CLINICAL SUPERVISION MANUAL:
FOR THE SUPERVISOR OF THE PARAPROFESSIONAL COUNSELLOR

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A project submitted
in partial fulfilment of the requirements for the degree of

MASTER OF COUNSELLING

in

APPLIED PSYCHOLOGY (COUNSELLING)

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University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

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Abstract

Clinical supervision has moved to the forefront of research as its value has become recognized. However, the practice of competent supervision is only recently become operationalized and many counsellors still receive inadequate supervision by well-meaning supervisors. The purpose of this project is to provide both a resource for supervisors of paraprofessional counsellors who do not have master level education, and for counsellors who are unregulated. Five questions are addressed: (a) What are the key elements of competent clinical supervision? (b) What do novice supervisors need to know about clinical supervision? (c) What are the ethical implications of clinical supervision? (d) What should be included in clinical supervision training process? (e) How can clinical supervisors incorporate multicultural competence into practice? The first section of the project addresses these questions by examining recent research. The applied portion of the manual operationalizes the seven domains of supervision practice that includes professional preparedness, structuring the supervisor relationship, relational supervision, assessment, evaluation and reporting, ethics, diversity and social justice and professionalism.

Acknowledgements

First, I would like to thank Dr. Blythe Shepard whose support, guidance, wisdom, and direction were invaluable. Thank you for being patient and keeping me focused. Your impact in the field of counselling and in particular clinical supervision, is inspiring to many, including me.

To Dr. Dawn McBride, thank you for helping in the final stages of this project. Your creativity, knowledge, insights and attention to detail were essential to its success.

I am indebted to my work family at the Boys and Girls Clubs of South Coast BC and in particular, Kathy Snowden, Mary Anne Crabtree, Sherry Grant and my fellow coordinators whose friendship, mentorship, and love over the years have helped me become the supervisor I am today.

To my family and especially my parents, Lanna and Gino. Thank you for your unwavering belief in me and cheering me on every step of the way. To my beautiful and intelligent step-daughters - Jenika, your support in the initial stages of applying for school and helping me understand new technology was so helpful. Maraike, thank you for the bringing me drinks, snacks, hugs and words of encouragement.

Finally, to my husband, Marc. I cannot express in words how your endless support and love throughout my academic journey has contributed to me accomplishing my goals and dreams. You make me a better person. This project is just as much yours as it is mine.

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CHAPTER 1: The Practice of Clinical Supervision

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." (Maya Angelou)

Nearly all clinical supervisors have been counsellors for part if not all of their careers and most are still practicing to some degree. While becoming a supervisor can feel like an exnsion of being a counsellor, clinical supervision requires skills, knowledge, and attitudes that are unique to the position (Falender & Shafranske, 2014). Becoming a supervisor entails a shift from thinking like a counsellor to thinking like a supervisor (Baker, Exum, & Tyler, 2002). In this chapter the importance of effective and competent clinical supervision in all counselling settings is examined. The development of the *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor* (see Appendix) is explained. Next the history of clinical supervision which is rooted in nursing practice in Europe is outlined. In the final chapter, terms that are relevant to the rest of the project are defined.

Significance and Importance

Historically, not-for-profit agencies have focused their limited resources on providing direct client care and have not always been able to provide sufficient resources for clinical supervision as a way to ensure quality service to clients (Center for Substance Abuse Treatment, 2009). If supervision is available, it tends to be more administrative than clinical with an emphasis on case management duties such as reviewing case records, facilitating case staffing conferences, and consulting on difficult cases. Direct clinical supervision that includes performance observation, feedback, and mentoring counsellors to improve their clinical skills and services is often lacking in smaller

agencies (Vito, 2015). In fact, Family Services of Ontario only recently included clinical supervision as part of their working plan (B. Shepard, personal communication, August 19, 2019). Incorporating clinical supervision into the agency's framework requires a significant change in operations.

The lack of clinical supervision can often be attributed to tight agency budgets leading to understaffing which can lead to a demand for supervisors to provide more direct services, a lack of appreciation for the importance of clinical supervision, a lack of training in clinical supervision, and an absence of standards for what constitutes competent and ethical clinical supervision (Tomlinson, 2015). When clinical supervision is provided, it is an improvement-oriented approach to clinical services that likely will lead to improved staff retention, enhanced counsellor skills, and better clinical outcomes (Rast, Herman, Rousmaniere, Whipple, & Swift, 2017; Watkins, 2011). If agencies wish to improve their supervisory practices, an operations manual for supervision can be a useful resource to support the development of competency as clinical supervisors.

Mental health professionals can benefit from receiving effective clinical supervision at various points in their careers. Clinical supervision is "a contractual relationship in which a clinical supervisor engages with a supervisee to discuss the direction of therapy and the therapeutic relationship; promote the professional growth of the supervisee; enhance the supervisee's safe and effective use of self in the therapeutic relationship; and safeguard the well-being of the client" (College of Registered Psychotherapists of Ontario, n.d., para. 1). Receiving clinical supervision is also an ethical necessity that benefits not only the supervisee and client but also the agency

where the counselling is taking place (Canadian Psychological Association [CPA], 2017; Shepard & Martin, 2012).

The term supervision can be confused with administrative supervision and consultation. Administrative supervision is about keeping the organization or agency functioning and therefore, the focus is on the health and survival of the organization (Center for Substance Abuse Treatment, 2009). Consultation is an informal arrangement between professionals in which the consultant provides a service, such as an opinion on a case, but the professional receiving the consultation has the right to accept or reject the opinion of the consultant (Ontario Association of Social Workers, n.d.). Clinical supervision, on the other hand, refers to a relationship in which the supervisor is responsible for ensuring the delivery of high-quality services, assisting supervisees to grow and develop, and safeguarding the well-being of clients (Center for Substance Abuse Treatment, 2009). In addition, supervisors assume legal liability for the actions of their supervisees (Camilleri, 2016). In summary, "consultation is focused on the sharing of skills and problem-solving capacity relative to a particular case. The two processes are quite different. A consultant does not take responsibility for decisions, only for sharing expertise" (Camilleri, 2016, p. 24).

Tromski-Klingshirn (2007, as cited in Kreider, 2014) estimated that about half of supervisees receive supervision from supervisors in both clinical and administrative roles. The dual role of administrative and clinical supervisory responsibilities can place the clinical supervisor in a difficult situation. While it is not necessarily unethical, the dual relationship is something that must be managed very carefully. Administrative supervisors have a fiduciary responsibility to the agency and to use resources and funds

appropriately and effectively for the intended purpose. Clinical supervisors have the responsibility of protecting clients and overseeing the supervisee's functioning as a counsellor, including their competence in using counselling skills, in developing and maintaining the client-counsellor relationship, addressing ethical issues, and conceptualizing client cases.

Outreach counselling programs may have counsellors with varying levels of education, credentials, and experience (Jamshidi, Aubry, Vandette, Valiquette-Tessier, & Fenn, 2018). Additionally, the supervision needs of counsellors in this setting can be different than those who have graduated from traditional master level counselling programs. The *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor* that is included in this project focuses on the needs of the counsellors who are providing services in community-based outpatient counselling programs. It will indirectly create an opportunity for agencies to re-vamp outdated practices.

According to the Canadian Counselling and Psychotherapy Association (CCPA) *Code of Ethics* (2007), supervisors are expected to be able to assess their own competence and only practice within those areas they are competent. There is no distinction in the literature between masters, doctoral level supervision, and paraprofessional supervision. Each are being practiced in community based, clinical, and hospital settings and supervision training continues to be a need. This project is unique because clinical supervision manuals are often designed for clinical and licensed settings.

According to Ellis et al. (2013), 90% of supervisees are receiving inadequate clinical supervision. Gazzola, Stefano, Theriault, and Audet (2013) found that 25% of supervisory skills are not only inadequate but also harmful to the supervisee. These

numbers are not altogether surprising given that 85%-95% of counsellors with 15 years of experience have engaged in clinical supervision (Gazzola et al., 2013) yet only 20% of those have received any formal training (Gazzola et al., 2013). The American Psychological Association (APA, 2015) argues that while clinicians may be competent in their area of practice, clinical supervision is a distinct skillset that requires a clear understanding of definition, assessment, and evaluation.

While it is assumed that most supervisors do not intend to be ineffective, the lack of training and understanding of roles and responsibilities can create a vulnerability that can lead to (a) disinterest, (b) lack of investment, (c) failure to provide timely feedback of skills, (d) inattention to supervisee's concerns or struggles, (e) a lack of focus on supervisees' growth or training needs, or (f) not listening to supervisee's opinions and feedback (Ellis et al., 2013). Challenges supervisors face include feelings of self-doubt, lacking confidence, maintaining boundaries, conducting ethical and honest assessments and evaluations (Bernard, 2006; Gazzola et al., 2013), and supporting problematic supervisees (Gizara, Forrest, Forrest, Elman, & Rodolfa, 2004). Novice clinical supervisors inevitably go through a shift in "perspective, attitudes and capabilities" (Goodyear, Lichtenberg, Bang, & Gragg, 2014, p. 1042). Proper training can support supervisors after issues arise in clinical supervision but can also prevent issues, as mentioned above, from occurring. It is essential that supervisors understand their roles and responsibilities.

While there is agreement that formal training for supervisors that is distinct from counselling and psychotherapy is needed (Gazzola et al., 2013), there is little consensus about what best constitutes competency training for supervisors (Falender & Shefranske,

2014; Hadjistavropoulos, Kehler, & Hadjistavropoulos, 2010). What is known is that supervisors should be competent in their area of practice. Adhering to the CCPA *Code of Ethics* requires that supervisors have the "necessary knowledge and skills to do so" (CCPA, 2007, p. 19).

Intent of the Project

Considering the breadth and depth of the supervisory responsibilities and roles, it is important supervisors have access to educational material designed to help them develop competency in offering supervision. The goal of this project is to create a manual that addresses supervisory competence for supervisors of counsellors who are trained in counselling skills but who do not hold a recognized counselling qualification- *the paraprofessional counsellor* (Nelson-Jones, 2013). The project makes supervision resources (information, tools, and templates) accessible to clinical supervisors who supervise counsellors in outpatient community-based settings. The objective is to enhance counselling supervisors' awareness and competence by providing concrete information as well as resource materials. As Gazzola et al. (2013) maintain, most supervisors are using their own clinical counselling experience as the foundation for their supervision practice. The CCPA's *National Clinical Supervision Framework: Qualifications, Competencies, and Best Practices* (2018) domains will provide a framework for topics that will be covered in the first part of the manual.

Personal Motivation for this Project

My interest in clinical supervision training stems from my formative experiences as an eager yet naïve supervisor 15 years ago. At the age of 29 and early in my career as a counsellor in an outpatient counselling program, I was asked if I could provide

supervision to a team of other counsellors. Unprepared for what that would entail, I eagerly accepted the challenge. I soon realized that counselling and supervision required quite different skill sets. Being a novice counsellor and taking on the role of supervisor was a recipe for disaster. I fumbled along and probably did some things well until I came across an employee who required a level of experience, knowledge, and support that I could not provide. This resulted in a personal and professional crisis and almost led to me leaving the profession all together. I was in over my head.

While there was great support provided by my supervisor and colleagues, it was off the side of their desks and there was no supervisor or training manual to refer to. I am convinced that even though I was a novice supervisor, had I had more thorough guidance and training, some of the issues that came up could have been prevented. At that time, training was mainly based on modeling, observation, and relying on one's own clinical experience and intuition. This is still the case amongst many master's level supervisors (B. Shepard, personal communication, October 6, 2018) and in many outpatient counselling programs today.

Fast forward 15 years, I am now the Senior Coordinator of Substance Use Services for the Boys and Girls Clubs of South Coast BC, a CARF-accredited agency that provides community outpatient counselling services. I currently supervise three counsellors and provide support to other supervisors. While I am very proud of the quality of supervision we provide, there is no manual available to ensure the highest quality of care. I would like to dedicate this project to enhancing clinical supervision in my workplace which will ultimately support the counsellors and clients as well. I would like to help provide my fellow supervisors with evidence-based models and tools that

have been developed in the last 15 years and to make available to them a clinical supervision manual for outpatient counselling programs.

One of the reasons I decided to pursue a Master in Counselling degree was to develop competency in both counselling and supervision. Drawing from the professional ethics course, and the philosophy of aspirational ethics, I am compelled to assist the agency I have dedicated my career to, to practice clinical supervision in a way that meets the highest standard of care and ethics. The premise of this project was to answer the following questions:

1. What are the key elements of competent clinical supervision?
2. What do novice supervisors need to know about clinical supervision?
3. What are the ethical implications of clinical supervision?
4. What should be included in clinical supervision training process?
5. How can clinical supervisors incorporate multicultural competence into practice?

A Short History of Clinical Supervision

The earliest traces of supervision in the human services field was in the 1800's in Europe. Florence Nightingale, a self-made nurse, recognized the need for professional standards and training shortly before establishing the Nightingale School for Nursing in 1860, and the Queen's Institute of District Nursing in 1887 (White & Winstanley, 2014). The earliest recording of supervision efforts in North America was between Nightingale and Linda Richards who established nursing programs throughout the United States (White & Winstanley, 2014).

Clinical supervision as we know it today, can be traced back to the early 1990s by the pioneer of psychoanalysis, Sigmund Freud. He was known to host weekly supervision meetings at his home in Vienna called the "Wednesday Psychological Society" (White & Winstanley, 2014). During the Great Depression, local war chests were created to support the growing need people had for social support. John Dawson, secretary of the Community Chest of Greater New Haven, Connecticut, published a generic list of duties related to supervisors that included "the promotion and maintenance of good standards of casework" (White & Winstanley, 2014, p.10).

Academic literature related to clinical supervision has its origins in the United States and made its way to Europe (White & Winstanley, 2014). By the early to mid-20th century, Alfred Kadushin, a social work academic who was influenced by the academic, Dawson, pioneered the professionalization of social work as a professor at the University of Wisconsin-Madison (White & Winstanley, 2014).

The history of clinical supervision and the early affinity between nursing, social work, and mental health has contributed to the cross pollination of these professional practices. Bernard and Goodyear (2014) posit that over the past 25 years, there has been an influx of research and development in the field of clinical supervision leading to its maturity and a narrower definition of what it means to be a clinical supervisor in the mental health field. According to the American Psychological Association (APA, 2015; Jamshidi et al., 2018), clinical supervision requires knowledge, skills, and values/attitudes specific to its practice. The main overarching goal of supervision has always been to protect the welfare of the client (The Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; White & Winstanley, 2014).

Generally, supervisors have done well in the realm of relationships and modelling their approaches for supervisees (Bernard, 2006). However, there was little room for diverse opinions and ways of learning (Bernard, 2006). In the 1980s, supervisees were screened for fit, theoretical and otherwise. Differences were ignored, not honoured and were seen as irrelevant (Bernard 2006). In contrast to the 1980s, today diversity in approach and thinking are to be "accessed and honored" (Bernard, 2006, p. 14). This shift in consciousness has been followed by a shift in the expectation of cultural competence in clinical supervision (Bernard, 2006; Crockett & Hays, 2015), an area that hadn't received a lot of attention until recently.

The specific goals in clinical supervision vary and must not be confused with administrative supervision which requires a different set of competencies and is often part of what is required in outpatient counselling supervision (Hewitt et al., 2004; Jamshidi et al., 2018; SAMHSA, 2014). The main goals in clinical supervision include improving job performance, and enhancing skills, knowledge, and abilities (Bernard & Goodyear, 2014).

Terms and Definitions

Administrative Supervision: The purpose of administrative supervision is to keep the organization or agency functioning with a focus on the day to day functioning and the health and survival of the organization. For example, administrative supervision involves hiring, firing, promoting, and managing schedules and workloads etc. (SAMHSA, 2014).

Clinical Supervision: Clinical supervision refers to an ongoing relationship in which the supervisor is responsible for ensuring the delivery of high-quality services to

clients, assisting supervisees to grow and develop, and safeguarding the well-being of clients (CCPA, n.d., para. 1). With those responsibilities, potential liability is inherent because together, with the counsellor, the supervisor is responsible for the outcome of the client.

Consultation: Consultation is an informal arrangement between professionals in which the consultant provides a service, such as sharing of skills, providing opinion on a case, problem solving, and brainstorming but the professional receiving the consultation has the right to accept or reject the opinion of the consultant. A consultant does not take on the legal responsibility or liability for decisions made by the therapist (Courtois, 2018).

Cultural Competency: Cultural competency refers to the ability of individuals and systems to respond respectfully and effectively to people of all cultures, backgrounds, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the worth of individuals, families, and communities, and protects and preserves the dignity of each (National Aboriginal Health Organization, 2009).

Direct Liability: Direct liability refers to clinical supervisors' acts of commission or omission that impact supervisees' clients or the supervisees themselves. In other words, clinical supervisors can be held legally liable for what they do or fail to do, if the conditions of malpractice are met (i.e., the breach of a standard of care leads to harm or injury that is clearly attributable to the actions or inactions of the clinical supervisor; Robinson & Landine, 2016).

Diversity: Diversity is simply all the ways we are unique and different from others. Dimensions of diversity include such aspects as race, religion and spiritual beliefs, cultural orientation, colour, physical appearance, gender, sexual orientation, physical and mental ability, education, age, ancestry, place of origin, marital status, family status, socioeconomic situation, profession, language, health status, geographic location, group history, upbringing, and life experiences (Sue & Sue, 2015).

Modelling: Modelling is an intentional supervision role to demonstrate a behaviour or skill. Using modeling in supervision increases the likelihood that a skill will be used in a session (Bearman et al., 2013).

Negligence: Negligence refers to the failure to exercise the level of care expected of a reasonably prudent person. In tort law, which focuses on wrongful acts or infringement of rights, negligence is concerned with harm resulting from carelessness (versus intentional harm). For example, during the past year of supervision, the supervisor canceled supervision 50% of the time (SAMHSA, 2014). The failure to provide supervision in a consistent and timely manner may have caused injury to a client or may not have provided adequate quality control to the supervisee.

Paraprofessional: *"*People trained in counselling skills who use them as part of their jobs, yet who do not hold an accredited counselling or psychotherapy qualification" make up the group of paraprofessionals (Nelson-Jones, 2013, p. 4).

Vicarious Liability: The supervisor may be held liable for the damages incurred as a result of the actions of the supervisee because they are in a position of authority and control (SAMHSA, 2014).

Conclusion

As the practice of clinical supervision matures, it takes on a breadth and depth that requires operationalizing. All mental health professionals' benefit and grow from consistent, effective, and competent supervision yet the literature has determined that most practicing supervisors feel ill-prepared (Gazzola et al., 2013). Moving from lip-service to practice, the *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor* is intended to provide support, guidance, and hope for clinical supervisors practicing in outpatient counselling settings.

CHAPTER 2: Competent Clinical Supervision - A Literature Review

In this chapter and based on a thorough review of the literature and current research, various frameworks of competent supervision will be explored, compared, and contrasted to determine which one is most suitable for a community-based setting and effective supervision of paraprofessional counsellors. Chapter 2 focuses first on determining the difference between regulated clinical supervision where supervisees are required to meet licensing requirements and unregulated clinical supervisors where supervisees have a range of educational and professional backgrounds (Shepard & Martin, 2012). Next, we will examine several supervision competency frameworks before settling on one that covers all the domains most appropriate to outpatient counselling settings and the supervision of paraprofessional counsellors, the *National Competency Framework: Qualifications, Competencies, and Best Practices* (CCPA, 2018).

Registered/Unregistered Competent Clinical Supervision

In most provinces there is no requirement that a supervisor in the counselling/ psychotherapy profession has met specific competencies as a supervisor. That is changing with regulation of the profession. For example, The College of Registered Psychotherapists of Ontario (CRPO, n.d.) requires the following:

- The supervisor must be a member in good standing of a regulatory college whose members may practise psychotherapy.
- The supervisor must have five years' extensive clinical experience.
- The supervisor must meet CRPO's "independent practice" requirement (completion of 1000 direct client contact hours and 150 hours of clinical supervision).

- The supervisor must have completed 30 hours of directed learning in providing clinical supervision. Directed learning can include course work, supervised practice as a clinical supervisor, individual/peer/group learning, and independent study that includes structured readings.
- The supervisor must provide a signed declaration that they understand CRPO's definitions of clinical supervision, clinical supervisor, and the scope of practice of psychotherapy.

While competency models are often developed to support registration requirements, both regulated and unregulated counsellors require and benefit from competent supervision.

The above noted level of training and competence is necessary when supervising professional therapists who are registered and must comply with regulatory requirements; however, counsellors are not regulated in British Columbia. Commonly, substance use and mental health counselling programs are staffed by paraprofessional counsellors with a wide range of training and education. The next section will explore what the literature deems as competent levels of supervision with special focus on outpatient, community-based counselling settings.

Given the high rates of untrained and unlicensed supervisors, and the increasing call for ethical and legal accountability (Gazzola et al., 2013), it is important to define competent clinical supervision that is relevant to unlicensed outpatient settings to provide an opportunity to increase quality. Competence in supervision is defined as

> a metatheoretical approach that provides systematic attention to the component parts of the supervision process. This approach enhances accountability and is reflective of both evidence-based practice generally and APA's new guidelines for clinical supervision. This approach systematically addresses the supervisory relationship, bidirectional feedback, infusion of multiculturalism and diversity, and ethical and legal standards. Competency-based supervision maintains a

> balance among the equally important priorities of protecting the client, gatekeeping for the profession, and enhancing the professional growth and development of the supervisee (Falender & Shafranske, 2013, p. 5).

Competent clinical supervision will vary depending on agency, program, and client demands. For example, there are some counselling environments that will lean heavier on clinical counselling skills based on funder requirements. Some outpatient counselling settings are less formal with counsellors who have a wide range of education and training.

Existing Competency Frameworks

There are many variations of competency frameworks in the literature that have been developed by counselling-related associations and regulatory bodies including the *National Competency Framework: Qualifications, Competencies, and Best Practices* (CCPA, 2018), Association for Counsellor Education and Supervision (ACES, 2011), Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), Association of Social Work Boards (ASWB) (2009), APA Board of Educational Affairs Task Force on Supervision Guidelines (2014), and Canadian Centre on Substance Abuse (2014). All the above bodies created competency frameworks that included domains related to the bare minimum expectations and best supervisory practices.

The Centre for Addiction and Mental Health (CAMH, 2008) developed a competency framework with six domains: knowledge, skills, values, social context, training in supervision competencies, and assessment of supervision competencies. In contrast, the six competency domains identified by the ASWB (2009) were: supervisory relationship, supervising practice, professional relationships, work context, evaluation, and lifelong learning and professional responsibility.

While some clinical supervision frameworks are vastly different than the ones outlined, many competency models share commonalities such as a focus on the working alliance between supervisor and supervisee, the development of skills and knowledge, and evaluation and performance review. There are some distinct differences as well. The framework by the ASWB (2009) includes a domain specific to community development that is absent in the Canadian Addictions and Mental Health (Centre for Addiction and Mental Health, 2008) framework. When an agency develops a framework, consideration is given to the context and focus of the work being done in that setting.

Outpatient counselling definition of competence. There is no competency framework that has been developed specifically for supervision in outpatient counselling centres where supervision is mostly focused on unregulated supervisees. Jamshidi et al.'s (2018) comparison of frameworks as they apply to community-based settings found that existing models' foci are attuned to more clinical aspects of the work and lacked focus on teamwork and team development. It is evident that no one model will speak perfectly to community-based supervision, however, community-based agencies must utilize what is available.

In recent years Canada's commitment to the practice of clinical supervision as a separate and distinct practice has been established (CCPA, 2018). Therefore, I will utilize the collective wisdom of current Canadian experts in clinical supervision who have established the *National Competency Framework: Qualifications, Competencies, and Best Practices* (CCPA, 2018) to guide the focus of the manual. Each domain will be presented in more detail in Chapter 3. The seven domains in the above framework include:

(1) professional preparedness;

(2) structuring;

(3) relational;

(4) assessment, feedback, evaluation, and reporting;

(5) ethical, legal, and regulatory;

(6) diversity and social justice; and

(7) professionalism (CCPA, 2018).

The application of this framework can be used for supervision licensing but for the purposes of this project, it will be used to help "align with the organizational learning culture and promote psychologically healthy supervisory relationships at individual, group, and organizational levels" (CCPA, 2018, p. 2).

Conclusion

In this chapter, the existing literature and research on the topic of competent clinical supervision and the commonalities and differences between frameworks was explored. The distinct needs between regulated and unregulated supervision was explored. Competence was defined according to Falender and Shafranske (2013). It was determined that the most relevant framework of clinical supervision for outpatient settings with counsellors with varying background is the *Competency Framework: Qualifications, Competencies, and Best Practices* (CCPA, 2018). Chapter 3 will explore in depth, the seven domains outlined by this framework. This chapter will entail a thorough examination based on an in-depth review of the literature of each of the seven domains of competence as outlined in the *National Competency Framework: Qualifications, Competencies, and Best Practices* (CCPA, 2018). The outcome of the

literature review will be used to support the framework and content of the *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor*

CHAPTER 3: Competencies and Best Practices - A Literature Review

Clinical supervision is the cornerstone of counselling (APA, 2015; Crunk & Barden, 2017; Ellis et al., 2013; Falender & Shafranske, 2004) and has long-term implications for the supervisee and in turn, the client. Clinical supervision done well, safeguards the client (CCPA, 2007; Hadjistavropoulos et al., 2010). Counsellors often models themselves after their supervisor (Gazzola et al., 2013). However, despite this, literature and training opportunities for clinical supervision is lacking (Bernard & Goodyear, 2014; CCPA, 2018; Destler 2017; Gazzola et al., 2013). Clinical supervisors are often better trained as therapists than supervisors (Ellis et al., 2013). Because of this situation and given the stakes and positive correlation between quality clinical supervision and client outcome (Ladany & Inman, 2008), professionalizing clinical supervision in outpatient settings needs to be a priority (Bernard, 2006).

The CCPA has been attuned to the lack of clinical supervision training and to the misalignment between heightened interest in this specialization and the paucity of resources and learning opportunities available to Canadian practitioners (CCPA, n.d.) CCPA responded by establishing the Canadian Certified Counsellor- Supervisor (CCC-S) credential and providing supportive resources (e.g., a clinical supervision handbook, an online graduate course in clinical supervision, and a multi-authored text on clinical supervision). More recently, a research based national clinical supervision competency framework was developed (CCPA, n.d.). Two experts in the area, Carol Falender and Janine Bernard, served as consultants. The CCPA research team interviewed supervisors who worked in different settings and who held a range of credentials. As a next step, a survey was sent out to the Association's membership who included supervision as part of

their practice and the framework was fine-tuned at four points during the research cycle. The 'framework' identifies seven domains of clinical supervision, and 76 qualifications, competencies, and best practices associated with those domains:

(1) Professional Preparedness;

(2) Structuring;

(3) Relational;

(4) Assessment, Feedback, Evaluation, and Reporting;

(5) Ethical, Legal, and Regulatory;

(6) Diversity and Social Justice; and

(7) Professionalism.

The domains are not fully discrete, and so some of the 76 qualifications, competencies, and best practices conceivably could also align with one or more of the other domains. However, in the interest of avoiding repetition and redundancy, each qualification, competency, and best practice is listed once only. The framework is intended to foster shared awareness of the constituents of qualified and competent clinical supervision and to guide best practice (CCPA, n.d.). The competency framework outlined by the CCPA (2018) provides guidance in creating an outline for *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor*. While the competency framework was developed for master level supervisors, some of the suggestions for clinical supervisors of paraprofessional counsellors have been adapted for the scope of this project. The remainder of this chapter will explore, in-depth, each competency domain.

Domain 1: Professional Preparedness

The first domain of competent clinical supervision, *professional preparedness,* refers to the depth of the supervisor's knowledge, skills, experience, and understanding of clinical supervision. This domain is focused on how well the supervisor is prepared to practice clinical supervision in a professional manner that meets the standards of the profession. Supervisors have been working in the field of counselling for several years and have some expert knowledge and experience that will guide their work with difficult or complex cases (Stefano, Hutman, & Gazzola, 2017).

Given that most supervisors are counsellors, it is likely that they bring with them a plethora of practical knowledge (Ellis et al., 2013). Supervisors have knowledge of, and an understanding of the issues and barriers that clients face (Jamshidi et al., 2018). Additionally, supervisors need knowledge and skills in the area of research and evidence-based interventions that relate to the client population. Further, the supervisor must understand the unique emotional demands that the work has on the supervisee and be trained in trauma informed practice (Jamshidi et al., 2018). Given that one of the main responsibilities of a supervisor is to ensure that clients are receiving the highest levels of ethical practice, it is essential that the supervisor has a clear understanding of ethical standards and regulations (Falender & Shafranske, 2004; Jamshidi et al., 2018). Finally, supervisors are expected to have knowledge of the essentials of supervision and the ability to use effective supervision techniques (Jamshidi et al., 2018). When supervisors think they can hide gaps in their knowledge, it is often evident to the supervisee. In Ladany, Mori, and Mehr's (2013) study on ineffective supervisors, insufficient knowledge included: (a) not knowing about the population being served, (b) not wanting

to engage in conversations about diversity, (c) not listening well, and (d) not providing constructive feedback.

Models of Clinical Supervision

Being a novice supervisor can bring up feelings of insecurity and uncertainty. The good news is that these skills and knowledge do not have to be developed overnight. It is a lifelong pursuit. A strong ego, patience with self, and a self-compassionate approach to learning will help along the way. There are three main schools of supervision models that provide an organizational map for the supervisor. No one model covers all aspects of supervision, but each helps to organize some of the main characteristics of effective supervision (Bernard & Goodyear, 2014). Supervisor's familiarity with the various models is important. The psychotherapy-based models are about passing on therapeutic approaches including psychodynamic, humanistic, cognitive-behavioral, systemic, and constructivist; developmental models focus on the learning styles of the supervisee; and the supervision process models maintain a focus on the supervision process itself (Bernard & Goodyear, 2014). Supervisors choice of a model, or a combination of models, structures their use of interventions in ways that can be helpful in supporting the supervisee (Bernard & Goodyear, 2014). The next section focuses on developmental, process, and second generation models.

Developmental models of supervision. Developmental approaches to supervision date back to the 1950s and have been embraced by the therapeutic community. Developmental models help supervisors conceptualize how the supervisee changes over time as they progress in their careers (Barnes & Moon, 2006; Bernard & Goodyear, 2014). Supervision needs, approach, and even monitoring (Borders, 2005, as

cited in Bernard and Goodyear, 2014) are determined based on assessment of the supervisee's professional stage of development in several domains. Two well known developmental models are the integrated developmental model (IDM) and Ronnestad and Skovholt's model (2003). The IDM model is briefly described as it is the most researched.

Integrated developmental models/Stoltenberg model. The IDM describes four levels of counsellor development from Level 1 supervisees who are entry level to Level 3 supervisees who are autonomous and engage in collegial challenging and a newer level, Level 3i, in which supervisees integrate practice across multiple domains including treatment, assessment, and conceptualization. Three markers are used at each stage to assess professional growth: (a) self-other awareness, (b) motivation, and (c) autonomy. Suggested strategies include catharsis, catalytic (asking questions to elicit self-exploration), supportive, prescriptive (advice giving), informative, and confronting. Johnson and Moses (1988, as cited in Bernard & Goodyear, 2014), emphasize the importance of challenging and supporting to prevent stagnation and defensiveness in the supervisee.

Developmental models of supervision are useful because they keep the supervisor attending to the different needs of supervisees at different levels in their training and development as professionals. Additionally, developmental models can be used in combination with any theoretical approach. However, developmental models give inadequate attention to cultural differences and learning style differences among supervisees (Bernard & Goodyear, 2014).

Supervision process models. This school of supervision is the most practical and widely used of the three schools of supervision models (Bernard & Goodyear, 2014). The most well- known and accessible model is the discrimination model (DM) first developed in 1977 Bernard, 1997; Bernard & Goodyear, 2014). As Crunk and Barden (2017) note, "The discrimination model is considered to be an accessible, empirically validated model for supervisors and can be adapted in complexity depending on the supervisor's level of readiness" (p. 66).

Bernard's discrimination model. The DM is often the first model that new supervisors are exposed to (Bernard & Goodyear, 2014). It is sometimes the preferred model with supervisors because it provides clear guidance for interacting with the supervisee (Bernard & Goodyear, 2014). The model is simple and clear with four separate foci for supervision: interventions, conceptualization, personalization, and professional issues. Four possible supervisor roles are also included in the model: teacher, counsellor, consultant, and mentor (Bernard & Goodyear, 2014; Shepard & Martin 2012). This gives the supervisor nine different ways (three roles x three foci) to respond to the supervisee. For example, the supervisor may take on the role of teacher while focusing on a specific intervention used by the supervisee in the client session, or the role of counsellor while focusing on the supervisee's conceptualization of the work. Supervisors more commonly use the teacher mode with new supervisees and the consultant role with more seasoned counsellors. Attunement to the supervisee's needs is important both to maximize professional growth and to enhance the supervisory relationship.

While there are a lot of merits to this approach, the Discrimination Model has been criticized for being overly simple (Shepard & Martin, 2012) in that the model itself

does not thoroughly address the supervisory relationship as seen in more recent models of supervision. Additional challenges with this model are its lack of specifics about the goals of supervision (Crunk & Barden, 2017). The model also does not provide enough information about specific techniques and interventions. The strengths of the model are its theoretical basis, the fact that the model does not emphasize one focus area over another, and that it is relatively easy to apply (Crunk & Barden, 2017).

Second generation models of supervision. Second generation models of supervision follow in the footsteps of recent findings in psychotherapy and are integrative and flexible in nature. For a few decades it has been widely known that regardless of the therapeutic technique being used, it is the therapeutic relationship that is the biggest predictor of change (Lampropoulos, 2003). Also, there is some speculation (Aten, Strain, & Gillespie, 2008, as cited in Bernard & Goodyear, 2014) that many models of supervision on their own are inadequate.

Combined models. Combined models take into consideration the influence the three main dimensions of supervision: theory, development, and processes. Combined models are a more recent phenomenon and allow supervisors flexibility in their approach to supervision. For example, utilizing the theory of a psychotherapy-based model with the roles in the discrimination model can be helpful to increase the depth of the experience for the supervisee (Bernard & Goodyear, 2014).

Common-factors models. Common factors supervision model is closely related to common factors theory in therapy (Lampropoulos, 2003). This model promotes what is widely known in psychotherapy, that it is the supevisory relationship, not the supervision technique, that is the biggest predictor of change (Lampropoulos, 2003). Therefore, as

would be expected, the common-factors model of clinical supervision has its focus on the supervisory relationship and particularly focuses on ruptures and repair, transference and countertransference (CT), and reducing anxiety about performance especially in the early stages of being a counsellor. This model promotes that counsellors will: (a) make some mistakes, (b) experience some counselling failures, and (c) not learn everything at once (Lampropoulos, 2003). The common-factors model promotes an eclectic approach to supervision (Lampropoulos, 2003).

Watkins, Budge, and Callahan (2015a) proposed a common/specific factors supervision model, identifying the supervisory relationship as the most important common factor and encouraging supervisors to apply this relationship-centered model to the specific factors of "some form of supervision" (Watkins et al., 2015a, p. 226). An example of a common factors approach is the Common Factors Discrimination model of supervision (Crunk & Barden, 2017) which seeks to understand what factors of supervision are most effective and common among all models. These common factors of supervision are integrated with the discrimination model of supervision proposed by Bernard (1997). However, more research is needed to examine the validity of applying common factors principles of psychotherapy to clinical supervision, as well as the empirical merit of an integrated common factors and discrimination model of supervision.

With many models to choose from and no one model perfectly covering every aspect of supervision, Corey et al. (2010, as cited in Shepard & Martin, 2012) recommend that each supervisor reflect on their own experiences as a supervisee and develop a model that works best for them. Robinson (2016) recommended that new

supervisors reflect on their philosophy of change, the nature of the supervisory relationships, obtain further training in the models, participate in peer consultation, and identify the developmental level of the supervisee when deciding on a supervision model.

Domain 2: Structuring the Supervisor Relationship

The second domain of competent clinical supervision is *structuring the supervisor relationship*. Structuring involves understanding roles, informed consent, a supervision contract, and documentation skills. This domain also includes the ability to take on the responsibilities of supervision.

Roles in Supervision

The clinical supervisor wears different hats when using supervision strategies with supervisees. These roles range from teacher to counsellor to consultant to mentor (Bernard & Goodyear, 2014; Shepard & Martin, 2012). Each role can contribute to the growth of the supervisee (Abiddin, 2006). The role that the clinical supervisor utilizes at any given time is dependent on the experience level of the supervisee and what they are trying to accomplish, whether it be in the area of interventions, conceptualization, personalization, or professional issues (Bernard & Goodyear, 2014).

A psychoeducational or *teaching* role in supervision often works well with novice supervisees whose knowledge base is limited and who are learning new skills (Bernard & Goodyear, 2014). Suggesting articles to read, reviewing and naming what was observed in sessions, identifying appropriate interventions, and demonstrating interventions are examples of how supervisors can utilize the role of teacher (Shepard & Martin, 2012). The *counselling* role provides emotional support to the supervisee and is generally a short- term role to support the supervisee to continue to perform their job effectively and

ethically (Abiddin, 2006). This becomes especially important when the supervisee is experiencing countertransference. The *consulting* role is often utilized as the supervisee becomes more confident in their counselling knowledge and skills and takes on more and more responsibility (Courtois, 2018). As Shepard and Martin (2012) outline, consultation can take several forms: providing or brainstorming alternative interventions or conceptualizations or encouraging the supervisee to initiate structure of the supervision session. *Modeling* is an intentional supervision role to demonstrate a behaviour or skill. Using modeling in supervision increases the likelihood that a skill will be used in a session (Bearman et al., 2013).

Responsibilities of the Supervisor

It is important to distinguish between clinical supervision and administrative supervision when discussing the responsibilities of a supervisor (Falender & Shafranske, 2014) with a supervisee. Clinical supervision responsibilities are limited to the professional growth of the supervisee in the areas of knowledge, skills, and attitudes/values as this will help to ensure the quality of the supervisee's counselling. The focus is on increasing clinical competency of the supervisee by developing a strong supervisory alliance and developing learning and evaluative strategies that fit with the requirements of the clinical settings (Falender & Shafranske, 2014).

While responsibilities will vary depending on the requirements of the setting, the clinical supervisor's main and primary responsibility is to the client, the public, and then the supervisee (CCPA, 2018; Shepard & Martin, 2012). The supervisor is responsible for creating an atmosphere where respect and a strong relationship is the foundation of the supervisory experience (Shepard & Martin, 2012). Taking on the supervisory

responsibility includes several components that are also outlined in the supervision contract (Bernard & Goodyear, 2014). A trusting relationship is developed in several ways including the supervisor abiding by limits of confidentiality, monitoring boundaries, and providing an environment where the supervisee feels respected, heard, trusted, understood, and challenged (Bernard & Goodyear, 2014; Falender & Shafranske, 2014). It is important to provide a space where supervisees can consider their experiences, discuss the content of their sessions, reflect, and engage in conversations that help increase their professional knowledge and skills (Bernard & Goodyear, 2014; Falender & Shafranske, 2014). An additional responsibility of the supervisor is to observe supervisees' counselling work and provide timely feedback and evaluation. Ultimately, it is the supervisor's responsibility to support counsellors to develop their skills, knowledge, and values in the counselling profession to ensure clients receive the highest quality service possible (Falender & Shafranske, 2014)

The Supervision Contract

A written supervision contract helps create security and clarity for all involved: the supervisor, supervisee, and the agency (Courtois, 2018; Ellis, 2017b; Thomas, 2014). One of the biggest ethical complaints by supervisees is a lack of clarity about what is expected of them (Ladany, 2014). The contract outlines and articulates the supervisor's background, expectations, guidelines, and approach and serves as a foundation for informed consent (Shepard & Martin, 2012; SAMHSA, 2014). It also includes informed consent and outlines the supervisor and supervisee rights and responsibilities, and expectations in supervision. The contract provides structure in which the supervisory work can happen and ensures that supervisor and supervisee are "on the same page"

(Ellis, 2017a; Falender & Shafranske, 2011, p. 134). The supervision contract is not legally binding but does provide a basis for clarification down the road if issues arise (Courtois, 2018).

> Supervision contracts or agreements of understanding have traditionally been good-faith documents … stipulating roles to be played…. Such agreements also spell out the responsibilities of all parties and the opportunities afforded to the supervisee for the duration of the contract. Although such contracts are not binding in a legal sense, they serve the purpose of increasing accountability for those concerned. (Bernard & Goodyear, 2019, p. 152).

It is an ethical imperative for supervisees to know what is expected of them (CCPA, 2007). It protects all involved, the agency, the supervisor, the supervisee, and the client (SAMHSA, 2014). Supervisees report feeling more secure when there is structure in place through informed consent and a contract because it protects them (Ellis, 2017a; Thomas, 2014).

There are many suggestions about what to include in a clinical supervision contract and having reviewed the literature I recommend a combined format that include several important sections. First, a *biography of the supervisor* that includes background that will introduce the supervisee to the areas of expertise of the clinical supervisor (Shepard & Martin, 2012). Next the *goals and purpose* of clinical supervision can inform the Individual Development Plan (IDP) as well as outline the agreed on *guiding principles* that sets the tone for the relationship and the ethical principles of supervision (Shepard & Martin, 2012; SAMHSA, 2014). Next, *evaluation* is addressed by agreeing on a schedule for evaluation, what will be evaluated, and how the supervisees work will be observed (Bernard & Goodyear, 2014). Finally, additional *notes* that can include logistics, limits of confidentiality, documentation, and addressing complaints (Shepard &

Martin, 2012; SAMHSA, 2014) should be included. Overall, the supervision contract attempts to set a tone, outline expectations, and address uncertainties.

Informed Consent

An informed consent process that starts at the beginning of the supervisory relationship lays the groundwork for the supervisor/supervisee relationship (Ellis, 2017a; Thomas, 2014). Dawn McBride (personal communication, 2018) introduced the concept of relational consent in therapy which might be equally beneficial in this context. The idea is that the contract and informed consent is a 'collaborative process' through conversation rather than a one-time discussion or 'event.' It can be a powerful and worthwhile experience, addresses the power dynamic and sets a tone of rights and collaboration from the start. Relational informed consent is part of a living breathing document in which the conversation is revisited throughout the supervisory relationship. Including these items in the informed consent can proactively eliminate potentially resolvable problems, or at least clarify the expectations of supervision. It protects both the supervisee and supervisor by visiting issues that could contribute to ruptures and misunderstandings further down the line.

Informed consent provides potential supervisees with information about the supervision that might reasonably influence their ability to make sound decisions about participation in supervision (Thomas, 2010). Thomas (2010) recommended that the following items be included in the informed consent document: (a) the supervisory method(s), (b) limits of confidentiality of supervisee disclosures and behaviour necessary to meet ethical and legal requirements for client protection, (c) financial issues related to payment, (d) documentation of supervision sessions, (e) risks and benefits of receiving

supervision, (f) evaluation criteria/procedures related to performance criteria, (g) complaint procedures against the supervisor, (h) termination criteria and procedures from the supervision contract, (i) supervisor's and supervisees responsibilities, (j) supervision sessions agenda and content to be addressed, (k) supervisory accessibility for crisis situations, (l) process for addressing supervisee issues, and (m) professional development goals.

Documentation

Documentation of clinical supervision sessions is a critical component of supervision that requires tracking of professional growth and development, and oversight of client welfare (Robinson & Landine, 2016). The main benefits of record-keeping are risk management and tracking a supervisee's professional growth. A personnel file should include: a signed contract, performance reviews notes on all supervision sessions, any progressive disciplinary steps taken, and the supervisor's recommendations (SAMHSA, 2014.). Like with clients, supervisees have a right to access their supervision file (Robinson & Landine, 2016).

Domain 3: Relational Supervision

The third domain of competent clinical supervision is *relational*. The strength of the supervisory working alliance has been found to have a positive effect on supervisees' learning and self-efficacy (Ladany, 2014; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Ladany et al., 2013; Watkins et al., 2015a). The ability to form a strong bond with the supervisee is one of the biggest contributions a supervisor can bring to the supervision experience (Ladany, 2014; Ladany et al., 1999, 2013; Watkins et al., 2015a). It will increase the likelihood that the supervisee will share important information

(Ladany, 2014; Ladany et al., 1999, 2013; Watkins, Reyna, Ramos, & Hook, 2015b). Research by Marmarosh et al. (2013) indicates that the supervisee's stage of development is likely to activate attachment behaviours. For example, Marmarosh et al. (2013) found that supervisee's who had higher levels of fearful attachment to their supervisor and who had avoidant attachment in their adult relationships tended to have less perceived counsellor self-efficacy.

Further supporting these assertions, Foster, Lichtenberg, and Peyton (2007) demonstrated an empirical association between trainee attachment style and self-rated development; that is, supervisees rated feelings of attachment to their supervisors at a degree that was similar to feelings of attachment in other close adult relationships. Foster et al. (2007) believe that subjective feelings that the supervisee experiences towards his or her supervisor is a vital piece of information that supervisees use to assess their level of development.

A relational tone set early in supervision whereby the supervisor approaches the supervisee-supervisor relationship with humility can foster openness and reflection, all of which can be crucial to the supervisee's learning, growth, and development (CCPA, 2018). Supervision interpersonal styles have been studied since the 1980's (Friedlander & Ward, 1984) and research has found that interpersonally sensitive (consultant) style supervision predicted a stronger working alliance (Bernard & Goodyear, 2014). Additionally, the more expert and relatable the supervisor was, the stronger the bond with the supervisee (Bernard & Goodyear, 2014). Some of the contributors and challenges to the supervisory alliance will be discussed in the next section.

Transference and Countertransference

People who enter the profession of counselling are likely to bring with them a history of unresolved experiences that will unwittingly be introduced into the counselling/supervisory process at some point. Supervisors are not immune to transference or countertransference (CT) either. In this context transference occurs when the supervisee's unresolved personal experiences are triggered in the context of the supervisory relationship (Falender & Shafranske, 2014). Clinical supervision and a strong working alliance between the supervisor-supervisee provide opportunity for supervisees to explore their often subtle, unresolved issues that include "beliefs, attitudes, life experiences, personality and interpersonal styles" (Falender & Shafranske, 2014, p. 1034) that impact the supervisory and counselling relationships. Alternatively, CT occurs when the supervisor's past personal lived experience is triggered in supervision, impacts the supervisory relationship, and distorts how the supervisor perceives the supervisee (Falender & Shafranske, 2014). Supervisors, like supervisees, may also be attracted to the helping profession as a result of their own histories of struggle (Courtois, 2018). Supervisors who have not worked through their own personal issues in psychotherapy bring with them a vulnerability for CT in the supervisory relationship (Courtois, 2018). Early recognition, working through, and monitoring personal reactions can have a positive impact on the working alliance and maintain focus on the supervisee and client (Corey, Corey, & Callanan, 2015; Courtois, 2018).

One of the roles of the supervisor is to be aware of indicators of CT in the supervisee's counselling practice. Counsellors may ignore the feelings that their clients create in them, and then model this minimization for their clients, thus modeling to the

client to avoid tough topics and thereby invalidating the impact of good counselling (Falender & Shafranske, 2014; Hayes, Geslo, & Hummel, 2011). Counsellors can also be at risk for experiencing CT when they are promoted to the position of clinical supervisor. A change in roles from colleague to supervisor can be awkward and sometimes isolating (Shulman, 1993). It is important to watch for signs of CT when feelings of isolation occur.

According to the literature there are signs to look for that indicate CT may be present for the supervisor. During supervision if the supervisor is taking on a counselling role by exploring the supervisee's feelings, worries, or triggers, it's important to check whether CT is in the 'room' (Corey et al., 2015; Shepard & Martin, 2012). Exploring these things in supervision may be perfectly fine if it is related to improved client care and isn't being triggered by an emotional response on the part of the supervisor (Ladany et al., 1999). If, on the other hand, the exploration is sparked by the supervisor's need to rescue, reduce the supervisee's pain, or fix a problem, CT is likely present (Corey et al., 2015). Another indicator of CT is when the supervisor doesn't like the supervisee and results in negative feelings that prevents them from wanting to work with the supervisee. Alternately, when a supervisor has a desperate need to be liked or fit in with their supervisee, there may be CT present (Corey et al., 2015). The awareness of CT's presence is an important step, so it doesn't impact the therapeutic alliance or cause harm. Suggested supervision interventions to explore transference/CT include modeling, self-reflective journaling, and seeking supervision for their supervision (Corey et al., 2015; Hawkins & Shohet, 2013) Recognizing and repairing ruptures that are related or unrelated to transference/CT, are be explored in the next section.

Recognizing and Repairing Ruptures

Along with a strong working alliance is the ability of the supervisor to recognize and repair ruptures in the relationship. The potential for conflict in the supervisory relationship is high due to the likelihood that some supervisees may respond to feedback about their skills in a sensitive, defensive, or angry manner. Their own transference with the supervisor that say, "I need to be perfect, my supervisor must like me, and if my supervisor gives me feedback I must be bad" can contribute to a rupture in the supervisory relationship. Due to the power dynamic in the relationship it is incumbent on the supervisor to recognize and take steps to repair these ruptures. Unresolved conflict in the relationship becomes a rupture. There are two main types of ruptures that can occur, confrontation or withdrawal ruptures and each type requires a different response to resolve (Safran & Muran, 2000). Due to the centrality of the supervisory alliance in clinical supervision and the legal responsibility that the clinical supervisor takes on in partnership with the supervisee, it is crucial that ruptures are handled with a high degree of care and attention.

There are several sources of relationship strain in the supervisory relationship. These include but are not limited to interpersonal conflict, mismatched expectations, and developmentally normative conflicts (Watkins et al., 2015b). Additionally, characteristics of the supervisor and supervisee can contribute to conflict. Grant, Schofield, and Crawford (2012) identified supervisee characteristics that can elicit relational challenges in the supervisory relationship including poor emotional awareness, lack of autonomy, anxiety due to fear of failure, personal issues, difficulties forming a professional identity, lack of respect for client differences, and lack of personal motivation, as well as resistance, and defensiveness. Supervisor behaviours such as lack of boundaries, poor communication skills,

mishandling of power, and cultural bias can contribute to an unsafe environment for the supervisee, and can lead to ruptures in the relationship (Bernard & Goodyear, 2014; Shepard, Martin, & Robinson, 2016).

Addressing Ruptures

Many ruptures are avoidable, however, when they do occur, recognizing and addressing either directly or indirectly is important (Bernard & Goodyear, 2014). Creating an atmosphere of transparency, non-defensiveness, and disclosure that goes both ways is helpful in addressing relational conflict before it becomes a bigger issue (Nelson, Barnes, Evans, & Triggiano, 2008). Watkins et al. (2015b) found that it is important to match the level of apology with the severity of the rupture. They note that supervisors cannot assume to know how the rupture was perceived by the supervisee. Only through collaborative and open discussion can an assessment be made about the impact of the event on the supervisee and only then can the supervisor provide an appropriate apology. In cases of a severe supervision alliance rupture, a more in-depth apology is required and should include a summary of the transgression, a statement of fault, and an honest expression of empathy towards the supervisee. A supervisor who admits their limitations/mistakes can reinforce the supervisees acceptance of their own limitations and model for them how to address conflict in relationships with clients (Nelson et al., 2008).

Watkins, Hook, Ramaeker, and Ramos (2016) promoted the use of humility as a healing agent to a ruptured supervisor/ee relationship. Humility involves two of the steps in the repair process: (1) bringing up the rupture issue and (2) discussing it openly with the supervisee (Watkins et al., 2016). Humility requires openness, willingness, and ability

to accurately reflect on self and achievements, and understanding one's limitations (Davis et al., 2013; Watkins et al., 2016).

Teamwork, Communities of Support and Positive Work Environment

Many community-based counselling services operate within context of a team environment (Jamshidi et al., 2018). Given the emotional demand on counsellors and supervisors, a positive workplace environment can contribute to self-care and fuels the work professionals do. Counsellors witness and see things that most of the population do not, therefore it is crucial to have a community of support to help 'shoulder' each other up (Reynolds, 2010). Positive workplaces foster qualities such as trust, collaboration, and friendship that enhances personal well-being and positive feelings (Geue, 2018).

The teamwork in community-based counselling programs has many functions that can include group supervision, co-vision, co-managing caseloads, and sharing administrative responsibilities. Supervisors can be fed by their work by creating and sustaining communities of support for the counsellors who walk alongside marginalized and struggling clients. The supervisor has a role in maximizing the potential of the team atmosphere because interpersonal relationships and even friendships within the workplace can play a pivotal role in job satisfaction, performance, team cohesion, and commitment to the agency they work for (Tse, Dasborough, & Ashkanasy, 2008). "The interplay of these dynamics suggests real-world activities that [supervisors] can utilize to engender positivity in the workplace" (Geue, 2018, p. 219). Spreitzer, Sutcliffe, Dutton, Sonenshein, and Grant (2005, as cited in Geue, 2018) asserted that social connections in the workplace enhances vitality, energy, feeling valued, and being productive, and overall

engagement. It is important for supervisors to encourage team activities that inspire a deeper, personal connection that might involve fun and play (Geue, 2018).

Domain 4: Assessment, Evaluations, and Reporting

"No matter how good you think you are as a leader, my goodness, the people around you will have all kinds of ideas for how you can get better. So for me, the most fundamental thing about leadership is to have the humility to continue to get feedback and to try to get better - because your job is to try to help everybody else get better." (Jim Yong Kim)

The fourth domain of clinical supervision is *assessment, feedback, evaluation, and reporting*. This domain covers everything related to assessing performance that includes methods and modalities of supervision. Additionally, this domain covers elements that are essential to providing evaluation and gatekeeping.

Assessing Performance

Assessing clinical skills in counselling is one of the most challenging responsibilities of the clinical supervisor (Ladany, 2004; Ladany et al., 2013). Therefore, as been emphasized many times throughout this chapter, a supervisory relationship needs to be based on "mutual trust and respect [and] serves as the foundation for effective clinical supervision" (Shepard et al., 2016, p. 167). It is through a combination of carefully thought out choice of method and modality that effective supervision assessment takes place.

It is ideal to utilize several different assessment methods that may include self-report, case conceptualization, consultation, live observation, Interpersonal Process Recall (IPR), modelling/demonstration, co-therapy, arts-based supervision, and self-supervision (CCPA, 2018; Shepard et al., 2016). It is important to check-in with the supervisee to see how the methods chosen are contributing to their experience and

professional development (Guiffrida, Jordan, Saiz, & Barnes, 2007). Methods of supervision refer to the mechanics while modalities refer to the structuring of the supervision process (Shepard et al., 2016).

Supervision Methods

The use of specific supervision methods necessitates having competence with the method and having a strong rationale for the use of the method. Generally, supervisors should have a range of approaches that they can use to help supervisees attain a variety of supervision goals. This recommendation aligns with Borders et al. (2014) belief:

> supervisor modifies his/her style of and approach to supervision (both within a session and across sessions) based on his/her assessment of client welfare, supervisee characteristics, supervisee's immediate needs, supervisee's developmental level, supervisee's supervision goals, environmental demands, as well as the supervision context. (p. 35)

The self-report is the most common method (Shepard & Martin, 2012). Urbani, Smith, Maddux, and Smaby (2002) recommended extending supervision beyond self-report because counsellors have been notoriously poor judges of their own competence and have been known to only pick up on 50% of the clinical issues present in the session (Bernard & Goodyear, 2014). Self-report "is only as good as the observational and conceptual abilities of the supervisee" (Bernard & Goodyear, 2014; Borders et al., 2014). Changes in technology has made audio-video recording easier than it was in the past and opens the door to what can be accomplished in clinical supervision. It is important that recorded sessions are planned properly taking into consideration client comfort, however, most clients, according to Bernard and Goodyear (2014) are open to being audio or video taped.

Experientially based learning that allows the marriage of theory and practice has been shown to expedite and solidify the learning process (Bernard & Goodyear, 2014; Milne, Aylott, Fitzpatrick, & Ellis, 2008). Some supervisors lean more heavily on live observation while others rely on reflective practices. Borders (2010, as cited in Bernard and Goodyear, 2014) provided factors to carefully consider when deciding on assessment methods that include supervisee/supervisor goals, experience of the supervisee, contextual factors (site policies or facility capabilities), and supervisor preference. Sometimes it can be helpful for supervisors to decide on assessment methods based on the goals. If the supervisee is requiring support, it may not be necessary to see a video session but if the goal is to change or shape their skills, then this may be the preferred option (Bernard & Goodyear, 2014). Supervisee growth happens in an environment where self-reflection is encouraged. It is a "search for understanding…with attention to the therapist's actions, emotions, and thoughts as well as the interactions between the client and therapist" (Bernard & Goodyear, 2014, p.144). Socratic questioning, journal writing, Interpersonal Process Recall (IPR), and the use of a reflecting team are the four methods recommended to inspire self-reflection in the supervisee (Bernard & Goodyear, 2014).

Modelling and demonstrations. Modelling and demonstrations can be an effective way to support supervisee professional growth and skill development (Shepard et al., 2016). Modelling is a more subtle approach whereby supervisees observe the supervisor in action. Demonstrations can be used as an education tool through videos or books but can also be interactive through role-plays, role reversals, or co-therapy. This method can be helpful to support supervisees to develop competence in many areas such

as relationship building, ethical decision making, problem solving, and self-care (Shepard et al., 2016).

Co-therapy. Co-therapy where two counsellors work together in a counselling session to provide counselling to a client or clients can be helpful. A form of modelling, co-therapy can provide a less experienced counsellor with an opportunity to witness the work of a seasoned therapist (Shepard et al., 2016). It is important to be aware that clients may feel outnumbered and the power differential between counsellors may be evident (Shepard et al., 2016). Prior to any co-therapy these potential roadblocks should be discussed with everyone involved.

Interpersonal process recall. IPR engages the supervisee in self-reflection based on internal reactions after watching or listening to a live recording of a counselling session (Shepard et al., 2016). By watching a video or listening to audio of a session, the supervisor or supervisee can stop the recording at any point to explore an internal response to something happening in the session. Bernard and Goodyear (2014) provided a list of leads that supervisors can use in this process.

Creative interventions. Creative approaches to supervision can be a great way to tap into some of the unconscious processes that might be present for the supervisee. Creative/art- based approaches to supervision can help to tap into right brain processes that may be less logical and linear (Shepard & Guenette, 2010). Anecdotally, but not yet supported by research, metaphor can help supervisees understand concepts such as evaluation and their own professional development (Guiffrida et al., 2007). Art therapy can tap into the subconscious and reduces the defenses that may be present with an

anxious supervisee (Guiffrida et al., 2007). The comfort level of the supervisor and supervisee in using metaphors must be considered in its overall effectiveness.

Presently there is a lack of empirical evidence to either support or to reject any of the methods referred to above. However, Bernard and Goodyear (2014) recommend the following questions to guide one's selection of an appropriate method.

- How will this method of supervision be received by the supervisee?
- Am I being true to my beliefs about how one learns to be a mental health practitioner?
- Am I considering the three functions of supervision (i.e., assessing learning needs; changing/shaping/supporting; and evaluating performance)?
- Am I considering the timing or relative structure of my supervision?
- Are administrative constraints real, or am I not advocating with a strong enough voice?
- What does this particular supervisee need to learn next? Am I using the best method for this purpose?
- Am I skilled in the use of this particular method or technique?
- Have I considered ethical safeguards?
- Is it time to try something new?
- Can I document the success of my method?
- Am I willing to confront my assumptions [about a particular method]? (pp.178-179).

Supervision Modalities

Supervision modalities provide a great mix of opportunities to solidify the supervisory relationship. There is no one right modality and utilizing a variety is the preferred approach. Individual, triadic, group, team, and peer supervision are all examples of supervision modalities.

Individual (dyadic) and paired (triadic) supervision.

Individual supervision has some benefits over shared, or triadic supervision. Individual supervision is the most common of all supervision types, however, the literature has demonstrated that supervisees generally support triadic supervision

(Shepard & Martin, 2012). Supervisees have also reported this approach as the safest of supervisory modalities because they feel that they can more easily share vulnerabilities (Shepard & Martin, 2012). Triadic supervision can reduce supervision bias and complacency and provide an opportunity for the supervisor to witness how the supervisee might be with clients based on a parallel process of what they are like with their colleague (Shepard et al., 2016).

Group supervision. Group supervision involves two or more supervisees who meet for clinical supervision. The benefits of group supervision are that it provides opportunity to benefit from "multiple perspectives, validation, normalizing, support, feedback, vicarious learning" (Shepard et al., 2016, p. 159). Group supervision that is complemented by individual or paired supervision is commonly used with novice counsellors (Shepard et al., 2016).

Peer supervision or co-vision. Peer supervision is a peer-based model of supervision where peers meet to discuss issues related to their counselling work. One of the benefits of peer supervision is the positive effect it has on reduced burnout and compassion fatigue. Additionally, this type of supervision modality is a non-hierarchical, non-evaluative type of supervision that can create a safe haven for supervisees to consult, leading to a positive effect on team dynamics (Shepard et al., 2016).

There are advantages and disadvantages to individual, triadic, and group supervision. Supervisees (n=31) in Border et al.'s study (2012) found individual supervision to: (a) be in-depth and safer, (b) to build confidence, (c) to increase self-awareness, and (d) to allow time for building the supervisory relationship and sharing supervisor feedback. Drawbacks for supervisees included having fewer perspectives,

coping with the power differential, and learning to work with supervisor behaviour (Borders et al., 2012).

Supervisees in Border's study saw many benefits to triadic supervision. They liked the amount and depth of feedback, they felt safer, they learned from their peer's experience, and had their counselling experiences normalized (Borders et al., 2012). Disadvantages included not having enough time, peer mismatch, and dynamics in the supervisory session (Borders et al., 2012).

Borders et al. (2012) found that group supervision offers supervisees many perspectives on the counselling process. In their study, supervisees learned through vicarious learning which created more educational opportunities, and normalized their experiences with clients (Borders et al., 2012). The challenges were similar to triadic supervision; that is, there was a limit on the amount of personal feedback received and overall there was not enough time for each member of the group to discuss their clients or to have their questions addressed.

An earlier study by Newgent, Davis, and Farley (2004), with a sample size of 15 supervisees, found that participants viewed individual and triadic models in a similar manner. Both models were viewed positively for facilitation of the working alliance, the relationship dynamics, and overall satisfaction with the supervision process. The group model was viewed less favourably; participants indicated that they had less time to discuss their client cases and identified a lack of consistency between their developmental levels.

Evaluation and Gatekeeping/Remedial Interventions

Evaluation is one of the most essential functions of supervision and one with which many supervisors struggle (Bernard & Goodyear, 2014; Ladany, 2014). Evaluation is any information, either direct or indirect, that a supervisor gives to their supervisee about their skills, knowledge, and behaviour (Hoffman, Hill, Holmes, & Freitas, 2005). Through a process of on-going formative and summative evaluation, gatekeeping occurs when the supervisee is not able to provide competent, professional care to a range of clients even after on-going feedback and evaluation (Robinson & Landine, 2016).

Evaluation. Supervisees should be evaluated fairly on criteria that are made clear in advance and should be evaluated on actual observation of performance. The criteria should be outlined in the supervisory contract during an initial meeting of the supervisor and supervisee. Establishing goals and objectives for supervision, as well as spelling out specific criteria on which the supervisee will be evaluated, should occur at the beginning of the supervisory process, and in writing.

Best practice is to provide feedback that is "systematic, timely, clearly understood, balanced between positive and negative statements, coming from a credible source, and reciprocal" (Ladany, 2004, p. 8). In the process of evaluation, supervisors assess job performance, progress towards professional development goals, explore future learning goals, and evaluate fitness for practice and competence (SAMHSA, 2014). It is challenging to assess supervisees accurately based on elusive criterion. For example, research continues to "challenge the assumption that particular types of therapist knowledge, skills, or level of experience determine client outcome" (Bernard & Goodyear, 2014, p. 204). Even with room for growth, the field has narrowed down some

of the criteria including personal characteristics necessary for positive client outcomes (Bernard & Goodyear, 2014).

Evaluative (both formal and informal) processes should be clearly outlined in the supervisee contract in the early stages of supervision. Regular and specific evaluation and feedback is important so that the supervisee knows what they need to work on and what they are doing well. There are three types of feedback, easy, difficult, and not given or non-disclosure (Hoffman et al., 2005; Ladany, 2014). It is likely that a supervisor's reluctance to deal with uncomfortable evaluation is related to CT and the need to be liked by or protect the supervisee from difficult emotions. When a supervisor does not provide the supervisee with difficult feedback there are potential professional implications which can impair the supervisor in fulfilling their gatekeeper role.

According to Hoffman et al. (2005), generally supervisors find it easier to give feedback about clinical skills and client welfare than about issues pertaining to the supervisory relationship, supervisees personality, or professional behaviour. The evaluation process needs to be handled carefully as a result of the deeply personal nature of counselling evaluation that delves into a supervisee's personal characteristics, and intuitions and can trigger shame and anxiety in the supervisee (Bernard & Goodyear, 2014).

Bernard and Goodyear (2014) provided some helpful suggestions to stay focused on the purpose of evaluation, that is, to help the supervisee grow professionally and to create a safe atmosphere. One suggestion included speaking openly about receiving feedback and the natural response of defensiveness. Supervisees may need to be reminded that the evaluation process is about support and helping them grow

professionally (Bernard & Goodyear, 2014). In line with culturally competent supervision, speaking about differences and how performance may be affected by differences of culture (e.g., age, ability, social class, religion/spirituality, gender, gender identity, and sexual orientation) are essential. The therapeutic process involves being able to relate in culturally flexible ways that demonstrates cultural sensitivity (Bernard & Goodyear, 2014). To promote feedback reciprocally, it can be helpful and disarming to discuss how the supervisor can better serve the supervisee to meet their professional development goals in the future (Bernard & Goodyear, 2014). Also, it is important that supervisees know that there is a place to go if they are unhappy with their evaluation or feel it is unfair or incomplete (Bernard & Goodyear, 2014). As noted throughout this chapter, Bernard and Goodyear (2014) recommend that supervisors stay focused on the working alliance and relationship with the supervisee because it is central to the work that will continue in supervision.

Although evaluation is a central component of ethical practice in supervision, it is also the most overlooked aspect of supervision because of the anxiety it generates as well as a lack of training among supervisors in how to effectively provide formative and summative feedback (Ellis, 2001). For example, Bogo, Regehr, Power, and Regehr (2007) found that supervisor leniency bias could be partially attributed to the professional values of counsellors such as being nonjudgmental and empathic to individual learning needs. Gonsalvez and Freestone (2007) suggested that supervisors should consult with others and have some aspects of supervisee performances assessed by other persons even when the evaluation is positive.

Gatekeeping/remedial interventions. Remedial intervention is sometimes necessary when a supervisee does not demonstrate that they are able to provide professional and competent services to clients. The supervisor's role is to develop a remedial action plan (Robinson & Landine, 2016). The action plan might consist of recommendations such as "personal counselling, increased supervision, reduced counselling, temporarily/permanent cessation of counselling/psychotherapy, [and] a leave of absence" and are intended to support the supervisee to manage the difficulties (Robinson & Landine, 2016, p. 81). If the supervisee is willing and able to work on recommendations and receive feedback openly, this should be taken into consideration, if the impact of their impairment isn't too great (Robinson & Landine, 2016). If the supervisee is unable or unwilling to accept the support or take actions that contribute to improved performance then it may be necessary to coach them out of counselling or terminate them from the position (Robinson & Landine, 2016).

Domain 5: Ethics and Legal Issues

The fifth domain of competent supervision includes *ethics and legal issues*. Supervisor ethical violations may include confidentiality breaches, lack of cultural sensitivity and awareness, lack of competency in various areas of practice, and challenges in differentiating counselling/psychotherapy from supervision (Bernard & Goodyear, 2014).

In several studies (e.g., Ellis, 2017b; Ellis et al., 2014; Ladany, 2014), supervisees reported very high rates of inadequate and harmful supervision. For example, Ellis et al. (2014) found that more than 90% of supervisees (n = 363) surveyed were currently receiving inadequate supervision with 35.3% currently receiving harmful supervision.

Shockingly, more than half reported their supervisor did not use a supervision contract or consent, and nearly 40% reported their sessions were not monitored, viewed, or reviewed. Wall (2009) found that 23% of her sample (n = 111) indicated their supervisor had conducted at least one ethical lapse or violation, while 26% questioned their supervisor's ethical judgment on at least one occasion during the internship. Improper or inadequate clinical supervision was identified as the ninth most frequently cited cause of disciplinary action by licencing boards (The Association of State and Provincial Psychology Boards [ASPPB], 2014).

The CPA (2009) developed specific ethical guidelines for supervision in psychology while the Ontario Psychological Association (2015) developed a self-assessment tool for best practices in clinical supervision to address the need for competent and ethical clinical supervision. The supervisor's primary ethical responsibility is to the client and public (CCPA, 2018). According to the *National Competency Framework: Qualifications, Competencies, and Best Practices* (CCPA, 2018), involving supervisees in regular review and discussions about the CCPA *Code of Ethics* (2007) and the CCPA *Standards of Practice* (2015) is important to ensure that there is a clear understanding of relevant codes and standards.

Ethical Principles

It is incumbent on the supervisor that supervisees understand and practice the six principles of the CCPA Code of Ethics (2007) that guide practice. The principles include (a) beneficence, (b) fidelity, (c) nonmaleficience, (d) autonomy, (e) justice, and (f) societal interest. The above principles are based on a proactive approach to respecting clients' rights and are intended to highlight the ethical duty counsellors have to guard

clients from intentional harm. Additionally, the principles guide practice in the areas of consulting and private practice, research and publication, and education, and training and supervision (CCPA, 2007). A detailed outline of the six principles are found in the CCPA Code of Ethics (2007).

Confidentiality

Addressing supervisor/supervisee confidentiality in supervision and the limits of confidentiality in a supervisory relationship can prevent disastrous situations from occurring. Robinson and Landine (2016) emphasized the importance of informing the supervisee of "information that will be shared; with whom, when, and in what manner" (p. 74). Additionally, supervisees must be made aware of circumstances when information might be shared outside of the expected third party. These circumstances will generally be about the safety of clients, or the supervisees safety to self or others (Robinson & Landine, 2016). Supervisees may mistakenly view supervision as synonymous with therapy and disclose information that can have serious implications. Therefore, supervisors have responsibility to ensure that their supervisees understand fully the limits of confidentially (or lack of such) of their communications with their supervisors. Supervisors have a responsibility to ensure that if electronic communication occurs (between client and supervisor, supervisee and supervisor, or client and therapist), clients and supervisees are informed in advance of the limits of confidentiality and the possibility that such communications may not be private.

Liability

Clients seeking professional counselling services have the right to expect that when they seek services that the counsellor is competent to provide those services. When

the counsellor is receiving supervision, the supervisor assumes legal responsibility for the counselling work and actions of those they supervise (SAMHSA, 2014). It is important for supervisors to understand that their role entails a degree of legal risk. The legal terms used to define a supervisor's role in harm to clients are vicarious liability, direct liability, and negligence.

Vicarious liability refers to a clinical supervisor's legal responsibility arising out of supervisee's act(s) of commission or omission that impact their clients and implicate their clinical supervisors. There are reasonable limits as to the degree of care, caution, and control that clinical supervisors are expected to exercise, such that findings of vicarious liability will depend on the following criteria being met:

- a supervisee must agree to engage in clinical supervision and offer informed consent to be under the control and direction of a specified clinical supervisor;
- the clinical supervisor has the authority to control and direct the practice of the supervisee;
- the supervisee fails to meet the established standard of care within the scope of practice identified by the clinical supervisor;
- the clinical supervisor reasonably could have expected the supervisee to competently carry out the action in question (whether the issue is omission or incompetent commission); and
- harm or injury ensues as a direct result of omission or incompetent commission of duties (Robinson & Landine, 2016).

Vicarious liability refers to the action(s) of supervisee. The supervisor is legally responsible to an extent and how much is based on the criteria (above) and standard of care (below). *Direct liability,* on the other hand, refers to the erroneous, improper, or unethical actions or omissions on the part of the supervisor directly. It implies a failure of the supervisor to provide supervision in a consistent and timely manner which may have caused injury to a client or may not have provided adequate quality control to the supervisee.

The term used to assess supervisor liability is *standard of care* which asks, 'Did the supervisor conduct themselves in a way that would be considered reasonable for someone in their position?' That is, was the action taken by the supervisor what the average supervisor would customarily or typically do in similar circumstances. *Negligence* occurs when a supervisor fails to observe the standard of care or make a reasonable effort to supervise, for example, during the past year of supervision, the supervisor only reviewed the supervisee's case notes every two months (SAMHSA, 2014).

After an exhaustive search and consultation with professionals in the field, there is some uncertainty about whether supervisors of paraprofessional counsellors have the same legal responsibility and liability as supervisors of master level supervisors. Assuming that both supervisors have the same liability, it is important to create a distinction between *financial liability* and *professional liability*. All supervisors who carry insurance or who are insured by the agency they work for are covered financially through the insurance policy. Professional liability on the other hand, can have severe consequences if a complaint is launched against the supervisor or supervisee. This consequence can be more damaging to the career prospects of the regulated or certified counsellor who is acting in the role of supervisor. Legal complaints may result in a suspended or revoked registration. Ideally, all supervisors of both certified and paraprofessional counsellors and whether they are certified or not, take steps to avoid this outcome by being diligent with their supervision practice and ensure that supervisees are well-versed in ethical and professional standards and expectations.

Domain 6: Diversity and Social Justice

Although greater attention is being directed to diversity, still data are emerging that supervisors often are not initiating consideration of multiple diversity factors in supervision, nor are factors of privilege, historical trauma, and oppression being addressed. (unknown)

Diversity and social justice are the focus of the sixth domain of supervisory competence. Within diversity and social justice, several important considerations were highlighted. Through the development of supervision skills, knowledge and attitudes, cultural competence is strengthened. An approach to culture infused practice and social justice with an attitude of cultural humility is recommended. An ecological model to frame cultural practice from micro and macrosystem perspectives is considered in addition to an awareness of power's impact on the working alliance. Ways to mitigate some of the innate power issues in the supervisory relationship are explored including an exploration of how supervision, community work, and social justice are at the heart of counselling. Finally, the role of spirituality and religion in clients' lives and the value of broaching spirituality and religion in supervision will be discussed.

There may be many reasons a supervisor may hesitate to engage in supervision using a culture informed lens including lack of understanding of its importance, fear of seeming less knowledgeable than the supervisee, or an investment in maintaining their power (Ober, Granello, & Henfield, 2009). Psychotherapy has deep roots in Western ideology that doesn't take into consideration the complexity of other ways of knowing and being (Arredondo, 1999; Prochaska & Norcross, 2015). There is a dearth of research that indicates the importance of culturally competent counsellors, and clinical supervision can be an entry point for rich conversation, supervisee development, self-efficacy, and stronger supervisee/supervisor working alliance (Hook et al., 2016; Ober et al., 2009).

However, some research indicates that supervisees feel more confident in their work when supervision is a place where conversations about diversity are not only embraced but initiated by the supervisor (Crockett & Hays, 2015). By demonstrating awareness of cultural differences and conveying warmth, supervisors not only improve the working alliance but also demonstrate multicultural competence (Walker et al., 2007, as cited in Crockett & Hays, 2015).

Skills Knowledge and Attitudes

Central to cultural competence (APA, 2015; Hook et al., 2016; Sue et al., 1995, as cited in Ober et al., 2009) is an awareness of one's development of skills, attitudes, and awareness of diversity. Cultural competence is the ability to solve problems in relation to clients' tension between maintaining tradition and adapting. Clients' behaviours are influenced by a combination of these factors and therefore must be a consideration throughout the therapeutic process (Ober et al., 2009). Critics have complained that this concept of cultural competence in counselling is too abstract and therefore difficult to teach/operationalize (Weinrach & Thomas, 2004, as cited in Ober et al., 2009).

Development of Cultural Competence

The APA (2015) has four suggestions for the development of cultural competence by supervisors. First, supervisors are advised to develop and maintain self-awareness regarding their diversity competence, which includes attitudes, knowledge, and skills. Second, it is recommended that supervisors strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of their supervisees (APA, 2015). Third, supervisors are encouraged to pursue ongoing training in diversity competence as part of their professional development

and lifelong learning (APA, 2015). And finally, APA (2015) recognizes the importance for supervisors to be knowledgeable about the effects of bias, prejudice, and stereotyping. Additionally, the APA (2015) encourages supervisors to model social justice through client advocacy and promoting change in organizations and communities in the best interest of their clients.

Ancis and Delany (2001, as cited in Ober et al., 2009) recognized the need for a comprehensive understanding of the interaction of diverse identities of the supervisor and the supervisee by developing the Heuristic Model of Non-oppressive Interpersonal Development Model (HMNID). This model focuses on the supervisor's level of multicultural awareness and the interaction *between* the complex multicultural identities and competencies of the supervisee and supervisor (Ober, 2009). The premise of HMNID is that cultural competence and racial identity of the supervisor influences and can stunt the cultural development of the supervisee (Ladany, 2004; Ober et al., 2009). This is especially noticed when the supervisor and supervisee are at different stages of development along the continuum of the four stages of multicultural awareness and competence. The first stage, *adaptation*, occurs when the person has limited awareness of oppression but recognizes ethnic and racial differences. This stage is recognized by complacency, apathy, and conformity. The second stage, *incongruence*, occurs when beliefs about difference begin to be challenged. There is a tension and confusion between old and new beliefs and experiences. Behaviours stay the same as in stage one. The third stage, *exploration*, is identified by behaviour changes that create congruence between beliefs and behaviour. The final and fourth stage, *integration*, is when self-awareness is

high, and the individual can recognize oppression and actively work toward producing change in others and their environment.

According to this model, there are three types of relationships that supervisors and supervisees have: (a) progressive, (b) parallel-advanced, and (c) regressive (Ober et al., 2009). It can be challenging when the supervisee is in a higher stage of cultural awareness and competence than the supervisor. This can be more common with experienced supervisors who are not up to date on professional development in this area. A progressive relationship takes place when the supervisor is further along the continuum. Parallel-advanced or parallel-delayed arises when both supervisor and supervisee are at similar stages of developments, and finally regressive happens when the supervisee is further along in their awareness than the supervisor. It makes sense, then, that supervisors strive to develop their cultural competence in order to have a progressive or parallel advanced relationship with their supervisee (Ober et al., 2009).

Cultural Humility

Hook et al. (2016) proposed that cultural humility is the antidote "to issues of diversity or microaggressions that may emerge" (p. 153). Approaching supervision from a not-knowing stance addresses assumptions more quickly, and levels the power dynamics innate in relationships between supervisor/ee (Watson, Raju, & Soklaridis, 2016). The not-knowing or learning stance facilitates self-reflection and demonstrates an attitude of respect, collaboration, and openness (Hooks et al., 2016; Watson et al., 2016). A culturally humble clinical supervisor is aware of their own worldview and biases, and models valuing other perspectives and working to reduce bias or blind spots. Most importantly, they "make culture a welcome part of the supervisory conversation" (Hook

et al., 2016, p. 154). The ecological model of cultural competence developed from the work by Bronfenbrenner provides a framework to support culturally sensitive supervision.

Ecological Model of Cultural Competence

Ecological theory as presented by Bronfenbrenner in the late 1970s continues to inform multicultural practice and can be extended to clinical supervision (Lau & Ng, 2014; Neville & Mobley, 2001). The model can be used to conceptualize issues when supervisees struggle with issues related to cultural competency (Forrest, Shen Miller, & Elman, 2008).

In recognition that supervisees' lives, and experiences do not exist in a vacuum, there is value in exploring supervision from an ecological perspective. Ecological theory names the wider system issues such as power, racism, and poverty as a player in influencing how people behave, make decisions, and respond. Ecological theory operates under the premise that human behaviour and how people interact with their environment is heavily influenced by the interaction of several social systems (e.g., micro, meso, exo, and macrosystems; Neville & Mobley, 2001). Consideration must be given to change on all levels that our clients interact with including at the individual, agency, and political levels. Microsystem address the immediate environment of the counsellor and supervisor. Macrosystems include agency level factors while metasystems are at the societal level. It is by understanding these interactions that supervisors can truly understand and support the supervisee in a culturally informed way.

Supervisors are in a privileged position to influence agency or macrosystem level policies. The APA (2015) encourages supervisors to model social justice through client

advocacy and promoting change in organizations and communities that are in the best interest of their clients.

Power in the Supervisory Relationship

Supervision is a professional relationship that provides support, education, and monitoring of quality, and creates a safe forum to reflect on professional practice. It should encourage constructive confrontation and critical thinking that informs and improves the practice of all parties. Respecting the inherent hierarchy in the relationship, it should accept the ethical responsibility to use power in a thoughtful manner. The dynamics in the supervisory relationship can create a parallel process in all other relationships including that of the client/counsellor.

Given the power inherent in the supervisory relationship, especially in the workplace where supervisees are not able to choose their supervisor (Courtois, 2018), it is critical that supervisors are aware of the responsibility they have to exercise an ethical use of power (Barstow, 2008; Stefano et al., 2017). In addition to the power imbalance inherent in the hierarchy of the supervisory relationship, it may be experienced differently or more intensely when the cultural backgrounds, including gender, ethnicity, and/or the sexual orientation between the supervisor and supervisee are different.

Supervisees experience negative use of power in several ways including preferential treatment, imposition of clinical style, violating supervisees confidentiality, and imposing their own agenda over the supervisees (Cook, McKibben, Wind, Roberts, & Bell, 2018). There have been few studies on the impact of power in the supervisory relationship and yet there are conditions about supervision that make the power dynamic

unique to this relationship and different from the counsellor client relationship (Stefano et al., 2017):

1) The supervisee doesn't usually get to choose their supervisor and doesn't have a choice but to receive clinical supervision.
2) Clinical supervision involves an evaluative process with high stakes that could result in loss of employment due to the gatekeeping role that the supervisor is responsible for.

While power is a real dynamic in these relationships, and not always negative, a study by Mangione, Meares, Vincent, and Hawes (2011, as cited in Stefano et al., 2017) found that it was very rarely brought to the surface and discussed. The study also concluded that supervisees were more likely to bring it up and acknowledge its existence than supervisors (Stefano et al., 2017). The existence of the power dynamic should not be ignored because it is alive and present.

Social Justice

Many of our clients and families come from experiences of oppression, marginalization, and trauma. To separate counselling from social justice and advocacy ignores, in many cases, the root struggle that clients face such as racism, colonization, homophobia, sexism, poverty, and violence. Social justice is about contesting neutrality whether by naming the oppression or by taking action (Reynolds, 2010).

According to Reynolds (2010), there is nothing neutral about community work with people who are marginalized. Additionally, she asserts that community workers are resisting all the time, but don't recognize it for what it is- *justice doing* (Reynolds, 2010). Justice doing is about resisting neutrality and recognizing power structures. It is a call to

action, a collective approach to systemic issues whereby counsellors work together to support one another's efforts to create meaningful change. Collective care is "relational, reciprocal and communal" (Reynolds, 2010, p. 65) and is the antidote to burnout. There are several ways that supervisors can support social justice that includes embracing a feminist approach to supervision, naming the oppressive structures that contribute to the struggles of clients, supporting and encouraging advocacy, and becoming an ally (Reynolds, 2010).

Decolonizing Practices

Incorporating decolonizing practices into supervision challenges western notions of counselling, healing, and ways of knowing (Smith, 2015). Given that Indigenous people are overrepresented in the mental health and addictions systems of care, it is incumbent on supervisors to engage in conversations that support knowledge and skill development in this area (Ladouceur, 2013). Working with Indigenous clients may require supervisees to have advanced understanding of intergenerational trauma, cultural oppression, and integrating spirituality into counselling practices (Smith, 2015). Supervision that reflects decolonizing practice may include recognizing limitations of western healing practices and necessitate involvement of the client's Indigenous community of support (Smith, 2015). Involving and consulting with Indigenous people when services are delivered to them is of crucial importance if services are going to appropriately and effectively serve the needs of the community (Kirmayer, Simpson, & Cargo, 2003, as cited in Ladouceur, 2013). Finding respectful and appropriate ways to involve Indigenous people in service delivery involves building trust by following protocols such as approaching community leaders, chiefs and councils, hosting luncheons

(feasts) and sharing circles, forming advisories, and providing honourariums to elders (Ladouceur, 2013).

Broaching Spirituality and Religion

Spiritual and religious beliefs and practices (SRBP) can be extremely relevant to client support, contributing to improved mental and physical health outcomes (Saunders, Miller, & Bright, 2010). Counsellor's recognition of spiritual and religion in client's lives, contributes to culturally informed care. Counsellors and supervisors are sometimes understandably reluctant to engage in conversations about SRBP out of fear of ethical violations and appearing to proselytize or judge.

There is opportunity in supervision to model spiritually conscious care by asking the supervisee about the role of spirituality in their own life, how it has helped them through challenging times, and how it supports their self-care practices. Spiritually conscious care encourages conversations about spirituality and religion from a place of curiosity and interest without inserting 'self' into the conversation (Saunders et al., 2010). I was working with a supervisee who had experienced a loss of one of their clients from an overdose. I asked them how their spirituality was helping them through this difficult time. They shared that they were having regular conversations with their higher power to help them understand and transform their grief into understanding and compassion. I responded by verbally honouring their practice and resourcefulness.

Spiritually integrated and/or directive care on the other hand, can have unique challenges in terms of boundaries and roles (Saunders et al., 2010). Spiritually conscious care is not aimed at influencing the client's belief system or how they practice, nor is it suggesting religious or spiritual activities to alleviate mental health or substance use

issues (Saunders et al., 2010). Spiritually conscious care is about general, sensitive, and respectful curiosity and exploration about whether their SRBP may influence the support you are providing. Are there aspects of their spiritual practice that will aid them in coping with the problem?

Saunders et al. (2010) caution that without proper training and self-awareness, the counsellor might take the discussion too far the other way towards spiritually directive care. There is a delicate balance between avoidance and being overly directive, personal, and explicit about religion with clients (Saunders et al., 2010). Supervisors should approach supporting supervisees to include spirituality in their practice cautiously and be assured that the counsellor has the skills and abilities to practice effectively and responsibly.

Domain 7: Professionalism

The final and seventh domain covers professionalism. Professionalism entails an increase in self-efficacy for both the supervisor and supervisee in which cognitive and emotional shifts occur. Importantly the supervisor can support the development of counsellor competence and increased self-efficacy. Finally, the importance of promoting self-care in supervision practice as a pre-emptive approach to addressing countertransference and longevity in the profession of counselling are addressed.

Developing Professionalism in the Supervisor

New supervisors go through a transition whereby self-efficacy is developed. Novice supervisors have noticed a redirection of their professional mindset as they move from therapist to supervisor. It may take time to adjust to not directly treating the client but rather supporting the supervisee to develop their skills and develop an appreciation of

their own self-efficacy (Bernard & Goodyear, 2014). It can be helpful to know that there are four predictable stages of development that most new clinical supervisors go through as they transition into their role as clinical supervisor: (a) role shock, (b) role recovery and transition, (c) role consolidation, and (d) mastery (Watkins, 1993, as cited in Baker et al., 2002).

Additionally, there are some key cognitive and emotional shifts that are predictable and were identified by Goodyear et al. (2014). It takes time to realize the complexity of the role of the supervisor. Not only is the supervisor supporting the professional development of the counsellor but must also ensure the client's well-being (Goodyear et al., 2014). Further, there is a socialization process that occurs as the supervisor starts to identify where to focus their attention, and which attitudes to adopt. Learning to think like a supervisor can be more challenging for someone who was a counsellor for a long time prior to becoming a supervisor because of entrenched ways of thinking (Goodyear et al., 2014). Also, an identity shift happens over time in which the supervisor settles into their role and has success. It starts to feel less like a role and more as an identity. A shift occurs where the supervisor thinks "I am a supervisor" not "I'm being a supervisor" (Goodyear et al., 2014).

Developing Professionalism through Self-Efficacy in the Counsellor

The learning curve of new supervisees is steep and is a life-long process that requires on-going learning and education for both the supervisee and supervisor (CCPA, 2018). Most supervisees strive to experience confidence in their abilities as counsellors and yet it can take a very long time before a person feels that their level of competence has reached a level in which they feel relatively autonomous and confident in their skills.

Supervisees report something called “impostor syndrome” where they worry that they will be ‘found out’ (Barnes, 2004). They fear someone will realize that they do not know what they are doing.

Self -efficacy, a term coined by Bandura (1997, as cited in Urbani et al., 2002), is defined as “people’s beliefs about their capabilities to exercise control over their own level of functioning and other events in their lives” (p. 92). ‘Impostor syndrome’ is often an indicator that supervisors “actual competence exceeds that of their felt competence” and that they have a low level of Counsellor Self-Efficacy (CSE; Barnes, 2004; Bernard & Goodyear, 2014, p. 99). CSE is an important aspect of counsellor development and the more robust the counsellor’s CSE, the more able they are to move through the counsellor developmental stages and perform at higher counselling skill levels (Barnes, 2004). There is some conflicting information about the extent to which a high CSE impacts counselling skills and client outcome (Barnes, 2004; Morrison & Lent, 2018).

It is possible to contribute to supervisees’ self-efficacy by engaging in feedback, and culturally informed practice. An intra-relational approach to supervision, experience, and skillful feedback in the context of a strong working alliance can lead themselves to feelings of self-efficacy. “How a therapist interprets his or her efforts at performing counselling behaviours is likely to be affected by comments, nonverbal cues and imagined reactions of important other, especially supervisors and clients” (Morrison & Lent, 2018, p. 513). Additionally, Crockett and Hays (2015) reported that trust in the supervisor’s cultural competence increases supervisees self-efficacy. In other words, the supervisee had to respect the work of the supervisor for impact on their own self-efficacy to occur (Morrison & Lent, 2018).

Promotion of Self-Care

The emotional and physical impact of focusing on the well-being of others, and the stresses of working in a complex system of care, can contribute to compassion fatigue and vicarious trauma in the counsellor and supervisor (Robinson & Landine, 2016). The focus on other's well-being without balancing self-care can also contribute to an exacerbation of countertransference. It is considered an ethical imperative for supervisors to encourage and model self-care practices (APA, 2015; CCPA, 2018). A pre-emptive approach whereby counsellors are encouraged to participate in self-care before signs of impairment emerge is important to stem the tide of psychological stress (Robinson & Landine, 2016).

Conclusion

In this chapter, a thorough literature review was completed whereby seven domains of clinical supervision were carefully and thoroughly examined. The first domain; professional preparedness explored the areas of knowledge necessary to practice competently. Included was an exploration of the various supervision models. Next, literature was examined in relation to the second domain; structuring the supervisory relationship. This included clarity on roles, informed consent, responsibilities, the supervision contract, and documentation. The third domain that focused on relational aspects of supervision was investigated. Here the elements of the supervision relationship such as transference and countertransference, supervisory ruptures, supervision style, boundaries, teamwork, and creating ideal work environments were considered. Fourth, the domain of assessment, evaluation, and reporting were examined. A more in-depth exploration of assessment, supervision methods, modalities, and evaluation and

gatekeeping arose as important topics. Next, in the fifth domain, principles in ethical supervision were reviewed. This provided opportunity to explore the CCPA code principles. The sixth domain, diversity and social justice highlighted the importance of culturally informed supervision and the development of skills, knowledge, and attitudes related to cultural competence. Included in this section was the ecological model of cultural competence as well as power in the supervisory relationship. Additionally, social justice, decolonizing practice, and broaching spirituality and religion were examined. Finally, the seventh domain, professionalism, focused on elements of competent supervision that revolved around professional practice. This included a focus on the experiences of role transition, and cognitive and emotional shifts, supporting self-efficacy in the supervisee, and continued self-care practices for both the supervisee and supervisor.

In the next chapter, personal background about the impetus for the completion of this project is presented. Next, the information gleaned from the literature reviews and the ways in which the information gained answered the questions posed is reviewed. The strengths and limitations of the project and final insights about future research are presented.

CHAPTER 4: Synthesis

The intent of this project was to develop a clinical supervision manual for supervisors of paraprofessional counsellors. In the first three chapters, the goal was to answer the following questions based on an exhaustive review of the literature, which supported the development of the manual:

1) What are the key elements of competent clinical supervision?
2) What do novice supervisors need to know about clinical supervision?
3) What are the ethical implications of clinical supervision?
4) What should be included in clinical supervision training process?
5) How can clinical supervisors incorporate multicultural competence into practice?

The final chapter of this project will address the questions, project applications, target audience, strengths and limitations, areas of future research, and methodology.

What are the Key Elements of Competent Clinical Supervision?

In Chapter 2, the key elements of competent clinical supervision were examined by exploring the various existing frameworks of competent supervision. What was found was that there are several different competency frameworks that have similar elements defining the skills and knowledge required. After an exhaustive search, I landed on a competency framework that combined all the elements required for regulated clinical supervision but could be adapted for supervisors in outpatient counselling programs who are supervising paraprofessional counsellors. While most of what is included in the competency framework is applicable to this population of supervisors, the main

difference is in the formality and clinical level of the master versus the paraprofessional supervisor.

Some sections of the manual were adapted to create a manual for supervisors of paraprofessional counsellors. There were a number of adjustments made. First, in the professional preparedness domain, while it is an advantage, it is not currently common practice for clinical supervisors in this area to have a graduate degree. Second, in the structuring domain, current clinical supervision practice with paraprofessional counsellors is not nearly as organized as it is for supervisors of registered or certified counsellors. Some of the emphasis on structure was highlighted in the literature review. For example, a written supervision contract is not common practice at this level. While the concept is introduced in this project, it may take some time before using the contract becomes widespread practice. Next, the relational section was closely aligned with practice. However, the more clinical aspects of the domain such as discussing transference, countertransference, parallel process, and isomorphism are not generally emphasized in practice. The main difference in domain four between master level and paraprofessional level supervision is the formality and intensity of evaluation. Additionally, supervisor engagement in self-monitoring and self-evaluation is not necessarily on-going and consistent. The domain on ethical and legal issues presented the most divergence when comparing supervision with graduate level counsellors and paraprofessionals. Supervisors of paraprofessional counsellors are generally not as well-versed in ethical, legal, and regulatory issues that are relevant to the practice of counselling. For example, supervisors do not engage in discussions of liability and even after an exhaustive search, there is a lack of clarity about the legal responsibilities of

supervisors of paraprofessional counsellors. Finally, the last two domains of diversity and social justice and professionalism were very much in line with the practices of supervisors of paraprofessional counsellors.

What Should be Included in Clinical Supervision Training Process?

Chapter 3 provides a breakdown of seven domains of competent clinical supervision in outpatient settings as was established early on in my research. It was decided that clinical supervision training should be based on the framework of competent supervision provided by the *National Competency Framework: Qualifications, Competencies, and Best Practices* (CCPA, 2018). Hence, the topics that were relevant were: professional preparedness, structuring the supervisor relationship, relational supervision, assessment, evaluation and reporting, ethics, diversity and social justice, and professionalism. These are the areas that will be focused on in the *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor*.

How can Clinical Supervisors Incorporate Multicultural Competence into Practice?

In Chapter 3, and domain six; diversity and social justice, an in-depth investigation into the factors important to multicultural competence in supervision led to some key findings. The literature overwhelmingly supported the need to focus on skills, knowledge, and attitudes within the framework of the non-oppressive interpersonal development model (HMNID). Supervisors who increased cultural competence by increasing their self-awareness and their recognition of oppression is the ideal mentality for supervisors. An awareness of the ecological model of cultural competence and micro and macro system changes are important in recognizing how supervisors can be involved in individual and agency-wide change initiatives. Additionally, social justice and

decolonizing practices are strongly encouraged in the research. The values that were highlighted in the literature guides cultural informed supervision by encouraging cultural humility, sensitivity to power structures, proactive approaches to injustice, and recognition of the importance of spirituality and religion in many people's lives including the lives of supervisees.

What are the Ethical Implications of Clinical Supervision?

In Chapter 3, each of the key dimensions of competent practice were expanded on, including ethical practice. One of the findings was the importance that the clinical supervisor possess competence in the realm of ethics. The supervisor must be committed to practicing ethically, have knowledge of the ethical principles and standards, and the ability to help the supervisee practice ethically (Jamshidi et al., 2018; Reynolds, 2010). The academic literature also pointed out the importance of supervisors having the tools to support supervisees as they navigate critical and sometimes complex ethical dilemmas with their clients.

What do Novice Supervisors Need to Know about Clinical Supervision?

All the information that resulted from this exhaustive literature review can be helpful to a novice supervisor, however, there were a few areas that were prominent in the findings specifically for this subgroup of supervisors. Initially choosing a supervision model to structure supervision can be daunting. The research recommends that the novice supervisor initially rely on Bernard's discrimination model because it is clear, simple, and structured which can be helpful early on in this new role. Next, understanding roles and responsibilities can help guide and direct the supervisor about where to focus their energy. Understanding how to recognize, repair, and avoid ruptures can be helpful for

supervisors who are new especially when they are trying to establish an environment of transparency and respect (Nelson et al., 2008). Establishing a supervision practice that is based on the ethical principles found in the CCPA (2007) provides a strong foundation. Finally, in establishing their professionalism, understanding the normative cognitive shifts that occur as they become more accustomed to their role and responsibilities can be crucial as supervisors become more confident and efficacious in their own skills and abilities (Goodyear et al., 2014).

Clinical supervision is the cornerstone of therapy. Most clinical supervisors have come from a background of therapy practice and are often more trained to be a therapist than a clinical supervisor. Gone are the days when clinical supervision was considered an extension of counselling. Clinical supervision requires unique values, attitudes, knowledge, and skills. Competent supervision is more narrowly defined, thanks to academics and practitioners like Bernard and Goodyear (2014), Shepard et al. (2016), and Reynolds (2010) who have dedicated their careers to professionalizing the profession of counselling.

Project Applications

Something I have learned to appreciate in my graduate studies is the value of research, academic literature, and its application to practice. Given the enormous responsibilities that clinical supervisors carry such as gatekeeping, supervisee support, cultural competence, client welfare, evaluation, and often administrative responsibilities, it is essential that proper infrastructure is in place to support their growth and development. It is my hope that the *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor* will provide a foundation for practice that can be

utilized to excel in their role as supervisors. The manual will provide thorough guidance to supervisors in many areas of clinical supervision that will include a combination of theoretical, practice support, and practical tools and forms. The project will be divided into four chapters and an appendix that will provide forms and tools for the supervisors that will support them to practice competently.

Target Audience

This project was created for all clinical supervisors and their supervisees. The specific target audience for this project are supervisors of outpatient counselling programs who supervise unregulated supervisees who have a less than masters level education and a range of professional experience. The invisible target audience is the client because the supervisor is ultimately responsible for the client. The level of experience of the supervisor is not relevant because the *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor* will be useful to all for different reasons depending on where they are in their own developmental process.

Strengths and Limitations

In this section, I will speak to two project strengths and one project weakness. The strengths include closing the gap between research and practice and the creation of a one-stop-shop manual. The limitation that I identified is the wide scope and lack of detail.

While many outpatient counselling programs have strong clinical supervision practices, a strength of this manual is that it can provide direction and support to close the gap between current evidence-based practice and what is happening in the mental health field. This manual will help guide clinical supervisors in their skill and knowledge development and will reinforce what they are already doing well.

A second strength is that clinical supervisors have many responsibilities on their shoulders and sometimes experience isolation and burnout as a result. Their roles as teacher, counsellor, mentor, guide, and consultant are some examples of the many different hats that are worn daily. This manual is intended to be a little gift that encourages them so supervisors can be reassured that they are doing a good job. It also provides evidence-based tools and templates; supervisors do not have to recreate the wheel. It is a one stop shop for supervisors in outpatient programs.

A limitation of this project is the wide scope of the manual that covers seven domains of supervision practice. While attempts were made to narrow it down, there are many issues relevant to the practice of clinical supervision. Due to the number of topics relevant to the practice of clinical supervision, it was difficult to thoroughly review and analyze all the issues that can arise in clinical supervision. There was recognition that each subheading could have potentially been a project on its own given the literature available. While the project is meant to support supervisors at all developmental and experience levels, it may be more beneficial to less experienced supervisors because of the scope and depth of what was covered.

Areas for Future Research

There are many opportunities for future growth in the area of clinical supervision and I will address a few of them in this section. One is training and education in the practice of clinical supervision. Many counsellors (85%-95%) eventually provide clinical supervision as they move through their careers and yet only a few graduate programs provide courses or education in the core of their program, particularly at the master level (Bernard & Goodyear, 2014; Destler 2017; Gazzola et al., 2013). Further, there has been

very little research completed in non-traditional counselling settings where the environment may be less clinical, more team-oriented, and with different client age groups. While I think the current definitions of competence is thorough, I would be interested to see how the definition would be adjusted for diverse work environments.

Methodology

The information in the *Clinical Supervision Manual: For the Supervisor of the Paraprofessional Counsellor* was gathered from a combination of sources. To maximize the credibility of the results, the literature review provided empirically relevant information on clinical supervision. The main electronic databases that were used included Ovid, PsychINFO, PsychARTICLES, ERIC via EBSCO and SocINDEX. Additionally, my project supervisor, Dr. Blythe Shepard provided resources from her work on clinical supervision with the CCPA. I scanned reference lists for relevant studies. The academic journal, *The Clinical Supervisor* was particularly useful and seven of the articles referenced in this project came from there. I purchased three reference books that could not be found in the library. An additional source of information was the CCPA, a counselling and psychotherapy association. I consulted with current outpatient supervisors who are in the profession to glean rich, experience-informed information that helped guide the process of creating the manual. Additionally, this project complies with both the CCPA (2007) and the CPA (2017) *Codes of Ethics*.

Conclusion

This has been the final chapter of this phase of the project. In this chapter I summarized the outcomes of the project by speaking to my personal reason for wanting to focus on this topic and the research questions. I then discussed the applications of this

project. Next, I spoke to the strengths and limitations of this project as well as areas of future research. I then spoke about the methodological approach that was used to gather the empirical evidence for this project.

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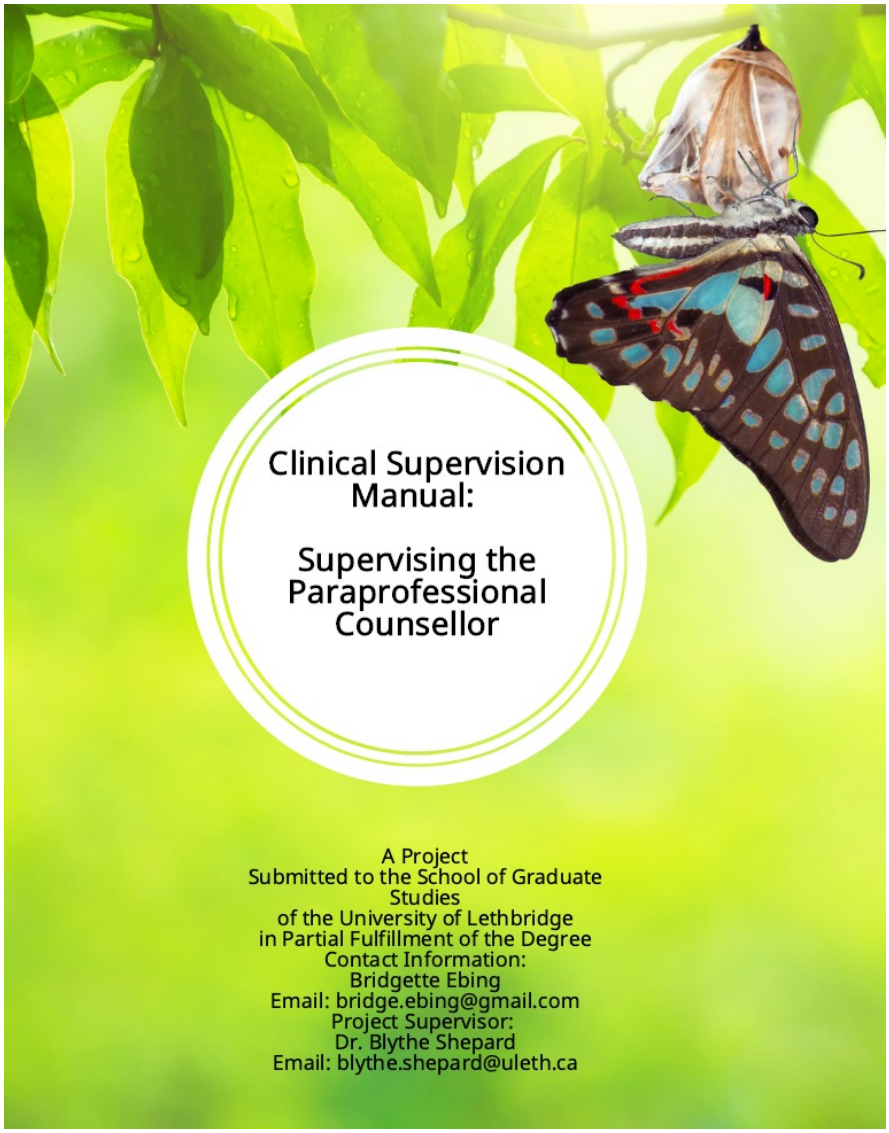
Appendix: Clinical Supervision Manual



PREAMBLE

Welcome to the applied portion of this project aimed at clinical supervisors with varying levels of experience who supervise paraprofessional counsellors in community-based counselling programs. It is intended for supervisors who wish to enhance clinical supervision practices, skills, and knowledge. The overall goal of the manual is to increase competence in seven domains that includes: (a) professional preparedness; (b) structuring the supervisor relationship; (c) relational supervision; (d) assessment, evaluation, and reporting; (e) ethics; (f) diversity and social justice; and (g) professionalism (CCPA, 2018).

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INTRODUCTION

Welcome to the *Clinical Supervision Manual: Supervising the Paraprofessional Counsellor.* You may be a new or experienced supervisor. Regardless, my hope is that this manual will provide you with support and clarity as you navigate your role. Mental health professionals can benefit from receiving effective clinical supervision. It can benefit not only the counsellor but also the agency where the counselling is taking place.

Table 1: *Benefits of Competent Clinical Supervision*

WHO BENEFITS	WHAT ARE THE BENEFITS
BENEFITS FROM AN AGENCY/ORGANIZATIONAL PERSPECTIVE	• Availability of support for counsellors, and a forum to discuss clinical issues (e.g., being triggered) and to seek case consultation; • Promotion of performance of core skills across the organisation; • Increased job satisfaction and self-confidence; and • Improved worker retention.
BENEFITS FROM A SUPERVISEE PERSPECTIVE	• Deepens their professional and counselling knowledge and skills; • Assists them in managing their caseload; • Increases awareness of their own responses generated by their counselling work; • Provides emotional support; • Helps to illuminate code of ethics and facilitates ethical decision making and ethical practice; and • Monitors the working process between client and counsellor.

Note. Adapted from "Clinical Supervision of the Canadian Counselling and Psychotherapy Profession" by B. Shepard, L. Martin, & B. Robinson (Eds.), 2016b, by Canadian Counselling and Psychotherapy Association.

A high 90% of counsellors are receiving inadequate supervision (Ellis et al., 2013). It is not surprising that up to 25% of supervisory skills are inadequate or harmful given that 85%-95% of counselors with 15 years of experience have engaged in clinical supervision without specific supervision training (Gazzola, Stefano, Theriault, & Audet, 2013).

Nearly all new clinical supervisors have been counsellors for part if not all of their careers and many are still practicing. While becoming a supervisor can feel like an extension of being a counsellor, clinical supervision requires skills, knowledge, and values that are unique to the position (Falender & Shafranske, 2014). Becoming a supervisor entails a shift from thinking like a counsellor to thinking like a supervisor (see Domain Seven). There is enormous responsibility on the shoulders of the clinical supervisor for not only the counsellor but also "the most vulnerable person in the room, the client" (D. McBride, personal communication, July 2018) and society.

REGISTERED VS. UNREGISTERED SUPERVISORS AND SUPERVISEES

Currently in most provinces there is no requirement that a supervisor has met specific competencies as a supervisor. That is changing with regulation of the counselling/psychotherapy profession. For example, The College of Registered Psychotherapists of Ontario (CRPO, 2018) requires the following:

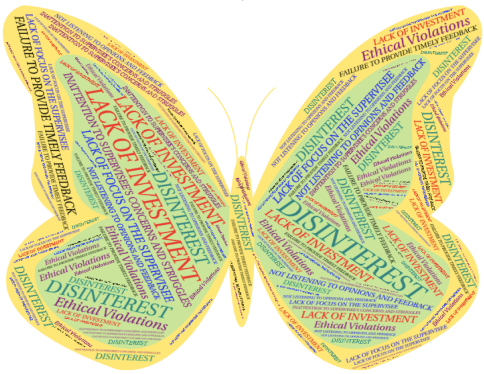
- The supervisor must be a member in good standing of a regulatory college whose members may practise psychotherapy.
- The supervisor must have five years' extensive clinical experience.
- The supervisor must meet CRPO's "independent practice" requirement (completion of 1000 direct client contact hours and 150 hours of clinical supervision).
- The supervisor must have completed 30 hours of directed learning in providing clinical supervision. Directed learning can include course work, supervised practice as a clinical supervisor, individual/peer/group learning, and independent study that includes structured readings.
- The supervisor must provide a signed declaration that they understand CRPO's definitions of clinical supervision, clinical supervisor, and the scope of practice of psychotherapy.

While competency models are often developed to support registration requirements, counsellors benefit from competent supervision.

While the above noted level of training and competence is necessary when supervising professional therapists who are registered and must comply with regulatory requirements, in British Columbia most counsellors are paraprofessionals, and supervisors are not regulated in this province. Commonly, group homes, school based, substance use, and mental health counselling programs are staffed by paraprofessional counsellors with a wide range of training experience, education, and are typically not regulated. The intent of the manual is to provide information and support in areas that are important in outpatient, community-based, paraprofessional counselling settings.

INTENT OF THE CLINICAL SUPERVISION MANUAL

While it is assumed that most supervisors do not intend to be ineffective, the lack of training and understanding of roles and responsibilities can create a vulnerability that can lead to the following:



It is important to understand the difference between the different types of supervision that are common in the field of counselling:

> ***Administrative Supervision*** focuses on the day to day functioning and keeping the organization or agency functioning (Substance Abuse and Mental health Services Administration [SAMHSA], 2014).
>
> ***Clinical Supervision*** refers to an ongoing relationship in which the supervisor is responsible for ensuring the delivery of high-quality services to clients, assisting supervisees to grow and develop, and safeguarding the well-being of clients (Canadian Counselling and Psychotherapy Association [CCPA], n.d., para1).
>
> ***Consultation*** is an informal arrangement between professionals in which the consultant provides a service, such as sharing of skills, providing opinion on a case, problem solving, brainstorm (Courtois, 2018).

Clinical Supervision is the cornerstone of counselling and has long-term implications for the counsellor and in turn, the client (Crunk & Barden, 2017). Counsellors often model themselves after their supervisors (Gazzola et al., 2013).

Given the stakes and positive correlation between quality supervision and client outcome (Ladany & Inman, 2008), it is important that supervisors are equipped to do this important job.

Clinical supervision is about much more than the working alliance and good intentions. It is about the competency in following domains that have been identified by the Canadian Counselling and Psychotherapy Association (CCPA, 2018). The competency framework outlined by the CCPA (2018) was helpful in developing a framework for *Clinical Supervision Manual: Supervising the Paraprofessional Counsellor*

The manual is divided into the following sections:

- **Domain One: PROFESSIONAL PREPAREDNESS**
- **Domain Two: STRUCTURING THE SUPERVISOR RELATIONSHIP**
- **Domain Three: RELATIONAL SUPERVISION**
- **Domain Four: ASSESSMENT, EVALUATION, & REPORTING**
- **Domain Five: ETHICS & LEGAL ISSUES**
- **Domain Six: DIVERSITY & SOCIAL JUSTICE**
- **Domain Seven: PROFESSIONALISM (CCPA, 2018)**

Note from the author: The vision for this manual came from my own experiences fifteen years ago when I became a supervisor in a team of paraprofessional counsellors in the field of substance use services. Back then, it was commonly believed that effective clinical supervision was an extension of being a counsellor and not a role that required training and support. Unfortunately, what I found was that the skills and knowledge I had gained as a counsellor were helpful but not sufficient. Since then, many leaders in the field, including Dr. Blythe Shepard who has supervised this project, have dedicated their careers to the professionalization of clinical supervision. I believe that if I had access to the research that is available today in an easily understandable and accessible manual such as this one, I would have been able to provide richer and more effective support to my supervisees and in turn clients.

There is no one right way to work through this manual. You may see it as a resource to have on your shelf or choose to use it as a way to better understand and build on your strengths and improve limitations as a supervisor by utilizing the many questionnaires, charts, tables, tips and recommendations. To start, I have provided you with some tips and recommendations for how to get the most out of this resource:

TIPS and RECOMMENDATIONS for USING THIS MANUAL

- Work with a small group of other supervisors to discuss concepts that are new to you or you would like to work on.
- Print copies of certain questionnaires and have a supervisee fill out, then discuss.
- Adapt templates to fit the needs of your program.
- Provide handouts to supervisees, e.g., Counsellor Bill of Rights and Performance Criteria
- Share your learning with other supervisors.
- Simply, refer to as necessary.

Enjoy!

PROFESSIONAL PREPAREDNESS: DOMAIN ONE

As I reflect on my own experiences as a counsellor, I have had some very different supervisors over the years who have had quite different levels of knowledge, experience, focuses, and approaches to supervision, all with seemingly similar desires to help me develop my own counselling skills, understand how people change, and serve those I worked with to the best of my ability. The relationships I had with each were unique and yet the similar thread in each was a safe place for me to stretch, learn by making mistakes, and grow.

Being a novice supervisor can bring up feelings of insecurity and uncertainty. The good news is that these skills and knowledge do not have to be developed overnight. It is a career-long pursuit. A strong ego, patience with self, and a self-compassionate approach to learning will help along the way.

Models of Clinical Supervision

- ***Developmental models*** focus on the learning styles of the counsellor.
- ***Supervision process models*** maintain a focus on the supervision process itself.
- ***Psychotherapy-based models*** are about passing on therapeutic approaches including psychodynamic, humanistic, cognitive-behavioural, systemic, and constructivist.
- ***Second generation models*** allow supervisors flexibility in approach to supervision utilizing a combination of models.

In the next section, various models that are helpful and easy to implement in outpatient counselling settings will be explored in more detail.

Developmental Models of Supervision
Developmental Models focuses on where a counsellor is in their developmental process. These models will help the supervisor identify the counsellor's needs and the most effective supervision approach, evaluation and assessment. The Integrated Development Model/Stoltenberg Model (IDM) is a clear and effective model to help in this process.

Integrated Development Model/Stoltenberg Model
There are specific supervision environments and approaches that are recommended in this model depending on the counsellor's developmental level. These approaches include catharsis (emotional release), catalytic (asking questions to elicit self-exploration), supportive, prescriptive (advice giving), informative, and confronting. An alternate version of interventions introduced by Johnson and Moses (1988, as cited in Bernard & Goodyear, 2014) is a decision to either support or challenge the counsellor couched in one of the supervision roles: teacher, consultant, and counsellor. Stagnation or defensiveness by the counsellor may be an indicator that they need more or less support or challenge from the supervisor (Bernard & Goodyear, 2014).

Table 2: *Integrated Development Model/Stoltenberg Model*

	COUNSELLOR CHARACTERISTICS	OPTIMAL ENVIRONMENTS	TIPS & RECOMMENDATIONS
1	**Dependent on Supervisor** Imitates others, high self-focus with little self-evaluation, concerned with doing it "right", minimal experience and training.	• Prescriptive • Catalytic questions • Observation • Role playing • Reading • Group supervision • Address strengths, then weakness • Encourage risk taking when autonomy grows • Closely monitor clients • Positive reinforcement	• *Role play having the supervisor playing the therapist.* • *Suggest approaches and techniques.* • *Think out loud to model internal thought process (Borders, 2009).* • *Provide concrete and direct feedback to the supervisee.* • *Encourage the supervisee to pay attention to nonverbal behaviour of client.* • *Encourage the supervisee to notice internal reactions in the session.*
2	**Dependency-Autonomy Conflict** Increasing self-awareness, initiative, increased ability to focus on client and show empathy, fluctuating confidence, striving for independence, may exhibit resistance, becoming more self-assertive and less imitative.	• Less instruction. Less structure • Observation • Role playing • Catalytic questions • Interpret dynamics • Group supervision • Broaden caseload (more difficult) • Supports emotional reactions • Encourages more autonomy	• *Role play having the supervisor play the role of the counsellor then the supervisee takes over the role of counsellor part way through.* • *Think out loud while working through case scenarios so that the supervisee can learn how to interpret what is going on beneath the surface for the client.* • *Ask about emotional reaction to clients.* • *Ask for the supervisee's thoughts and hunches.*
3	**Conditional Dependency** Personal counsellor identity is developing with increased insight, more consistent trust in their own judgement, increased empathy, and more differentiated interpersonal orientation	• Peer supervision • Catalytic questions • Group supervision • Strive for Integration (personal and professional) • Develop a consultative relationship with less evaluation	• *Explore transference/ countertransference to incorporate the personal and professional.* • *Ask open questions that have the supervisee share insights about the client. For example, you might ask "What are some of the things you will consider with this client?*
4	**Master Counsellor** Adequate self- and other awareness, insightful of own strengths and weaknesses, demonstrates personal autonomy, willfully interdependent with others and has integrated standards with personal counsellor identity	• Less structures environment • Peer supervision • Conceptual • Group supervision • Supervision now becomes more collegial if continued.	• *Use a consultation approach whereby the supervisor asks how to support supervisee.* • *Encourage the supervisee to practice peer supervision.* • *Explore the clients they struggle with the most to unearth potential countertransference.*

Note. Adapted from "Approaching supervision from a developmental perspective: The counselor complexity model," by C. Stoltenberg, 1981, *Journal of Counseling Psychology, 28*(1), p. 59-65.

Supervision Process Models

This school of supervision is the most practical and widely used of the three schools of supervision models (Bernard & Goodyear, 2014).

Bernard's Discrimination Model

The Discrimination Model is often the first model that new supervisors are exposed to. It is sometimes the preferred model because it provides clear guidance for interacting with the counsellor (Bernard & Goodyear, 2014). The model is simple and clear with four foci for supervision: interventions, conceptualization, personalization, and professional issues. Four possible supervisor roles are included in the model: teaching, counselling, consulting, and mentoring (Bernard & Goodyear, 2014; Shepard & Martin 2012).

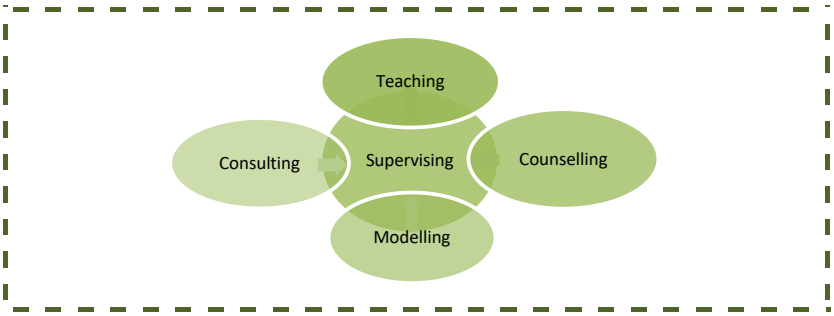


Figure 1. **Bernard's Discrimination Model**. Supervisors more commonly use the teaching mode with new counsellors and the consulting role with more experienced counsellors. Attunement to the counsellor's needs is important both to maximize professional growth and also to enhance the supervisory relationship.

The clinical supervisor wears different hats. A supervisor who identifies that a counsellor is struggling in the area of interventions may choose to approach the issue from one of the four main roles depending on what the supervision goal might be (Bernard & Goodyear, 2014). The four roles are; *teacher, counsellor, consultant, and mentor*. Each role can contribute to the growth of the counsellor, depending on their goals and experience level (Abiddin, 2006). The role that the clinical supervisor utilizes at any given time is dependent on the experience level of the counsellor and what they are trying to accomplish. Ladany (2004) cautions supervisors not to use a developmental cookie cutter approach to work with counsellors. In other words, just because a counsellor is new doesn't mean the teaching role is always appropriate.

Table 3: *Bernard's Discrimination Model*

ROLE	DESCRIPTION	TIPS AND RECOMMENDATIONS
TEACHING	A psychoeducational or teaching approach can work well with novice counsellors whose knowledge base is limited and with counsellors who are learning new skills (Bernard & Goodyear, 2014).	• *Suggest articles or books to read;* • *Review and name what was observed in sessions.* • *Identify appropriate interventions (Shepard & Martin, 2012).*
COUNSELLING	The counselling role provides emotional support to the counsellor and is generally a short-term role to support the counsellor to continue to perform their job effectively and ethically. The secondary impact of the counsellor role is to create safety and trust and to have a positive effect on the working alliance (Abiddin, 2006).	• *Explore counsellor's feelings that concern counselling or a specific technique or intervention (Shepard & Martin, 2012).* • *Reflect on issues of supervisee countertransference with client that may have emerged.*
CONSULTING	The consulting role is often utilized as the counsellor becomes more confident and takes on more responsibility (Courtois, 2018).	• *Provide or brainstorm alternative interventions or conceptualizations.* • *Encourage the counsellor to initiate structure of the supervision session.* • *Elicit discussion of client problems and motivations in counselling (Shepard & Martin, 2012).*
MODELLING	Modelling is an intentional role that supervisors take when they want to demonstrate a behaviour or skill. When there is opportunity for the counsellor to practice what they have witnessed models, knowledge transfer is more likely (Shepard, Martin, & Robinson, 2016a). Using modeling in supervision increases the likelihood that a skill will be used in a session (Bearman et al., 2013).	• *Supervisees generally watch the supervisor very closely and model themselves after them. Keep this in mind when doing relational informed consent, self-disclosing, setting boundaries and self-care practices.* • *Demonstrate appropriate interventions to meet the learning needs of the supervisee*

Second Generation Models of Supervision

Combined Model

Combined models take into consideration the influence of the three main dimensions of supervision: theory, development, and processes.

Combined models are a more recent phenomenon and allows supervisors flexibility in their approach to supervision.

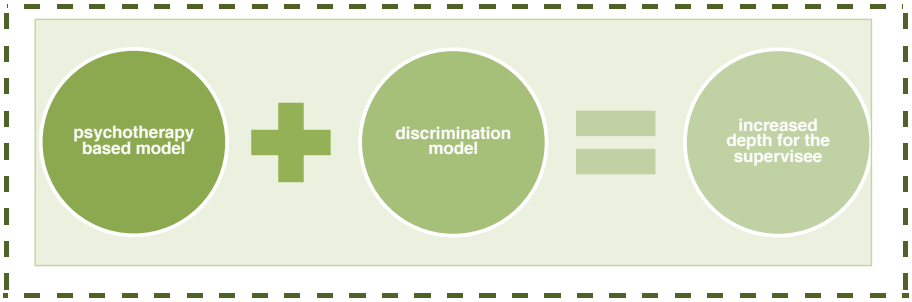


Figure 2. **Example of a Combined Model**

Common-Factors Model

This model is based on the premise that regardless of the therapeutic technique being used, it's the therapeutic relationship that is the biggest predictor of change (Lampropoulos, 2003).

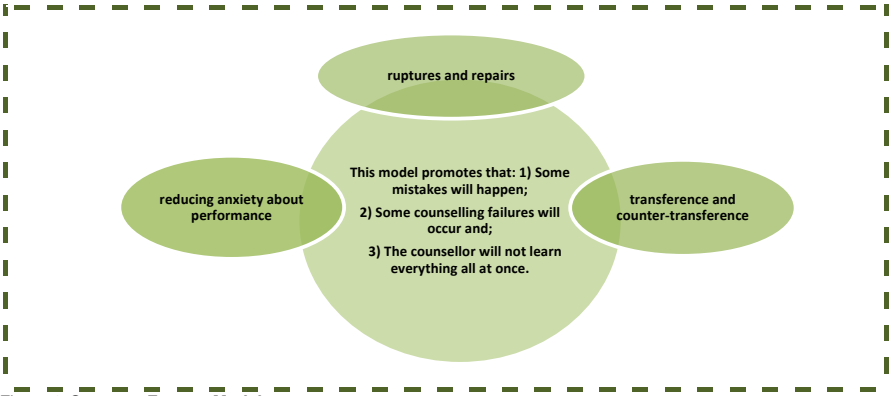


Figure 3. **Common Factors Model**

With many models to choose from and no one model perfectly covering every aspect of supervision, it is recommended that each supervisor reflect on their own experiences as a counsellor and develop a model that works best for them (Corey, Corey, & Callanan., 2010, as cited in Shepard & Martin, 2012).

TIPS and RECOMMENDATIONS
To DECIDE WHICH SUPERVISION MODEL TO USE

- Reflect on your philosophy of change. For example, do you believe that people change by a process of scaffolding (steps)? Do you believe that people change through a process that creates some discomfort but not too much?
- Reflect on your own expertise and training. If using the psychotherapeutic model, the supervisor should have extensive training in the theory they are using;
- A development model is recommended for newer supervisors;
- Reflect on the nature of the supervisory relationship. For example, if you are supervising experienced counsellors in a setting that utilizes primarily cognitive behavioural therapy, but you want to incorporate common factors, you may want to use the combined model. If you are supervising counsellors with varying levels of experience, you may want to work from a developmental approach.
- Obtain further training in a model you are interested in focusing on;
- Participate in peer consultation so you can check out your use of the model and;
- Identify the developmental level of the counsellor (Robinson, 2016).

STRUCTURING THE SUPERVISOR RELATIONSHIP: DOMAIN TWO

Responsibilities of the Supervisor

It is important to distinguish between clinical supervision and administrative supervision as well as consultation and counselling when discussing the responsibilities of a supervisor (Falender & Shafranske, 2014). In a nutshell, clinical supervision responsibilities are limited to the professional growth in the areas of knowledge, skills, and attitudes/values to ensure the quality of counselling and increase clinical competency of the supervisee by developing a strong working alliance, and developing learning and evaluative strategies that fit with the requirements of the clinical settings (Falender & Shafranske, 2014).

While responsibilities will vary depending on the setting, the clinical supervisor's main and primary responsibility is *to the client, the public and then the supervisee* (CCPA, 2018; Shepard & Martin, 2012). The supervisor is responsible for creating an atmosphere where respect and a strong relationship is the foundation of the supervisory experience (Shepard & Martin, 2012). Taking on the supervisory responsibility includes several components that are also outlined in the supervision contract (Bernard & Goodyear, 2014).

1. To develop a trusting relationship in an environment where the supervisee feels respected, heard, trusted, understood, and challenged.
2. To provide a space where supervisees can consider their experiences, discuss the content of their sessions, reflect, and engage in conversations that help increase their professional knowledge and skills.
3. To support counsellors to develop their skills, knowledge, and values in the counselling profession to ensure clients get the highest quality service possible (Falender & Shafranske, 2014)

The First Supervision Session and Relational Informed Consent

A relational informed consent process that starts at the beginning of the supervisory relationship lays the groundwork for a supervisor/counsellor relationship (Ellis, 2017; McBride, 2018). The idea is that informed consent is a 'collaborative process' through conversation rather than a one-time discussion or 'event.' It can be a powerful and worthwhile experience, addresses the power dynamic, and sets a tone of rights and collaboration from the start. Relational informed consent is part of a living, breathing document in which the conversation is revisited throughout the supervisory relationship.

The first time you meet with the supervisee, it is tempting dive in too quickly. Chances are anytime you are meeting a supervisee for the first time, there may be quite a bit of red or blue energy in the room which will make absorbing and relaying new information challenging (see Figure 4).

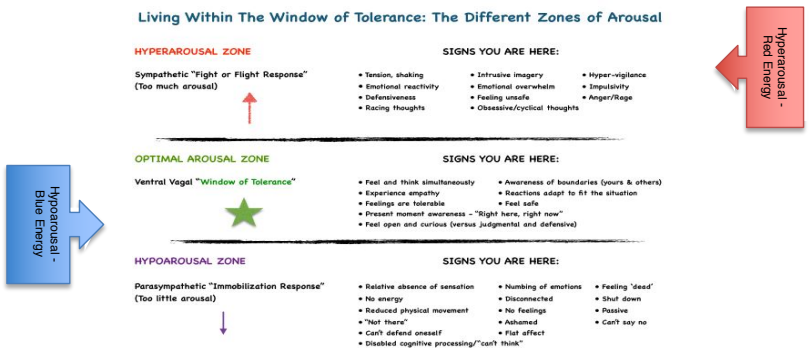


Figure 4. **Living Within the Window of Tolerance: The Different Zones of Arousal**. Adapted from "Living Within the Window of Tolerance. The Different Zones of Arousal," by Crowe Associates Limited, n.d. Retrieved from http://www.crowe-associates.co.uk/psychotherapy/window-of-tolerance/

TIPS and RECOMMENDATIONS For the FIRST SUPERVISION MEETING

- Do spend some time getting to know each other before launching into anything serious. Try and create extra time in your schedule so the first session is not rushed (1.5-2 hours)
- Try to project a warm, curious, collaborative energy. To regulate my own energy, I may say to myself "I am solid, I am safe, I am ok, and I am very humbled to meet this new person".
- Get comfortable, let the supervisee choose where they would like to sit, offer a coffee, tea or water. Ask about interests, hobbies, or what brought them to supervision.
- Do not rush the first meeting no matter how important the paperwork/logistics might be. Focus on being relationship centered, not paperwork/task centered.
- Aim to introduce informed consent in order of topics that naturally come up.
- Provide choice ie. "would you like to start with logistics or your rights?".
- Get them talking as much as you can because the first time you meet should not be a monologue about informed consent.
- Aim for a dialogue about informed consent. For example, "I'm sure you are aware of the limits of confidentiality in relationships with clients. How do you think that's different or the same in our supervisory relationship?"

Note. Adapted from "The First Counselling Session-Professor Dawn," by D. McBride, 2018, *CAAP 6611 Practicum course*

Informed Consent Agreement

A written contract that includes informed consent and outlines both the supervisor's and supervisee's rights and responsibilities, and expectations in supervision provides an opportunity to create structure in which the supervisory work can happen and ensures that supervisor and counsellor are "on the same page" (Ellis, 2017; Falender & Shafranske, 2011, p. 134). The supervision contract is recommended but *not legally binding*. It does provide a basis for clarification down the road if issues arise (Courtois, 2018). However, it is an ethical imperative for counsellors to know what is expected of them (CCPA, 2007).

Overall, the supervision contract attempts to set a tone, outline expectations, and address uncertainties.

Boys and Girls Clubs of South Coast BC
Counselling Stream Informed Consent Agreement
(Template)

This is an agreement between (supervisor's name) and (supervisee's name)

Supervision start date_____

Supervisor Bio

Supervisor background to introduce the counsellor to the areas of expertise, history with the agency and in the field. (Each supervisor to write their own).

Goals and Purpose

Built on a foundation of safety and trust we will strive to support you to provide the best services to clients that will support your professional development. Together, we will strive to ensure clients are getting the best possible support. The safety and welfare of clients is the highest priority.

Procedures and Guidelines for Supervision

- We will aim to meet formally once every two weeks.
- We will also meet informally as needed and when we are both available.
- My hope is that we will be able to work through disagreements but If it cannot be resolved in supervision, I encourage you to talk to the Director of Counselling Programs.
- In my absence, you can reach me on my cell or I will arrange for an alternate supervisor to be available.
- For emergencies I can be reached on my personal cell phone _____

Duties and Responsibilities

I, your supervisor, will:

- Honour commitments made to you including supervision meetings
- Present, suggest and model appropriate clinical interventions.
- Review your paperwork including case notes, progress reviews, and initial services plans.
- Provide helpful feedback and evaluation that will support your work with clients
- Intervene if necessary when client well-being is at risk.
- Ask about approaches and techniques you are using with clients.
- Ensure that ethical guidelines are upheld.

You, as the supervisee will:

- Honour commitments made to me including prioritizing supervision meetings.
- Be prepared to discuss client cases.
- Discuss approaches and techniques that you are using with clients.
- Share any boundary blurs or concerns immediately.
- Uphold all ethical guidelines.
- Respect and protect the confidentiality of clients, the program and the agency.
- Follow the recommendations given by me.
- Adhere to all agency policies and procedures.

Performance Review

- You will receive an outline of what is going to be evaluated so you know what is expected of you in preparation for the performance review (see Table 10).
- For accurate assessment, your performance will be witnessed by me through either co-therapy or audio taping your sessions.
- We will meet regularly where you will receive on-going, formative feedback and support.
- Close to the six-month mark we will meet to discuss probation where a summative (overall) review will be conducted and decision will be made regarding ending or extending probation.
- A summative (overall) review will be conducted annually after probation.

Note:

- I will consult with my supervisor and supervision team as needed which means that at times, I will have to share information pertinent to supervision. The goal will always be what is in yours and the client's best interest.
- There are times when someone outside of this group may have to be consulted. If, for example, I am concerned about yours or someone else's safety I may have to consult outside of the counselling team.
- The notes taken during supervision are kept in a secure place and are confidential. You can access them at anytime.
- This agreement will end if/when either of us leaves our position within the BGC of South Coast BC.
- All supervision is conducted in line with the BGC Policies and Procedures and the Counselling Handbook.

I have read and understand the above terms of agreement and I agree to accept and abide by them throughout the supervisory process and until such time as the agreement is cancelled.

_____ _____

Counsellor *Date*

_____ _____

Supervisor *Date*

Figure 5. ***Informed Consent Agreement*** *(template).* Adapted from "Supervision of Counselling and Psychotherapy: A Handbook for Canadian Certified Supervisors and Applicants," by B. Shepard & L. Martin, 2012, Ottawa: Canadian Counselling and Psychotherapy Association; "Clinical Supervision and Professional Development of the Substance Abuse Counselor," 2014, *Substance Abuse and Mental Health Services Administration [SAMHSA].* Retrieved from https://store.samhsa.gov/system/files/sma14-4435.pd

Counsellor Bill of Rights

Be supervised

- You have the right to have your supervisor invested and committed to supervision and your professional development.
- You have the right to meet with your supervisor face-to-face on a regular basis.
- You have the right to meet with the supervisor in an environment that insures appropriate confidentiality.
- You have the right to be informed of an alternative supervisor who will be available in case of crisis situations or known absences.

Know the expectations, goals, and objectives of supervision

- You have the right to be provided information regarding expectations, goals, responsibilities, and roles of the supervisory process.
- You have the right to be informed of the supervisor's expectations of the supervisory relationship.
- You have the right to discuss the supervisor's expectations regarding the structure and/or the nature of supervision sessions.
- You have the right to receive the supervisor's help to identify and attain professional growth.

Feedback and evaluation

- You have the right to be provided with the criteria for evaluation.
- You have the right to receive accurate and timely feedback on your professional performance.
- You have the right to routinely receive verbal feedback and periodic formal written feedback.

Be respected and treated as an individual

- You have the right to ask respectfully for what you want and need.
- You have the right to be treated with respect and dignity.
- You have the right to be recognized as an individual.
- You have the right to be treated with respect and sensitivity to culture, race, and diversity identities.
- You have the right to discuss openly the influence of race, ethnicity, gender, sexual identity, religion, age, social class, and such on clinical work and supervision.

Address and resolve conflicts

- You have the right to discuss problems and issues you have with your supervisor or supervision.
- You have the right to disagree respectfully with your supervisor.
- You have the right to appeal unsatisfactory evaluations.

Be treated ethically

- You have the right to not be harmed, exploited, or abused by your supervisor or colleagues.
- You have the right to be free from sexual harassment from your supervisor or colleagues.
- You have the right to be free from being counselled on issues irrelevant to your work with clients or your professional development.
- You have the right to be free of other exploitative relationships with your supervisor.
- You have the right to expect the supervisor to consult with his or her peers regarding supervisory concerns and issues.

Figure 6. **Counsellor Bill of Rights**. Adapted from "Clinical Supervision Contract and Consent Statement and Supervisee Rights and Responsibilities," by M. V. Ellis, 2017, *The Clinical Supervisor*, *36*(1), pp. 145-159.

Documenting Supervisory Activities

Documentation of clinical supervision is a critical component of supervision that requires tracking of professional growth and development, and oversight of client welfare (Robinson & Landine, 2016). The main benefits of record-keeping are risk management, tracking professional growth and development, and working through personnel issues with a counsellor (SAMHSA, 2014). A supervisee file should include:

- a signed contract, performance reviews;
- notations of all supervision sessions (including group supervision where the focus is on clients);
- progressive disciplinary steps taken, and;
- supervisor's recommendations (SAMHSA, 2014.).

As with clients, supervisees have the right to access their supervision file at anytime (Robinson & Landine, 2016).

TIPS and RECOMMENDATIONS For DOCUMENTATION

Include:

Documentation for supervision sessions
- formal and informal feedback
- frequency of supervision (date, time, location)
- foci of supervision
- clients discussed
- topics of countertransference (between supervisee and clients

A signed copy of the informed consent form or supervisory contract.

Document all conversations with supervisees where a directive has been given about safety issues that includes:
- Concerns about confidentiality
- Duty to report situations
- Recommendations that have been made about this situation
- Any incident reports that have been completed.

RELATIONAL SUPERVISION: DOMAIN THREE

"The supervisory relationship is a relationship about a relationship about other relationships" John Fiscalini

The third domain of competent clinical supervision is *relational supervision*. The strength of the supervisory working alliance has been found to have a positive effect on the counsellor's learning and self-efficacy. The ability to form a strong bond with the counsellor is one of the greatest contributions a supervisor can bring to the supervision experience. It will increase the likelihood that the counsellor will share important information with the supervisor (Ladany, 2004).

A relational tone set early in supervision where the supervisor approaches the relationship with humility, can foster openness and reflection which is crucial to counsellor learning, growth, and development (CCPA, 2018). Supervision styles have been studied since the 1980's (Friedlander & Ward, 1984) and research has found that interpersonally sensitive (consultant) style supervision predicted a stronger working alliance (Bernard & Goodyear, 2014). Additionally, the more expert and relatable the supervisor was, the stronger the bond between with the counsellor (Bernard & Goodyear, 2014). In this section, we will explore the vast literature on the relational approach to supervision and some of the opportunities and challenge to the supervisory alliance. People who enter the profession of counselling are likely to bring with them a history of unresolved experiences that will unwittingly be introduced into the counselling/ supervisory process at some point (Courtois, 2018) that emerge as transference and countertransference issues.

Transference and Countertransference

Transference	***Countertransference***
(The supervisee is triggered by the supervisory relationship)	**(Supervisor is triggered by the supervisee or client relationship)**

A Short Story About Struggle that Relates to Countertransference:

A man spent hours watching a butterfly struggling to emerge from its cocoon. It managed to make a small hole, but its body was too large to get through it. After a long struggle, it appeared to be exhausted and remained absolutely still.

The man decided to help the butterfly and, with a pair of scissors, he cut open the cocoon, thus releasing the butterfly. However, the butterfly's body was very small and wrinkled and its wings were all crumpled.

The man continued to watch, hoping that, at any moment, the butterfly would open its wings and fly away. Nothing happened; in fact, the butterfly spent the rest of its brief life dragging around its shrunken body and shrivelled wings, incapable of flight.

What the man – out of kindness and his eagerness to help – had failed to understand was that the tight cocoon and the efforts that the butterfly had to make in order to squeeze out of that tiny hole were Nature's way of training the butterfly and of strengthening its wings.

Sometimes, a little extra effort is precisely what prepares us for the next obstacle to be faced. Anyone who refuses to make that effort, or gets the wrong sort of help, is left unprepared to fight the next battle and never manages to fly off to their destiny

(Coelho, 2007).

Table 4: *Signs of Countertransference in the Supervisory Relationship*

		Y/N
1.	More often than not taking on the counselling role with the supervisee.	
2.	Feeling the need to fix the problem or reduce pain of the supervisee or client.	
3.	The need for approval and acceptance as a knowledgeable supervisor.	
4.	Not liking a supervisee which leads to not wanting to work with them or avoiding them.	
5.	Wanting to distance from certain types of behaviours that you see in the supervisee.	
6.	Catering to or withdrawing from individuals from specific cultural background that hinders their professional development.	
7.	Left wondering if you are sharing too much or too little with the counsellor.	
8.	Sexual or romantic attraction towards certain supervisees.	

Note. Adapted from "Issues & ethics in the helping professions" by G. Corey, M. Corey, & C. Callanan, 2015, Stamford, CT: Cengage Learning.

TIPS and RECOMMENDATIONS for IF YOU ARE EXPERIENCING SIGNS OF COUNTERTRANSFERENCE

- Look for clues (see above) that countertransference (CT) is occurring.
- Try using a self-reflecting journal exercise that explores any of the following questions. Write without editing…free write.
  - How is this supervisee affecting me? What is my behaviour towards this supervisee in response to these feelings?
  - When was the last time I felt like this?
  - What am I afraid of (or worried about) and how realistic is this to happen? If this did happen, how would I handle it?
  - How does this situation remind me of something from my past?
  - What can I do to release some of the past?
  - What are the gems (what can I learn from) in this situation?
  - What can I appreciate and what are the strengths of this person?
- Avoid judging yourself. CT is common and can be positive if aware.
- Think about seeking out counselling or supervision for what is getting triggered and might be unresolved from your own past-it is always recommended that counsellors and supervisors are set-up with their own therapists.
- Check in with peers and seek additional supervision. This is where working with a team of other supervisors can be helpful.

Table 5: *Personal Counselling vs. Clinical Supervision*

PERSONAL COUNSELLING	CLINICAL SUPERVISION
The goal is personal growth and development, self-exploration, becoming a better person.	The goal is to make the counsellor a better counsellor.
Requires exploration of personal issues.	Requires monitoring of client care and facilitating professional training.
The focus of exploration is on the origins of the manifestations of cognitions, affects, and behaviours associated with life issues and how these issues can be resolved.	The focus is on how issues may affect client care, the identification of the problems and counselling process, and accomplishment of client goals.

Note. Adapted from "Substance Abuse and Mental Health Services Administration (SAMHSA)," 2014, *Clinical supervision and professional development of the substance abuse counselor.* Retrieved from https://store.samhsa.gov/system/files/sma14-4435.pd

Supervisors who have not worked through their own personal traumas in counselling bring vulnerability into the supervisory relationship. There are signs to look for that indicate countertransference 'may be in the room.' Recognizing and repairing ruptures that may or may not be related to transference or CT, will be explored next.

Recognizing and Repairing Ruptures

Along with a strong working alliance, the ability of the supervisor to recognize and repair ruptures in the relationship is essential to an effective and ethical supervisory relationship. The potential for conflict in the supervisory relationship is high due to the combination of the therapeutic and evaluative nature of the relationship. Unresolved conflict in the relationship can become a rupture. There are two main types of ruptures that can occur: confrontation or withdrawal ruptures and each type requires a different response to resolve (Safran & Muran, 2000).

Characteristics of the supervisor and counsellor can contribute to conflict as well as issues that come up that can include: unrecognized transference and CT, anxiety due to fear of failure, trust issues, mishandling of power, diversity issues, and personal conflicts (Watkins 1993 as cited in Falender & Shafranske, 2014; Shepard & Martin, 2012).

Many ruptures are avoidable, however, when they do occur, recognizing and addressing is important (Bernard & Goodyear, 2014).

TIPS and RECOMMENDATIONS for RECOGNIZING and REPAIRING RUPTURES

Recognizing a Rupture:

- Use attunement and non-verbal cues to assess whether there has been a change in the supervisee's behaviour.
- Don't be afraid to 'check out' suspected ruptures with the supervisee. Ask them. Worst-case scenario you are showing humility, willingness, and care for the relationship.

Repairing a Rupture:

- QTIP: (Quit taking it personally) If there is tension between you and the supervisee check in with yourself to make sure that anxiety isn't being mistaken for tension.
- Timing. Address the rupture at a time that works for both the supervisee and yourself. Sometimes the rupture is best repaired right away and other times it's best to give some time for reflection and a cooling off period.
- Be humble and don't be afraid to acknowledge a mistake. Acknowledging a mistake and asking for forgiveness goes a long way in the supervision relationship. Humility also models awareness and acceptance of our own limitations.
- Use humility every time. You cannot go wrong!

Boundaries

> *"The supervision relationship provided a crucial context for supervisor self-disclosure, serving as the soil in which the supervisor self-disclosure was planted. In fertile soil, a healthy result grew; in soil of questionable fecundity, a more tenuous crop emerged…"*
> *Knox, Edwards, & Hess., 2011, p. 340.*

Supervisors report that self-disclosure, also referred to as the ***therapeutic use of self,*** is essential to build trust, to teach skills, and to normalize counsellors' struggles (Knox et al., 2011).

Appropriate supervisor self-disclosure has a positive effect on the supervisory alliance and creates opportunities for growth (Bernard & Goodyear, 2014). Self-disclosure to normalize struggles and intentional self-disclosure is generally experienced positively by counsellors (Knox et al., 2011).

There are two different types of self-disclosures (Knight, 2012; Knox et al., 2011):

1. ***There and Then*** about the supervisor as a person outside the session
2. ***Here and Now*** about immediacy; supervisor's thoughts in the session.

Overall supervisor self-disclosure is experienced in positive ways and contributes positively to the working alliance, future supervisory and client relationships, and leads to a more open relationship where counsellors were more likely to disclose their struggles.

Similar to the importance of therapeutic alliance in client/counsellor relationships in predicting client outcomes, so too, is the importance of a strong working alliance between supervisor and counsellor (Bell, Hagedorn, & Robinson, 2016; Bernard & Goodyear, 2014).

Some reasons that counsellors do not share pertinent information with supervisors are:

- *Shame*
- *Embarrassment and,*
- *Discomfort*

which can be exacerbated by a poor relationship and lack of trust. (Bell et al., 2016)

"We should not underestimate our role and the necessity to make it safe for supervisees to express their doubts and fears" (Friedlander, 2014, p.177).

Supervisors' responsiveness is critical if they are to create a safe place for counsellors to share their vulnerabilities (Friedlander, 2014). The benefits include

- an internalization of the supervisor's skills;
- increased job satisfaction; and
- stronger emotional bond and therapeutic working alliance (Bernard & Goodyear, 2014).

A strong supervisory alliance is about attitudes and values including "respect, fostering autonomy, or empowerment" (Falender & Shafranske, 2014, p. 1033).

TIPS and RECOMMENDATIONS for SELF-DISCLOSURE

- Be careful that what you are not sharing something that the supervisee is going to feel the need to support you.
- Only share what you would be ok with hearing other people know about you. Once shared, there's no control about what happens with the information.
- Be aware of the kind of relationship you have with the supervisee and use good judgement when sharing anything personal. Remember there is a power dynamic and certain sharing may make the supervisee uncomfortable.
- Try to share things that you think will enhance the work of the supervisee.

Teamwork, Communities of Support and Positive Work Environment

"I believe this work is profoundly collaborative: We do this work on the shoulders of others and we shoulder others up… isolation looms as one of the greatest threats to sustaining ourselves in this work" (Reynolds, 2010, p. 3,10).

Many community-based counselling services operate within context of a team environment. Given the emotional demand on counsellors and supervisors, a positive workplace environment can contribute to self-care and fuels the work we do. Counsellors witness and see things that most of the population do not, therefore it is crucial to have a community of support to help 'shoulder' each other up (Reynolds, 2010). A positive workplace fosters trust, collaboration, and friendship that enhances personal well-being and positive feelings (Geue, 2018).

The teamwork in community-based counselling programs has many functions that can include:

- group supervision;
- co-vision;
- co-managing caseload and;
- sharing administrative responsibilities.

Supervisors can be fed in our work by creating and sustaining communities of support for the counsellors who walk alongside marginalized and struggling clients. The supervisor has a role in maximizing the potential of the team atmosphere because interpersonal relationships and even friendships within the workplace can play a pivotal role in job satisfaction, performance, team cohesion, and commitment to the agency they work for (Tse, Dasborough, & Ashkanasy, 2008). "The interplay of these dynamics suggests real-world activities that [supervisors] can utilize to engender positivity in the workplace (Geue, 2018, p. 219). Social connections in the workplace enhances vitality, energy, feeling valued, and being productive, and overall engagement. It is important for supervisors to encourage team activities that inspire a deeper, personal connection that might involve fun and play (Geue, 2018).

DUAL RELATIONSHIPS:

Social connections on teams can introduce dual relationships whereby the Supervisor's role can be misunderstood. The potential for boundary blur is high. Unavoidable dual roles should be discussed openly throughout the supervisory relationship and be included in the consent process. For example, you may want to discuss with the supervisee that sometimes you are required to wear different hats (supervisor hat versus social hat) and let them know which hat you are wearing. Always remember your ultimate role as supervisor which involves a strong working alliance but is also evaluative in nature.

Table 6: *Effective Supervision*

EFFECTIVE SUPERVISORY	EXAMPLES OF *EFFECTIVE SUPERVISION* FROM 128 COUNSELLORS	OPPORTUNITIES TO PRACTICE EFFECTIVE SUPERVISION
AUTONOMY	• expressed trust in my ability to work autonomously • gave me flexibility to provide the type of therapy I wanted	• Assess their strengths and give ample opportunity to shine in those areas. For example, if you know that the supervisee is great at sharing knowledge, give them opportunities to show their peers. • If there is something that they have recently learned ask them to share their learning with their peers.
STRENGTHENED SUPERVISORY RELATIONSHIP	• being non-judgemental regarding mistakes • demonstrate trust and confidence in my abilities • making me feel like I am working with them instead of for them • providing a safe space in supervision	• Use evaluation as an opportunity to share all of the things you see them doing well as well as potential for improvement. • When giving feedback be genuine and compassionate. • Focus on strengths as well.
OPEN DISCUSSION	• brainstormed ideas with me • ability to ask difficult or uncomfortable questions regarding my thoughts and feelings and perceived development	• Be open to learning from the supervisee. They may have thought of something you haven't. • Let them know what you have learned from them.
DEMONSTRATION OF CLINICAL KNOWLEDGE AND SKILLS	• strong analysis of transference/countertransference issues • provided concrete examples of potential intervention strategies	• Notice and gently broach topics of transference and countertransference • Model intervention strategies to supervisees
OFFERING FEEDBACK AND REINFORCEMENT	• provided effective feedback • demonstrated the ability to deliver constructive criticism in the most positive manner	• Take some deep breaths and make sure you are emotionally regulated before providing any feedback. • If the supervisee sees your discomfort, it may increase theirs.
ENGAGEMENT AND VALUING SUPERVISION	• listened to tapes and provided ideas • continued to be available if needed • treating the time as important, e.g., not taking phone calls, minimizing interruptions	• Let the supervisee know what you appreciate the supervision time you have with them. • Initiate setting up supervision meetings with the supervisee

Note. Adapted from "Effective and ineffective supervision," by N. Ladany, Y. Mori, & K, Mehr, 2013, The *Counselling Psychologist, 41*(1), pp. 28-47.

Table 7: *Ineffective Supervision*

INEFFECTIVE SUPERVISION	EXAMPLES OF *INEFFECTIVE SUPERVISION* FROM 128 COUNSELLORS	OPPORTUNITIES TO AVOID INEFFECTIVE SUPERVISION
DEPRECIATING SUPERVISION	• she seemed very busy. She often cut supervision hour short • took phone calls during supervision	• Make supervision a priority and let the supervisee know how much you value your time together. • Remove possible distractions from the supervision space so you can focus.
WEAKENED SUPERVISORY RELATIONSHIP	• entered into the relationship in an attacking way • making me feel like I am working for them instead of with them • assumed that his interpretation of my feelings was correct and if I disagreed, I was in denial	• Check with yourself: Have you gotten into a habit of seeing a supervisee in a certain way? Are you jumping to conclusions about the intention or something that happened? Are you asking open ended questions?
INSUFFICIENT KNOWLEDGE AND SKILL DEVELOPMENT	• not very knowledgeable about the population • was not aware of multicultural issues in counselling and shied away from the topic when I would bring it up. • extensive positive feedback with no detail or constructive criticism • insufficient positive encouragement and or feedback about what I did well. • vague and non-specific feedback	• Be transparent and humble about what you know and don't know. It shows the supervisee that you are human and learning too. • If you are unable to come up with constructive criticism, ask the supervisee what areas they would like to improve. • Check in with clients or colleagues to see if there's anything they would suggest are areas to work on.
NEGATIVE PERSONAL AND PROFESSIONAL QUALITIES	• Judgmental • Opinionated • Injects own agenda into work at times • Micromanaging me every step of the way	• Be aware that you may have countertransference (see section on countertransference for ideas on how to address. • Consider engaging in professional development specifically on supervision.

Note. Adapted from "Effective and ineffective supervision," by N. Ladany, Y. Mori, & K, Mehr, 2013, The *Counselling Psychologist, 41*(1), pp. 28-47.

ASSESSMENT, EVALUATIONS, & REPORTING: DOMAIN FOUR

Assessing counselling skills is one of the most challenging responsibilities of the clinical supervisor (Ladany, 2004). Therefore, a supervisory relationship based on "mutual trust and respect serves as the foundation for effective clinical supervision" (Shepard et al., 2016a, p. 167). It is through a combination of carefully thought out choices of methods and modalities that effective assessments take place.

Retrieved from https://pixabay.com/images/search/?pagi=2

Supervision Methods

It is ideal to utilize several different assessment methods that may include **self-report, case conceptualization, consultation, live observation, Interpersonal Process Recall (IPR), modelling/demonstration, co-therapy, arts-based supervision, and self-supervision** (CCPA, 2018; Shepard et al., 2016a). In this next section, we will explore a number of different methods in more detail.

It is important to check-in with the counsellor to see how the methods you have chosen are contributing to their experience and professional development (Guiffrida, Jordan, Saiz, & Barnes., 2007).
If the counsellor is requiring support, it may not be necessary to see a video session but if the goal is to change or shape their skills, then this may be the preferred option (Bernard & Goodyear, 2014).

Table 8: *Methods of Clinical Supervision*

METHOD	PROS OF METHOD	CONS OF METHOD
SELF-REPORT	• Does not require equipment or anything extra from the client • Informal • Time efficient • Can be spontaneous in response to the situation • Least time consuming for supervisor	• Counsellors are notoriously poor judges of their own competence and have been known to only pick up on 50% of the clinical issues present in the session (Bernard & Goodyear, 2014). • *Self-report "is only as good as the observational and conceptual abilities of the supervisee" (Bernard & Goodyear, 2014, p. 164).* • Non-verbal cues are missed
Tips & Recommendations for Self-Report	• Review and name what was observed/experienced in sessions. • Identify what the counsellor perceived worked and didn't work as well but ask the supervisee what led them to this conclusion.	
AUDIO-VIDEO RECORDING Changes in technology has made audio-video recording easier than it was in the past and opens the door to what can be accomplished in clinical supervision. It's important that recorded sessions are planned properly taking into consideration client comfort (Bernard & Goodyear, 2014).	• Can provide insight into client/supervisee relationship issues • Audio is unobtrusive medium • Can be used to suggest other approaches	• Supervisee may feel anxious (usually subsides with experience) • Easy to miss non-verbal cues in audio recordings • Poor sound quality due to limitation of the technology • Can be seen as intrusive to the therapeutic process
Tips & Recommendations for Audio-Video Recording	• Notice opportunities to discuss transference/ countertransference by exploring hunches. • Discuss what is observed about the client's reaction • Notice how well the supervisee is tracking what is being said/expressed by the client. • Notice counselling skills and highlight especially the use of Rogerian skills (attending, empathy, unconditional positive regard, and attunement). • Make specific recommendations for future sessions.	

METHOD	PROS OF METHOD	CONS OF METHOD
DEMONSTRATIONS AND MODELLING *Demonstrations* can be used as an education tool through videos, books, and role-plays. *Modelling* is a more subtle approach whereby counsellors observe the supervisor in action.	• Enlivens the learning process • Helps supervisee gain a different perspective • Supervisee sees how the supervisor might respond • Can be helpful to support counsellors to develop competence in many areas that include relationship building, ethical decision making, problem solving, and self-care (Shepard et al., 2016a).	• Supervisor must be careful not to overwhelm the supervisee with information
Tips & Recommendations for Demonstrations and Modelling	• Review the concept of the skill that is being demonstrated • Ask them to watch for certain aspects of the demonstrations and then practice the skills with you or a partner. • Ask the supervisee to video tape their roleplay and reflect on their skills and experience of practicing the new skill.	
CO-THERAPY Where two counsellors or counsellor and supervisor work together in a counselling session to provide counselling to a client or clients can be helpful. A form of modelling, co-therapy can provide a less experienced counsellor with an opportunity to witness the work of a seasoned therapist (Shepard et al., 2016a).	• Allows the supervisor to model while witnessing the work of the counsellor • Client gets two counsellors instead of one. • Allows the supervisor to support the supervisee with difficult clients.	• The client may lose confidence in the skills of the supervisee • The supervisee may lose confidence in themselves • Can be time consuming • Client may feel outnumbered
Tips & Recommendations for Co-Therapy	• Discuss beforehand the roles of each counsellor in the session. One may want to take a lead while the other may observe and summarize • Let the supervisee know what you want them to look for • Ask the supervisee what their goal for the session might be	

Note. Adapted from B. Shepard & L. Martin, 2012, *Supervision of counselling and psychotherapy: A handbook for Canadian certified supervisors and applicants*. Ottawa: Canadian Counselling and Psychotherapy Association.

TIPS and RECOMMENDATIONS for DECIDING ON THE METHOD OF SUPERVISION

Chose a supervision method that you think the supervisee will respond best to.

Chose a method that you think will help the supervisee learn. Consider their learning needs, changing/shaping/supporting, and evaluating performance.

Consider agency constraints and whether it's feasible to use certain methods.

Use methods that you feel competent in or are interested in learning.

Supervision Modalities

Regardless of the method, a relational approach to supervision is best practice (CCPA, 2018) and has many benefits. Supervision modalities provide a great mix of opportunities to solidify the supervisory relationship. There is no one right modality and utilizing a variety is the preferred approach. Individual, triadic, group, team, and peer supervision are all examples of supervision modalities.

Table 9: *Supervision Modalities*

SUPERVISION MODALITY	DESCRIPTION	CONS OF MODALITY	PROS OF MODALITY
INDIVIDUAL (DYADIC)	Individual supervision with one supervisee and one supervisor has some benefits over shared, or triadic supervision. Individual supervision is the most common of all supervision types.	• Might be intimidating for supervisee with no one else present to observe or break up the intensity of the one-to-one focus. • Potential for boundaries to be blurred and to slip into personal experiences.	• In-depth and safe • Builds confidence • Increases self-awareness • Builds supervisory relationship
PAIRED (TRIADIC)	The literature has demonstrated that counsellors generally support triadic supervision where two supervisors meet with a supervisor at the same time (Shepard & Martin, 2012).	• There is a limit on the amount of personal feedback received. • Not enough time for each member of the triad to discuss their clients.	• Learn from peers' experiences • Counselling experiences are normalized • By witnessing how supervisee is with their fellow supervisee, the supervisor can witness how they may be with clients.
GROUP SUPERVISION	Group supervision involves two or more counsellors who meet for clinical supervision. The challenges are that there is a limit on the amount of personal feedback received and overall there is not enough time for each member of the group to discuss their clients or to have their questions addressed.	• Less opportunity to build self-awareness and reflect on transference/countertransference. • May feel less safe to the supervisee depending on the dynamics of the group.	• Provides multiple perspectives • Opportunity for education • Validates supervisees experiences • Opportunity for team building and support
PEER SUPERVISION OR CO-VISION	Peer supervision is a peer-based model of supervision where peers meet to discuss issues related to their counselling work (Shepard et al., 2016a).	• May be less helpful with new counsellors who require a bit more of a teaching method or guidance in their practice. • No input from others outside the dyad. • Potential to be too personal.	• Can reduce burnout rate • Non-hierarchical and non-evaluative that can create safety • Can contribute to team cohesion

Note. Adapted from B. Shepard & L. Martin, 2012, *Supervision of counselling and psychotherapy: A handbook for Canadian certified supervisors and applicants*. Ottawa: Canadian Counselling and Psychotherapy Association.

Evaluation

It is best to provide feedback that is **"systematic, timely, clearly understood, balanced between positive and negative statements, coming from a credible source, and reciprocal"** (Ladany, 2004, p. 8). In the process of evaluation, supervisors assess.

- job performance,
- progress towards professional development goals,
- explore future learning goals,
- evaluate fitness for practice and competence (SAMHSA, 2014).

It is challenging to assess counsellors accurately based on elusive criterion. For example, research continues to "challenge the assumption that particular types of therapist knowledge, skills, or level of experience determine client outcome" (Bernard & Goodyear, 2014, p.204). Even with room for growth, the field has narrowed down some of the criteria including personal characteristics necessary for positive client outcomes (Bernard & Goodyear, 2014).

Both summative and formative evaluation is required to effectively assess the supervisee's competence. Summative evaluation is a formal assessment of knowledge and skills that the supervisee has demonstrated over a period of time. Often summative evaluations are called performance reviews and are conducted at the end of probation and annually after that. Formative evaluation is conducted informally on a regular basis in supervision sessions. The supervisee learns what they are doing well and what they need to work on. The feedback to the supervisee is meant to improve supervisee skills and client outcome. Generally, supervisors find it easier to give feedback about clinical skills and client welfare than about issues pertaining to the supervisory relationship, counsellors' personality, or professional behaviour (Hoffman et al., 2005).

Evaluation is one of the most essential functions of supervision and is also one that many supervisors struggle with (Bernard & Goodyear, 2014; Ladany, 2004). Evaluation is any information, either direct or indirect, that a supervisor gives to their counsellor about their skills, knowledge, and behaviour (Hoffman et al., 2005). Gatekeeping occurs when the supervisee is not able to provide competent, professional care to a range of clients even after on-going feedback and evaluation (Robinson & Landine, 2016). Feedback is any information, either direct or indirect that a supervisor gives to their counsellor about their skills, knowledge, and behaviour (Hoffman et al., 2005).

TIPS and RECOMMENDATIONS
for PROVIDING EVALUATIONS and FEEDBACK

- Provide the supervisee with a list of the criteria that they will be evaluated on (see Table 10)
- No surprises! Every attempt should be made to give the supervisee feedback prior to the summative evaluation and let them know early in the relationship that you plan to do that.
- Speak openly about receiving feedback and the natural desire to feel defensive and reminding them that evaluation is about support and helping them grow professionally.
- Start with strengths and move to areas for improvement.
- Remember, some people really want and expect constructive feedback.
- Stay focused on the working alliance and relationship with the counsellor because it's central to the work that will continue in supervision. The working alliance and the evaluative role in the supervisory relationship is a dual role and poses an ethical dilemma. You have asked the supervisee to trust you and yet you have power to promote, demote, give pay raise etc. This can be tricky!
- Be compassionate to the stress the supervisee may be experiencing. If they are experiencing red or blue energy (see Figure 5), give them a choice if they would like a break or to continue.
- Check in with the supervisee to see if the feedback is making sense and if they are having any thoughts about what they are hearing?
- Invite feedback about how you can better meet their professional development goals moving forward.
- Stick to what is observed behaviour, not feelings and hunches.
- If the supervisee doesn't agree with the feedback, remind them using relational informed consent - "Do you remember we talked about if you are unhappy with how things are in supervision, that you can always talk to my supervisor?"

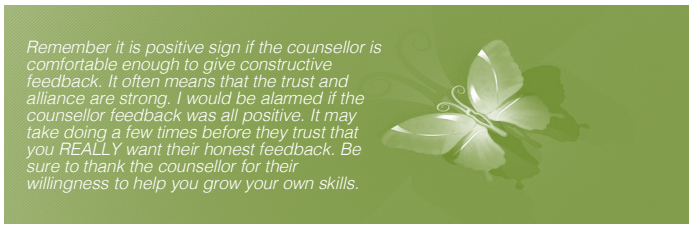
Table 10: *Supervisee Performance Criteria*

COMPETENCY AREA	Needs Improvement	Shows Promise	Able To Perform	Proficient	Excels Consistently
Constructive and integral to the team • Makes time to debrief with others on the team • Recognizes and acknowledge other's strengths • Checks in with team and supervisor throughout the day • Has strong work ethic and takes on their fair share of responsibilities • Can receive and provide feedback as needed					
One to one counselling • Builds rapport and trust with clients • Understands theory that is necessary to use with clients • Demonstrates skills in identified approaches • Understands the depth of client issues					
Crisis interventions • Makes themselves available and flexible with hours • Is reliable to clients • Responds appropriately • Takes initiative in crisis situations and doesn't count on others to take the lead					
Drop-in Environment • Ensures a safe environment • Creates a supportive nurturing environment • Uses creativity while facilitating drop-in • Is organized and ensures there are food and snacks available					
Facilitates support groups • Can facilitate with ease and confidence • Uses appropriate strategies to engage clients • Uses process and content					
Provide outreach services • Engages with a variety of youth • Initiates conversations with staff and clients					
Treatment Planning • Develops goals collaboratively with the client • Assesses youth and family needs • Evaluates client's progress					
Maintains up-to-date records • Completes notes in a timely manner • Maintains organized client files • **Records sessions daily**					
Confidentiality • Maintains confidentiality when discussing clients with other professionals. • Stows files in locked cabinets at all times. • Does not offer youth's names in drop-in or when other youth ask about them					

COMPETENCY AREA	Needs Improvement	Shows Promise	Able To Perform	Proficient	Excels Consistently
Knowledge of community resources • Collaborates with other service providers • Refers youth to the appropriate community resources.					
Other related duties as required • Demonstrates consistent willingness, initiative and skill in taking on duties as required.					
Leadership • Takes on responsibilities without being asked • Follows through on commitments to team and supervisor					
Communication • Communicates what is happening with their caseload in a timely fashion • Responds to all new referrals within 24 hours of receiving it • Always communicates with supervisor about issues of duty to report					
Self-Management • Completes petty cash and mileage regularly and on-time • Arrives on time for work and meetings with clients and in the community • Takes on responsibilities independently without being reminded or asked • Is organized with appointments and commitments					
Service attitude • Represents the agency well in all community professional interactions					
Flexibility • Willing to work weekends as necessary • As necessary takes on duties required to keep program running					
Diversity and Cultural Practices • Understands diversity • Promotes appropriate strategies • Demonstrates cultural humility and openness • Initiates conversations about culture and diversity					
Health and Safety • Takes precautions with youth while working in community • Doesn't meet with youth alone in the program space • Carries naloxone kit					

Promoting a Culture of Feedback

Promoting a culture of feedback requires courage, willingness, and demonstrates respect for the counsellor's wisdom. It also models for the supervisee how to seek feedback from clients. Supervisee's feedback can provide valuable information to the supervisor to continue their own professional development and growth as well as validate areas of strength.



Before asking supervisees to complete an evaluation of your performance (see Table 11), it is important to recognize some of the pros and cons of using this process given the power difference in the relationship.

Pros	Cons
• Supervisees have experienced your work first-hand and probably over a period of time so will likely be able to provide an accurate picture of your strengths and areas • Equalizes power and can contribute to a stronger working alliance. It is a positive message that the supervisees opinions and experience is valued. • Being evaluated by supervisees is an opportunity to improve skills. • Counsellors and supervisors are not the best judges of their own performance.	• There is a chance that the supervisee will not feel comfortable answering honestly if they are worried it will affect their performance evaluation. • In some cultures, it is considered disrespectful to give supervisors or people who are older negative feedback.

Table 11: *Counsellor Evaluation of Supervisor Form*

Name of Counsellor:_____
Supervisor's name: _____
Date: _____

Directions:

PART A: Using the scale below, indicate the degree to which you believe your supervisor has provided the listed supervisory activities.

PART B: Reflecting on your comments in Part A, provide comments on the topics listed below.

PART A					
Supervisory Relationship and Tasks	Almost Never 1	2	3	4	Almost Always 5
1. My supervisor clearly communicates what is expected of me in my role.					
2. On average, my supervisor spends at least one hour per week with me in informally, individual or group supervisory (in staff meetings) sessions.					
3. My supervisor offers constructive feedback in a compassionate way.					
4. I feel comfortable working with my supervisor and they actively listen to me.					
5. My supervisor works with me at my speed and understands my professional growth needs.					
6. My supervisor knows how to be emotionally supportive but doesn't act like my therapist.					
7. My supervisor treats me with respect; we have a positive rapport.					
8. My supervisor is aware of power and uses it in a way that is helpful.					
9. My supervisor engages with me in conversation about diversity issues and cultural competence.					
10. I feel comfortable being honest with my supervisor about my concerns, shortcomings, errors, insecurities, and/or vulnerabilities.					
11.My supervisor gives me helpful feedback for my professional development and counselling workload.					
12. My supervisor encourages a positive work environment by encouraging relationships within the team.					
13.My supervisor and I engage in conversations about client-centred practice, harm reduction, and trauma informed care.					
14. I feel comfortable disagreeing with my supervisor. We resolve differences easily when they arise.					
15. I could benefit from additional feedback from my supervisor for personal and professional growth.					

PART B: Counsellor Comments
How do you think your supervision experience could be improved?
What are some strengths of your supervisor?
Would you recommend your supervisor to another counsellor? Explain.

Note. Adapted from B. Shepard & L. Martin, 2012, *Supervision of counselling and psychotherapy: A handbook for Canadian certified supervisors and applicants.* Ottawa: Canadian Counselling and Psychotherapy Association.

Gatekeeping/Remedial Interventions

Gatekeeping addresses the question of who should or should not be a counsellor. Remedial intervention is sometimes necessary when a counsellor does not demonstrate that they are able to provide professional and competent services to clients. The supervisor's role is to

1) recognize and provide timely feedback in a sensitive way;
2) determine the severity of the conduct, and;
3) develop a remedial action plan (Robinson & Landine, 2016).

Providing feedback is always going to be an important step in gatekeeping and remedial action. Documenting the feedback that is given is crucial. Here are some tips in delivering feedback effectively.

TIPS and RECOMMENDATIONS for DELIVERING FEEDBACK in REMEDIAL SITUATIONS

- Create a culture of feedback by discussing things that you are working on so when feedback is given, it is received with a more open mind and less anxiety.
- Be clear about the problem/impairment, e.g., being late regularly, seeming distracted, treating some clients differently, negative feedback from clients, moodiness, not being forthcoming about work with clients or sharing pertinent information in a timely manner,
- It is sometimes helpful to talk through your concerns with a trusted supervisor especially if it's difficult to put your finger on the issue. Naming the issue is half the work.
- Once you've determined the feedback that must be given, sit down with the supervisee as soon as possible. Remember you are providing the supervisee with an opportunity for professional growth.
- Broach the topic by starting with "I have some feedback I'd like to share with you that has me concerned"

The action plan might consist of recommendations such as

- personal counselling and increased supervision;
- reduced counselling;
- temporarily/permanent cessation of counselling, [and/or] a leave of absence (Robinson & Landine, 2016, p. 81).

If the counsellor is willing and able to work on recommendations and receives feedback openly, this should be taken into consideration, if the impact of their impairment isn't too great (Robinson & Landine, 2016). If the counsellor is unable or unwilling to accept the support or take actions that contribute to improved performance then it may be necessary to coach them out of counselling or terminate them from the position (Robinson & Landine, 2016).

ETHICS & LEGAL ISSUES: DOMAIN FIVE

The fifth domain of competent supervision involves *ethics and legal issues*. Due to the complex demands of therapy, it is essential that both supervisees and their supervisors are well-versed in ethical standards, principles, and ethical decision-making models in Canada. Ladany (2004) asserted that most supervisors have utilized revised versions of ethics related to therapy and are not well-versed in ethical practice expectations for supervisors. The supervisor's primary ethical responsibility is to the client and public (CCPA, 2018).

Code of Ethics

It is incumbent on the supervisor that counsellors understand and practice minimally the six principles of the CCPA Code of Ethics (2007, p.2) that guide practice. The principles include:

(a) beneficence: being proactive in promoting the best interest of the client
(b) fidelity: honouring commitments made
(c) nonmaleficence: avoiding any activities that do or risk harm to clients
(d) autonomy: honouring the client's right to make their own decisions
(e) justice: promoting just treatment to all
(f) societal interest: respecting the need to be responsible to society

The above principles are based on a proactive approach to respecting clients' rights and are intended to highlight the ethical duty counsellors have to guard clients from intentional harm. Additionally, the principles guide practice in the areas of consulting and private practice, research and publication, and education and training and supervision (CCPA, 2015). A detailed outline of the six principles are found in the CCPA Code of Ethics (2007).

Reynolds (2010) asserts that exploring counsellors' relationships with ethics is the heart of supervision. She encourages supervisors to get curious about the ethical stance of the counsellor and how they work alongside marginalized clients (Reynolds, 2010). Delving a little deeper, supervisors have an opportunity to explore what ethics mean to the counsellor. How does it show up for them in how they practice?

Supervisor ethical violations may include but are not limited to confidentiality breaches, cultural sensitivity and awareness, expertise and competency issues, and differentiating counselling from supervision. Ethical violations can have a negative impact on the supervisory alliance (Bernard & Goodyear, 2014; Ladany, Lehrman-Waterman, Molinaro, & Wolgast 1999). According to Ladany et al. (1999), one-third of ethical violations that were reported by counsellors were about unfair evaluative practices.

Confidentiality

TIPS and RECOMMENDATIONS ABOUT CONFIDENTIALITY

- Discuss confidentiality in the informed consent process and at the beginning of the relationship. Try not to just tell them but create opportunity for conversation.
- It's important supervisees know what and with whom information might be shared outside the supervisor/ee relationship. For example, it is common if working within a team of supervisors that a supervisee information may be discussed if it impacts team dynamics or client care.
- Make sure the supervisee knows when information will be shared outside of the expected third party, for example, the safety of clients, or the supervisees safety to self or others (Robinson & Landine, 2016). For example, if issues pertaining to safety arise that could affect the agency, the CEO may have to be informed.

Liability

It is important that supervisors know that they are assuming a greater risk of liability and potential ethical violations when they supervise. People seeking services from professionals have the right to expect that when they seek services that the professional is competent to provide those services. The supervisor is responsible for ensuring that effective counselling is provided to clients.

Lawyers use the term standard of care which means **'did the supervisor conduct themselves in a way that would be considered reasonable for someone in their position?'** That is, the action taken is what the average supervisor would customarily or typically do in similar circumstances.

All supervisors who carry insurance or who are insured by the agency they work for are covered financially through their insurance. Professional liability on the other hand, can have severe consequences if a complaint is launched against the supervisor or supervisee, especially for a regulated or certified counsellor who is acting in the role of supervisor. It may result in **a suspended or revoked registration.**

Those counsellors who do not belong to an association or a regulatory body have less to lose, however, regulation of the counselling profession is occurring across most provinces. Best practice is to belong to a provincial or national association

Table 12: *Negligence vs. Vicarious Liability*

NEGLIGENCE	VICARIOUS LIABILITY
Negligence occurs when a supervisor fails to observe the standard of care or make a reasonable effort to supervise. For example, • during the past year of supervision, the supervisor only reviewed the supervisee's case notes every two months (SAMHSA, 2014). The failure to provide supervision in a consistent and timely manner may have caused injury to a client or may not have provided adequate quality control to the supervisee. This failure would be termed direct liability or the erroneous, improper, or unethical actions or omissions on the part of the supervisor.	Vicarious liability refers to clinical supervisor liability arising out of supervisee acts of commission or omission that impact their clients and implicate their clinical supervisors. There are reasonable limits as to the degree of care, caution, and control that clinical supervisors are expected to exercise, such that findings of vicarious liability will depend on the following criteria being met: • a supervisee must agree to engage in clinical supervision and offer informed consent to be under the direction of a specified clinical supervisor; • the clinical supervisor has the authority to direct the practice of the supervisee; • the supervisee fails to meet the established standard of care within the scope of practice identified by the clinical supervisor; • the clinical supervisor reasonably could have expected the supervisee to competently carry out the action in question (whether the issue is omission or incompetent commission); and • harm or injury ensues as a direct result of omission or incompetent commission of duties.

Note. Adapted from "Clinical supervision of the Canadian counselling and psychotherapy profession," by B. Robinson & J. Landine, 2016, *Ethical and legal considerations and practices in clinical supervision.* pp. 66-97. Copyright by the Canadian Counselling and Psychotherapy Association.

TIPS and RECOMMENDATIONS THAT PROTECT THE SUPERVISOR

- Let the supervisee know clearly that there is an expectation for them to inform you right away if a safety issue has come up in a session so that action can be taken right away.
- Document all conversations with supervisees where a directive has been given about safety issues.
- At the beginning of each supervision session ask the supervisee if there are any safety issues with clients that you should know about.
- Pay special attention and address any issues of dual relationships, unprofessional (discourteous, uncompassionate) behaviour, lack of adherence to client confidentiality.
- Always treat supervisees with dignity and respect.
- Document all ethical dilemmas and the process that preceded the decision.

Ethical Dilemmas

As important as codes of ethics and standards of practice are, many scenarios don't fit into a tidy box where a resolution is obvious. Most codes offer ethical decision-making models that provide step by step suggestions to work through complicated and layered scenarios that do not have straight forward resolutions. Three ethical dilemma tools have been included in this manual to support a process of working through dilemmas that do not have straightforward resolutions:

- The Five Ethical Tests,
- Virtue-Based Ethical Decision-Making, and;
- SAMHSA Ethical Dilemma Flowchart

It is important that the ethical decision-making process is documented clearly in case the decision comes into question.

The Five Ethical Tests

One of the ways that supervisors can assess whether they are making a sound decision about an ethical dilemma is to run the scenario through the following tests. (CCPA, 2007, p. 4)

What is the Ethical Dilemma?		
Type of Test	**Ask Yourself:**	**Comments:**
1.Publicity Test	Would you want your action, along with your name, to be published in the local newspaper? On social media?	
2.Reversibility Test	Is this how I would want to be treated, if the situation were reversed- if I were the supervisee or client?	
3.Professional Test	What would a committee of my peers say about my actions? What would a person of high moral character say?	
4.Universality Test	Would you make the same decision with other supervisees/clients?	
5.Test of Gain	Do I gain more than the supervisee or client by my decision? E.g., Gain power? Gain fame? Gain strokes or relief of not having to do my job?	
Now that you have completed the 5 ethical tests reflect on the ethical dilemma. How do you think about the decision now?		

Virtue-Based Ethical Decision-Making

The virtue ethics approach (CCPA, 2007, p.4) is based on the belief that counsellors are motivated to be virtuous and caring because they believe it is the right thing to do.

Virtue ethics focus on the counsellor as an ethical agent with the capacity to make complex ethical decisions. Although there is no step-by-step methodology for virtue ethics, the following questions may help the counsellor in the process of virtue-based ethical decision-making:

1. What emotions and intuition am I aware of as I consider this ethical dilemma and what are they telling me to do?

2. How can my values best show caring for the client in this situation?

3. How will my decision affect other relevant individuals in this ethical dilemma?

4. What decision would I feel best about publicizing?

5. What decision would best define who I am as a person?

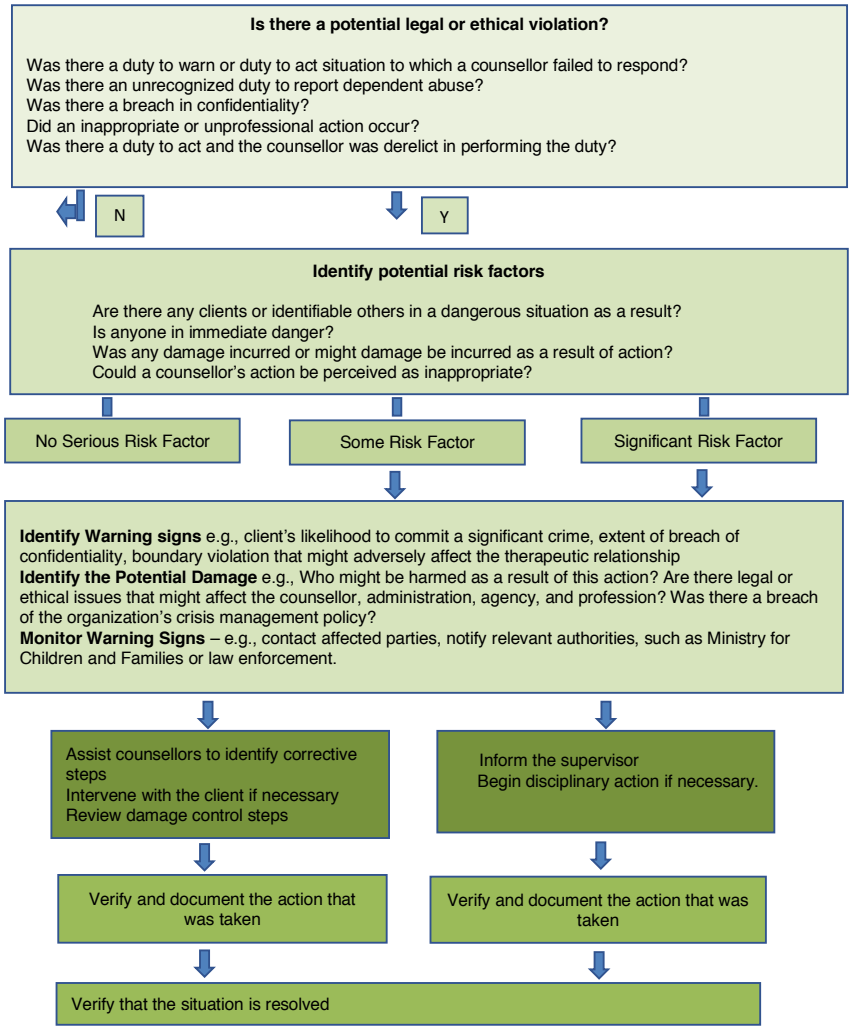
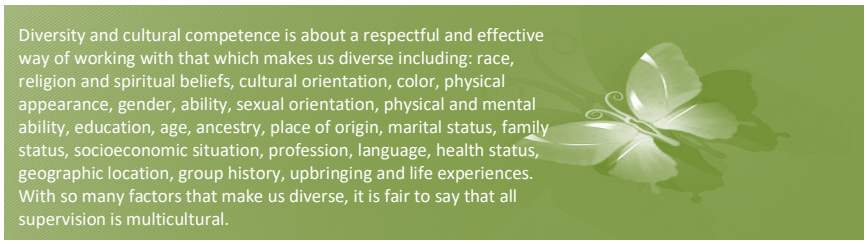


Figure 7. **Virtue-Based Ethical Decision-Making Flowchart**.
Copied directly from "Clinical Supervision and Professional Development of the Substance Abuse Counselor," 2014, *Substance Abuse and Mental Health Services Administration [SAMHSA].* Retrieved from https://store.samhsa.gov/system/files/sma14-4435.pdf

DIVERSITY AND SOCIAL JUSTICE: DOMAIN SIX

"Embracing diversity is one adventure after another, opening new paths of discovery that connect an understanding to caring, listening, and sharing with others who are different than ourselves."
-April Holland



Counselling has deep roots in Western ideology that doesn't take into conside ration the complexity of other ways of knowing and being (Prochaska & Norcross, 2015). Clinical supervision can be an entry point whereby conversation, counsellor development, self-efficacy, and a stronger counsellor/supervisor working alliance develop (Hook et al., 2016). Counsellors feel more confident in their work when supervision is a place where conversations about diversity are not only embraced but initiated by the supervisor (Crockett & Hays, 2015). By demonstrating awareness of diversity and conveying warmth, supervisors not only improve the supervisory alliance but also demonstrate multicultural competence (Walker et al., as cited in Crockett & Hays, 2015).

This section focuses on the importance of both the supervisor and the counsellor's development of cultural competence. Starting with a framework of non-oppressive interpersonal development, the focus is on the development of cultural competence at micro and macro levels. Next there is a focus on how to manage and reduce power in the supervisory relationship followed by a focus on promotion of decolonizing practice. The following section is focused on social justice in counselling and tools and suggestions for how to work in a culturally informed way conclude this section.

Heuristic Model of Non-oppressive Interpersonal Development Model (HMNID)

Cultural competence and racial identity of the supervisor influences and can stunt the cultural development of the counsellor (Ladany, 2004). This is especially noticed when the supervisor and counsellor are at different stages of development along the continuum that names four stages of multicultural awareness and competence.

Table 13: *HMNID Levels of Development*

LEVEL	DESCRIPTION	WHERE ARE YOU?	WHERE IS THE SUPERVISEE?
ADAPTATION	The supervisor/ee has limited awareness of oppression but recognizes ethnic and racial differences. This stage is recognized by complacency, apathy, and conformity.		
INCONGRUENCE	The supervisor/ee's beliefs about difference begin to be challenged. There is a tension and confusion between old and new beliefs and experiences. Behaviours stay the same as in stage one.		
EXPLORATION	The supervisor/ee's behaviour changes occur that create congruence between beliefs and behaviour.		
INTEGRATION	The supervisor/ee's self-awareness is high and the individual can recognize oppression and actively work toward producing change in others and their environment.		

Note. Adapted from "A Synergistic Model to Enhance Multicultural Competence in Supervision," by A. Ober, D. Granello, & M. Henfield, 2009, *Counselor Education and Supervision, 48*(3), p. 204-221.

According to this model, there are three types of relationships that supervisors and counsellors have: progressive, parallel-advanced, and regressive (Ober, Granello, & Henfield, 2009). It can be challenging when the counsellor is in a higher stage of cultural awareness and competence than the supervisor which is quite common with more experienced supervisors who do not have current professional development about diversity.

1. ***Progressive relationship*** occurs when the supervisor is further along the continuum than the supervisee. The supervisor should encourage the supervisee to seek training around issues of diversity.
2. ***Parallel-advanced or parallel-delayed*** takes place when both supervisor and supervisee are at similar stages of development
3. ***Regressive*** transpires when the supervisee is further along in their awareness than the supervisor. The supervisor should seek out opportunities for training in cultural competence and decolonizing practices.

It makes sense, then, that supervisors strive to develop their cultural competence in order to aim for a progressive or parallel advanced relationship with their counsellor (Ober et al., 2009).

Development of Cultural Competence

Skills, Knowledge and Attitudes

It is through the focus on *our* knowledge, *our* skills, and *our* values and beliefs that cultural competence is developed, and unconscious bias is mediated. It's important as we develop cultural competence to identify the areas of strength and areas where more work is needed. The following exercise will help identify which domain (skills, knowledge, values, and attitudes) requires the most time and attention as you develop your cultural competence.

Table 14: *Exploring Supervisor's Knowledge/Skill/Values and Beliefs*

Reflect on the following two questions:

1. Reflect on a situation in which you were involved in providing support to a counsellor where either the counsellor or client's background was significantly different from your own.
2. Identify three instances in which you were aware of being satisfied and/or dissatisfied with how you handled the situation. What made you feel this way?

Once you have had an opportunity to answer both questions, answer the following questions based on the themes or examples identified:

In what way was the satisfaction and/or dissatisfaction I experienced related to my knowledge/lack of knowledge about

		True
1.	The counsellor/client's needs?	
2.	The counsellor/client's cultural background? (can include ethnicity, gender, sexual orientation, ability, etc.)	
3.	The counsellor/client's language or communication patterns?	
4.	The institutional barriers that the counsellor/client faces? Or experiences of power?	

In what way was the satisfaction and/or dissatisfaction I experienced related to my skill or lack of skill in:

		True
4.	Accurately understanding the counsellor/client's needs within their presenting situation?	
5.	Accurately communicate my understanding of the counsellor/client's needs?	
6.	Building a strong and trusting relationship with the counsellor?	
7.	Advocating on the counsellor/client's behalf?	
8.	Selecting and implementing appropriate action/counselling strategies?	

In what way was the satisfaction and/or dissatisfaction I experienced related to my values and beliefs:

		True
9.	My beliefs/assumptions about the counsellor/client's culture?	
10.	My beliefs about them working with extended systems of care (e.g., family, elders) and confidentiality?	
11.	My beliefs about what *should* be done based on an individualistic cultural background?	
12.	My belief that I know what interventions are best for the client?	

Note. Adapted from "Counselling Alberta's Aboriginal youth: A Manual of What Helping Professional Must Know," C. Ladouceur, 2013, *(Unpublished master's project).* University of Lethbridge, Lethbridge, AB, Canada.

Ecological Model of Cultural Competence
In recognition that problems do not exist in a vacuum, consideration must be given to change on all levels that our supervisees and clients interact with including individual, agency, and political levels. Microsystem changes address the immediate environment, for example, counsellors and supervisors. The macrosystem are the agency level changes while metasystems are societal changes.

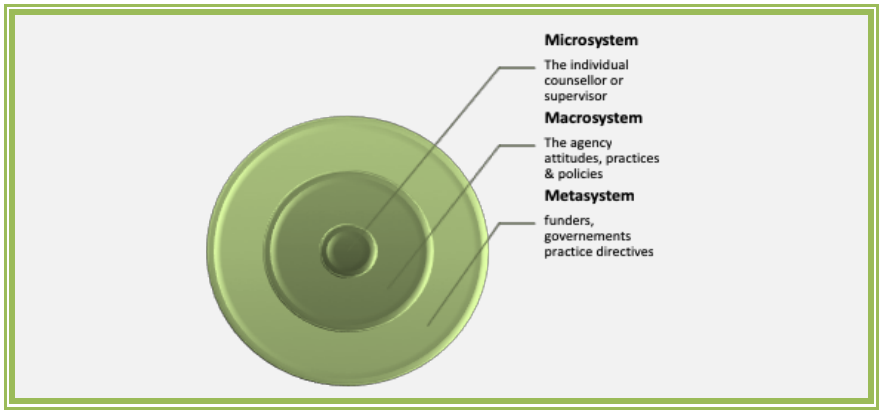


Figure 8. **Ecological Model of Cultural Competence.** Adapted from "Promoting System-Wide Cultural Competence for Serving Aboriginal Families and Children in a Midsized Canadian City," by R. Ambtman, S. Hudson, R, Hartry, & D. Mackay-Chiddenton, 2010, *Journal of Ethnic and Cultural Diversity in Social Work, 19*(3), pp. 235-251. doi:10.1080/15313204.2010.499328

Microlevel cultural competence. The American Psychological Association [APA]; 2015) have four suggestions for the development of cultural competence by supervisors:

1. Develop and maintain self-awareness regarding diversity competence, which includes attitudes, knowledge, and skills (APA, 2015).
2. Strive to enhance diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of counsellors (APA, 2015).
3. Recognize the value and pursue ongoing training in diversity competence as part of professional development and lifelong learning (APA, 2015).
4. Recognize the importance for supervisors to be knowledgeable about the effects of bias, prejudice, and stereotyping.

Macrolevel cultural competence. Supervisors are in a privileged position to influence, on some level, agency policies. The APA (2015) encourages supervisors to model social justice through client advocacy and to promote change in organizations and communities that are in the best interest of their clients. Some examples of how agencies can become more culturally competent include:

1. Changing how they do business by looking at hiring practices and how they support religious or cultural needs of the staff.
2. Advocating for metalevel changes with funders, governments, and other systems that impact clients.
3. Seeking to hire and retain staff in all capacities (especially at upper- and middle-management levels) who represent the clients the agency serves.
4. Supporting diverse staff to obtain professional credentials.

5. Providing cultural training and opportunities for a diversity of staff voices to be heard.
6. Developing appropriate conflict resolution mechanisms.
8. Recognizing and validating lived experience, cultural skills, knowledge, and values in hiring and performance review processes,
9. Developing the organization's relationships with and accountability to the communities it serves, and
10. Developing a management structure that models culturally competent practice.

Adapted from "Promoting System-Wide Cultural Competence for Serving Aboriginal Families and Children in a Midsized Canadian City by R. Ambtman, S. Hudson, R. Hartry, R, & D. Mackay-Chiddenton, 2010, *Journal of Ethnic and Cultural Diversity in Social Work, 19*(3), pp. 235-251. doi:10.1080/15313204.2010.499328; "Counselling Alberta's Aboriginal youth: A Manual of What Helping Professional Must Know," C. Ladouceur, 2013, *(Unpublished master's project).* University of Lethbridge, Lethbridge, AB, Canada.

Cultural Humility

Cultural humility is the antidote "to issues of diversity or microaggressions" (Hook et al., 2016, p.153). Approaching supervision from a not-knowing stance addresses assumptions more quickly, and levels the power dynamics innate in relationships between supervisor and counsellor (Watson, Raju, & Soklaridis, 2016). Being in the not-knowing or learning stance facilitates self-reflection and demonstrates an attitude of respect, collaboration, and openness (Hooks et al., 2016; Watson et al., 2016). A culturally humble clinical supervisor is aware of their own worldview and biases, and models valuing other perspectives and working to reduce bias or blindspots. Most importantly, they "make culture a welcome part of the supervisory conversation" (Hook et al., 2016, p.154).

TIPS and RECOMMENDATIONS for CULTURALLY HUMBLE SUPERVISION

- Ask open-ended questions that aim to explore and better understand supervisee's cultural background and experiences.
- Acknowledge a lack of understanding when you don't know.
- Make statements that specifically communicate respect for the culture of the client and supervisee, for example, use 'they' if that is their pronoun.
- Approach supervision from a 'not knowing' perspective, suspending judgements (Hook et al., 2016).

Mapping Your Cultural Orientation

Individuals demonstrate a wide range of values and preferences across a variety of cultural dimensions. Map your own cultural orientation by placing an x at the spot that most accurately reflects your values on each continuum below. Remember that a continuum represents an infinite number of possibilities between the two opposing ends. There are no right or wrong answers

Monochronic		**Polychronic**
I like to be on time and expect the same of others.		What happens is more important than when it starts and ends.
Low Context		**High Context**
When rules are presented, I prefer that every detail is spelled out clearly.		Some rules are understood by everyone so it's not necessary to spell everything out.
Individualistic		**Collectivistic**
I prefer to work independently and be recognized independently.		I prefer to work as part of a group and think it's better than when individuals are not singled out.
Egalitarian		**Hierarchical**
All people should be treated the same, no matter what their position is.		People should be treated differently depending on their title, position, and rank.
Task Focused		**Relationship Focused**
When working on a project, I prefer to focus on getting the job done and become inpatient with socializing.		When working on a project, I value time spent time building relationships and work better with people when I get to know them.
Surfacing Differences		**Maintaining Harmony**
I directly address differences when there is an issue so the problem can be solved quickly.		I prefer to deal with differences indirectly behind the scenes, to avoid causing upset.
Emotionally Restrained		**Emotionally Expressive**
It's better to keep emotions private.		It's better to express emotions openly.
Being		**Doing**
I derive more of my identity from who I am and who my family is.		I derive more of my identity from what I do: schoolwork, activities, etc.

Reflection

- How does your cultural orientation help you in your life?
- How does your cultural orientation hold you back in your life?
- How is your cultural orientation map similar or different from your peers?
- Which traits are difficult for you to deal with in other people?

Review

Highlight each category that may reflect a particular cultural affiliation

Figure 9. **Mapping your Cultural Orientation**. Published with permission to use from Dr. Noella Piquette, University of Lethbridge

Power in the Supervisory Relationship

Power is inherent in the supervisory relationship, especially in the workplace where counsellors are not able to choose their supervisor (Courtois, 2018). It is critical that supervisors are aware of the responsibility they have to exercise an ethical use of power (Barstow, 2008; Stefano, Hutman, & Gazzola, 2017). In addition to the power imbalance inherent in the hierarchy of the supervisory relationship, it may be experienced differently or more intensely when the cultural backgrounds, including gender, ethnicity, and/or the sexual orientation between the supervisor and counsellor are different.

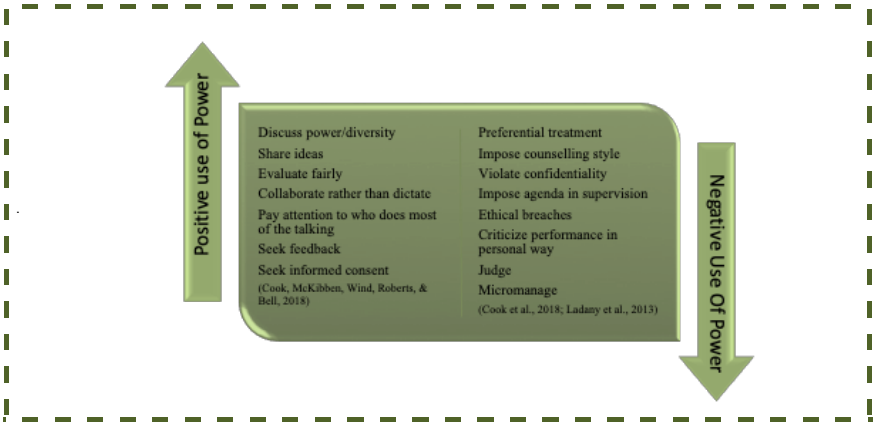


Figure 10. **Positive and Negative Uses of Power in Clinical Supervision**. *Adapted from "Issues & Ethics in the Helping Professions" by G. Corey, M. Corey, & C. Callanan, 2015, Stamford, CT: Cengage Learning*

Ethical violations do impact the supervisory alliance, yet, because of the power differential, only one-third of counsellors will bring ethical issues to the supervisor's attention (Ladany et al., 1999).

Supervisor/Counsellor Power Versus Counsellor/Client Power (Stefano et al., 2017):

1. The counsellor doesn't usually get to choose their supervisor and doesn't have a choice but to receive clinical supervision.
2. Clinical supervision involves an evaluative process with high stakes that could result in loss of employment due to the gatekeeping role that is the responsibility of the supervisor.

Power is rarely talked about in clinical supervision and when it is, it's usually the counsellor who brings it up (Stefano et al., 2017).

By initiating a conversation about power in therelationship, you are acknowledging what the counsellor is already feeling. Check out some other ideas to reduce power structures in the supervisory relationship below.

Decolonizing Practices

Incorporating decolonizing practices into supervision challenges western notions of counselling, healing, and ways of knowing (Smith, 2015). Given that Indigenous people are overrepresented in the mental health and addictions systems of care, it is incumbent on supervisors to engage in conversations that support knowledge and skill development in this area (Ladouceur, 2013). Working with Indigenous clients may require supervisees to have advanced understanding of intergenerational trauma, cultural oppression, and integrating spirituality into counselling practices (Smith, 2015). Supervision that reflects decolonizing practice may include recognizing limitations of western healing practices and necessitate involvement of the client's Indigenous community of support (Smith, 2015).

> *"Culture is treatment...the resiliencies and strengths of Aboriginal culture are the most effective tools to promote the healing of urban Aboriginal youth"*
> *(Ladouceur, 2013, pp.53, 56)*

A common misconception: The term elder is not speaking about age alone. Elders are keepers of traditional knowledge that bridges the past and present. It is a term of respect. There are political elders and spiritual elders. Political elders focus on socio-political and cultural needs whereas spiritual elders focus on spiritual guidance towards a path of healing.

Table 15: *Evaluation of Supervisor's Indigenous Competency*

Rate your current level of competency to incorporate Indigenous culture in your supervision process.
Please rate as follows: 1= Poor, 2= Fair, 3= Good, 4= Very Good, 5= Excellent
Once you have rated yourself, indicate your plan to address those areas in which you rated your current level as poor or fair.

	Question	1 Poor	2	3	4	5 Excellent
1	The physical environment of my office visibly welcomes and celebrates all Indigenous people and reflects a place of safety, belonging, and trust.					
2	Those who I supervise understand the diversity of Indigenous culture in B.C.					
3	Those who I supervise have knowledge of Indigenous cultural beliefs, practices, and ideas of health.					
4	I have encouraged supervisees to be educated about the legacy of residential school and its intergenerational impacts.					
5	Supervisees have knowledge of the issues and barriers experienced by urban Indigenous clients.					
6	Supervisees assessments, case conceptualizations, and treatment plans account for the barrier's clients face in their everyday lives.					
7	I encourage supervisees to connect clients to family and significant community members in family and/or group therapy.					
8	Supervisees' work with urban Indigenous youth is grounded in the principle of "culture as treatment."					
9	Supervisee's treatment plans are client-driven, flexible, and incorporate a variety of both Indigenous healing and western therapeutic interventions.					
10	My supervision practices restore belonging, hope, and self-determination in youth.					
11	When appropriate, I help supervisee's increase their self-esteem by restoring pride in their cultural identity.					
12	When using narratives and stories in counselling, I choose stories that illustrate the humour, strength, and resilience of urban Indigenous people.					
13	I bridge supervisees to culturally appropriate traditional healing practices such as: • Elders • Healing, talking, or sharing circles • Traditional ceremonies • Cultural teachings					
14	I bridge supervisee's to appropriate community services that can support and maintain their healing such as: • Indigenous organizations • Housing services • Childcare • Employment agencies • Educational funding • Cultural programs • Community					
15	I support multidisciplinary and inter-agency practices.					
16	I encourage supervisees to provide advocacy for clients who require support.					
17	I receive guidance and support from respected Elders and traditional teachers.					

Note. Adapted from "Counselling Alberta's Aboriginal youth: A Manual of What Helping Professional Must Know," C. Ladouceur, 2013, *(Unpublished master's project).* University of Lethbridge, Lethbridge, AB, Canada.

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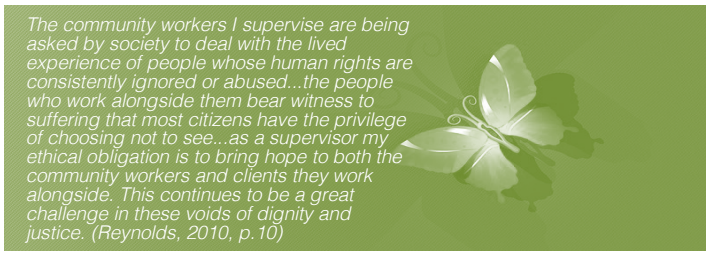
TIPS and RECOMMENDATIONS for DECOLONIZING PRACTICES

- Practice cultural humility (see previous section).
- If possible, hire Indigenous people who may have less education than is required and be prepared to assist them in obtaining training. Consider the value of how their lived experience makes up for it.
- Consult with Indigenous people before implementing practices that directly affect them and provide honourariums.
- Incorporate group work into programming and seek an elder to co-facilitate.
- Build trust by hosting lunches, sharing circles, advisories, and providing honourariums.
- When consulting always provide tobacco and an honourarium.
- Complete the Supervisor Indigenous Competency to evaluate your practice.

Social Justice at the Heart of Counselling

Many of our clients and families come from experiences of oppression, marginalization, and trauma. To separate counselling from social justice and advocacy ignores, in many cases, the root struggle that clients face such as racism, colonization, homophobia, sexism, poverty, and violence. Social justice is about contesting neutrality whether by engaging in naming the oppression or by taking action (Reynolds, 2010).

According to Reynolds (2010), there is nothing neutral about community work with people who are marginalized. Additionally, she asserts that community workers are resisting all the time, but don't recognize it for what it is- *justice doing* (Reynolds, 2010*)*. Justice doing is about resisting neutrality and recognizing power structures. It is a call to action, a collective approach to systemic issues whereby counsellors work together to support one another's efforts to create meaningful change. Collective care is "relational, reciprocal and communal" (Reynolds, 2010, p. 65) and is the antidote to burnout.



TIPS and RECOMMENDATIONS for SOCIAL JUSTICE in SUPERVISION

Name oppressive structures that contribute to the struggles that our supervisees/clients experience: abuses of power, poverty, colonialism, racism, and homophobia. Clients who live in the margins of society are exposed to a daily barrage of discrimination that can contribute to pathology. Speaking about pathology in contextual terms helps externalize the problem and is more strengths focused. Addictions, mental health issues, poverty, and abuse do not exist in a vacuum.

Model resistance to being cynical towards the agencies and organizations that are trying to help: Resources are limited and far from perfect. Criticism of the very agencies that are there to support may alienate the supervisee/client in a time of need.

Support supervisee using advocacy when clients are being harmed even within our own workplace. Remember that advocacy can also make things worse for clients so exercise caution when approaching power structures where advocacy might reduce access to support and resources.

Develop and model tolerance for discomfort. Sometimes conversations about abuse or misuse of power or oppression can be difficult especially when from the dominant culture. Change happens in the context of discomfort.

Encourage supervisee to listen for "no." It is not always easy for people who have less power to say a clear "no." Look at body language, what they don't say, silence, and pauses for the "no." Frame suggestions as options.

Foster a spirit of critique: while being cautious to cynicism.

Change language: Model the use of non-binary pronouns and any other appropriate language such as Indigenous instead of First Nations where appropriate.

Becoming an ally: Show up to witness other's oppression and be prepared to respond to the backlash.

Broaching Spirituality/Religion

It is not required in supervision but spiritual and religious beliefs and practices (SRBP) can be extremely relevant to supervisee support, contributing to improved mental and physical health outcomes (Saunders, Miller, & Bright, 2010). Supervisor's recognition of spiritual and religion in client's lives contributes to culturally informed care. Counsellors and supervisors are sometimes reluctant to engage in conversations about SRBP out of fear of ethical violations and appearing to proselytize or judge. There is a continuum of spiritual care that ranges from an avoidance of talking about it to a direct and explicit focus on spirituality and religion in the counselling relationship (Saunders et al., 2010).

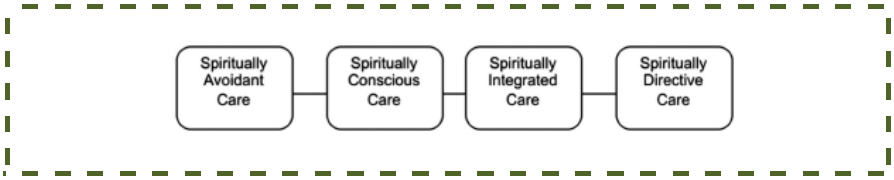


Figure 11. **Continuum of Spiritual Care**. Adapted from "Spiritually Conscious Psychological Care," by S. Saunders, M. Miller, & M. Bright, 2010, *Professional Psychology: Research and Practice*, *41*(5), pp. 355-362. doi:10.1037/a0020953

Spiritual Conscious Care

There is opportunity in supervision to model spiritually conscious care by engaging in conversations with supervisees about the role of spirituality in their own life, and how it's helped them through challenging times and supported their self-care practices. It is integral to ethnicity and culture. Spiritually conscious care encourages conversations about spirituality and religion from a place of curiosity and interest without inserting 'self' into the conversation (Saunders et al., 2010).

Supervisors worry about competence when incorporating spiritual conversations into supervision. Here are some tips and recommendations that may help.

	Category	**Sample Questions**
H	Source of hope	What are your sources of hope, strength, comfort, and peace? What do you hold on to during difficult times?
O	Organized religion	Are you part of a religious or spiritual community? Does it help you? How?
P	Personal spirituality and practices	Do you have personal spiritual beliefs? What aspects of your spirituality or spiritual practices do you find most helpful?
E	Effects on medical and end-of-life issues	Does your current situation affect your ability to do the things that usually help you spiritually? As a supervisor, is there anything that I can do to help you access the resources that usually help you?

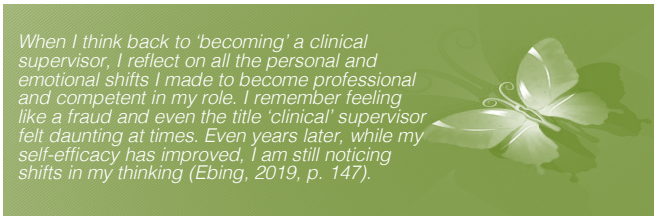
Figure 12. **HOPE for Spiritual Assessment Tool**. Adapted from "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment," by G. Anandarajah & E. Hight, 2001, *Journal of Osteopathic Medicine, (4)*1, p. 31. Doi:10.1016/s1443-8461(01)80044-7

TIPS and RECOMMENDATIONS for SPIRITUALLY CONSCIOUS CARE

- This approach is an exploration of the supervisee's beliefs that help them cope and with self-care. Do not try to influence the supervisee's spiritual activities or beliefs.
- Be transparent with the supervisee that you would like to acknowledge if there is a role that spirituality plays in their self-care and coping. Be clear with them that this is not a philosophical discussion of religion or spirituality.
- Until you are comfortable with *spiritually conscious* care it's probably best to avoid spirituality and religion in conversations with supervisees. Like other issues of diversity, it might be good to obtain support and training from a supervisor who is competent in this area.
- Be sensitive, respectful, and curious how their spiritual or religious beliefs help them in challenges in counselling. For example, if a client passes away or relapses, are there SRBP that help them to cope or make sense of things during these times? Are there aspects of their own spirituality and beliefs that will help them cope and practice self-care?
- Use the HOPE questions (above) to engage in conversations.
- **Do not share your own spiritual or religious beliefs and practices even if you share the same religious faith as the supervisee.**

PROFESSIONALISM: DOMAIN SEVEN

The final and seventh domain covers professionalism. Professionalism entails a shift in supervisor and counsellor mentality, managing countertransference and practicing and promoting self-care.



Developing Professionalism in the Supervisor

New supervisors go through a transition whereby self-efficacy is developed. Novice supervisors have noticed a redirection of their professional mindset from therapist to supervisor. It may take time to adjust to not directly treating the client but rather supporting the counsellor to develop their skills and develop an appreciation of their own self-efficacy. (Bernard & Goodyear, 2014).

It can be helpful to know that there are four predictable stages of development that most new clinical supervisors go through as they transition into their role as clinical supervisor.

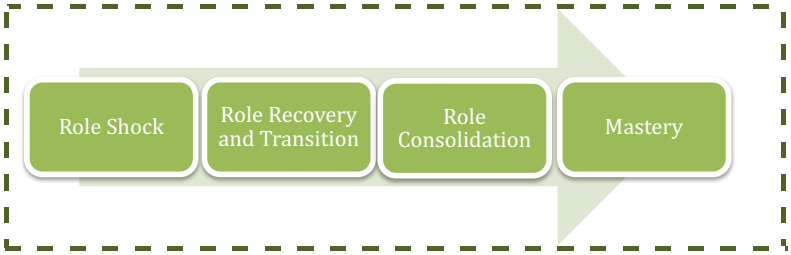


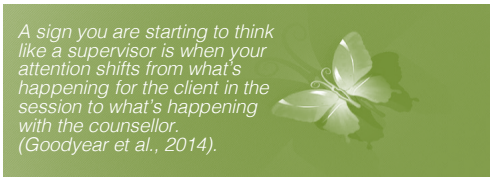
Figure 13. **Four Stages of Supervisor Development**. Adapted from "The Developmental Process of Clinical Supervisors in Training: An Investigation of the Supervisor Complexity Model," by S. Baker, H. Exum, & R. Tyler, 2002, *Counselor Education and Supervision, 42*(1), p. 15.

Table 16: *Cognitive and Emotional Shifts of a Supervisor*

COGNITIVE AND EMOTIONAL SHIFT	DESCRIPTION	TIPS & RECOMMENDATIONS IN SUPERVISION SESSIONS
BECOMING ABLE TO PERCEIVE/ACT ON COMPLEX RESPONSE OPPORTUNITIES	It takes time to realize how complex the role of supervisor is. Not only is the supervisor supporting the professional development of the counsellor but is also ensuring the client's well-being.	Try verbalizing your hunches about what is going on with the client as well as verbalize hypotheses of what might be going on between the client and the supervisee.
LEARNING TO THINK LIKE A SUPERVISOR	There is a socialization process that occurs as the supervisor starts to identify where to focus their attention, and which attitudes to adopt. Learning to think like a supervisor can be more challenging for someone who was a counsellor for a long time prior to becoming a supervisor because of entrenched ways of thinking.	Focus your attention more on the supervisee than the client. Be aware of playing favourites with certain supervisees.
DEVELOPING THE ABILITY TO BE ONESELF	One begins to allow one's 'self' to emerge is a gift that can be given to the counsellor as they develop their own voice	Take more risks with self-disclosure and mistakes keeping in mind what's appropriate.
LEARNING TO VIEW ONESELF AS A SUPERVISOR	An identity shift happens over time in which the supervisor settles into their role and has success. It starts to feel less like a role and more as an identity. A shift occurs where the supervisor thinks "I am a supervisor" not "I'm being a supervisor."	Take risks and be more directive. Share your professional opinion! You likely have many years of experience that gives you an understanding of the issues that the supervisee may not have.
PROFESSIONAL IDENTITY EVOLVING	One's identity solidifies as one uses critical self-reflection as a way to monitor bias and worldviews that impact those we supervise. The supervisor develops the capacity to use self-reflection as a tool to monitor biases and effect on others. The supervisor demonstrates openness and builds trust in others.	Check things out with the supervisee. Discuss issues of culture and diversity by sharing and asking about cultural bias. Name your privilege/oppression with the supervisee.

COGNITIVE AND EMOTIONAL SHIFT	DESCRIPTION	TIPS & RECOMMENDATIONS IN SUPERVISION SESSIONS
DEVELOPING CONFIDENCE IN ONE'S JUDGMENTS ABOUT WHAT CONSTITUTES EFFECTIVE COUNSELLING	Over time the supervisor develops confidence in their ability to assess counsellor efficacy through observation methods that extend beyond self-report but also include audio/video taping and group supervision.	Practice giving feedback to the supervisee about their strengths and areas of growth. Start by consulting with a more senior supervisor if you are not sure. This will allow you to name the issues in a concise and clear manner when you do give feedback.
DEVELOPING CONFIDENCE IN ONE'S COMPETENCE AS A SUPERVISOR	The role of supervisor carries responsibility that may feel hard at first. As time passes it's important that the supervisor receives supervision and obtains feedback from the counsellor in order to obtain accurate feedback	Let the supervisee clearly know that you must be informed about safety issues as soon after the session as possible. When confronted with an issue, think out loud so that they can hear your critical thinking processes about scenarios as they emerge. Ask the supervisee for feedback or if there's anything more they require from you.
DEVELOPING PATIENCE WITH THE PROCESS OF COUNSELLOR DEVELOPMENT	New supervisors can become distracted by new counsellors 'getting it right' as a reflection of their own capacity as a supervisor. The focus starts to shift from themselves and to the counsellor as they focus on the counsellor's functioning and relax into their new role.	Even when the supervisee is learning, remain strength based pointing out what they are doing well. Ask them powerful questions (instead of telling) that may help illuminate and encourages reflection.
DEVELOPING THE COURAGE TO DO THE RIGHT THING IN THE GATEKEEPER ROLE	Given their responsibility to clients and society, it can be challenging for the supervisor who has developed a close connection with the counsellor to always do the 'right thing.'	Be open to the idea that not all supervisees are meant to be counsellors. Consult a supervisor if you think that this is happening.
LEARNING TO UNDERSTAND AND MANAGE POWER	The more the supervisor seeks to understand and recognize power in the supervisory relationship, the more prepared they will be to manage and address it effectively.	Encourage their ideas and thoughts. Be as transparent as possible about internal processes or why you have made certain decisions about client.

Note. Adapted from "Ten Changes Psychotherapists Typically Make as They Mature in the Role of Supervisor," by R. Goodyear, J. Lichtenberg, K. Bang, & J, Gragg, 2014, *Journal of Clinical Psychology: In Session, 70*(11), pp. 1042-1050. doi:10.1002/jclp.22125



Building Supervisor Resilience

The emotional and physical impact of focusing on the well-being of others, and the stresses of working in a complex system of care, can contribute to compassion fatigue and vicarious trauma in the counsellor and supervisor (Robinson & Landine, 2016). Some signs are:

- Regularly not feeling regulated (fight, flight, freeze)
- Trouble sleeping
- Increased substance use
- Feelings of anxiety or depression
- Lack of enjoyment in things that once brought enjoyment
- Isolating self
- Persistent thoughts about the experience

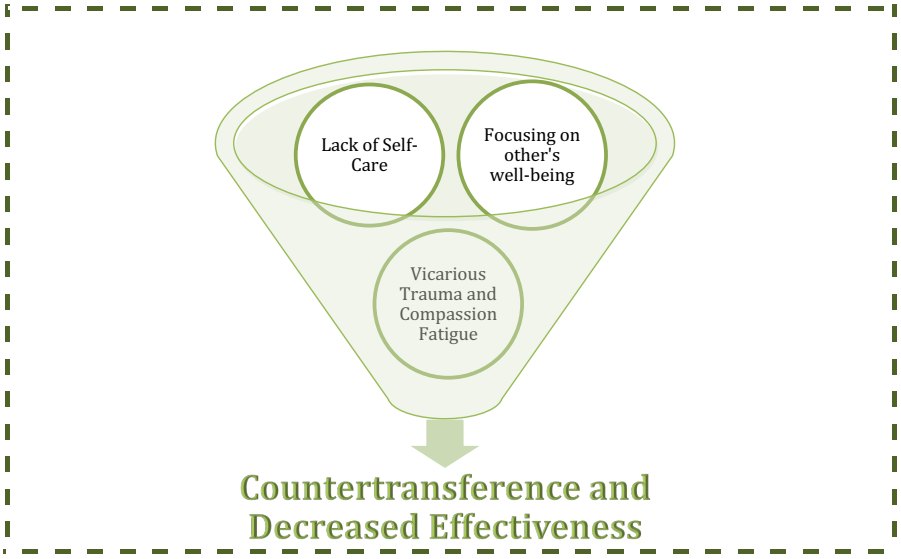


Figure 14. **Contributions to Countertransference in the Supervisor Relationship**

TIPS and RECOMMENDATIONS for what to LOOK OUT for with TRANSFERENCE AND COUNTERTRANSFERENCE

- Taking on the counsellor role with the supervisee.
- Feeling the need to FIX the problem or REDUCE THE SUFFERING of the supervisee or client.
- The need for approval and acceptance from everyone, supervisees, supervisor, clients, and the team you are working with.
- Not liking a supervisee and showing preference for others.
- Wanting to distance from certain behaviours you see in the supervisee rather than to address them.
- Sharing too much or too little with the supervisee.
- Sexual or romantic feelings towards certain supervisees.

The focus on other's well-being without balancing self-care can also contribute to an exacerbation of countertransference. It is considered an ethical imperative for supervisors to encourage and model self-care practices (APA, 2015; CCPA, 2018). A pre-emptive approach whereby counsellors are encouraged to participate in self-care before signs of impairment emerge is important to stem the tide of psychological stress (Robinson & Landine, 2016).

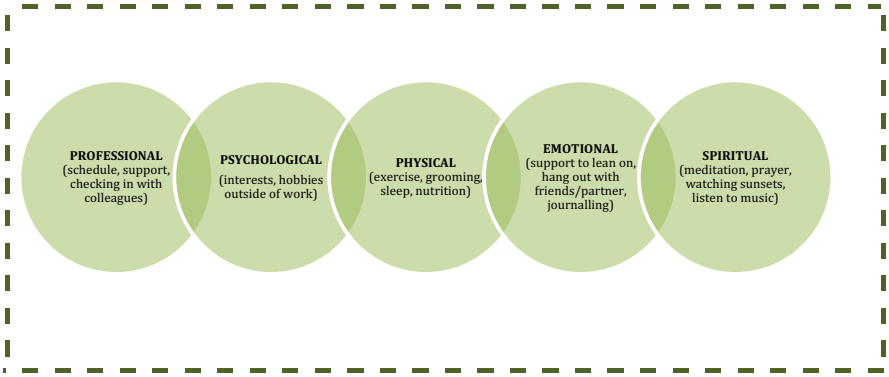


Figure 15. **Areas of Well-Being.** Adapted from "Teaching Self-Care: The Utilization of Self-Care in Social Work Practicum to Prevent Compassion Fatigue, Burnout, and Vicarious Trauma," by M. Lewis & D. King, 2019, *Journal of Human Behavior in the Social Environment, 29*(1), pp. 96–106. doi:10.1080/10911359.2018.1482482

TIPS and RECOMMENDATIONS
for BUILDING RESILIENCY IN THE SUPERVISOR

- Learn to recognize signs that you are becoming unregulated ie. Emotional reactivity, racing thoughts, impulsivity, defensiveness, no energy, can't think, numbing of emotions
- Prioritize self-care to create a balance between professional and personal.
- Listen to your internal signal giver. What are your body, mind, and emotions telling you? Once recognized, listen to what you need and take some steps to take care of yourself.
- Set boundaries and learn to say no to things.
- If you have been working long days, give yourself permission to take a day off, plan a staycation day.
- It may be helpful to write down/journal some distressing workplace events.
- Try to build in light daily exercise to your schedule
- Take breaks away from desk and office (go for a walk or stretch)
- Explore a hobby or interest unrelated to work
- Keep up connection with family, friends, and supports

It is my hope that you found this manual useful and that it has provided some clarity about this important, rewarding, and challenging job as a clinical supervisor. Clinical supervision is layered and requires a process of lifelong and career long learning.

I would like to acknowledge a few individuals who without their support, insight, knowledge, academic expertise and leadership, this manual would not have been possible.

- Dr. Blythe Shepard, Professor in the Faculty of Education at the University of Lethbridge and past president of the Canadian Counselling and Psychotherapy Association (CCPA).
- Dr. Dawn McBride, Registered Psychologist (clinical) and Associate Professor in the Faculty of Education at the University of Lethbridge.
- Kathy Snowden, MSW, Director of Counselling Services @ Boys and Girls Clubs of South Coast BC.

Thank you ☺

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DEFINITIONS

Administrative supervision: Many outpatient program supervisors are required to participate in both administrative and clinical supervision responsibilities that are geared towards ensuring that counsellors are following agency policies and procedures as well as the day to day operations of the program (Substance Abuse and Mental health Services Administration [SAMHSA], 2014).

Clinical supervision: Clinical supervision is distinct from both counselling and administrative supervision in purpose, outcome, time frame, agenda, and basic processes. The purpose and intended outcomes of clinical supervision is to improve job performance, and to enhance skills, knowledge, and abilities of the counsellor. While clinical supervision is the most common term used in research, it is synonymous with counselling supervision, psychology supervision, and psychotherapy supervision (Bernard & Goodyear, 2014).

Competency-based supervision: Competency-based supervision is an approach that provides systematic attention to the supervision process. This approach enhances accountability and is reflective of both evidence-based practice generally and CCPA's framework for clinical supervision. This approach systematically addresses the supervisory relationship, bidirectional feedback, infusion of multiculturalism and diversity, and ethical and legal standards. Competency-based supervision maintains a balance among the equally important priorities of protecting the client, gate-keeping for the profession, and enhancing the professional growth and development of the supervisee (Falender & Shafranske, 2013)

Consulting: Consulting is often utilized as the supervisee becomes more confident in their counselling knowledge and skills and takes on more and more responsibility (Courtois, 2018). As Shepard and Martin (2012) outline, consultation can take several forms: providing or brainstorming alternative interventions or conceptualizations or encouraging the supervisee to initiate the structure of the supervision session.

Counselling: Counselling is a relational process based upon the ethical use of specific professional competencies to facilitate human change. Counselling addresses wellness, relationships, personal growth, substance use, career development, mental health, and psychological illness or distress (CCPA, 2011).

Cultural Competency: Cultural competency refers to the ability of individuals and systems to respond respectfully and effectively to people of all cultures, backgrounds, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the worth of individuals, families, and communities, and protects and preserves the dignity of each (Cross Cultural Health Care Program, 2002 as cited in Alberta Health Services [AHS], 2005).

Diversity*:* Diversity is simply all the ways we are unique and different from others. Dimensions of diversity include such aspects as race, religion and spiritual beliefs, cultural orientation, colour, physical appearance, gender, sexual orientation, physical and mental ability, education, age, ancestry, place of origin, marital status, family status, socioeconomic situation, profession, language, health status, geographic location, group history, upbringing and life experiences (Agger-Gupta,1987 as cited in AHS, 2005).

Modelling: Modelling is an intentional supervision role to demonstrate a behaviour or skill. Using modeling in supervision increases the likelihood that a skill will be used in a session (Bearman et al., 2013).

Paraprofessional: "People trained in counselling skills who use them as part of their jobs, yet who do not hold an accredited counselling or psychotherapy qualification" (Nelson-Jones, 2013, p. 4).

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