supportive and challenge), giving structure (especially during crisis), role induction (e.g., addressing it and using contracts)
 - [Anticipatory Supervisee Anxiety Scale](#)

PROCESS & OUTCOMES

Process/Interaction Factors

- Positive correlates:
 - 1) Use of a supervision contract
 - 2) Clear and fairly conducted evaluation practices
 - 3) Honest discussion of supervisor and supervisee ethnicity
 - 4) Advanced racial identity levels: both parties
 - 5) Supervisor-supervisee interaction complementarity
- Negative correlates:
 - 1) Negative supervision
 - 2) Role conflict or ambiguity: [Role conflict and Role Ambiguity Inventory](#)
- Examples:
 - [Counseling Supervision Contract](#)
 - [Reciprocal Supervision Agreement](#)
 - [Supervisee's Bill of Rights](#)

Outcome Factors

- Consequences of poor supervisory working alliance
 - 1) Supervision-related outcomes
 - Less likely supervisee would disclose important information
 - Supervisee's satisfaction with supervision
 - Supervisee's ratings of supervision outcomes
 - 2) Therapy-related outcomes
 - Quality of supervisee's alliance with own clients
 - Supervisee's adherence to treatment protocol
 - 3) Supervisee
 - Burnout, well-being, job satisfaction



EVALUATIVE ASPECTS OF SUPERVISION

Criteria for Evaluation

Fouad et al (2009): 15 competencies

- **7 core:**
 - Professionalism
 - Reflective Practice/Self Assessment/Self Care
 - Scientific Knowledge and Methods
 - Relationships
 - Individual and Cultural Diversity
 - Ethical Legal Standards and Policy
 - Interdisciplinary Systems
- **8 Functional:**
 - Assessment
 - Intervention
 - Consultation
 - Research/Evaluation
 - Supervision
 - Teaching
 - Management
 - Advocacy

Process of Evaluation

- How supervisors conduct supervision and how they incorporate the issue of evaluation from the beginning of supervision to its completion
- **6 elements:**
 - 1) Negotiating a supervision-evaluation contract
 - 2) Choosing evaluation methods and supervision interventions
 - 3) Choosing evaluation instruments
 - 4) Communicating formative feedback
 - 5) Encouraging self-assessment
 - 6) Conducting formal summative evaluation sessions

Favorable Conditions for Evaluation

RELATIONSHIP!!!!

1. Unequal nature of the supervisory relationship
2. State administrative and clinical roles clearly
3. Supervisees' openness (least resistance)
4. Individual differences respected
5. Mutual and continuous process
6. Occur within a strong administrative structure
7. Premature evaluations of supervisees avoided
8. Supervisees need to witness the professional development of supervisors
9. Supervisors keep an eye on the relationship, which influences all aspects of supervision
10. Supervisors should enjoy the process of supervision

Formative versus Summative Evaluation

- Formative:
 - Performance is typically assessed **during** the development or early implementation to provide information about how best to revise and modify for improvement
 - **Focus on process and progress** of professional competence, rather than outcome
- Summative:
 - Goal is to **evaluate** supervisee learning at the **end** of an instructional unit by comparing it against some standards/benchmark
 - Often high stakes - they have a high point value
 - Supervisor must be clear about the criteria against which they are measuring supervisee
 - Mid-term, final evaluation forms

Evaluation Instrument

- The most common summative evaluation instrument continues to use a Likert scale, open-ended questions as well
- Too many evaluation instruments to share but many evaluation instruments have not been subjected to rigorous validity or reliability checks
- Rubrics can be generic or behaviorally specific

Generic versus Specific

- Level 1: Perform *inadequately* on this skill/skill set. Need Close Supervision
- Level 2: Performs skill set only in most *rudimentary fashion*. Need Close Supervision
- Level 3: Performs skill set *adequately*, although somewhat self-consciously
- Level 4: Performs skill set with competence
- Level 5: Demonstrates mastery of skill set
- Unacceptable:
 - Not forthcoming in supervision
 - Does not provide follow-up on agreed-on supervision suggestion
 - Does not hear or assimilate supervisor input
- Exemplary:
 - Comes to supervision with recordings cued
 - Realistic about what is being done well; seeks input to improve performance

Formative Feedback

- A process in which supervisor verbally shares thoughts and assessment of supervisee's progress, either explicitly or implicitly
- Easier to provide feedback on supervisee' work with clients
- More challenging to deliver messages that are personal to the supervisee or about the relationship between supervisor and supervisee
- Supervisee openness, strong positive relationship, clear need for feedback, supervisor feeling competent to impart feedback – all work favorably for the delivery of feedback
- Accurate feedback is the key, whether it is positive or negative

- Based on learning goals
- Offered regularly and timely
- Balanced between supportive and challenging
- Supervisor should use listening skills
- Supervisee want honest feedback

Supervision – Evaluation Contract

- Supervision plan
- Goal-directed supervision
- All supervision contracts should:
 - Establish learning goals
 - Describe criteria and competencies for evaluation
 - Establish supervision methods that to be used
 - Describe the length and frequency of supervision contracts
 - Establish how a summative evaluation will be achieved
 - See previous example/link

Summative Evaluation

- Usually occur at least twice during supervisory relationship, e.g., mid-semester and a final summative evaluation
- Cumulation of evaluations
- First summative evaluation is more important
- Summative evaluation should be conducted face to face and be put in writing
- Must be specific

Client Outcome/Feedback

- Reese et al (2009) when comparing supervisees who received constant client feedback over one year period with a similar group of supervisees in the no-feedback condition , those receiving feedback had twice the rate of improves clients outcomes
- Examples:
 - Isupe: [iSupelive.com](http://Supelive.com): Supervisor License = \$50 for 2 year subscription; Supervisee License = \$5 for 2 year subscription
 - E-System for Observing Family Therapy Alliances (e-SOFTA): <http://softa-soatif.com/soatif-2>
- Partners for Change Outcome Management System (PCOMS): <https://betteroutcomesnow.com/about-pcoms/>
 - [Outcome Measure Software](#): Session Rating Scale, Outcome Rating Scale
 - OQ®-Analyst: <https://www.oqmeasures.com/>
 - Outcome Questionnaire (OQ)

Self-Assessment

- Important aspect of supervision
- Graduate students supervisee were accurate self-evaluators but should be a skill to be developed under supervision
- Performance feedback for the supervisor have positive impact on self-efficacy and anxiety
- The balance between support and challenge must be tailored for each supervisee to arrive optimal result
- Self-critique to lead to more supervisees openness to supervisor critical feedback
- Having supervisees identify their own performance deficiencies – can minimize resistance from trainees
- Best viewed as a developmental issue for supervisees rather than a parallel process of evaluation
- Self assessment should never be a test
- Part of responsibility of clinical supervisor - assist supervisees in establishing a habit of self-evaluation

Methods to Stimulate (Self) Reflection

- Socratic questioning – assumes that supervisee has answers – asking “how” and “what” questions
- Journal writing – helps focus on internal reality
- Reflection team – triadic supervision
- Self-Reflection– promotes lifelong learning
- Other methods- metaphor, sandtray, psychodrama, biblio-supervision

[Counselor Activity Self-Efficacy Scales \(CASES\)](#)

[Counseling Self-Estimate Inventory \(COSE\)](#)

Reflective Practice

- Process of engaging the self in attentive, critical, exploratory and iterative interactions with one's thoughts and actions, and their underlying conceptual frame, with a **view to changing them** and with a **view on the change itself**"
- Clinical supervisors engage in reflective practices by priming learning opportunities, observing learner motivations and pressures, prompting learners to process clinical experiences and feedback, and reinforcing learner choices and use of feedback.
- Clinical supervisors use self-reflections related to learner interactions to appraise thoughts, emotions, and behavior, and how each affects the learner's experience in supervision

(Curtis, Duran, Elkins, & Venta, 2016)

Five Components of Reflective Practice

- 1) S: The self component, which recognizes the significance of personal behaviors and beliefs in interacting with others.
- 2) VC: Alterations in the content or process of reflection, including changes in behavior following reflection or the ability to clarify meaning.
- 3) CF: Explanations for TA, including one's conceptual frame or underlying theoretical framework
- 4) ACIE: Attentive, Critical, Exploratory, and Iterative [thinking]
- 5) TA: Thoughts and Actions

See examples in the next three slides of a reflective writing from a practicum student, post-doctoral fellow, and an attending psychologist

Practicum Student

“I remember feeling nervous but believing that I was prepared for the Competency Evaluation—I had just about memorized the training materials (TA, S). I met with a post-doctoral fellow and role played sessions from our intervention (TA). She played the part of the parent and I played the clinician (TA). Although I was well-prepared, I was caught off guard when she switched roles—into the role of clinical supervisor—to ask me how I would react to these materials if I were the parent (ACEI). She held me to that reflection through various questions: ‘What might you be thinking as a parent (ACEI, CF)? What would be hard for you about this (S)? What would be hard for your own parents about this intervention (CF)? What would your cultural group have to say about what you are asking these parents to do (CF)?’ These questions were challenging and I didn’t have the answers at the time, but they prompted me to reflect (ACEI), both privately and with her, about ways in which my own values and upbringing (CF) might interact and conflict with treatment delivery (VC). I was so lucky to have addressed these conflicts—conflicts I did not even know I had (CF)— before beginning to work with families (S). Because of that experience, I was able to recognize my own connection to these families’ issues (CF) and openly engage parents in discussions about these conflicts (VC)”

Post-doctoral Fellow

“One of the most memorable experiences of my fellowship involved working with a family of a teen with significant conduct and mood-related concerns. Despite implementing evidence-based treatment practices with this family, progress was slow in changing the family dynamics. The case management demands were high due to crisis management and school consultation needs. I was becoming frazzled and frustrated with this family’s lack of improvement despite my increasing efforts (S, CF). I recall sharing my frustration within individual supervision with my faculty supervisor (TA). In a moment of his own self-reflection, my supervisor shared that he felt “stumped” about how to be most helpful to me in planning the next steps for this family. This admission shocked me at first (S), but then I realized how his response paralleled how I was feeling with this family— unsure of how I might best help them (ACEI, CF). This led to a discussion of my own deeper emotion toward the family, primarily feelings of fear that I would fail them if I didn’t continue the high level of work to manage all of the details of the treatment (CF, S). My supervisor’s self-reflection prompted me to reflect on both my affect (S, VC) and my actions with this family (TA, VC), and it was a perfect example of how I might transfer some of the “work” of therapy back to the clients (VC). In fact, I shared my feeling of being “stumped” with the family, which led them to engage in more active problem solving about their progress in treatment (TA, VC). Using reflective practices helped this family begin to move forward again and prompted significant growth for me as a

Attending Psychologist

“In conducting ‘supervision of supervision’ with a postdoctoral fellow, she expressed concern about her learners’ defensiveness when given mid-session feedback behind the mirror. She described how difficult it had been for her to get learners to listen to her and trust in her ‘behavioral expertise.’ These concerns subsequently led the fellow to increasingly use simple, clear, but very directive feedback, which to her dismay was seldom applied by her learners in session. I resisted my initial urge to approach the other learners to discuss the need for respectful and responsive participation in live supervision (S, TA). Instead I reflected on similar experiences I encountered as a junior faculty member (S, CF). I also considered how these other learners have responded quite differently (positively) to other supervisors (and to me) within the same clinical contexts (ACEI, CF). I tried to imagine what it was like for my new fellow to become a part of an already established team, expecting to be recognized by others for her specialized training and background experiences (ACEI, VC). Finally, I reflected on how my new fellow’s developmental needs could be addressed while maintaining my own aims to create a safe environment for learning within the therapy clinic (CF). After considering these many reflections, I invited the fellow to take a step back from the immediate challenge at hand to consider her goal to develop greater skills for leadership (VC, S). Shifting the focus of discussion to leadership allowed me to prompt the fellow to reflect upon qualities of effective and ineffective leaders (CF). In doing so, I was able to use Socratic inquiry to help the fellow understand different ways of providing feedback to learners (ACEI, VC) – particularly in ways that promote greater critical thinking and independence (VC). After prompting the fellow to make these self-informing observations, I then pointed out how I had just modeled this process by letting the fellow work through this inquiry rather than giving directive feedback (TA). In addition to seeing changes emerge in her supervisory behaviors, I was excited when the fellow came to supervision wanting to continue our discussion about



SCENARIOS AND DISCUSSIONS

Supervisees with Problems of Professional Competence

- Unprepared supervisee – remedial work
 - Video Examples:
 - <https://www.youtube.com/watch?v=ICW4L1t7Zo4>
 - <https://www.youtube.com/watch?v=wfWvWDymehY>
- Unqualified supervisee – competency and gatekeeping issue
- Problem of Professional Competence
- Common problems:
 - “Psychological concerns” such as depression, anxiety, personality disorders, eating disorders, substance use → referral for independent counseling
 - “Professional concerns” such as boundary concerns, lack of awareness of impact on others, poor interpersonal skills → supervisors can assist in addressing in individual supervision
 - Additional supervisee challenges: next slide for video examples

Useful Videos Examples

- Dealing with confidence:
<https://www.youtube.com/watch?v=eIDhKWAsWuY>
- Moving beyond the superficial:
<https://www.youtube.com/watch?v=oWMNskk8nzY>
- Dealing with a supervisee having attraction to client:
<https://www.youtube.com/watch?v=o6AdcHbVujg>
- Not taking direction:
<https://www.youtube.com/watch?v=SxXPqLbrYWo>
- Complimentary:
https://www.youtube.com/watch?v=IAA4QVAfWhc&feature=player_embedded

Remediation and Due Process

- 1) Provide written notice of standards and expectation, and communicate clearly to all supervisees at the beginning of the supervisory relationship
 - a. Identify qualities and behaviors expected of supervisees
 - b. Reach faculty consensus on expectations (multiple reinforcers)
 - c. Devise rating form to list these qualities and behaviors
- 2) Provide and communicate written notice of standardized procedures to deal with competency (or lack of)
- 3) Educate and require faculty to follow procedures
- 4) Apply established standards consistently
- 5) Establish internal review and evaluation procedure that respect confidentiality
- 6) When problem arises, focus on the behaviors that is problematic in relation to training goals
- 7) Design, recommend and enforce remediation actions
- 8) Consider safety issues
- 9) Written records and documentations
- 10) Do not delay in addressing issues

Ingredient of Supervisor Failure

Relates to Ladnay's case:

- 1) Denigrate the Supervisory Relationship
- 2) Demonstrate Multicultural Incompetence
- 3) Become an Unethical Supermodel - "Set by example"
- 4) Make Your Supervisee Your Surrogate Psychotherapist
- 5) Teach Your Supervisee How to Diagnose Narcissism By Example
- 6) Goal-setting and Feedback Not Done Properly
- 7) Infantilize Your Supervisee
- 8) Collude with Your Supervisee



CONCLUDING TIPS AND RESOURCES

Tips for New Supervisors

- 1) Quickly learn the organization's policies, procedures and human resources procedures.
- 2) Ask for a period (suggest 3 months) to allow yourself to learn about new role.
- 3) Take time to learn about your supervisees, their career goals, interests, developmental objectives and perceived strengths.
- 4) Work to establish a contractual relationship with supervisees with clear goals and methods of supervision.
- 5) Learn methods to help reduce stress, address competing priorities, resolve staff conflicts, and other interpersonal issues in the workplace (for all personnel involved).
- 6) Obtain training in supervisory procedures and methods.
- 7) Find a mentor, either internal or external to the organization.
- 8) Shadow a supervisor you respect who can help you learn the ropes of a supervisor.
- 9) Ask often and as many people as feasible for feedback on performance and how can you improve.
- 10) Ask for regular meetings with administrator for training and instruction.
- 11) Seek supervision of your supervision (meta supervision).

Tips and Summary

- Supervision is a deliberate effort that requires some preparation/training and planning (can be short in duration or longer in formal training).
- Prior knowledge about:
 - Models of supervision, supervisory styles, expectations.
 - Methods of supervision.
 - How to build a therapeutic relationship, provide feedback and deal with challenging situations.
- Consider supervision a formal process with contracts and documents
- Use of measures to “quantify” and guide some of the constructs and challenges
- Regular self reflection
- Build in a primary supervisor that supports core knowledge and skills (e.g. counseling, assessment, case conceptualizations)

Tips and Summary

- Having a secondary supervisor that provides expert consultation.
- Individual supervision builds rapport and addresses individual challenges
- Case conferencing and group seminars automatically build in “group supervision”, as well as group learning and roles of other disciplines
 - Case managers providing their duties, roles, and process of case management and all parties involved from referral to discharge.
 - Medical professionals providing medical aspects and impacts of disability
 - Nurses providing medication presentations
 - Occupational therapists and physical therapists providing their roles and functions, as well as duties on physical rehabilitation
 - Rehabilitation psychologists providing roles and functions, duties, as well as unique topics such as psychosocial aspects of disabilities, environmental and family attributes in affecting successful rehabilitation

Figure 2. Counselor Developmental Model

Developmental Level	Characteristics	Supervision Skills Development Needs	Techniques
Level 1	<ul style="list-style-type: none"> • Focuses on self • Anxious, uncertain • Preoccupied with performing the right way • Overconfident of skills • Overgeneralizes • Overuses a skill • Gap between conceptualization, goals, and interventions • Ethics underdeveloped 	<ul style="list-style-type: none"> • Provide structure and minimize anxiety • Supportive, address strengths first, then weaknesses • Suggest approaches • Start connecting theory to treatment 	<ul style="list-style-type: none"> • Observation • Skills training • Role playing • Readings • Group supervision • Closely monitor clients
Level 2	<ul style="list-style-type: none"> • Focuses less on self and more on client • Confused, frustrated with complexity of counseling • Overidentifies with client • Challenges authority • Lacks integration with theoretical base • Overburdened • Ethics better understood 	<ul style="list-style-type: none"> • Less structure provided, more autonomy encouraged • Supportive • Periodic suggestion of approaches • Confront discrepancies • Introduce more alternative views • Process comments, highlight countertransference • Affective reactions to client and/or supervisor 	<ul style="list-style-type: none"> • Observation • Role playing • Interpret dynamics • Group supervision • Reading
Level 3	<ul style="list-style-type: none"> • Focuses intently on client • High degree of empathic skill • Objective third person perspective • Integrative thinking and approach • Highly responsible and ethical counselor 	<ul style="list-style-type: none"> • Supervisee directed • Focus on personal-professional integration and career • Supportive • Change agent 	<ul style="list-style-type: none"> • Peer supervision • Group supervision • Reading

Source: Stoltenberg, Delworth, & McNeil, 1998

Figure 3. Supervisor Developmental Model

Developmental Level	Characteristics	To Increase Supervision Competence
Level 1	<ul style="list-style-type: none"> • Is anxious regarding role • Is naïve about assuming the role of supervisor • Is focused on doing the “right” thing • May overly respond as an “expert” • Is uncomfortable providing direct feedback 	<ul style="list-style-type: none"> • Follow structure and formats • Design systems to increase organization of supervision • Assign Level I counselors
Level 2	<ul style="list-style-type: none"> • Shows confusion and conflict • Sees supervision as complex and multidimensional • Needs support to maintain motivation • Overfocused on counselor’s deficits and perceived resistance • May fall back to being a therapist with the counselor 	<ul style="list-style-type: none"> • Provide active supervision of the supervision • Assign Level 1 counselors
Level 3	<ul style="list-style-type: none"> • Is highly motivated • Can provide an honest self-appraisal of strengths and weaknesses as supervisor • Is comfortable with evaluation process • Provides thorough, objective feedback 	<ul style="list-style-type: none"> • Comfortable with all levels

Source: Stoltenberg, Delworth, & McNeil, 1998

Wright's Values and Principles for Clinical Supervision for Rehabilitation Psychologists

Table 1

Rehabilitation Psychology Value-Laden Beliefs and Principles

1. Every individual needs respect and encouragement; the presence of a disability, no matter how severe does not alter these fundamental rights.
2. The severity of a handicap can be increased or diminished by environmental conditions.
3. Issues of coping and adjusting to a disability cannot be validly considered without examining reality problems in the social and physical environment.
4. The assets of the person must receive considerable attention in the rehabilitation effort.
5. The significance of a disability is affected by the person's feelings about the self and his or her situation.
6. The active participation of the client in the planning and execution of the rehabilitation program is to be sought out as fully as possible.
7. The client is seen not as an isolated individual but as a part of a larger group that includes other people, often the family.
8. Because each person has unique characteristics and each situation its own properties, variability is required in rehabilitation.
9. Predictor variables, based on group outcomes in rehabilitation, should be applied with caution to the individual case.
10. All phases of rehabilitation have psychological aspects.
11. Interdisciplinary and interagency collaboration and coordination of services are essential.
12. Self-help organizations are important allies in the rehabilitation effort.
13. In addition to the special problems of particular groups, rehabilitation clients commonly share certain problems by virtue of their disadvantaged and devalued position.
14. It is essential that society as a whole continuously and persistently strives to provide the basic means toward the fulfillment of the lives of all its inhabitants, including those with disabilities.
15. Involvement of the client with the generally life of the community is a fundamental principle guiding decisions concerning living arrangements and the use of resources.
16. People with disabilities, like all citizens, are entitled to participate in and contribute to the general life of the community.
17. Provision must be made for the effective dissemination of information concerning legislation and community offerings of potential benefit to persons with disabilities.
18. Basic research can profitably be guided by the question of usefulness in ameliorating problems, a vital consideration in rehabilitation fields, including psychology.
19. Persons with disabilities should be called upon to serve as coplanners, coevaluators, and consultants to others, including professional persons.
20. Continuing review of the contributions of psychologists and others in rehabilitation within a framework of guiding principles that are themselves subject to review is an essential part of the self-correcting effort of science and the professions.

(Beatrice A. Wright, 1983)

Common Challenges and Issues

- Boundary issues/Dual relationships
- Power and authority
- Interpersonal processes
- Conflicts with supervisee
- Supervisee resistance
- Supervisor resistance
- Differences in age, ethnicity and discipline

Scenario

Imagine yourself as a 60 year old male White supervisor trained in clinical psychology with a 28 year old female Asian supervisee completing her pre-doctoral internship for her counseling psychology degree. What are the potential impacts on the supervisory alliance (positive and negative). Consider:

- Potential differences in “disciplines”
- Age difference
- Gender difference
- Difference in seniority
- Difference in ethnicity

What things to consider and actions to take in order to facilitate a successful supervisory experience?

Tips for Supervisor:

- Be aware of his position as a male and an experience clinician. Take advantage of the power in a positively influential way.
- Be aware of own potential limitations of supervising someone whose orientation may be trained differently than him.
- Be aware of how cultural factor may play a role in terms of interaction styles, expectations.

Actions:

- Self reflection of own values, attitudes and actions.
- Deliberate efforts to understand supervisee of her own discipline can have added values and compliment own. Perhaps discuss and do an exercise or two to work on
- The above serves to build a strong working alliance with the supervisee and to empower supervisee to collaborate.
- This also serves to provide a positive role model by example.
- As a senior clinician, share stories of how to overcome challenges as part of the process of being a clinician.
- When the working alliance is transparent, supervisee may be more open to addressing difficulties situations down the road.
- Seek supervision, i.e., consultative supervision from another colleague who understands the counseling psychology discipline and the cultural aspects.
- Supervisees should be rewarded for raising relationship issues in supervision.
- Regular evaluation and to compliment positive performance while facilitating opportunities for additional opportunities.
- May be necessary to transfer supervisee if any challenges cannot be resolved.

ADDITIONAL RESOURCES



Recommended Materials:

- Aasheim, L. A. (2012). *Practical Clinical Supervision for Counselors. An Experiential Guide*. New York, NY: Springer Publishing Company, LLC.
- **American Psychological Association (2014). APA Guidelines for Clinical Supervision for Health Service Psychology. Retrieved from <http://apa.org/about/policy/guidelines-supervision.pdf>**
- Bean, R. A., Davis, S. D., & Davey, M. P. (2014). *Clinical Supervision Activities for Increasing Competence and Self-Awareness*. Hoboken, NJ: John Wiley & Sons, Inc.
- **Bernard, J. M. & Goodyear, R. K. (2018). *Fundamentals of Clinical Supervision, (5th Edition)*. Upper Saddle River, NJ: Pearson.**
- Campbell, J. M. (2000). *Becoming an Effective Supervisor. A Workbook for Counselors and Psychotherapists*. New York, NY: Routledge. Taylor & Francis Group.
- Campbell, J (2011). *Essentials of Clinical Supervision*. Hoboken, NJ: John Wiley & Sons, Inc.
- Corey, G., Haynes, R., & Moulton, P. (2010). *Clinical Supervision in the Helping Professions. A Practical Guide (2nd ed.)*. Alexandria, VA: American Counseling Association.
- Falender, C. A., & Shafranske, E. P. (2014). *Casebook for Clinical Supervision. A Competency – based Approach (3rd Ed)*. Washington DC: American

Recommended Materials:

- Scaife, J. (2010). *Supervision in Clinical Practice. A Practitioner's Guide* (2nd ed.). New York, NY: Routledge. Taylor & Francis Group.
- Tackett, M. J., Nash, L., Stucky, K. J., & Nierenberg, B. (2016). Supervision in rehabilitation psychology: Application of Beatrice Wright's value-laden beliefs and principles. *Rehabilitation Psychology*, 61(1), 74-81.
- U.S. Department of Health and Human Services (2009). *Clinical Supervision and Professional Development of the Substance Abuse Counselor*. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment.
- **Clinical supervision for psychologists:**
http://www.psychceu.com/super/superindex_psych.asp
- **Choice of course by profession and state:**
<https://www.mindfulceus.com/ceu-categories/supervision-ce.php>
- AAFMT supervision training:
<https://networks.aamft.org/conference/conference-institutes/approved-supervision>
- Beck's Institute on CBT and supervision training: <https://beckinstitute.org/get-training/topics/specialty-workshops/teaching-supervising-cbt/>
- BACB supervision training: <https://www.bacb.com/information-for-supervisors/>