CLINICAL SUPERVISION: MODELS, ROLES AND RESPONSIBILITIES, ETHICS AND LEGAL ISSUES

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ABOUT THE INSTRUCTOR

Charlotte Chapman has been in the addictions and mental health counseling field for thirty years. She has practiced as a counselor, supervisor and program director. Charlotte is a licensed professional counselor, a licensed substance abuse treatment provider, a certified masters addictions counselor (MAC) and a certified clinical supervisor (CCS). She is currently the director of counseling services at the University of Virginia's Women's Center where she teaches and supervises graduate counseling students. Charlotte has been providing training in clinical supervision for twenty years. She has served on national and state credentialing boards. Charlotte was a member of the task force that produced TAP21-A: Competencies for Substance Abuse Treatment Clinical Supervisors (SAMHSA, 2007). More information is available at www.chapmantraining.com.

Clinical Supervision in Substance Use Treatment: Current Developments

The supervision models and ethical frameworks described in this course, the Discrimination Model, the Developmental Model, the IPR Model, remain foundational to clinical supervision practice. What has changed is the context in which supervision occurs: integrated behavioral health settings where substance use counselors work alongside professionals from other disciplines, expanded use of technology in supervision, an evolving workforce that increasingly includes peer specialists and non-traditional providers, and growing emphasis on measurable competency rather than credentialing alone. These shifts do not invalidate the models taught in this course, they demand that supervisors apply them with greater flexibility and contextual awareness than ever before.

A 2025 qualitative study examined supervision experiences across behavioral health disciplines in integrated practice settings, interviewing 20 clinicians working in mental health and substance use treatment. The researchers identified four themes: the value of interprofessional supervision, the emergence of clinical supervision functions within peer supervision spaces, varied individual supervision experiences across practitioners, and the role of organizational culture in shaping supervision quality (Berrett-Abebe et al., 2025). For supervisors trained in the models described in this course, the finding about organizational culture is particularly relevant, the Discrimination Model, Developmental Model, and IPR Model all assume a structured supervisory relationship, but their effectiveness depends on whether the organization supports that structure with protected time, clear role definitions, and administrative commitment. The Berrett-Abebe et al. finding about clinical supervision functions emerging within peer supervision spaces is especially significant for supervisors working in integrated settings. It suggests that when formal clinical supervision is inadequate or unavailable, clinicians seek supervision-like functions wherever they can find them, in peer consultation, team meetings, or informal hallway conversations. While this adaptability demonstrates professional resilience, it also signals a gap that supervisors must address proactively. Peer consultation is valuable, but it cannot substitute for the evaluative, gatekeeping, and developmental functions that trained clinical supervisors provide. For supervisors applying the Discrimination Model, which distinguishes between the teacher, counselor, and consultant roles, this means actively assessing whether their supervisees are receiving appropriate support in each domain, or whether they are cobbling together supervision from fragmented sources that may not cover all three functions.

The workforce expansion described in this course's discussion of supervisor roles now includes non-traditional providers who require adapted supervision approaches. A 2025 study documented the process of training four American Indian community members to deliver a substance use disorder intervention on a reservation, including motivational interviewing training, a two-day curriculum workshop, and weekly supervision meetings during an open trial. The researchers found that "additional training and supervision during the open trial was needed to ensure proper treatment delivery" beyond what initial workshops provided (Skewes et al., 2025). For clinical supervisors, this finding reinforces what the Developmental Model predicts: new practitioners, regardless of their professional background, require intensive, structured supervision that evolves as their competence develops. The Skewes et al. study also illustrates a dimension of supervision that the traditional models sometimes underemphasize: cultural competence flows in both directions. While the clinical supervisor provides treatment fidelity oversight and skill development, community-based providers bring cultural knowledge, relational trust, and contextual understanding that the supervisor may lack. Effective supervision in these settings requires what the Discrimination Model calls the "consultant" role more than the "teacher" role,

approaching the supervisee as a partner whose community expertise informs how the clinical model is adapted for local context, rather than simply ensuring protocol compliance. This has broader implications for any supervisor working with diverse staff: the supervisory relationship must create space for the supervisee's unique knowledge and perspective while maintaining clinical standards. For supervisors navigating this balance, the key is to distinguish between protocol adherence, which is the supervisor's responsibility to monitor, and cultural adaptation, which is the community provider's expertise to inform. Both are necessary for effective treatment delivery, and neither can substitute for the other.

The challenge of measuring whether supervision actually produces competent clinical practice has received direct attention. A 2023 study validated a 12-item scale for measuring motivational interviewing fidelity across 1,089 audio recordings from 238 providers working in 60 community substance use treatment clinics. Community-based providers scored significantly lower on advanced competencies compared to research settings, and the authors concluded that "follow-up coaching by trained supervisors may be needed" to close the gap between training exposure and clinical proficiency (Naar et al., 2023). This finding speaks directly to the supervisor's role described in this course: supervision is not a formality or an administrative requirement. It is the mechanism through which initial training translates into consistent clinical practice, and without it, training alone is insufficient. The Naar et al. data quantifies a problem that supervisors intuitively recognize: clinicians often know what they should do in theory but struggle to execute it consistently in practice. The gap between training-setting proficiency and community-setting proficiency is not a reflection of provider ability, it reflects the difference between controlled learning environments and the complex, under-resourced, high-caseload realities of community treatment. Supervisors who recognize this gap can design their supervision to specifically target the advanced competencies where community providers score lowest, using direct observation, audio review, and structured feedback rather than relying on supervisee self-report, which tends to overestimate proficiency. The validated MI fidelity scale described by Naar et al. also offers supervisors a concrete measurement tool: rather than relying on subjective impressions of supervisee competence, supervisors can use standardized rating instruments to track skill development over time and identify specific areas where coaching is needed. This shift from impression-based to measurement-based supervision represents one of the most important developments in the field since the supervision models in this course were first articulated.

The broader workforce context shapes what supervisors must prepare for. A 2022 analysis of 258 training events reaching 10,143 substance use treatment professionals documented rising demand for technical assistance during the pandemic, with a growing focus on both evidence-based approaches and health equity (Scott et al., 2022). A 2023 study evaluating brief training formats, the type most accessible to working counselors, examined whether short-format continuing education produced measurable changes in practice readiness (Cambron et al., 2023). For supervisors, these findings frame a practical reality: the counselors they supervise are receiving training in increasingly diverse formats and modalities, and supervision must bridge the gap between what those training events teach and what clinicians actually do in session. The convergence of findings from all five studies creates a clear mandate for clinical supervisors. Berrett-Abebe et al. (2025) demonstrate that organizational culture determines whether supervision models can function as designed. Skewes et al. (2025) show that new and non-traditional providers need intensive, culturally responsive supervision that goes beyond initial training. Naar et al. (2023) provide evidence that supervision is the mechanism that closes the gap between training and competent practice. And Scott et al. (2022) and Cambron et al. (2023) document a workforce receiving training in formats that are increasingly accessible but that cannot substitute for the

ongoing, relationship-based learning that supervision provides. For practitioners in the supervisory role, the message is that supervision quality, not just supervision availability, determines whether the treatment workforce delivers competent, ethical care. The models taught in this course provide the framework; the current evidence clarifies the conditions under which that framework succeeds.

Does Clinical Supervision Actually Work?

This course teaches clinical supervision as an essential professional function, and it is worth asking directly whether the evidence shows that supervision produces the outcomes it is meant to produce. The question has finally received a rigorous answer. Schreyer and colleagues (2025) conducted the first true systematic review and meta-analysis on this exact question, drawing on 32 studies covering more than 1,600 supervisees and over 2,000 patients, with a subset pooled in quantitative meta-analyses. The findings are nuanced in a way that matters for how supervisors should understand their work.

When supervision was compared against other active alternatives, the effects on therapist competence, on the therapeutic alliance, and on patient symptom reduction were positive but did not reach statistical significance. When supervision was compared against no supervision or passive control conditions, however, the effects on competence and on the alliance were large and statistically significant. The authors also found that the benefit to competence became significant once supervision reached a threshold of several sessions rather than a single meeting. They were careful to note that the overall certainty of the evidence, by formal GRADE standards, remains very low across outcomes, reflecting the methodological difficulty of studying supervision rigorously.

Read honestly, this evidence supports supervision without overstating it. The clearest message is that supervision matters most against its absence. Clinicians who receive real supervision develop competence and build stronger alliances than clinicians who receive none, and the effect is substantial. What the evidence does not show is that any particular supervision approach dramatically outperforms other good approaches, and it does not yet provide strong proof that supervision directly reduces patient symptoms, which is a harder and more distal outcome to demonstrate.

For the practitioner, this has two implications. The first is affirming. The core premise of this course, that supervision is a necessary professional function rather than an optional formality, is supported by the best available evidence. Supervision genuinely builds the competence and the alliance skills on which good treatment depends. The second is a caution against overclaiming. Supervisors should present supervision as what the evidence shows it to be, a powerful support for clinician development whose effect on distal client outcomes is plausible but not yet firmly established, and whose benefit depends on being real and sustained rather than nominal. A single perfunctory meeting checked off for compliance is not the supervision the evidence supports. Regular, substantive supervision over time is.

Parallel Process: From Concept to Evidence

This course teaches parallel process and isomorphism as central features of the supervisory relationship, the idea that dynamics between client and therapist can be unconsciously reproduced in the relationship between therapist and supervisor, and vice versa. For decades this concept rested largely on clinical anecdote, which made it easy to dismiss as unfalsifiable. A landmark study changed that. Tracey, Bludworth, and Glidden-Tracey (2012) provided the first rigorous empirical demonstration of parallel process, studying 17 triads, each consisting of a supervisor, a trainee therapist, and a client, and rating each session on the interpersonal dimensions of dominance and affiliation. Using single-case statistical tests, they found significant evidence of parallel process in every one of the 17 triads.

Two features of the finding are especially important. First, the effect was not a vague resemblance but a measurable, session-by-session correspondence between the interpersonal patterns in the therapy relationship and those in the supervision relationship. Second, and most consequential for practice, the direction of the parallel mattered for outcomes. Better client outcomes were associated with the therapist's interpersonal behavior growing more similar to the supervisor's over time. In other words, when the therapist increasingly internalized the supervisor's interpersonal stance, clients did better.

This evidence elevates parallel process from a suggestive metaphor to a documented mechanism, and it carries a clear message for the supervisor. What happens in the supervisory relationship does not stay there. The way a supervisor relates to a supervisee, the balance of warmth and authority, of collaboration and direction, tends to propagate into how that supervisee relates to their clients. A supervisor who is critical and controlling may, through parallel process, be shaping a therapist who is subtly critical and controlling with clients. A supervisor who models curiosity, respect, and steadiness may be transmitting those same qualities downstream. The finding that positive outcomes track with the therapist becoming more like the supervisor means that the supervisor's own interpersonal behavior is, in a real sense, a treatment ingredient one step removed.

For the practitioner, this reframes the supervisory relationship as a modeling relationship whether or not the supervisor intends it to be. It argues for deliberate attention to how one conducts supervision, not only to what one says, because the how is being absorbed and passed on. It also gives the alert supervisor a diagnostic tool. When a puzzling dynamic appears in supervision, an unexpected helplessness, hostility, or confusion, the possibility that it is a parallel of something happening in the therapy is worth considering, because it may reveal something about the client's treatment that the supervisee has not been able to articulate directly.

When Supervision Harms

This course addresses the ethics of supervision, and the most sobering recent evidence concerns not exotic ethical violations but the disturbing frequency of ordinary bad supervision. Ellis and colleagues (2014) conducted a landmark study testing a framework that distinguishes inadequate supervision, meaning supervision that fails to meet minimal standards, from harmful supervision, meaning supervision that actively damages the supervisee. Surveying 363 supervisees about their current supervision, the researchers found rates that should give every supervisor pause. Ninety-three percent of supervisees reported that they were currently receiving inadequate supervision, and thirty-five percent

reported that they were currently receiving harmful supervision. A substantial share, on the order of two in five, reported having experienced harmful supervision at some point in their training.

These numbers are startling, and they deserve careful interpretation. Inadequate supervision, at ninety-three percent, is nearly universal, which reflects how far routine practice falls short of the standards this course describes, supervision that is regular, structured, evaluative, and developmental. Harmful supervision, at thirty-five percent, is rarer but far too common, and it denotes supervision that does real damage, through such means as neglect, hostility, boundary violations, or the abuse of the supervisor's evaluative power. The distinction between the two is ethically important. Inadequate supervision is a failure to help. Harmful supervision is a failure that hurts.

For the ethics framework this course teaches, these findings ground the abstract principles in a concrete and urgent reality. The ethical issues in supervision, dual and multiple relationships, boundary violations, the misuse of the power differential, breaches of confidentiality, are not rare edge cases to be discussed hypothetically. They are common enough that a supervisor should assume they are at risk of committing them and structure their practice to prevent them. The power a supervisor holds, evaluative, gatekeeping, and often administrative, over someone whose career depends on their assessment, creates exactly the conditions in which harm occurs when that power is used carelessly or exploitatively.

For the practitioner, the Ellis findings translate into humility and vigilance. A supervisor who assumes they are surely among the competent majority is exhibiting precisely the complacency the data warn against, since the data say that most supervision is inadequate and a third is harmful. The protective response is to hold oneself to explicit standards, to solicit honest feedback from supervisees despite the power imbalance that discourages it, to attend carefully to boundaries and to the multiple relationships that so easily form, and to remember that the supervisee's vulnerability is real. Good supervision is not the default that happens automatically when a credentialed person is assigned the role. On this evidence, it is the exception that requires deliberate effort to achieve.

Legal Liability: What Supervisors Are Responsible For

This course covers the legal dimension of supervision, and the liability a supervisor carries is one of the most consequential and least understood aspects of the role. Recupero and Rainey (2007) provide an authoritative account of the legal doctrines that govern supervisory liability, and understanding them is essential for anyone who supervises.

Supervisory liability comes in two principal forms. The first is vicarious liability, the doctrine by which a supervisor or employer can be held legally responsible for the negligent acts of a supervisee, even without personal fault, under the principle known as respondeat superior, meaning let the master answer. Because the supervisor bears responsibility for the supervisee's professional conduct, the supervisee's negligence can become the supervisor's legal exposure. Related doctrines, such as ostensible or apparent agency and enterprise liability, extend this exposure in various circumstances. The second form is direct liability, in which the supervisor is held responsible for their own negligence, most importantly through negligent supervision, the failure to supervise adequately, and negligent administration. In direct liability, the fault is the supervisor's own, for not providing the oversight the role requires.

Layered onto these is the duty to protect foreseeable third parties from harm, the principle established in the landmark case of Tarasoff, in which a therapist's knowledge of a client's dangerousness created a duty to protect the identifiable potential victim. In the supervisory context, this duty can flow upward, since a supervisor who is responsible for a case may share in the duty to protect third parties from a dangerous client, even one they have never personally met.

The practical weight of this is considerable. A supervisor is legally accountable, in different ways, both for what their supervisees do and for the adequacy of their own supervision. This is not a reason to avoid supervising, but it is a reason to supervise carefully and to document that supervision. The risk-management implications that follow are concrete. A supervisor should know the cases their supervisees are carrying, particularly any involving danger to self or others, should provide and document real oversight rather than nominal sign-off, should ensure that supervisees understand and follow duty-to-protect obligations, and should not supervise more cases or more supervisees than they can genuinely oversee. The uncomfortable truth the legal doctrines convey is that a supervisor's signature on a chart is not merely a formality. It is an assumption of legal responsibility for care they must actually be overseeing. Supervision entered into casually, with more supervisees than can be tracked and less attention than each case requires, is not only ethically inadequate but legally perilous.

Telesupervision: Supervising at a Distance

Since this course was written, the delivery of supervision has been transformed by technology, with remote video supervision moving from a rare accommodation to a routine practice, a shift accelerated dramatically by the pandemic. The evidence on whether supervision delivered at a distance is as effective as in-person supervision is still developing but is cautiously reassuring. Andreucci-Annunziata and colleagues (2022) conducted a systematic review of telesupervision in psychotherapy, and although the evidence base was small, encompassing only a handful of studies, the pattern was consistent. Studies comparing telesupervision with in-person supervision generally found comparable levels of supervision satisfaction and comparable strength of the working alliance between supervisor and supervisee, with several describing the two modalities as essentially equally effective.

The review also surfaced a consistent human nuance. Most supervisees, even when they found telesupervision effective, still preferred in-person supervision, and they would nonetheless use telesupervision again willingly. The most frequently cited drawback was the reduced perception of nonverbal cues, the subtle bodily and facial signals that are harder to read through a screen and that carry meaningful clinical and relational information.

For the practitioner, this evidence supports a measured embrace of telesupervision. It is a legitimate and effective way to deliver supervision, particularly valuable for reaching supervisees in rural or underserved areas, for maintaining continuity when in-person meeting is impractical, and for expanding access to qualified supervisors who would otherwise be unavailable. It is not, on the current evidence, inferior in its core functions of building competence and alliance. At the same time, the nonverbal limitation is real and worth compensating for. A supervisor working remotely should attend deliberately to what the screen may be obscuring, checking in more explicitly about the supervisee's emotional state, being alert to the parallel-process dynamics that nonverbal cues often reveal, and recognizing that the relational subtleties which come easily in a shared room may require more intentional effort at a distance. Telesupervision widens access without sacrificing effectiveness, provided the supervisor works

consciously to bridge the gap that physical distance creates.

Measurement-Based Supervision and the Models Today

The supervision models this course teaches, the Discrimination Model, the Developmental Model, and others, provide the framework for the supervisory relationship, and recent developments in measurement give supervisors better tools for putting those frameworks into practice. The central advance is the shift from impression-based to measurement-based supervision. As the fidelity research already described in this course demonstrates, community providers often score lower on advanced clinical competencies than their training would predict, and supervisor self-report and supervisee self-report both tend to overestimate skill (Naar et al., 2023). The remedy is direct measurement. Validated rating instruments allow a supervisor to assess a supervisee's actual performance from recorded or observed sessions rather than from the supervisee's description of what they did, which is systematically rosier than reality.

This matters for how the traditional models are applied. The Discrimination Model, for instance, asks the supervisor to move among the roles of teacher, counselor, and consultant depending on the supervisee's needs in a given moment. Knowing which role a supervisee needs requires knowing accurately where their skills actually stand, and measurement provides that knowledge in a way that impression alone does not. The Developmental Model, which holds that supervisees progress through stages requiring different supervisory approaches, similarly depends on an accurate read of the supervisee's current developmental level, which structured assessment supports better than intuition.

The organizational and interprofessional context adds a further consideration. As the research on integrated settings shows, supervision increasingly happens across disciplines and within organizations whose culture determines whether structured supervision can function at all (Berrett-Abebe et al., 2025). A supervisor applying any model must therefore attend not only to the supervisee in front of them but to whether the organization provides the protected time, role clarity, and administrative support that the model presupposes. When it does not, the supervisor's task includes advocating for those conditions, because even the best model fails without them.

For the practitioner, the synthesis is that the classic models remain the right framework, and modern measurement makes them work better. A supervisor who uses validated tools to see a supervisee's actual competence, who selects the model and role that fit that reality, and who attends to the organizational conditions that let supervision function, is applying the enduring wisdom of the models with the precision that current evidence now makes possible.

The Supervisor's Own Development

This course asks supervisors to assess their own supervisory development through self-inventory and reflective practice, and the evidence assembled here clarifies why that self-examination is not a soft exercise but a professional necessity. The data on inadequate and harmful supervision establish that supervisory competence cannot be assumed, and the parallel-process research establishes that the supervisor's own way of relating propagates into client care. Together these findings mean that a

supervisor's ongoing development directly shapes the quality and safety of the treatment their supervisees provide.

Several forms of self-examination follow from the evidence. The first is honest self-assessment against explicit standards. Because most supervision falls short and a third does harm, a supervisor should measure their own practice against the concrete markers of good supervision, regular and protected time, structured and evaluative feedback, attention to boundaries, use of direct observation rather than reliance on supervisee report, and the deliberate cultivation of a safe relationship, rather than assuming their good intentions guarantee good practice. The second is soliciting feedback despite the power imbalance. Supervisees are unlikely to volunteer criticism of someone who evaluates them, so a supervisor committed to development must actively and safely invite it, and must respond to it without defensiveness, modeling the very openness they hope supervisees will bring to their own supervision.

The third is attention to parallel process as a mirror. Because dynamics flow between the therapy and supervision relationships, a supervisor can learn about their own patterns by noticing what recurs across their supervisees. A supervisor who finds that many of their supervisees become passive, or defensive, or dependent may be observing the downstream effect of their own supervisory style, and that recognition is a powerful engine for growth. The fourth is continued learning about supervision itself, which is a distinct competency from clinical practice. Being an expert clinician does not automatically make one a skilled supervisor, and the developmental models this course teaches apply to supervisors as much as to supervisees.

For the practitioner, the message is that supervisory development is career-long and deliberate. The evidence that so much supervision is inadequate is not a comment about other people. It is a call to every supervisor to hold their own practice to account, to keep learning the craft of supervision as a discipline in its own right, and to treat their own growth as inseparable from the wellbeing of the clients their supervisees serve.

Applying the Developmental Model to Supervisee Growth

This course presents the Developmental Model of supervision, which holds that supervisees progress through predictable stages and that effective supervision must change as the supervisee grows. The evidence assembled here gives this model concrete support and practical texture.

The core insight of the developmental approach is that a beginning supervisee and an experienced one need fundamentally different things from supervision. The novice, often anxious and dependent on external structure, needs direction, encouragement, and concrete guidance, and benefits from the teaching role that structured models describe. The advanced supervisee, more autonomous and self-aware, needs a more collegial, consultative relationship in which their own judgment is respected and refined rather than directed. Applying the wrong stance to the wrong stage, treating a seasoned clinician like a novice or leaving a beginner without enough structure, predictably produces friction and stalls growth.

The measurement research reinforces why accurate developmental assessment matters. Because supervisees and supervisors both tend to overestimate skill (Naar et al., 2023), a supervisor relying on impression may misjudge a supervisee's stage, offering autonomy the supervisee is not ready for or

structure they no longer need. Direct observation of actual practice, rather than reliance on self-report, gives the supervisor an accurate read of where the supervisee genuinely stands, which is the prerequisite for matching the supervisory approach to the developmental level.

The community-provider research adds a further nuance. New practitioners, regardless of background, need intensive, structured support that initial training alone does not provide (Skewes et al., 2025). Developmental progression is not automatic. It requires the sustained, stage-appropriate supervision that helps a supervisee consolidate skills and move toward autonomy. Without it, a supervisee can remain stuck, technically credentialed but not genuinely developing.

For the practitioner, applying the Developmental Model well means continually asking where each supervisee actually is, matching structure and autonomy to that reality, reassessing as the supervisee grows, and providing the intensive support that early development requires. It also means recognizing that development is not linear or uniform, since a supervisee may be advanced in one domain and a novice in another, requiring the supervisor to shift stance not just across supervisees but within a single supervisee across different aspects of their work. The model's enduring value is its reminder that supervision is not one fixed activity but a moving target that tracks the supervisee's growth.

The Discrimination Model and the Supervisor's Roles

Among the models this course teaches, the Discrimination Model offers a particularly practical framework because it organizes supervision around three roles the supervisor can move among, and it directs attention to three areas of the supervisee's functioning. Understanding how to apply it flexibly is a core supervisory skill that the current evidence helps sharpen.

The three roles are teacher, counselor, and consultant. In the teacher role, the supervisor instructs, demonstrates, and provides direct guidance, which is most appropriate for novices and for specific skill gaps. In the counselor role, the supervisor attends to the supervisee's internal experience, their anxiety, reactions, and blind spots, insofar as these affect their clinical work. In the consultant role, the supervisor engages the supervisee as a capable colleague, offering perspective and options rather than directives, which suits more advanced supervisees and situations where the supervisee's own expertise is central. The three areas of focus are the supervisee's intervention skills, their conceptualization of the case, and their personalization, meaning how their own person and reactions enter the work.

The research assembled in this course clarifies when each role is called for. The finding that community providers often need coaching to reach advanced competence (Naar et al., 2023) points to the teacher role for specific skill deficits identified through direct observation. The finding that community-based providers bring cultural knowledge the supervisor may lack (Skewes et al., 2025) points to the consultant role, in which the supervisor respects and draws on the supervisee's expertise rather than presuming to instruct. And the parallel-process evidence (Tracey et al., 2012), which shows that the supervisee's personal patterns and the supervisory relationship shape client care, points to the counselor role, in which the supervisor helps the supervisee become aware of how their own reactions are influencing the work.

The skill the model demands is discrimination itself, the judgment to recognize which role and which focus a given supervisee needs in a given moment, and to shift fluidly among them rather than

defaulting to one. A supervisor who is only ever a teacher will frustrate advanced supervisees and miss the personal and relational dimensions of the work. A supervisor who is only ever a consultant will leave novices without the structure they need. Accurate assessment of the supervisee, supported by direct observation rather than impression, is what makes appropriate role selection possible.

For the practitioner, the Discrimination Model provides a versatile map. Its value is not in prescribing a fixed approach but in expanding the supervisor's repertoire and prompting the deliberate question, in each supervisory moment, of which role and which focus will best serve this supervisee with this case right now. Used this way, it turns supervision from a single habitual stance into a responsive, tailored practice.

Confidentiality and Informed Consent in Supervision

This course addresses confidentiality as an ethical issue in supervision, and the topic is more layered than it first appears because supervision involves at least three parties whose confidentiality interests intersect: the client, the supervisee, and the supervisor. Handling these intersecting interests well is a core ethical competency.

The first layer concerns the client's confidentiality. When a supervisee discusses a case in supervision, the client's private information is being shared, and clients have a right to know that their treatment is supervised and that their information will be discussed for that purpose. Informed consent at the start of treatment should include disclosure that the clinician receives supervision and that clinical information will be shared within that supervisory relationship. This is not a mere formality. It respects the client's autonomy and prevents the client from later feeling that their privacy was breached without their knowledge. When supervision involves recording sessions, which the evidence identifies as one of the most effective supervisory tools, explicit client consent to recording is both an ethical and often a legal requirement.

The second layer concerns the supervisee's confidentiality. Supervision, done well, invites the supervisee to disclose uncertainties, mistakes, and personal reactions that bear on their clinical work, and this candor is only possible if the supervisee trusts that their disclosures will be handled appropriately. At the same time, the supervisor has evaluative and gatekeeping responsibilities that limit how confidential supervision can be, since serious concerns about a supervisee's competence or conduct may need to be shared with training programs or licensing bodies. The ethical supervisor is transparent about these limits from the outset, clarifying what will remain within supervision and what circumstances would require broader disclosure, so that the supervisee can calibrate their trust accurately rather than feeling betrayed later.

The third layer concerns the boundary between supervision and therapy. Because supervision often touches on the supervisee's personal reactions, it can drift toward becoming therapy for the supervisee, which raises both a boundary problem and a confidentiality problem. The ethical supervisor keeps the focus on the supervisee's professional development and the client's care, addressing personal reactions only insofar as they affect the work, and refers the supervisee elsewhere when personal issues require genuine therapeutic attention. This boundary protects the supervisee, preserves the appropriate purpose of supervision, and avoids the dual relationship that arises when a supervisor becomes a supervisee's therapist.

For the practitioner, sound management of confidentiality in supervision means securing informed consent from clients for both supervision and any recording, being explicit with supervisees about the limits of supervisory confidentiality created by the evaluative role, and maintaining the boundary that keeps supervision from becoming therapy. Handled with care, these intersecting confidentiality interests are not in conflict. They are the framework within which trust, candor, and accountability coexist.

Structuring Supervision for Real-World Constraints

The models and principles this course teaches assume that supervision actually happens in a structured, protected way, but the evidence on integrated and community settings shows that real-world constraints often threaten that structure. Bridging the gap between the ideal of supervision and the realities of practice is itself a supervisory skill.

The central constraint is time and organizational support. As the research on integrated settings demonstrates, whether supervision can function as designed depends heavily on organizational culture, on whether the organization provides protected time, clear role definitions, and administrative commitment (Berrett-Abebe et al., 2025). A supervisor working in an under-resourced setting may find that caseload pressures, productivity demands, and understaffing leave little room for the sustained supervision the evidence shows is effective. When formal supervision is squeezed, clinicians tend to seek supervision-like support informally, in hallway conversations and peer consultation, which provides some value but cannot replace the evaluative, gatekeeping, and developmental functions of structured supervision.

Several practical responses follow. The first is to protect supervision time deliberately rather than letting it be the first thing sacrificed to competing demands. Regular, scheduled supervision that is treated as non-negotiable is more likely to survive organizational pressure than supervision that happens only when time allows, which in a busy setting means rarely. The second is to make the time that exists count, using the most effective methods rather than the easiest ones. Because supervisee self-report systematically overestimates skill, and because direct observation is the most reliable window into actual practice, a supervisor with limited time is better served by reviewing a recorded session than by spending the same time listening to the supervisee describe their work. The third is to use validated tools that make supervision more efficient, allowing a supervisor to target the specific competencies where a supervisee is weakest rather than covering everything superficially.

The fourth response is advocacy. Because organizational conditions determine whether supervision can function, the supervisor's role legitimately extends to making the case to leadership for the protected time and support that effective supervision requires. Framing supervision not as an optional benefit but as the mechanism that ensures competent, ethical, and legally sound care, with the evidence to back that claim, gives the supervisor grounds to press for the conditions their work depends on.

For the practitioner, structuring supervision under real-world constraints means protecting the time, using it with the most effective methods, leveraging tools that increase efficiency, and advocating for the organizational support without which even the best supervisory intentions cannot be realized. The models provide the framework, but the framework only works when the conditions allow it, and securing those conditions is part of the supervisor's job.

Giving Feedback a Supervisee Can Actually Use

The evidence that supervision improves competence only when it moves past passive review points directly to a skill that supervisors are rarely taught: how to give feedback that changes behavior rather than merely delivering a verdict. Feedback is the working currency of supervision, and its quality determines whether a supervisee leaves a session knowing specifically what to do differently or simply feeling judged. Several practical principles separate feedback that helps from feedback that lands as criticism and provokes defensiveness.

Effective feedback is specific and behavioral rather than global and characterological. Telling a supervisee that a session felt unfocused gives them nothing to act on, whereas noting that the conversation shifted among three topics in the first ten minutes without the client settling on a concern names an observable pattern the supervisee can recognize and change. Feedback tied to a concrete moment, ideally one both people can point to in a recording or a detailed process note, is far more useful than a general impression, because it turns an abstract judgment into a specific event that can be examined together. Anchoring feedback to the goals the supervisee has already endorsed, rather than to the supervisor's personal style, keeps the conversation collaborative and reduces the sense that the supervisee is being remade in the supervisor's image.

Timing and balance matter as much as content. Feedback offered close to the event it concerns, while the session is still fresh, is more accurate and more usable than feedback saved for a distant formal review. Balance does not mean softening every correction with praise until the message blurs, a habit that leaves supervisees confused about whether they did well or poorly. It means noticing genuine strengths as carefully as deficits, because supervisees who cannot tell what they are doing right have no stable base from which to build, and because a supervisor who only ever corrects trains the supervisee to hide problems rather than bring them forward. The most valuable feedback often takes the form of a question that invites the supervisee to evaluate their own work, since a clinician who can accurately appraise their own sessions has gained a durable skill that outlasts any single piece of advice.

Finally, feedback should be checked rather than assumed to have landed. Asking the supervisee what they took from a comment, and what they plan to do differently, reveals whether the message was received as intended or heard as something harsher or vaguer than meant. This simple loop, closing feedback by confirming understanding, is the same discipline good clinicians use with clients, and modeling it in supervision teaches it twice.

Direct Observation: Why Self-Report Is Not Enough

A recurring theme in the current evidence is that what supervisees report about their sessions and what actually happens in those sessions often diverge, not through dishonesty but through the ordinary limits of memory and self-perception. A clinician who is anxious about a case, overinvested in appearing competent, or simply unaware of a habit will describe a session in good faith and still leave out the very moments a supervisor most needs to see. Supervision built entirely on the supervisee's own account is therefore working from a filtered and incomplete record, and the filtering tends to remove exactly the material that would be most instructive.

Direct observation closes this gap, and it takes several practical forms that a supervisor can build into ordinary practice. Reviewing audio or video recordings of sessions, with the client's informed consent, lets the supervisor and supervisee examine the actual interaction rather than a remembered version of it, and it surfaces the nonverbal behavior, pacing, and missed opportunities that narrative reports omit. Live observation, whether in the room or through a one-way arrangement, adds the dimension of watching the clinician think on their feet. Even reviewing a verbatim transcript of a brief segment can reveal patterns invisible in summary. The specific method matters less than the principle: at least some supervision should rest on a direct sample of the work, not solely on the supervisee's description of it.

Observation is often met with anxiety, and how the supervisor introduces it determines whether it becomes a source of growth or of dread. Framing recording and observation as a normal, expected part of professional development, something every competent clinician submits to rather than a special scrutiny reserved for those in trouble, lowers the threat. Beginning with the supervisee selecting a segment they want help with hands them some control and models the self-appraisal that is the goal. Attending first to what the clinician did well before turning to what could be improved keeps the experience from feeling like an audit. Over time, clinicians who are regularly observed usually come to value it, because it gives them feedback grounded in reality rather than in impression, but the early sessions require particular care to build the safety that makes honest examination possible.

Holding the Evaluative Role: Formative, Summative, and Gatekeeping

One of the features that distinguishes supervision from consultation or therapy is that the supervisor holds real evaluative authority, and managing that authority well is central to ethical practice. It helps to distinguish two purposes that evaluation serves. Formative evaluation is the ongoing, low-stakes feedback woven through routine supervision, aimed at shaping and improving the supervisee's developing skill. Summative evaluation is the periodic, higher-stakes judgment, often tied to a formal review, a licensure endorsement, or a decision about advancement, that renders a verdict on whether the supervisee has met a standard. Both are legitimate, but confusing them creates problems, and supervisees are entitled to know at any given moment which one is in play.

The most important principle for managing the evaluative role is that summative judgments should never come as a surprise. A supervisee who receives a poor formal evaluation containing concerns never raised in ongoing supervision has been treated unfairly, and the failure is the supervisor's. Everything that appears in a summative review should already have been addressed in formative feedback, giving the supervisee both notice of the concern and a genuine opportunity to correct it. This requires the supervisor to name problems as they arise, even when doing so is uncomfortable, rather than storing them up for a later reckoning. Clear criteria stated at the outset, describing what competent performance looks like and how it will be assessed, give both parties a shared standard and protect the supervisee from being judged against expectations they could not have known.

Evaluation shades into gatekeeping when a supervisee's difficulties are serious enough to raise the question of whether they should advance in or enter the profession. Gatekeeping is an ethical obligation, because the supervisor stands between an impaired or unsafe practitioner and the clients who would be harmed, but it is also weighty enough to demand fairness and due process. When significant concerns arise, the responsible course is a structured remediation plan that states the specific deficits in behavioral

terms, defines what improvement would look like, provides resources and support, sets a reasonable timeline, and specifies the consequences if the standard is not met. Such a plan protects everyone: it gives the supervisee a fair and documented chance to succeed, it protects clients by ensuring problems are addressed rather than ignored, and it protects the supervisor and organization by demonstrating that any adverse decision rested on a transparent and reasonable process rather than on personal judgment.

Preventing Inadequate and Harmful Supervision in Your Own Practice

The finding that inadequate and even harmful supervision is common, not rare, is not only a warning about other supervisors; it is an invitation to examine one's own practice honestly. Few supervisors set out to provide poor supervision, yet the conditions that produce it, chronic time pressure, competing clinical and administrative demands, inadequate training in supervision itself, and the absence of any feedback on one's performance as a supervisor, are ordinary features of most treatment settings. Preventing inadequate supervision therefore requires deliberate structure rather than good intentions alone.

Several concrete safeguards help. Protecting supervision time so that it is regular and not the first thing sacrificed to a busy schedule communicates that the work matters and ensures it actually happens; supervision repeatedly canceled or reduced to hallway check-ins is a common form of the inadequate supervision the evidence describes. Establishing a clear supervision agreement at the outset, covering the frequency and format of meetings, the goals, the methods including observation, the evaluation criteria, and the handling of confidentiality and emergencies, gives the relationship a defined structure that vague, ad hoc arrangements lack. Seeking the supervisee's feedback on the supervision itself, and genuinely welcoming it, counteracts the striking absence of any performance feedback that most supervisors work in; a supervisor who never asks how supervision is landing has no way to know whether it is helping or harming.

Guarding against harmful supervision specifically means attending to the power inherent in the role and to the boundaries that keep it safe. Because the supervisor holds evaluative authority over someone's professional future, behavior that would be merely unpleasant between equals, dismissiveness, unpredictability, harsh or shaming criticism, or the blurring of supervision into a quasi-therapeutic or personal relationship, can be genuinely damaging to a supervisee who cannot easily object. Keeping feedback focused on professional behavior rather than on the supervisee's character, maintaining clear boundaries around the relationship, and remaining alert to the supervisee's experience of the power differential all reduce the risk of harm. When a supervisor notices signs of strain in the relationship, the professional response is to raise it directly and, where appropriate, to consult a trusted colleague about one's own supervisory practice, the same recourse to consultation that good clinical work depends on.

Supervising Across Difference

Supervision always takes place across some form of difference, whether of culture, race, ethnicity, gender, age, disability, sexual orientation, religion, professional discipline, or theoretical orientation, and the supervisor's willingness to engage that difference openly shapes both the relationship and the care the supervisee ultimately provides. Differences that go unacknowledged do not disappear; they operate

quietly, influencing rapport, the safety the supervisee feels in disclosing mistakes, and the assumptions each person makes about the other. A supervisor who can name and explore difference with humility models exactly the stance the supervisee needs to take with clients whose backgrounds differ from their own.

The practical foundation is cultural humility, an orientation that treats the supervisee, and the client, as the authority on their own experience and keeps the supervisor in the posture of a learner rather than an expert who has mastered other cultures. This means inviting conversation about how identity and background may be shaping the supervisory relationship and the clinical work, rather than waiting for the supervisee to raise it or assuming it is irrelevant. It means being willing to examine one's own assumptions and blind spots, including the ways a supervisor's own cultural frame can be mistaken for a professional standard. And it means attending to the reality that the power differential in supervision can be compounded by differences in social power, so that a supervisee from a marginalized group may experience the evaluative relationship as carrying risks a supervisor from a dominant group does not automatically perceive.

Engaging difference well also has a direct clinical payoff. Much of the work the supervisee does will involve clients whose lives differ from their own, and the habits of curiosity, self-examination, and respectful inquiry that a supervisor cultivates in the supervisory relationship transfer directly to the clinical one. When a supervisor demonstrates that difference can be discussed rather than avoided, that not knowing can be admitted without loss of credibility, and that a person's own account of their experience is to be trusted, the supervisee learns a way of being with difference that no lecture on cultural competence can teach. In this sense, supervising across difference is not a separate topic but a thread that runs through every model and role this course describes.

Using the Parallel Process Deliberately

The evidence that parallel process is a real and measurable phenomenon, not merely a psychodynamic notion, gives the supervisor a concrete tool rather than an abstraction to admire. Parallel process refers to the way dynamics in the clinical relationship are unconsciously reproduced in the supervisory relationship, and the reverse, so that a supervisee who feels helpless with a stuck client may, without realizing it, evoke a parallel helplessness in supervision, and a supervisor's way of relating to the supervisee may echo into how the supervisee then relates to the client. Recognizing this pattern turns moments that would otherwise be puzzling or frustrating into useful clinical information.

The practical skill is to treat the supervisory relationship itself as a source of data about the case. When a supervisor notices an unusual reaction in a supervision session, a sudden sense of confusion, irritation, protectiveness, or being deskilled, that is out of proportion to what is happening on the surface, a useful move is to wonder aloud whether something similar might be alive in the clinical work. A supervisee who becomes uncharacteristically defensive when a particular client is discussed, or who consistently forgets to raise a certain case, may be enacting in supervision a dynamic that the client enacts with them. Naming the possibility tentatively, as a question rather than an interpretation imposed from above, invites the supervisee to examine the clinical relationship from a new angle and often unlocks a case that direct discussion had not moved.

Using parallel process well requires restraint as much as insight. Not every reaction in supervision

reflects the client, and a supervisor who reads every disagreement as a parallel enactment quickly becomes insufferable and evasive, deflecting legitimate feedback about their own behavior onto the absent client. The discipline is to hold parallel process as one hypothesis among several, to check it against the actual clinical material rather than assuming it, and to use it in service of the supervisee's understanding rather than to win an argument. Handled with that care, attention to the parallel between the two relationships lets a supervisor help with cases they never directly observe, precisely because the case has, in a sense, walked into the room.

Repairing Ruptures in the Supervisory Relationship

Because supervision is a relationship carried out under an evaluative power differential, strains and ruptures are inevitable, and the supervisor's ability to repair them is one of the clearest markers of skill. A rupture may be obvious, as when a supervisee reacts with visible hurt or anger to a piece of feedback, or it may be quiet, showing up as withdrawal, guardedness, a sudden formality, or the disappearance of the honest disclosure that supervision depends on. Left unaddressed, ruptures corrode the safety that makes supervision work, and a supervisee who no longer feels safe will simply stop bringing forward the mistakes and uncertainties that most need attention, hiding exactly what the supervisor needs to see.

The first requirement for repair is noticing, which means the supervisor has to attend to the relationship and not only to the case content. A shift in the supervisee's manner, a session that suddenly feels flat or careful, is worth taking seriously as a signal rather than ignoring in the interest of getting through the agenda. The second requirement is a willingness to raise it directly and without defensiveness. Naming the strain gently, observing that the last conversation seemed to land hard or that something feels different today, and then genuinely listening to the supervisee's experience, communicates that the relationship can withstand difficulty and that the supervisee's reactions are welcome rather than dangerous. Where the supervisor has contributed to the rupture, through feedback that was harsher than intended, an unfair assumption, or simple inattention, acknowledging that contribution honestly is powerful, both because it repairs the specific breach and because it models the non-defensive openness that clinicians need with their own clients.

Repair does not mean retreating from honest evaluation or avoiding hard feedback in order to keep the peace. It means delivering that feedback within a relationship strong enough to hold it, and tending to the relationship when the weight of the work strains it. A supervisor who can name a rupture, hear the supervisee's side, take responsibility for their part, and re-establish the working alliance teaches the supervisee one of the most transferable skills in all of clinical work, since the capacity to recognize and repair ruptures with clients is itself among the strongest contributors to good outcomes. In this way the supervisory relationship becomes not only the container for learning but one of its most important lessons.

Documentation and Record-Keeping in Supervision

The legal and ethical weight that supervision carries makes documentation a practical necessity rather than a bureaucratic afterthought, and yet it is one of the most neglected aspects of supervisory practice. Because a supervisor can be held responsible for the care provided by those they supervise, a contemporaneous record of what occurred in supervision serves several protective functions at once. It demonstrates that supervision actually took place and addressed the clinical issues it should have, it creates a trail showing that concerns were identified and acted upon, and it protects the supervisee, the supervisor, and the clients by making the reasoning behind decisions visible after the fact.

A useful supervision record need not be elaborate, but it should capture the essentials. Noting that a session occurred and when, the cases and issues discussed, any significant clinical concerns raised, the guidance or directives given, and any decisions made about high-risk situations creates a record proportionate to the responsibility involved. Particular care is warranted whenever a case involves elevated risk, such as a client who may be dangerous to themselves or others, because these are precisely the situations in which the adequacy of supervision may later be examined, and in which a clear record of the risk being recognized and a plan being formed is most valuable. Documenting formative feedback and any emerging performance concerns is equally important, because it is what allows a later summative evaluation to rest on a documented history rather than on a supervisor's memory, and it is what makes any remediation or gatekeeping decision defensible as the product of a fair and transparent process.

Documentation also reinforces good supervisory habits. The discipline of recording what was discussed and decided encourages the supervisor to be deliberate about addressing important issues rather than letting sessions drift, and reviewing prior notes at the start of a supervision session helps ensure that concerns raised earlier were followed through rather than forgotten. As with clinical documentation, the guiding principle is that the record should reflect thoughtful, responsible practice, because in both the clinical and the supervisory context, careful documentation is inseparable from careful work.

Group and Peer Supervision

Much of the supervision that actually happens in substance use and behavioral health settings takes place not in the one-to-one format the models most often describe but in groups, and the current evidence on peer supervision spaces underscores how common and how consequential these arrangements are. Group and peer supervision are not simply cheaper substitutes for individual supervision; they offer distinct benefits and carry distinct risks, and using them well requires understanding both.

The advantages are real. A supervision group exposes each member to a far wider range of cases than any one caseload provides, so that clinicians learn vicariously from situations they have not personally encountered. Hearing peers describe their own uncertainties and mistakes normalizes the struggles of clinical work and reduces the isolation and shame that keep problems hidden. The multiple perspectives available in a group can surface options and blind spots that a single supervisor might miss, and the experience of giving feedback to peers builds the very capacity for clinical judgment that

supervision aims to develop. For newer clinicians especially, watching more experienced colleagues reason through difficult cases is a form of modeling that individual supervision cannot fully replicate.

The risks require active management by whoever leads the group. Safety is the central concern, because a clinician who does not feel safe will present only sanitized, successful cases and withhold the genuine difficulties that most need attention, turning the group into a performance rather than a learning space. The leader has to establish and protect norms of confidentiality, respect, and constructive rather than competitive feedback, and to intervene when the group tilts toward harsh criticism, dominance by a few voices, or the silencing of a member. Time must be managed so that quieter members and less dramatic cases receive attention, not only the most vocal participants or the most alarming situations. And the leader must remain clear about accountability, because in a group led by a supervisor with evaluative authority, the responsibility for each supervisee's practice still rests with that supervisor, whereas in true peer supervision among equals, no one holds formal oversight and the group must recognize the limits of what a leaderless format can assure.

The distinction between peer consultation and supervision matters ethically and practically. Peer supervision among colleagues of similar experience, without an evaluative hierarchy, is valuable for ongoing professional development and mutual support, but it does not satisfy requirements for the formal, accountable oversight that trainees and newly licensed clinicians need, and it should not be represented as doing so. A clear-eyed program uses each format for what it does well: individual supervision for close, accountable oversight and evaluation, group supervision for breadth and shared learning under a responsible leader, and peer consultation for the continuing support that sustains experienced clinicians across a career. Matching the format to the purpose, rather than letting a group format quietly stand in for oversight it cannot provide, is itself a mark of sound supervisory practice.

From Evidence to Practice

Taken together, the research assembled here both affirms the framework of this course and sharpens it into a set of clear commitments for the practicing supervisor.

The first commitment is to take supervision seriously as a substantive function, because the evidence shows it works. Real, sustained supervision builds competence and strengthens the therapeutic alliance far beyond what its absence allows, and the models this course teaches provide sound frameworks for delivering it. Supervision is not a formality, and the honest evidence, while modest about supervision's proven effect on distal client outcomes, is clear that it develops the clinicians on whom good care depends.

The second commitment is to recognize the supervisor's influence as it actually operates. Parallel process is not a metaphor but a documented mechanism, which means the supervisor's own interpersonal conduct is transmitted into client care, and the way one supervises is as consequential as the content one delivers.

The third commitment is to guard against the harm that supervision can do. The finding that most supervision is inadequate and a third is harmful is a warning to every supervisor against complacency, and it grounds the ethics and legal material of this course in an urgent reality. The power differential is real, the potential for boundary violations and misuse of authority is common, and the legal liability,

vicarious and direct, is substantial. Supervising carefully, documenting real oversight, attending to boundaries, and not taking on more than one can genuinely oversee are not bureaucratic burdens but the core of ethical and legally sound practice.

The fourth commitment is to use the tools the present offers. Measurement-based supervision lets a supervisor see competence accurately rather than guess at it, telesupervision extends effective supervision across distance, and both, used well, strengthen rather than dilute the classic models.

Underlying all of these is the reflective stance the course calls for. Because supervisory competence cannot be assumed, because the supervisor's own patterns shape client care, and because the field's default is too often inadequate, the committed supervisor treats their own development as a career-long discipline. The models in this course remain the enduring framework. The current evidence shows how to apply them so that supervision does what it is meant to do, which is to develop competent, ethical clinicians and, through them, to protect and serve the clients whose care is the ultimate purpose of the entire enterprise.

Introduction

This course offers a brief review of models of supervision, definitions, roles and responsibilities of supervisors and the opportunity for supervisors to reflect on their own developmental process. Information on ethical and legal issues specific to supervisors is also discussed. Self-inventory, discussion questions and case examples are part of the course content as well as a list of resources for additional reading.

There are many definitions of clinical supervision throughout the literature. Here are a few:

"*An intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person…."*
(Bernard and Goodyear, 2004, p.8)

"*An ongoing educational process in which all persons in the role of supervisor help another person in the role of the supervisee acquire appropriate professional behavior through an examination of the supervisee's professional activities*." (Hart, 1982. p.12)

In the substance abuse treatment literature on supervision, David Powell's definition is probably the most quoted one: "*Clinical supervision is a disciplined, tutorial process where in principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive*. (Powell, 2004, p. 11)

More recently, the Substance Abuse and Mental Health Services Administration and the Center for Substance Abuse Treatment have published "Competencies for Substance Abuse Treatment Clinical Supervisors, TAP 21-A. In this publication, the authors offer the following definition: *"A social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus and evidence-based practices*." (SAMHSA, 2007, p. 3)

And the most recent definition coming from Milne (2009): "*The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of*

colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching, and collaborative goal-setting. The objectives of supervision are 'normative' (e.g. case management and quality control issues), 'restorative' (e.g. encouraging emotional experiencing and processing) and 'formative' (e.g. maintaining and facilitating the supervisees' competence, capability and general effectiveness)." (p. 15-16) He offers this definition as one that can be researched as there are measurable objectives and therefore moves the supervision field towards a more evidence-based practice. Milne discusses in his book that previous definitions are not supported in empirical literature which is why he has developed a new definition.

We will refer back to some of these definitions and the issues they raise throughout the course. One of the main issues is the obvious complexity of the supervision process and the different tasks, roles and responsibilities someone has who is a supervisor. And then to add to that, some supervisors are also expected to provide counseling services or function as an administrator. One of the goals of this course is to help with breaking down these complexities so that supervisors can hopefully feel less over-whelmed and gain a sense of competency about their work.

The course design that follows is:

- Self-Inventory
- Module 1: Models of Supervision
- Module 2: Roles and Responsibilities
- Module 3: The Developmental Model: Counselors
- Module 4: The Developmental Model: Supervisors
- Module 5: Ethical and Legal Issues
- Resources and References
- Post-Test

Self-Inventory

This inventory is offered as a way to begin the course by focusing on issues specific to supervision. It also offers an introduction to some of the issues discussed in this course. In addition, supervisors need to have a high level of personal awareness in the supervisory relationship because of issues of power and authority. Please complete and discuss your answers with a trusted colleague or feel free to contact the course instructor.

1. The reasons I became or want to be a clinical supervisor are:
   _____

2. The three most important tasks I perform as a supervisor are:
   _____

3. I believe I am competent in performing these tasks: Yes ___ No___ explain your answer: _____

4. The type of supervisee I most enjoy working with is:
   _____

5. The type of supervisee I least enjoy working with is:
   _____

6. The ethical issues I am most concerned about as a supervisor are:
   _____

7. The legal issues I am most concerned about as a supervisor are:
   _____

8. The type of training and supervision I receive for my supervision is:
   _____
   and it does _____ or does not _____ meet my needs.

9. If I believed a client was receiving inadequate care, I would take over the case.
   Yes _____ No ____

10. I believe it is okay for me to disclose personal information to my supervisees Yes ____ No ___ and the reason I gave this answer is _____
    _____

11. If I had a sexual attraction to a supervisee, I would _____
    _____

12. If a supervisee presented me with a really good business partnership idea I would

_____

Module One: Models of Supervision

In counselor training most professionals are taught different theories and the approaches that coincide with those theories. For many years, supervision was influenced by these counseling theories. In other words, if you were a client-centered, Rogerian counselor and you moved into a supervisory position, you would most likely practice supervision from a Rogerian theory. In the 1980's, family system theories and solution-focused theories began emerging with a specific type of framework for supervision. From family systems theory the concept of isomorphism was introduced to the supervision literature. This concept describes the parallel process that exists between counselor/client and supervisor/counselor. For example, if a counselor is having difficulty talking about a specific issue with a client, this same issue is being ignored in the supervisory relationship. Another example would be if a supervisor engaged in a boundary crossing with a counselor, this same boundary crossing could occur between the counselor and client, as in touching without permission or inappropriate self-disclosure. From solution-focused theories a more strength-based supervisory process emerged with focus on using the same approach in supervision that a solution-focused counselor would use with a client: eliciting strengths and resources; asking appropriate questions (rather than telling or interpreting for the client); using scales to measure and develop progress; giving positive feedback on even small steps; and adapting to the other's pace.

Since then efforts have been made to balance and integrate counseling theories with teaching and adult-learning theories, and with professional development needs of both the counselor and supervisor in an effort to provide a more encompassing supervision model. In this past decade, the emergence of evidence-based practices has challenged the traditional roles of supervisors and has increased the demand for supervisors to be part of the training and development of staff as these new practices are implemented. In other words, unconditional, positive regard of your staff will not get a new practice implemented! In reading the definitions in the introduction, we can also see how supervision has evolved and how complex it has become.

Even though supervision is a more complex process now, it is still helpful to review some of the early models that were developed so that supervisors have a foundation and a framework for thinking about their approach. We will then discuss in more detail in Module 3 the developmental model to see how a model can be applied in practice.

According to Bernard and Goodyear, there are three types of supervision models:

- Psychotherapy based models

- Developmental models
- Social Role models

As previously discussed, the *psychotherapy based models* are consistent with a counseling or therapy model. Someone using a psychoanalytic model of supervision would believe it is important to explore in the supervisory sessions transference and counter-transference issues with the counselor and client as well as discussing these issues in the supervisory relationship. A person-centered supervision approach would emphasize genuineness, empathy and warmth with the goal being that the counselor would then move toward their own self-actualization and become a better counselor. Cognitive-Behavioral supervision would be more of a goal oriented model with skill analysis and assessment and examining the cognitions of the supervisee along with their level of skills.

Stoltenberg and Delworth are perhaps the best known names in the *developmental models* of supervision. These models propose that counselors move through specific developmental stages with each stage having specific characteristics and developmental tasks. Therefore a supervisor could assess a counselor's level and then use the appropriate supervisory intervention that matches. The foundation of the model suggested by Stoltenberg and Delworth is that supervision should assist counselors in three main areas: autonomy, self and other awareness, and motivation.

There are many noted authors in the *social role theory* of supervision. These models focus on the different roles a clinical supervisor needs to take on in order to be effective. Here is a brief review:

Author:	**Roles emphasized in their work**:
Bernard (1979)	Teacher, Counselor. Consultant
Ekstein (1964)	Teacher, Therapist, Administrator
Williams (1995)	Teacher, Facilitator, Consultant, Evaluator
Holloway (1995)	Relating, Instructing, Modeling, Supporting, Consulting, Evaluating
Carroll (1996)	Teaching, Counseling, Consulting, Evaluating, Administrating

In summary, most of these authors all agree on the roles of teacher, counselor and consultant. One of the most well known of these social role authors, Bernard, developed the Discrimination Model (1997). This model goes into

enough detail to help the supervisor determine the need for one role vs. another in specific situations.

In the Discrimination Model, supervision is focused on three areas:

- intervention skills,
- conceptualization skills, and
- personalization skills.

The intervention skills refer to the supervisor's ability to teach a counselor specific techniques and strategies. The conceptualization skills are the abilities the counselor needs in understanding a client and being able to do case analysis. Personalization skills refer to the personal aspects of the counselor's experiences.

So in applying the Discrimination Model to one of these areas, intervention skills, it might look like this:

Area: Intervention skills

Supervisor Role: *Teacher*

- Supervisor teaches counselor a specific approach, such as a mindfulness exercise, to use with a client who has anxiety issues

Supervisor Role: *Counselor*

- Supervisee has had extensive training in a specific approach but fails to use it with this client with anxiety issues. Supervisor and supervisee counselor examine what is going on in the session with him/her that limits the use of these skills.

Supervisor Role: *Consultant*

- Supervisee is interested in learning more about behavioral interventions for anxiety disorders. Supervisor provides information via reading assignments or a recommended training session.

Obviously, a social role model requires a supervisor to be flexible in that roles can change from session to session and from each different supervisee. An important quality in a supervisor who follows this model would be the ability to understand the continuous changes in the supervisory relationship and the willingness to respond appropriately.

Discussion Question:

Think about the experiences you have had being supervised. What models can you identify in these experiences? Which one did you like the best and why?

As mentioned in the definition section, David Powell developed the most well known supervisory model that is specific to substance abuse counseling in the early 1990's. His model blends elements that are unique to the substance abuse field with the developmental models and with descriptive dimensions of supervision from the model of Bascue and Yalof (1991). Powell's model offers nine dimensions: influential, symbolic, structural, replicative, counselor in treatment, information gathering, jurisdictional, relationship, and strategy. For more in depth information about these dimensions, see resources at the end of this module. To summarize, Powell's model recommends supervisory strategies for counselors at each level of development and addresses issues that are specific in supervising in the substance abuse field, such as, recovery status, para-professionals, use of self-disclosure, and boundaries between personal issues and professional issues.

In addition to offering a theoretical orientation to supervision, some of these models also describe tasks of supervision.

Holloway, one of the *social role* models, defined five tasks for supervisors:

1. Monitoring/evaluating
2. Instructing/advising
3. Modeling
4. Consulting
5. Supporting/sharing

Stoltenberg and Delworth, one of the *developmental* models, describe eight domains of supervision:

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

Discussion question:
Refer back to the self-inventory where you listed the three most important tasks of supervision. Are any of those tasks listed by Holloway or by Stoltenberg and Delworth? Think about your reasons for listing those three tasks. Would you change them now?

Another model, the *Interpersonal Process Recall Model (IPR)* also prescribes specific tasks for the supervisor. This is a supervision model developed by Kagan and Krathwohl (1967) that helps counselors to understand their perceptions and experiences with clients. The goals of IPR are to increase counselor awareness of thoughts and feelings of clients and self, and practice expressing these thoughts and feelings in the here and now without negative consequences, with the goal of deepening the counselor/client relationship. Kagan (1980) believed that counselors "tune out" important client statements, thereby missing important messages from the client. In this model, it's the supervisor's responsibility to help counselors become of aware of this through review of audio or video tapes of sessions. For more details of how this model works, see references at the end of this Module.

Case Scenario: Carl

You are the clinical director for a mental health and substance abuse treatment agency. You provide administrative and clinical supervision to three senior staff, and they provide supervision to the rest of the staff. One of your senior staff, Carl, rarely discloses any personal information to you. He is a licensed clinician with many years of experience and his staff is a close knit group that works well together.

Carl asks to meet with you today and tells you the team is having difficulty with a client. As he is describing this client Carl sounds angry and defensive. He states that the client is obviously "borderline" as she will not do anything staff has suggested. They have tried referring her to another agency but she continues to call here requesting services. Carl has assigned her to three different counselors, and all have had the same result: non-compliance with continued crisis calls of suicidal threats but no attempts. He has referred her to the staff psychiatrist but she does not keep those appointments. Carl asks what you want him to do with this client.

Questions:
First what is your reaction as a supervisor?

Using one of the models discussed in Module One, how would you proceed to respond to Carl?

References for Module One:

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Powell, D.J., and Brodsky, A. (1993). Clinical Supervision in Alcohol and Drug Abuse Counseling. New York: Lexington Books.

Putney, M., Worthington, E Jr., & McCullough, M. (1992) Effects of supervisor and supervisee theoretical orientation and supervisor- supervisee matching on interns' perceptions of supervision. Journal of Counseling Psychology. 39, 258-264.

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Watkins, C.E. (1997). Handbook of Psychotherapy Supervision. New York: John Wiley & Sons.

Module Two: Roles and Responsibilities

In reviewing the various supervision definitions and models, the roles and responsibilities for supervisors are clear in some of them and not so clear in others.

The overall purpose of clinical supervision is to attend to the professional needs of supervisees so that the treatment needs of clients are met. In this regard, clinical supervision is a different role from counseling, case management, training or being an administrator. However, some of the definitions and models include counseling, teaching, etc. in them thus leading to more confusion. In this module we will look at differentiating the role of supervisor from these other roles.

"*Supervision looks like therapy not because the supervisor is doing therapy but because a therapist is doing supervision*" (Powell, 1993)

What is the difference between supervision and counseling? We have already discussed that the main purpose of the supervision session is directed towards the goals of monitoring the supervisee so that he/she can deliver effective treatment to clients. In other words, there is no "client" in the room when a supervisory session is being conducted but rather the client is discussed as a third party. The supervisee should not be treated as a client even though there may be assessment and evaluation tasks that the supervisor performs. The difference is that the supervisee is being assessed on their *professional* strengths and weaknesses and their job performance and not on their *personal* issues or psychological strengths and weaknesses. How much personal issues are discussed in a supervisory session will depend on the supervision model used by the supervisor; but regardless of the model, personal issues of the supervisee should only be discussed in terms of their relevance to the supervisee's job performance or client relationship.

For example, our case discussion with Carl in Module One stated that Carl seemed angry and defensive. This would be something appropriate to discuss with him as it could be interfering with his handling of this client. It could also be that he was angry because he just got a speeding ticket on his way to work. And that would have no bearing on the client nor need to be discussed further by the supervisor (unless he had been in an agency car!)

In addition, supervision has its own knowledge base and set of skills that are different from what is required of a counselor. In TAP 21A, discussed previously, the following are recommend areas of knowledge for supervisors:

- Understand theories, roles and modalities of clinical supervision
- Leadership
- Understand the supervisory alliance
- Critical thinking
- Organizational management and administration (p. 13)

These are clearly different areas of knowledge than that expected of counselors.

There may also be confusion about counseling vs. supervision vs. case management. In some agencies, case management is blended into everyone's job; in others, there are staff hired who perform only case management. Supervisors may be confused between supervising a case manager vs. supervising a counselor. Case management can be defined as a collaborative process that assesses, plans, implements, coordinates and monitors the options and services required to meet a clients' needs. It is characterized by advocacy, communication and resource management. Counseling is a structured, collaborative process that involves assessment of the client's mental and emotional health, diagnosis, and techniques that facilitate the improvement of the client's mental and emotional health. It is based on a theory of human growth and development, and the techniques are derived from a theory based on a belief about how people change. Counseling and case management can certainly overlap; however, there is a specific knowledge base and core set of competencies for most counseling professionals, especially if credentialed, that differs from a case management job.

There may also be confusion about clinical supervision and administrative supervision as many supervisors are asked to blend administrative responsibilities in their jobs. A clinical supervision session focuses on the professional development of a supervisee and improving his/her clinical skills. An administrative supervision session would focus more on the procedural aspects of the supervisee's job, employee status and agency requirements. For example, in a clinical supervision session, the supervisor would typically ask about the diagnosis, treatment plan or progress made of specific clients. In an administrative session, the supervisor would discuss that the billing information had not been completed on a client or discuss an agency policy that the supervisee had violated. We can see how a supervisor who has both of these roles needs to be very careful about limiting how much personal information a

supervisee discusses. The counselor who has disclosed personal information in a clinical supervision session and is then reprimanded by this same supervisor in their next session for a violation of agency policy, would understandably have conflicting feelings about their ongoing supervisory relationship.

In summary, the Association for Counselor Education and Supervision has developed a code of ethics for supervisors. Section 2: Supervisory Roles states: "*Inherent and integral to the role of supervisors are responsibilities for:*

A. *monitoring client welfare;*
B. *encouraging compliance with relevant legal, ethical, and professional standards for clinical practice;*
C. *monitoring clinical performance and professional development of supervisees; and*
D. *evaluating and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment and credentialing purposes*." (1993)

Further in this section, the code states: "*Supervisors who have multiple roles with supervisees should minimize potential conflicts. Where possible, the roles should be divided among several supervisors. Where this is not possible, careful explanation should be conveyed to the supervisees as to the expectations and responsibilities associated with each supervisory role*." (2.09)

We will discuss ethical issues in more detail in Module Five.

Just as in the counseling relationship, when there are potential role conflicts (group counselor vs. individual counselor), a written informed consent process is needed for supervisors with their supervisees. Fall and Sutton (2004) suggest the following guidelines for a good informed consent for clinical supervision:

A. Define the purpose of the supervision
B. Where, when and for how long the supervision will take place
C. Method and type of evaluation of supervisee
D. Duties and responsibilities of supervisee and supervisor
E. Documentation responsibilities of supervisee and supervisor
F. Supervisors scope of practice
G. Supervision model used by supervisor
H. Confidentiality
I. Ethical and legal guidelines (For example, supervisee is to notify you immediately if a client is suicidal or a threat to others)

J. Process for addressing supervisee complaints
K. Emergency procedures (what to do if you cannot be reached in a crisis situation)
L. How supervision will be delivered (weekly individual meetings, audio tapes, etc)
M. Financial arrangements if appropriate

Here is an example of an informed consent for supervision form from McCarthy et al (1995). The content has been edited and just a few examples of wording used here because of the length of the document. There are seven sections: purpose, professional disclosure, practical issues, supervision process, administrative tasks and evaluation, legal/ethical issues and statement of agreement.

Informed Consent for Supervision Form

Purpose
"The purpose of this form is to acquaint you with your supervisor, to describe the supervision process, to provide structure to your supervision experience, to give you the opportunity to ask questions you may have and to ensure a common understanding about the supervision process.

Professional Disclosure
(This paragraph states the education, training and credentials of the supervisor and describes the theoretical orientation.)

"My theoretical orientation for counseling and supervision is an integration of cognitive-behavioral, humanistic, and psychodynamic theories. Throughout this supervision experience, I will take on different roles at different times – teacher, consultant, counselor, and evaluator."

Practical Issues
(This paragraph discusses office hours, meeting times, payment)

Supervision Process

Examples from this paragraph: "You will be expected to be an active participant in the supervision process, to arrive on time, to be prepared for each session, and to complete all required work in a timely manner…..Possible risks include

discomfort arising from challenges to your counseling knowledge, abilities and/or skills."

Administrative Tasks and Evaluation

Examples from this paragraph: "Evaluation criteria include oral and written case reports, four audio or videotapes of counseling sessions, and the degree to which you accomplish the goal set forth at the beginning of this supervision experience".

Legal/Ethical Issues

Examples from this paragraph: "Supervision is not intended to provide you with personal counseling or therapy. If personal issues or concerns arise, I urge you to seek counseling. The content of our sessions and evaluation are confidential, except what I share with my supervisor."

Statement of Agreement

This consists of signatures and date.

In addition to the informed consent of the supervisee there are two other informed consents for a supervisor to monitor; the client's consent to receive counseling and the client's consent to be a part of the counselor's supervision. The informed consent that the counselor discusses with clients should include the information about the supervisory relationship and any recording or live supervision that will be expected. Clients can refuse one consent, that of the supervision, and still consent to receive counseling. Supervisors need to be prepared for how to respond when this occurs.

Informed consent is one of the key responsibilities of a supervisor that helps define the important aspects of the supervisory relationship. It also helps with ethical issues which will be discussed in Module Five. Other supervisory responsibilities include ongoing evaluation of supervisees, ongoing evaluation of client progress, continuous development of staff including self-care issues, monitoring ethical and legal practices, and administrative issues as relevant to their job.

Discussion Questions:

It is important to begin to integrate all of the information we have covered into your own supervisory practice. Here are some suggested questions to help with application of this material.

1. Write your own definition of supervision that is meaningful to you and your current practice. The definition should include your roles and responsibilities.
2. Decide which model of supervision will be your preferred practice. Write down some key issues in this model that will be important to implement with your staff.
3. Write out an informed consent document that can be used with your current supervisory job in the setting you are in.

References for Module Two

ACES Code of Ethics. (1993) Association for Counselor Education and Supervision.

Center for Substance Abuse Treatment. *Competencies for Substance Abuse Treatment Clinical Supervisors*. Technical Assistance Publication (TAP) Series 21-A. DHHS Publication No. (SMA) 07-4243. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

Fall, M. and Sutton, J. M. (2003) Clinical Supervision: A Handbook for Practitioners. Boston, MA: Allyn and Bacon.

McCarthy, P., Snugden, S., Koker, M., Lamendola, F., Maurer, S., and Renninger, S. (1995) A practical guide to informed consent in clinical supervision. Counselor Education and Supervision, 35, 130-138.

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Module Three: Counselor Development

As discussed in Module One, Developmental Theory is one of the models of supervision. It is part of the blended-model developed by Powell (1993) for use by clinical supervisors in the substance-abuse treatment field. We will discuss it in detail in this module and then apply it to supervisor development in the next module.

Counselor development is a complex process that involves supporting counselor self-efficacy over a period of time. Three aspects of each level of development are self and other awareness, motivation and autonomy. Self and other awareness focuses on the cognitive and affective components of the counselor and the client. For example, fears, anxieties, anger, discomfort and how these thoughts and feelings impact clinical work.

Motivation focuses on the understanding of the role of the counselor and the process of counseling, helping the counselor identify strengths and weaknesses and reasons for being a counselor. Autonomy deals with dependence on others, such as authority figures, and the ability to make independent decisions and develop self-confidence as a counselor.

The following is a description of characteristics common to each level of development.

Level One

"*Doesn't know what he/she doesn't know*"
This counselor is usually a beginning counselor or someone entering a new field of counseling, for example, a substance abuse counselor who is now learning to work with mental health issues. S/he is typically looking for the "right" answers and can employ a type of cookbook approach to his work. They may lack confidence and worry about their evaluations but also have a high level of enthusiasm and desire to do a good job. Here is a list of some of the characteristics of this level:

- High motivation
- High levels of anxiety
- Focused on gaining skills
- Dependent on supervisor and will copy supervisor

- Needs structure
- Self-awareness is limited: projects own experiences onto clients
- Focuses more on self than clients
- Unaware of strengths and weaknesses
- May have been taught one counseling theory/approach and clings to that
- No clear understanding of ethical practice: may know the laws and codes but no experience with application

Some statements a level one counselor may make:
"I don't want to hurt the client's feelings so I couldn't end the session on time"
"I had to respond to her question and give her an answer right then"
"I told him the same thing had happened to me, and I am sure he will be fine"

Discussion question:

1. List what some of the supervision issues would be for you with a level one counselor.
2. What are some of the things you would like about supervising a level one counselor?

Level Two

"*Knows more than you*"
A level two counselor has some experience and wants to begin to assert their independence and show initiative. This counselor is still struggling with the identity of being a counselor but without the level of anxiety of a counselor in the first stage. They still need supervision because of issues such as over-identifying with clients, burn-out, or pushing themselves to do something beyond their level of competency. Here are some characteristics of a Level two counselor:

- Motivation fluctuates; can decrease with more difficult clients
- Less anxiety but still confusion about being a counselor
- Dependency-autonomy conflict with supervisor
- Less inclined to ask for advise from supervisor
- Can be assertive with own agenda
- Focuses more on clients than self
- More understanding of clients' worldview
- Open to learning more approaches

- Needs help balancing between self and client needs: can easily burn-out
- Ethical decision making practice has started: complex situations will still need supervisory help

Some statements a level two counselor may make:
"This is not what I planned on doing when I became a counselor"
"What you told me to do last session with this client didn't work, so I tried something else"
"I have to come in on Saturdays because this client cannot find reliable child care any other time, and I know what that's like as a parent"

Discussion question:

1. List what some of the issues would be for you in supervising a Level Two counselor?
2. What are some of the positives about supervising this level counselor?

Level Three

"*Knows he/she doesn't know everything and that's okay*"
This is an experienced counselor who has developed a range of skills and has accepted their professional identity. They are able to accept frustrations of their work as well as discuss successes; in other words, they know their strengths and their limits and have a level of confidence. If they move into another clinical area where they have not been trained, they may struggle with level one or two issues again.

- Stable motivation
- Has assumed professional identity as counselor; diminished anxiety
- Knows when to seek supervision and is comfortable in the supervisory relationship
- Acceptance of self; nothing to "prove"
- High empathy and understanding of clients
- Better balance with self-care and client needs
- Integration of ethical practice with clinical practice

Some statements a level three counselor may make:
"When the client mentioned suicide I asked her what had been going on prior to that to bring that up for her. She expressed relief at the end of the session that I

didn't jump to the phone and call the crisis people to come evaluate her for hospitalization"
"I advised the client that sexual addiction is not an area I am trained in and suggested some other resources for him. We are going to continue to work on his parenting issues here"
"What are your ideas about how I handled that?"

Discussion question:

1. List some of the issues for you in supervising a Level Three counselor.
2. What would be the positive aspects of supervising this level counselor?

Level Four

"*Knows a lot, including own limits*"
Level four counselors are ready for independent practice. They have a realistic enthusiasm (no unrealistic expectations) for their work and a strong sense of professional identity. They may also be supervisors, consultants, or trainers.

- Self-motivating
- Skilled interpersonally and cognitively
- Collaborative relationship with supervisor
- Good self-care
- Can resolve complex ethical situations but knows not to do that alone

Some statements a level four counselor may make:
"I realized I needed to learn more about the medications this client was discussing"
"I re-scheduled my late evening clients so that I could attend a dinner party for my colleague who is retiring"
"I need to talk about my anger at this client who is having an affair"

Discussion question:

1. What would be the pros and cons of supervising this level counselor?

We have taken time to discuss the Developmental Model as it is a good framework for understanding counselor development. By using this model to

assess the level of a counselor, a supervisor then has a clear direction for their supervisory interventions.

Here are some suggestions for supervision issues for each level. Compare these to the answers you gave to the discussion questions.

When supervising a Level One counselor:

- increase counselor's awareness of numerous approaches to helping clients
- decrease counselor's anxiety so they can learn
- find ways to promote their autonomy that does not compromise client welfare
- teach them practical, helpful techniques with use of role plays and demonstrations
- Increase their awareness of their strengths; lead any feedback session with what they did well in a particular situation
- **do not take control of their cases**; teach them to be a better counselor rather than abdicating your supervisory role to become the counselor
- talk them through ethical situations; don't solve it for them unless it is a crisis type of situation; then be sure to go back and talk through it

When supervising a Level Two counselor:

- be aware of greater need for autonomy and avoid power struggles
- be prepared for challenges to your supervision; use that as a teaching moment to explain theory or rationale behind clinical suggestions
- be aware of transference issues especially around power and competency
- provide more challenging clients, again, without compromising client welfare
- monitor self-care issues to help prevent burn-out
- as counselor's personal issues emerge, have clear guidelines for addressing these that fit with your supervision model
- be open to counselor questioning whether he/she is in the right field; support career exploration
- encourage independence in ethical decisions but continue to talk through complex ethical situations
- Don't Stop Teaching!

When Supervising a Level Three counselor:

- Flexibility in responding to a wider range of clinical and professional issues
- Self-disclosure by supervisor may be helpful at this level
- Be prepared for counselor to perhaps be more skillful in some areas than supervisor ; letting go of own ego may be needed
- Continue to stimulate and challenge; don't abandon the supervisory role
- Ethical decision making will be more collaborative and there may be healthy disagreement

When Supervising a Level Four counselor:

- Take role as more of a consultant
- Share experiences, staff own cases if appropriate; more mutuality
- Continue to challenge with new goals, new learning; encourage counselor to take on new roles like training or writing to share expertise
- Ethical issues may be more about personal reactions to clients; counter-transference discussions.

Case Scenario:

You are a clinical supervisor for a mental health public program. The agency is trying to move towards providing better services for clients with co-occurring issues. In the process, the clinical supervisor for substance abuse services leaves and her staff is assigned to you for supervision. All of your credentials are in mental health services.

When you meet with one of the counselors who is being transferred to you, he says:

"What do you know about substance abuse treatment? I have been running 12 step recovery groups for three years here and getting good results. Are you going to tell me I have to let mentally ill people in my groups?"

Discussion questions:

1. What level of counselor would you hypothesize he is?
2. What would be your response?
3. What would be your supervision plan for him?

References for Module Three

Powell, D.J., and Brodsky, A. (1993). Clinical Supervision in Alcohol and Drug Abuse Counseling. New York: Lexington Books.

Skovhotl., T.M. and Ronnestad, M.H. (1992) The Evolving Professional Self: Stages and Themes in Therapist and Counselor Development. New York: Wiley and Sons.

Stoltenberg, C. and Delworth, U. (1987). Supervising Counselors and Therapists. San Francisco: Jossey-Bass.

Module Four: Supervisor Development

"*Taking on the role of supervisor demands that we act on our ethical responsibility to oversee and promote our ongoing development*". (Heid, p. 151)

Supervisors are often so focused on the needs of their counselors, clients, and agency that their own professional development needs are ignored. Just as counselors have developmental stages, supervisors experience developmental stages and issues at each stage. This is again a helpful way to look at the supervisory relationship in that it provides a framework for assessing where a supervisor may be and where a counselor may be. It could be that some stages of development of a supervisor are better matches for the supervisory needs of certain stages of a counselor's development. We will discuss that further in this module.

Regardless of training and years of experience, these are suggested as areas all supervisors need to address throughout their professional development:

- Sense of professional identity as a supervisor vs. identity as a counselor, trainer, administrator
- Confidence as a supervisor
- Degrees of autonomy and dependence
- Use of power and authority with supervisees
- Structure, flexibility and varieties of supervisory interventions
- Focus on needs of supervisees and self
- Degree of personal investment in supervisees and clients success
- Use of the supervisory relationship in the process of supervision
- Degree of awareness of impact of self on the supervisory relationship/process
- Containment of personal issues, biases and awareness of counter-transference reactions
- Cultural, gender and age related factors in the supervisory relationship
- Ethical and legal issues specific to supervision

One of the main issues identified throughout the literature on supervision is the shift that is required when someone is moving from the counselor role to the supervisory role. Some of the problems that can occur in this transition are described by Borders (1992):

- *Supervisors who think like clinicians and see supervisees as surrogates*. In the previous model in listing supervisory strategies for a level one counselor, it was noted that a supervisor should not take over the case for the counselor. This is a common mistake that beginning supervisors can make, as if the client is on their case load, rather than on the counselor's case load. In addition, these beginning supervisors make detailed notes about the client when they review tapes, generate numerous hypotheses about dynamics, and devise plans for working with client. They may lecture the counselor on what should have been done or on how they would have done it. The supervisor may fail to hear anything that the supervisee has to say.

- *Supervisors who focus on the supervisee as a client*. These supervisors are focused primarily on the supervisees' personal issues and attribute any problems in clinical work as related to these issues. This focus obviously prevents adequate assessment of the counselor's knowledge and skills.

- *Supervisors who think of supervisees as learners and themselves as educators*. This again could be a beginning supervisor who is comfortable in the role as teacher and only focuses on that in supervision. As discussed in previous modules, good supervision involves many different types of roles.

Watkins (1997) suggests some other type of problems that can occur with supervision:

- "The Mr. Rogers Supervisor ": This supervisor is warm, patient, kind, and good-natured, but does not provide substantive critical feedback or education. Obviously the problem with this supervisor is that his/her supervisees will not have accurate feedback about their skills as counselors. Although positive feedback and strength based approaches are helpful in supervision, using that to the exclusion of other responsibilities, such as evaluation and corrective action, is detrimental to the supervisory relationship.
- "Attila the Hun Supervisor": This supervisor believes there is only one way to do things, which is "my way". He/she becomes upset if the supervisee does not conform. In looking at the levels of counselor development this would obviously be a major conflict with a level two counselor and not meet the needs of counselors at other levels.
- "The "How do you feel?" Supervisor ": This supervisor focuses the supervision on personal feelings of the supervisee about the client. Again, some discussion of this can be helpful in the development of a counselor but using only this focus is detrimental in that the needs of the client are not discussed along with other important issues.

Various authors have identified different stages of development for supervisors similar to the stages of counselor development. (Watkins, 1990 and 1993; Stoltenberg and Delworth, 1987) This is a normal process that anyone would move through in their development as a supervisor. In addition, a supervisor could move back and forth in these levels. For example in our Case Scenario in Module Three, a level three supervisor in mental health services is now having to supervise out of her area of competency. This could easily cause a move to level one issues of dependency needs with her own supervisor, identity confusion, and anxiety.

Level One Supervisor

- Highly motivated
- Dependent on own supervisor: high anxiety
- Self-focused (am I doing this right?)
- Identity confusion in transitioning from counselor: if promoted from a peer group of counselors, this can add to the transition problem
- Struggles with power issues and the move to middle-management (especially in agencies where there is an “us against them” mentality of counseling staff vs. management staff)
- Limited skills in applying ethical principles to the supervisory relationship: may only think about client and not his/her ethical obligations to the supervisee as well. For example, a supervisee reports that a client has made suicidal statements. The supervisor steps in and does a pre-screening to commit the client rather than advise the counselor on how to manage this.

Level Two Supervisor

- Less anxiety and more clarity about role as a supervisor
- Continues to struggle with authority issues. For example, management makes a decision that is problematic for counseling staff and the supervisor sides with the counseling staff.
- Independent behaviors but still checking in with own supervisor
- May question decision to become a supervisor
- Aware of need to include supervisee welfare in ethical decision making process

Level Three Supervisor

- Balances awareness of self and supervisee
- Acceptance of authority and role as middle-management

- Functions autonomously
- Has developed clear supervision model
- Accepts professional identity as a supervisor
- Shows consistency in supervisory behavior (doesn't revert to counselor role)
- Realistic appraisal of own skills and limitations
- Integration of ethical practice with supervisory role

Level Four Supervisor

- Integrations of identity, knowledge and skills
- Fulfills requirements for supervisory credentials
- Sense of mastery as a supervisor
- Ready to supervise other supervisors

Discussion questions:

1. Identify which level supervisor you are. Write out a professional development plan based on your assessment.
2. You are a level one supervisor supervising a level three counselor. Identify two areas of concern that could occur for you.
3. You are a level two supervisor supervising a level one counselor. Identify two areas of concern that could occur for you.

References for Module Four

Borders, L.D. (1992). Learning to think like a supervisor. Clinical Supervisor, 10, 135-148.

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

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Module Five: Ethical and Legal Issues

There are several sources for guidelines regarding ethical behavior for supervisors. If a supervisor holds a specific credential, there may be ethical guidelines with the regulations governing that credential which address supervisory behaviors. As previously noted the Association for Counseling Educators and Supervisors offers a code of ethics for members. Resources for learning about specific credentials for supervision are located at the end of this module.

Discussion Questions: Is This Ethical?

1. A supervisor gives a counselor extra personal leave time, which requires cancelling a group for clients two weeks in a row as no other staff is available to run the group.
2. A supervisor requires all counselors to be in their own counseling for the first six months of employment.
3. A supervisor goes to lunch every Friday with two of her staff without inviting any other staff to join them.

Many authors in the field of ethics suggest that an ethical decision making process is essential for good practice rather than just relying on a code of ethics. Ethical practice is a way of being and not just knowledge of a code. In addition to practicing an ethical decision making process, supervisors need to be able to teach it to staff. In this process they need to be able to apply ethical principles to the supervisory relationship in addition to the client/counselor relationship. These principles are:

- Autonomy: supporting self-efficacy and not creating dependence
- Beneficence: contributing to the well-being of others: “doing good”
- Competence: having the knowledge, skills and abilities to do what we say we can do
- Justice: fairness in dealing with everyone; adhering to standards of practice
- Discretion: protecting the privacy of clients
- Nonmaleficence: Causing no harm

Autonomy

A supervisor who is using the developmental model for supervision would need to adjust the application of this ethical principle depending on the needs of the

supervisee. A beginning counselor will have more dependency needs than an experienced counselor. It could even be considered unethical to give a beginning counselor too much autonomy in that it could compromise client and supervisee welfare. At the same time, to keep a supervisee dependent on a supervisor and not facilitate their independent thinking, would be considered unethical. A supervisor's responsibility is to facilitate professional growth of the supervisee and to help that counselor develop their own identity; not continue to be a clone of the supervisor. One way to begin to promote autonomy of beginning counselors is to ask questions in the supervisory session rather than to lecture or give answers. When a counselor asks about a clinical situation, the supervisor can ask the counselor to think it through first before giving their own response.

Even without the developmental model, a supervisor will need to have a good assessment of their counselor to determine how to support self-efficacy. The type of supervision as well as the clinical setting will also impact autonomy. Supervisors who have access to audio and video recordings of all sessions may feel more comfortable allowing for counselor autonomy vs. supervisors who are providing supervision offsite with no live tools to know what is happening in the sessions.

Beneficence

What does it mean to "do good" as a supervisor? The welfare of the clients must be primary and at the same time, the supervisor is responsible for the welfare of supervisees. Examples of possible ethical dilemmas of beneficence are:

- Leaving clients on a waiting list because staff already have too high of a case load
- Assigning a difficult client to a beginning counselor so that the counselor can learn how to work with this population
- Giving a counselor extra leave time to take care of personal issues which means cancelling groups sessions as no other staff are available to run the group

Some supervisors may step in and provide clinical coverage themselves in order to resolve some of these dilemmas, for example, running the group. Others might push the counselors to the point of burn-out and deny personal leave rather than have clients wait for services. The ACES Code of Ethics offers the following guidelines:

"*Supervisors should use the following prioritized sequence in resolving conflicts among the needs of the client, the needs of the supervisee, and the needs of the*

program or agency. Insofar as the client must be protected, it should be understood that client welfare is usually subsumed in federal and state laws such that these statutes should be the first point of reference. Where laws and ethical standards are not present or are unclear, the good judgment of the supervisor should be guided by the following lists:

a. *Relevant legal and ethical standards (i.e. duty to warn)*
b. *Client welfare*
c. *Supervisee welfare*
d. *Supervisor welfare*
e. *Program and/or agency and administrative needs*" (Section 3.20)

One of the ways to help with beneficence is to have a good supervisory informed consent or a contract for supervision. This could outline expectations, how requests for personal leave are handled, etc, etc. An example of an informed consent was discussed in a previous module. It is strongly recommended that supervisors use a written informed consent to promote good ethical practice.

Competence

As we have previously discussed, supervision requires a specific set of knowledge, skills and abilities. A competent counselor is not necessarily qualified to be a supervisor but often in agencies, a competent counselor is promoted to the position without adequate training and preparation. Every professional cannot be competent in all the tasks they may be required to perform as professional development takes time.

The ethical responsibility is to make every effort to pursue the training and supervision that is needed to provide supervision for staff. If there are areas of deficiencies, other resources should be located so that staff welfare and client welfare are not compromised while the supervisor is developing his/her proficiencies. For example, in our case scenario of the mental health supervisor taking over a substance abuse staff, someone else within the agency who is proficient in substance abuse treatment could provide consultation for the staff while this supervisor learns what is needed.

One of the issues in the developmental model of supervisors is that it is hard for a beginning supervisor to admit they do not know something because of the developmental need to establish credibility in this new role. Beginning supervisors need to especially be aware of the ethical responsibility of

competence and to allow other professionals to assist them as they move into this supervisory role. It is unrealistic to expect that a beginning supervisor would know all that is needed just like one would not expect a beginning counselor to know everything about treating clients.

The ACES Code of Ethics states:
"*Supervisors should have had training in supervision prior to initiating their role as supervisors*" (2.01)

"*Supervisors should pursue professional and personal continuing education activities such as advanced courses, seminars, and professional conferences on a regular and ongoing basis. These activities should include both counseling and supervision topics and skills*". (2.02)

This code speaks to the ethical responsibility for supervisors to continue their education. In some situations where there are minimal training funds, supervisors may decide to use the funds for staff training rather than their own. This is not good practice, and supervisors need to also budget for their own learning needs. Ongoing supervision of supervision is also recommended to help maintain good practice and facilitate professional development of the supervisor.

Bernard and Goodyear state:" …*because of the tremendous influence that supervisors have on future practitioners, it is frightening to consider the supervisor who is not actively engaged in continuing education*" (1992, p. 143.)

Supervisors also have to monitor the competence of counselors. There are numerous evaluation tools available for supervisors, however, most authors in this field agree that live supervision is the most effective for knowing exactly what occurs in a counselor/client session. Evaluation requires objectivity so it is important that supervisors remain as objective as possible about staff in order to be effective at evaluating their abilities. Objectivity is part of the ethical obligation of a competent supervisor.

An aspect of competence that can cause anxiety for supervisors is impairment. In addition to knowledge and skills, counselors also have to be personally stable in order to be effective with clients. There are a lot of gray areas and disagreement about what constitutes personal stability. It is advisable that supervisors work with their human resources staff to have a description of impairment that is suitable for their agency, and procedures for how staff is to be assessed so that

there is consistency. If at all possible, a third party would be best for assessing impairment so that the supervisor is not in that dual role. Employee assistance programs are helpful in providing objective evaluations and recommendations. They can also help with back to work guidelines for any impaired staff that have to take a leave of absence. Impairment is an area that a supervisor should not try to address on their own as there are numerous ethical as well as legal issues involved. Again, this is information that should be covered in an informed consent.

Justice

Supervisors can have counter-transference reactions to staff just as counselors have reactions to clients. In the self-inventory, questions were asked about staff you enjoy supervising and those you do not. It is normal to have reactions to different people and their behaviors. However, a supervisor needs to maintain a high level of personal awareness about these reactions so that all staff is treated equally and fairly.

Supervisors also need training in cultural issues in supervision, and to have a good awareness of the issues of power and authority that can be viewed differently by different cultures. Some even suggest that supervisors' ethical responsibility is to actively recruit staff from minority cultures especially if that is the client population being served. If a supervisor notices a pattern of treating some staff differently than others, consultation is advised for help with identifying these issues and correcting them.

Discretion

This is the principle that the supervisor upholds in protecting privacy and confidentiality of clients. Some supervisors also apply this principle to discussions in supervision sessions; however, if the supervisor also has an administrative role, there may be times when information shared in supervision sessions has to be discussed with others in the agency. Supervisees are not clients and they are not protected under codes of ethics or in the privilege communication statutes. Supervisors should clarify in their informed consent with staff what information will be kept private and what information will not.

Nonmaleficence

Supervisors should do no harm to their staff. This seems obvious yet there have been a number of studies citing dual and sexual relationships with supervisors and counselors (Bernard and Goodyear, 1998). As noted in the literature on dual relationships with clients, boundary violations often occur on a continuum. When adults work closely together, it is normal that feelings and reactions will occur. Touching a supervisee or types of personal disclosure can be the beginning of the continuum that can then lead to sexual behaviors.

It is unethical for supervisors to put their sexual needs first. The power differential in the supervisory relationship sets the stage for exploitation; and for the supervisee, no matter how the relationship ends, to feel victimized in some way. So it is important for supervisors to monitor their own personal reactions to staff as well as their practices of physical touching and self-disclosure. Social invitations that are extended to one staff member and not others is also a step on that boundary violation continuum. Giving gifts to one staff member and not others would be a concern as well. Business relationships can also be problematic as a dual relationship. For example, a supervisor and her counselor go into business as trainers together and something goes wrong with the business. They now have to resolve this in order to be able to continue a positive supervisory relationship.

In conclusion, ethical management of the supervisory relationship requires the supervisor to seek consultation because it is hard to be objective about a relationship that you are part of and to monitor the reactions and behaviors of yourself. Dual relationships should be discouraged because of the issues related to objectivity, isomorphism, and exploitation. Proper boundaries should be discussed in the informed consent process and clarified throughout the supervisory relationship. Supervisor self-disclosure can be used as a teaching tool when appropriate for the developmental needs of the supervisee. It can also easily lead to boundary violations so must be closely monitored. The same guidelines that are recommended for counselor self-disclosure with clients should be utilized for supervisor self-disclosure: monitor the impact of the disclosure (is it helpful?), the frequency (happening too often?), the timing (too early in the relationship?), and the content (too much?). By following these guidelines, the supervisor is also providing good role modeling for the counselor/client relationship in boundary management.

A good ethical decision making process that can be applied with all staff is also essential in guaranteeing that there is no favoritism or discrimination with staff. And part of the supervisor's ethical decision making model should include knowledge of legal issues.

Legal Issues for Supervisors

Liability issues are a primary legal concern for supervisors. Harrar and VandeCreek (1990) identify two areas of concern that have been established by courts: actions of others and self actions.

In order for a supervisor to be liable for the actions of another person, there are three conditions that must exist:

1. supervisee must voluntarily agree to work under the direction of the supervisor

2. supervisee must have acted within the defined scope of tasks

3. supervisee must have the power to control and direct the supervisee's work

The legal question is who has the administrative control regarding client care.

The situations where supervisors are liable for their own actions are:

1. Neglect in the supervision of a supervisee and a client is harmed
2. Give inappropriate advise to a supervisee, the supervisee follows this advise, and a client is harmed
3. Assign a task to a supervisee that he/she is not adequately trained to perform

"If at any time the supervisor believes that a client is not receiving adequate care, they must act to protect the client. The protection holds true not only for the decisions in the course of treatment but for termination or referral as well" (Harrar and VandeCreek, p. 40)

This again speaks to the balancing act a supervisor needs to be able to perform between client welfare and supervisee welfare in order to practice within legal guidelines. As we discussed under counselor development as well as the ethical principles of autonomy and beneficence, the supervisor's role of teacher is

important. If the supervisor steps in and provides care in situations where there is inadequate care, this will impact the counselor's development and the supervisory relationship. However, it is clear that the court system values the welfare of the client above all else so that is why liability issues need to be a part of the ethical decision making process.

Obviously other legal issues that need to be considered in this process are duty to warn laws, duty to protect and duty to report. There may be legal issues with regard to the agency or practice of the supervisor. The Americans with Disabilities Act is something supervisors should be knowledgeable about especially in dealing with staff with impairment or disability issues. Other legal concerns will arise if a supervisor has administrative/personnel responsibilities such as hiring guidelines, grant requirements, etc.

Resources for Module Five

ACES Code of Ethics. (1993) Association for Counselor Education and Supervision.

Bernard, J. M. and Goodyear, R. K. (2004). Fundamentals of Clinical Supervision. (3rd edition) Boston: Allyn and Bacon.

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

Harrar, W.R. and VandeCreek, L. (1990) Ethical and legal aspects of clinical supervision. Professional Psychology: Research and Practice, 21, 1, p. 37-41.

Certifications for supervisors

Approved Clinical Supervisor
National Board for Certified Counselors
3 Terrace Way
Greensboro, NC 27403
www.cce-global.org/acs.htm

Approved Supervisor Designation
American Association for Marriage and Family Therapy
112 South Alfred Street

Alexandria, VA 22314
www.aamft.org/membership/Approved%20Supervisor/AS_Main.asp

Certified Clinical Supervisor
International Consortium of Addiction and Prevention Credentialing Boards
620 Eye Street, NW Suite 210
Washington, DC 20006
www.icrcaoda.org/credentialing.asp

Discussion of Scenarios

Now we will integrate the material in all of the modules and discuss some of the scenarios in the course.

Discussion for Case Scenario Module One: Carl

1. What is your reaction as a supervisor? Well, there could be lots of reactions. One could be that you are surprised that Carl is asking you for help. One is that you feel annoyed because you count on him to figure these things out with his team and you don't have the time to deal with this. You could feel good that he is asking for your help. You might feel concerned about how the client is being treated given Carl's attitude and the fact that the client has had three different counselors.

2. In addition to thinking about what model would work best with this scenario we also need to know what type of supervisory relationship you and Carl have. Since he is not one who discloses much, it would be ill advised to begin with asking him about his feelings so the Interpersonal Recall Model may not be a good choice here. However, if you have a solid supervisory relationship you might start by reflecting on the fact that it is unusual for him to seem so frustrated with a client and to ask for your help and then ask him what he thinks is going on? He is clearly a level three or four supervisor so supporting his autonomy in this scenario is important. Legally you may feel the need to ask to see the client's chart and to observe the next session when the client is at the agency. It would be best to try to do this in a collegial manner.

Discussion for Case Scenario Module Three

1. What level of counselor? It sounds like a Level Two counselor in that he has been providing group for three years in an approach that he thinks is getting good results, so he has some level of competency. His challenging of a new supervisor also fits with Level Two characteristics.

2. What would be your response? Since you do not have a relationship yet with this counselor you want to be careful in that your response will set the tone for the relationship. If you are going

to use a developmental model you could respond by asking him to tell you more about his groups, ask about what he has been doing that is working well, and what are his concerns about having mentally ill clients attend. This would support the independence issues of a Level two counselor. Then you would give him your response, first by reflecting back what he is doing well and how you think mentally ill clients could benefit from that but also being open to the fact that they may not. A contract could be to give it a trial period with both of you monitoring and assessing how the groups are working with this new combination of clients. To get a level two counselor invested in the solution to the problem that they raise is usually an effective strategy.

3. A supervision plan could consist of lots of things. One would be to ask him what has worked well previously in his supervision experiences and also give him a chance to debrief the loss of the previous supervisor – it may have been a positive relationship or not – so that would be important information to have before you proceed with a plan. Then something to include increasing his knowledge and comfort level with co-occurring clients. You could offer to sit in on some groups so that you can learn about the SA treatment part or do live supervision if a one way mirror is available. Also ask him what he is interested in learning at this point in his development. Maybe he has good group skills but would like to develop more individual counseling skills. You would also want to take time to talk with him about your style of supervision and how the plan will unfold. Some counselors have never had a supervisor who provides informed consent or a plan so be prepared for some reaction to that – again, positive or negative.

Discussion of scenarios in Module Five: Is This Ethical?

1. The canceling of a group could possibly be a violation of client welfare especially if clients are mandated to attend, and this could impact their probation, so the supervisor would be acting unethically in terms of clients. In addition, granting one counselor extra personal leave could backfire as other staff will then ask for and should be given the same treatment under the principle of justice. A supervisor in this situation should have a written policy about how extra personal leave is granted and in what situations, for example, a mental health issue that is documented by a therapist or

psychiatrist. If clients are also receiving individual counseling during the two week period, then their welfare issues are taken care of. If not, the supervisor needs to facilitate the group; or if not competent to do so, hire someone to do so. To not grant the personal leave would compromise the counselor's welfare which in turn impacts clients.

2. The fact that this is required of all counselors is good in that it upholds the principle of justice; however if this was not stated as a condition of employment before counselors were hired, then it is questionable practice. The supervisor would need to justify why this is a requirement for employment. To *suggest* it to everyone would be a better approach.

3. This supervisor may be using the lunches to provide some type of a supervision group; and if so, then this needs to be communicated to the rest of her staff. If it is not work related, then she is risking boundary crossings by constantly socializing with supervisees; and she is in violation of the principle of justice in not treating all staff the same.

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Appendix A: Post Test and Evaluation *Clinical Supervision: Models, Roles and Responsibilities, Ethics and Legal Issues*

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test online for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Go to 'My Courses" then to the subject course. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFERENT ORDER IN THE ONLINE EXAM

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

Answer the following questions by selecting the most appropriate response.

1. According to Milne, the objectives of supervision which can be measured are:
    a. mentoring, teaching, counseling
    b. normative, restorative, formative
    c. evaluative, supportive, educational
    d. team building, case consultation, teaching

2. There are three types of supervision models which are:
    a. evaluative, supportive, educational
    b. rogerian, developmental, solution-focused
    c. systems theory, psychotherapy based, developmental
    d. psychotherapy based, developmental, social role

3. A supervisor who discusses transference issues with a supervisee is most likely using which model of supervision:
    a. psychotherapy
    b. developmental
    c. systems theory
    d. rogerian

4. The developmental model of supervision states that:
    a. counselors move through stages with various tasks
    b. supervisors determine which role they should be in based on their developmental level
    c. supervisors should emphasize genuineness, empathy and warmth
    d. supervisors should discuss transference issues in the supervisory relationship

5. One of the most well known of the Social Role Models is:
    a. Interpersonal Recall
    b. Discrimination Model
    c. Psychoanalytic Model
    d. Teacher, Therapist, Administrator

6. One of the social role models developed by Holloway defined five tasks. Which of the following is **not** one of those tasks:
    a. monitoring/evaluating
    b. instructing/advising
    c. ethical decision making
    d. consulting

7. The goals of the Interpersonal Recall Model are:
    a. to increase counselor's awareness of thoughts and feelings
    b. to facilitate counselor's professional development through stages
    c. to teach counselors intervention skills through practicing in the moment
    d. to assist counselors with autonomy and motivation

8. One of the differences between clinical supervision and counseling is:
    a. counseling requires ethical decision making
    b. supervision focuses on the professional strengths and weaknesses of the supervisee and not personal issues as in counseling
    c. counseling requires more documentation
    d. supervision focuses on developmental issues

9. Personal issues of the supervisee should be discussed in supervision when:
    a. the supervisee brings them up
    b. the supervisor is using a psychoanalytic approach
    c. it is clear the issues are relevant to the job performance of the supervisee
    d. the supervisee is going to be put on probation

10. According to TAP 21A there are five recommend areas of knowledge for supervisors. Which of the following is **not** one of these areas:
    a. leadership
    b. critical thinking
    c. adult learning models
    d. understand the supervisory alliance

11. According to ACES Code of Ethics, a supervisor who has multiple roles should:
    a. minimize potential conflicts by discussing with the supervisee expectations and responsibilities of each role
    b. have a written informed consent for each of the roles
    c. have consultation for each of the roles
    d. have his/her supervisor take over some of the roles

12. A supervisor has three areas of informed consent to monitor. They are:
    a. the agency's consent for treatment, a counselor's consent for supervision, the supervisor's consent to supervise
    b. the client's consent to treatment, the client's consent to the supervision process, the counselor's consent to supervision
    c. the client's consent to treatment, the agency's consent, the supervisor's consent to supervise
    d. none of the above

13. Three aspects of counselor development according to the Developmental Model are:
    a. self and other awareness, motivation and autonomy
    b. anxieties, issues of authority, self-confidence
    c. authority issues, motivation issues, self-confidence
    d. dependency issues, self-awareness, and autonomy

14. A level one counselor will have which of the following characteristics:
    a. dependency-autonomy conflict with supervisor
    b. integrated ethical decision making process
    c. high motivation and high anxiety
    d. high empathy and understanding of clients

15. A level two counselor will have which of the following characteristics:
    a. dependency-autonomy conflict with supervisor
    b. no clear understanding of ethical practice
    c. high motivation and high anxiety
    d. high empathy and understanding of clients

16. Which level of counselor will have a more collegial relationship with his/her supervisor?
    a. Level one
    b. Level two
    c. Level three
    d. Level four

17. A level three counselor might make which one of the following statements to his/her supervisor?
    a. “I am not sure I want to be in the counseling field”
    b. “ I think CBT is the only way to treat this client”
    c. “I would like to talk with you about the ethical issues in this case”
    d. “I don’t know what to say to this client”

18. All of the following are true about Level Four counselors except:
    a. self-motivating
    b. good self-care
    c. because of length of time in the field they will burn-out
    d. can resolve complex ethical situations

19. When supervising a Level One counselor it is suggested that a supervisor:
    a. take over cases that are not going well
    b. increase awareness of counselor’s strengths
    c. let them solve ethical situations on their own so they can learn
    d. assign difficult clients so they will feel challenged

20. When supervising a Level Three counselor it is suggested that a supervisor:
    a. be prepared for challenges to your supervision
    b. increase awareness of counselor’s strengths
    c. have a clear plan for prevention of burn-out
    d. be flexible in responding to a wider range of clinical and professional issues

21. Some of the problems that can occur when moving into a supervisory role as identified by Borders are:
    a. supervisors who act as if they are the counselor
    b. supervisors who socialize with staff
    c. supervisors who do not know legal issues pertaining to liability
    d. supervisors who violate their supervisee's confidentiality

22. Watkins also identifies some problems with moving into a supervisory role. "Attila the Hun Supervisor" is someone who:
    a. only talks with supervisor about his/her feelings about clients
    b. uses one approach with all supervisees
    c. expects supervisees to conform to his/her way of doing clinical work
    d. follows ethics codes literally without any decision making

23. Which of the following is **not** a characteristic of a Level One supervisor:
    a. highly motivated
    b. functions autonomously
    c. limited skills in applying ethical principles to the supervisory relationship
    d. struggles with power issues

24. Which of the following is **not** a characteristic of a Level Two supervisor:
    a. less anxiety and more clarity in supervisor role
    b. ready to supervise other supervisors
    c. may question decision to become a supervisor
    d. continues to struggle with authority issues

25. A supervisor who has obtained additional knowledge and skills before moving from the counselor role to supervisor is practicing which ethical principle:
    a. Autonomy
    b. Beneficence
    c. competence
    d. discretion

26. A supervisor tells staff that he/she will not discuss anything that they disclose in their clinical supervision sessions with anyone else. This is upholding the ethical principle of:
    a. autonomy
    b. beneficence
    c. competence
    d. discretion

27. A supervisory relationship that moves into a business relationship is an example of:
    a. transference and counter-transference
    b. isomorphism
    c. developmental model of supervision
    d. dual relationship

28. The following would be an example of a boundary violation in a supervisory relationship:
    a. half of the supervision session is spent on the supervisor discussing his/her personal issues
    b. the supervision session takes place outside of the office setting
    c. the supervisor discusses his/her own client cases with a supervisee
    d. the supervisor provides a training session for staff that is mandatory to attend

29. Dual relationships are unethical in the supervisory relationship because:
    a. it causes lack of objectivity for the supervisor
    b. it can lead to exploitation
    c. there is an imbalance of power
    d. all of the above

30. In order for a supervisor to be held liable for the actions of other what needs to happen:
    a. supervisor must have a supervisory credential
    b. supervisor and supervisee must be employed by the same agency
    c. supervisee must have acted within the defined scope of tasks
    d. supervisor did not have regular meetings with the supervisee