A clinical supervisor has the opportunity to affect thousands of clients by shaping and supporting their counselors. Yet the skills required of an effective clinical supervisor do not evolve effortlessly from counseling experience alone. This highly practical text for graduate and post-master’s level supervision courses contains all of the information clinical supervisors will need to attain a high level of competence and effectiveness in community mental health and private practice settings. It aligns with current supervision standards issued by the Association for Counselor Education and Supervision, and with the recommendations of the American Association for State Counseling Boards.

The book integrates theoretical and practical information while addressing all stages of the supervision process from initial conceptualization and preparation to direct application and advanced skill use. Special attention is paid to supervision models and techniques, ethical and legal issues, professional development, multicultural competence, evaluation, supervisory alliance, parallel process, and advanced supervision strategies. The text presents helpful tools for effective problem solving, including the supervisor self-concept exercise that guides the student in solidifying his or her identity as a supervisor. It will be useful for all levels of experience from novice to advanced supervisors.

Key Features:

- Explains what constitutes effective supervision and how to achieve it
- Aligns with current national and state-specific supervision standards
- Engages readers in multiple exercises that readily facilitate application of concepts and theories
- Provides solutions to common and emerging supervision dilemmas
- Addresses such underrepresented supervision components as group supervision and dilemmas specific to private practice or agencies
Practical Clinical Supervision for Counselors
Lisa Aasheim, PhD, NCC, ACS, is the coordinator of the School Counseling Master’s Program and the director of the Community Counseling Clinic at Portland State University. She also maintains a private practice offering counseling, clinical supervision, and agency and school consultation. She is a chapter author of numerous textbooks and has presented at ACES, ACA, and the Oregon Counselors Association. Dr. Aasheim has participated in the Oregon Board of Licensed Therapists and Counselors, the Teachers Standards and Practice Commission regarding social work licensure, and in clinical supervision revisions and standards.
Practical Clinical Supervision for Counselors
An Experiential Guide

Lisa Aasheim, PhD, NCC, ACS
This book is dedicated to my lovely Madeline Rose,
whose empathic, warm, curious, and beautiful nature
inspires my work and play.
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My passion for clinical supervision was born one sunny afternoon on a park bench in Portland, Oregon. I had just left the university bookstore with Holloway's *Systems Approach to Supervision* in hand and, with an hour to spare before class, I decided to preview this required textbook while taking advantage of the early spring sunshine. Within a few moments, I was so deeply engrossed in the book that I, ironically, barely made it to the actual clinical supervision class on time.

It was on that park bench that I learned that supervision is not merely a task or duty assigned to a senior therapist. Instead, supervision is a field of study, complete with theories and models, practice standards, a code of ethics, credentialing, professional conferences, and professional organizations. It is a field of study and practice that is transdisciplinary and is relevant to many kinds of helpers in many helping professions. It was on that bench that I learned that the supervision relationship is core. Admittedly, that was not entirely new information; as a counselor, I already respected the critical importance of a strong, trusting relationship in any helping arrangement. I had also learned through experience that the relationship between a counselor and his or her supervisor was crucially important as well. I knew that my supervisors could directly impact my clinical work with clients through conversation, role modeling, demonstrations, and carefully guided discussion. I also knew my supervisors could directly impact my emotional and psychological experiences at work; the nurturance, guidance, and support afforded me in supervision somehow alleviated much of the frustration, helplessness, and isolation I felt as I did my best to help others live and function well. I did not understand, at the time, the mechanisms by which these supervisors could be so impactful. I just knew that my supervisors had the potential for great power in my professional (and personal) life; they had the power to influence and shape my relationships with my clients, my work setting, my colleagues, and my profession, for better or worse. I had certainly experienced both.

On that marvelously sunny afternoon, I first learned one approach to supervision; in the subsequent weeks and months, I learned the rest. Following that transformative hour on a park bench, I spent an evening and the following day listening with unswayable interest to my professor, Dr. Miars, share his knowledge and passion for this practice called “clinical supervision.” I listened with great curiosity and mild skepticism as Dr. Miars insisted that...
with skill, practice, and forethought, we could all be effective supervisors. Then, at the end of less than ten hours, Dr. Miars sent the group of us off to provide supervision to Masters-level trainees and insisted, contrary to our insecure cries, that we would do alright. My profound disappointment at the brevity of the workshop was overshadowed by my excitement for what I had learned. Little did I realize that I, after consuming one book and a one-credit class, was actually more trained than many of my own supervisors had been.

Following that impactful experience, I used that one required book as a compass to direct my further investigation into this enigmatic practice called "clinical supervision." I used that initial book’s reference section as a reading list and devoured every article and book I could find. I used each article to lead me to more articles, more information, until I could no longer find anything novel pertaining to the practice. Frustrated that the well of information had perhaps run dry, I attended every training and workshop I could find pertaining to the practice of clinical supervision. To my dismay, such workshops were few in number and far in distance. So, with a wide breadth of knowledge and a passion for the practice, I turned most of my professional attention to providing and practicing supervision so that I could learn experientially the many methods and approaches that I had merely read about. I offered supervision to Masters-level clinical mental health trainees, associate and bachelor-level addictions counselors, prelicensed and licensed counselors. I used individual, triadic, group, and classroom formats, all to gain a more intimate knowledge of the mechanisms and phenomenon that make supervision work. The hunger was mutual: I wanted to supervise as much as my counseling supervisees wanted supervision. We all longed for the powerful, formative experiences, and my supervisees and I looked forward to our time together and lamented at the end of each session that once again, time had flown by too quickly.

After completing a doctoral degree that focused on counselor education and supervision, then teaching counseling courses at two universities, I have finally landed at the very same university where I first learned about supervision. I teach alongside my dear colleague, Dr. Russell Miars, the very same professor who planted the "supervision seeds" many years ago. We and our colleagues take great delight in training supervisors for their future work with supervisees in a multitude of settings. It is for these supervisors that this book is written.

This book is for the supervisors who would like a practical guide to supervision, a framework that is applicable to any work context and most any situation; the supervisors who, like myself, wanted to learn supervision thoroughly so that it could be provided with the highest level of competence and effectiveness; the supervisors who also recognize that knowledge alone is not sufficient; our experiences, past and future, inform us as readily as the literature does. In reality, many supervisors have little time to gather
vast amounts of information. Instead, this book brings that information directly to them in a way that integrates lived experiences with scholarly information.

My passion for clinical supervision continues as I teach classes for master’s and doctoral level counselors who wish to provide supervision for licensure purposes. I conduct research to examine the quality and experiential aspects of counselor supervision in various settings, and I continue to practice, practice, practice. I direct a training clinic where I have the luxury of providing supervision and witnessing others provide supervision from behind a two-way mirror. I have a learning laboratory at my doorstep and take great pleasure in sharing my knowledge, experience, and enthusiasm with others both locally and nationally. You, as a reader of this book and an active participant in your learning process, will learn from my experiences as well as your own. This book is not didactic in nature; that is, it imparts information, but much of the learning will occur as you reflect, consider, and intentionally create your supervision experience.

Supervision is meant to be beneficial and fulfilling to all parties. While clinical supervision is an invariably challenging and, at times, distressing practice, it provides supervisors with the opportunity to impact thousands of clients by shaping and supporting their counselors. As you prepare to begin or continue your supervision practice, I invite you to find a spot on a lovely bench and dive into this book with the same curiosity, passion, and eagerness that drove your initial entry into the counseling field. Spend some time with this book and the opportunities therein; you will gain new knowledge, learn new concepts, and be introduced to new techniques and ideas. You will have the chance to reflect upon your own experiences, plan your future practices, and create your identity as a clinical supervisor. You may feel, at times, tempted to skip an exercise, section, or chapter. Resist the urge. Instead, allow yourself to be guided through the material and experiences therein. Your experiences, knowledge, and wisdom influence your learning and the meaning of this book’s content. Engage fully in the activities and return to this book’s material as often as needed so that you may make new sense of the information at a later time. From this point forward, read, learn, and supervise with intention. Enjoy.
Acknowledgments

I am profoundly grateful for the support of my colleagues and mentors who listen to my endless musings about all-things-supervision: Susan Halverson-Westerberg and Russ Miars, who inspired my career with their support, wisdom, and guidance, and who have each provided me with countless opportunities to learn, grow, practice, and create; Deborah Rubel, who quite unintentionally inspired this book and quite intentionally taught me how to write, research, and write research; Cass Dykeman, who provided supervision-of-supervision and a myriad of opportunities to learn, teach, reflect, and practice; and Rick Johnson, a mentor who somehow knows just when to teach, support, guide, protect, praise, encourage, listen, and laugh. Additionally, I appreciate Kim Hattig for her tireless enthusiasm, relentless energy, and impeccable competence as a research assistant and colleague. I also thank Megan Scheminske and Tammy Schamuhn for their research assistance, and my dear colleagues Hanoch Livneh, Tina Anctil, Don Mihaloew, Kathy Lovrien, and David Capuzzi for their continued support and listening ears.

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Finally, and most important, without the love and support of my family, I would not have the great fortune of sharing my work and passion with others. I am immensely grateful for my loved ones, who support me as I continue to live, work, and follow my passion.
PART I

PREPARING TO SUPERVISE
Clinical supervision is not merely an activity specific to the counseling profession; rather, it is a distinct field of preparation and practice (Dye & Borders, 1990) that is interdisciplinary and maintains its own code of ethics, standards of practice, professional organization (The Association for Counselor Education and Supervision), national credential (the Approved Clinical Supervisor Credential, CCE Global), and scholarly journals (Counselor Education and Supervision and The Clinical Supervisor).

When one enters a new field of practice, it is reasonable to expect that additional field-specific training is needed to build competence in the new practice area. This is certainly the case with clinical supervision. Some believe
that a highly competent, effective counselor will naturally become a skilled clinical supervisor. This is simply not the case. A skilled supervisor is not merely an experienced counselor. A skilled supervisor has received training specific to clinical supervision so that he has knowledge, skills, and disposition to meet the practice standards specific to the clinical supervision field (Borders & Leddick, 1987). Experience alone does not transform a counselor into a competent supervisor (Stevens, Goodyear, & Robertson, 1997); rather, experience as a counselor is simply one feature of the complete supervisor skillset.

DEFINING CLINICAL SUPERVISION

Clinical supervision has been described as an essential, mutually advantageous, and impossible task (Borders & Brown, 2005; Zinkin, 1989). Further, defining clinical supervision has proven nearly as complicated as the practice itself. The literature presents a multitude of definitions, and the complexity of these definitions reminds supervisors of the complexity and multifaceted nature of the task itself.

In its simplest form, clinical supervision could be defined as “a controlling mechanism instituted to oversee directly the skills utilized in the treatment of patients” (Lyth, 2000, p.723) based on the literal meaning of the words clinical and supervisor. However, many would argue that the simple definition is inaccurate in that it omits most major defining variables of the practice. While it is agreed that the field lacks a strong, operational definition of the term clinical supervision, the term still carries strong implications for practice and tasks therein.

The most frequently cited definition, coined by Bernard and Goodyear (2009), defines clinical supervision as an intervention provided by a seasoned member of the field to less-experienced counselors in the course of an ongoing, evaluative relationship. That relationship aims to improve professional functioning of the newer counselor, monitor professional services rendered by the newer professional, and screen those who are attempting to enter the field (Bernard & Goodyear, 2009). Another notable researcher in the clinical supervision field notices some problems in operationalizing that definition for research purposes and presents the following definition as an alternative:

The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops, and evaluates the work of colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisee’s performance, teaching, and collaborative goal-setting. The objectives of supervision are “normative” (e.g., case management and quality control issues), “restorative” (e.g., encouraging emotional
One: What is Clinical Supervision?

experiencing and processing), and “formative” (e.g., maintaining and facilitating the supervisees’ competence, capability and general effectiveness). These objectives could be measured by current instruments (e.g., “Teachers PETS”; Milne et al., 2002) (Milne, 2009).

Supervision has additionally been defined as a “learning alliance that empowers the trainee to acquire skill and knowledge relevant to the profession and to experience interpersonal competence in the supervisory relationship” (Holloway, 1994). Drapela (1983) also focused on competence when he defined clinical supervision as a process of overseeing, guiding, and evaluating professional activities for the purpose of ensuring a high quality of counseling services for the clients served. Clinical supervision has also been defined as a practice in which a supervisor assists a counselor in working more effectively with clients to achieve successful outcomes (Herbert, 1997). Although readers are left to speculate about whether “successful” is defined by the supervisor, supervisee, or client, there is little doubt that the author is focusing on supervision as a tool for competence building.

The repeated cries for a unified definition is important on two levels: first, researchers who would like to conduct studies on the usefulness of supervision need a definition that lends itself to strong, empirical study. Second, clinical supervision as a practice is widely varied in the field. That is, the clinical supervision one counselor receives from one supervisor in one particular setting may be quite different from the clinical supervision another counselor receives from a different supervisor in another setting.

Clinical supervision is clinical in nature; that is, its focus is on the clinical services delivered to the client and the clinical skills of the counselor delivering such service. Often times, administrative tasks are necessarily intermingled with clinical tasks. Administrative tasks are tasks that necessarily accompany client care. These tasks are supplemental to direct service provision and include documentation and clinical communication (e.g., progress notes, case reviews, formal treatment plans). Managerial tasks, by contrast, center on meeting agency and bureaucratic needs (Haynes, Corey, & Moulton, 2003) and may include tasks that sustain agency operations and policies (e.g., budgeting, scheduling, systems coordination) (Spence et al., 2001). Clinical tasks, by contrast, focus more specifically on counselor and client needs (Kaiser, 1997) and include tasks such as case conceptualization, treatment planning, examination of the therapeutic relationship, and repairing alliance strains. Despite the inherent disparities, these clinical and managerial tasks often seem to exist within the same job description (Holloway, 1995; Powell, 2004).

In some cases, agency administrative needs (managerial tasks) may take precedence above clinical focus and supervisee development. This typically creates great role strain for the clinical supervisor, who attempts to balance clinical and managerial foci and typically creates dismay for the supervisees who would often rather attend to client care. Research
I. Preparing to Supervise

reveals that supervisees prefer a clinical focus during supervision as opposed to an administrative one (Crimando, 2004; English, Oberle, & Byrne, 1979; Herbert & Trusty, 2006) and find great frustration with supervision sessions that do not adequately attend to client care needs. One study of rehabilitation counselors found that counselors who indicated their supervisor “always” took an administrative role (engaging in administrative tasks) were most dissatisfied with their “clinical” supervision experiences. This same study indicates that counselors who were much more satisfied with supervision when their supervisors “often, rarely, or never” engaged in administration roles and focused instead on clinical tasks (Herbert & Trusty, 2006, p.74).

Clinical supervision is intended to protect the welfare of the supervisee’s clients above all else. Following that, supervision provides counselors with a means to improve their performance and build additional clinical and professional competence. Supervision welcomes counselors into the profession by providing developmental support from an objective, skilled, and experienced colleague who has the power to greatly influence the supervisee’s experience of his clients, his clinical work, and his professional identity.

THE PREVALENCE OF CLINICAL SUPERVISION

Virtually all counselors have some relationship with clinical supervision at some point in their careers. Clinical supervision is acknowledged as a critical and core function of counselor early training and development. The accreditation bodies who recognize counselor preparation and clinical psychology programs require ongoing and regular supervision of counselors in training (e.g., CACREP, AAMFT, APA). Clinical supervision is also recognized by state licensing boards as a critical and core function of prelicense counselor preparation (e.g., American Association of State Counseling Boards), and most states require prelicensed counselors to engage in clinical supervision while earning licensure (Pearson, 2000). Once licensed, most counselors are typically legally allowed to practice autonomously without additional clinical supervision. However, many of the recipients of effective, impactful supervision understand its value and prefer to continue to access supervision well into their professional career (Usher & Borders, 1993). Further, many employers and agencies require ongoing supervision of their counselors for the betterment of client care, oversight, and protection for all.

THE PURPOSES OF CLINICAL SUPERVISION

Clinical supervision, above all else, is for the protection of client welfare. Every task and activity related to clinical supervision either directly or indirectly impacts client welfare. Supervisors help supervisees develop and
maintain clinical competence so that clients will be more optimally served. Supervisors ensure that supervisees are practicing in an ethical manner so that clients are not harmed in the therapeutic process. Client welfare is at the core of all clinical supervision; supervisors help counselors gain and sustain clinical competence to that end.

**Developing and Maintaining Clinical Competence**

Counselor supervision is essential in developing and maintaining clinical competence (Bernard & Goodyear, 2009; Borders & Leddick, 1988; Cross & Brown, 1983; Hansen, Pound, & Petro, 1976; Page & Wosket, 2001). The supervisor’s job is primarily to create a relationship and environment in which the supervisee can learn essential skills that then transfer into the therapeutic exchange with clients (Holloway, 1995). Furthermore, supervisors help supervisees to connect the science and practice of counseling (Holloway & Wolleat, 1994), a task that is growing increasingly important with the strengthening emphasis on the utilization of evidence-based practices in agency settings (American Counseling Association (ACA) Code of Ethics, 2005; Blume, 2005). Supervision may additionally be used with counselors who need specialized or remedial training and guidance (Cobia & Pipes, 2002). In fact, increased clinical supervision is often required by state regulatory boards who find a counselor operating below acceptable practice standards. Finally, supervision by nature is evaluative: that is, supervisors are tasked with constantly evaluating the counselor’s work in accordance with professional practice standards. This evaluation provides supervisees with necessary feedback about where their competence may be improved for optimal performance.

**Building and Sustaining Ethical Practice**

Another key function of clinical supervision is to ensure that the supervisees are engaging in sound ethical practices. Clinical supervision affects the supervisee’s level of ethical competence and, consequently, increases the quality of service delivery to the client (Cormier & Bernard, 1982; Herlihy, 2006). Counselor supervisors are ethically bound to ensure the well-being of the clients with whom the supervisee is working (Cormier & Bernard, 1982), while at the same time honoring the growth and continual development of the supervisee. So, supervisors take care to role model and provide ongoing evaluative feedback to supervisees with regard to optimal ethical practices (Borders & Brown, 2005; Cormier & Bernard, 1982).

Supervisees engaged in supervision will likely be encouraged to examine issues of informed consent, dual relationships, confidentiality, and ethical service provisions (Borders & Brown, 2005; Cormier & Bernard, 1982). Supervisors have the opportunity to provide training to
supervisees and can engage in practice activities regarding ethical issues (Cormier & Bernard, 1982). Supervisors also serve as gatekeepers to the profession, meaning that they are responsible for keeping unethical practitioners away from the profession (and thus, away from clients) (Pearson & Piazza, 1997).

**HOW SHOULD CLINICAL SUPERVISION BE CONDUCTED?**

The majority of this book provides supervisors with information so that they may make informed, well-considered decisions about how to practice clinical supervision in their particular practice setting. However, all clinical supervision practice should align with the practice standards and competencies specific to the supervision field.

The ethical guidelines for supervision were originated in the 1980s by the Association for Counselor Education and Supervision’s (ACES) Supervision Interest Network (SINACES). This network created and recommended the Ethical Guidelines for Counseling Supervisors (Borders & Brown, 2005). The ACES Executive Council endorsed these guidelines and formally adopted them in March 1993 as a way to guide and inform supervisors in their practice (Borders & Brown, 2005; Hart, Borders, Nance, & Paradise, 1995). Currently, ethical guidelines for supervisors are embedded in the American Counseling Association’s Code of Ethics (ACA, 2005).

The ethical guidelines clarify the responsible delivery of effective clinical supervision. The guidelines focus on client welfare and rights, the supervisory role, and the program administration role that is at times held by a supervisor (Supervision Interest Network/SINACES, 1993). The guidelines recommend that supervisors should utilize the following sequence when making decisions regarding supervision and supervisory tasks: relevant legal and ethical standards, client welfare, supervisee welfare, supervisor welfare, and program or agency service and administrative needs (Supervision Interest Network/SINACES, 1993). That is, clinical needs are the top priority, administrative tasks the lowest.

**SUPERVISOR DEVELOPMENT**

Many new or untrained supervisors experience thoughts and feelings reminiscent of their days as novice counselors. They feel eager to perform well, are nervous that they will not know how to perform well, and wish they were beyond the point of being so concerned about their performance. Indeed, clinical supervisors move from novice to expert in a manner similar to that of most counselors and experience the same types of uncertainty, impatience, and at-times painful introspection along the way.
Watkins (1990; 1993) presents a supervisor development model that consists of four developmental stages. The first stage, *role shock*, involves a novice supervisor experiencing the “imposter phenomenon” so common of early counselors who worry that someone will notice that they are not actually a “real” counselor and quite probably have no idea what they are doing. This stage involves the struggle to build competence and a concern for “doing it right.” Supervisors at this stage are concerned with learning and following the rules, and are eager to know concretely what the “rules” actually are so that supervision can be done “correctly.”

The second stage is the *role recovery/transition* stage, in which supervisors begin to exercise some flexibility and relax a bit into the supervisor role. They have developed enough confidence at this point to tentatively address issues such as transference and countertransference but are not yet confident enough to effectively challenge a supervisee’s performance deficits.

The third stage of the Watkins (1990) model is *role consolidation*. In this stage, the supervisor gains a greater understanding and confidence in his role and feels more ready to exert influence in the supervision process. This supervisor has adopted a theory or approach to supervision and is engaging in more flavorful practice as he tries new techniques and uses new tools.

The fourth and final stage is *role mastery*. This stage is typically a more comfortable one for the supervisor, as he has a clearer understanding of his competence as a supervisor. He uses a sense of humor and enjoys the intricacies of the supervision process. Further, he has integrated the supervisor role and operates comfortably from that position.

Many supervisors are excited to arrive at that final role mastery stage. However, they recall from their early days as counselors that there is work to be done before true mastery can be achieved. While enhancing their knowledge and skill base, supervisors learn to engage in ongoing *reflectivity* about their supervision practice so that they may move to optimal, autonomous functioning as supervisors. Concurrently, they will help their supervisees move toward optimal, autonomous functioning as reflective, self-monitoring counseling professionals.

**TOWARD REFLECTIVE PRACTICE**

Reflectivity, or self-reflection, is a core tool in developing critical thinking, self-evaluation, insight, and autonomy in one’s work (Orchowski, Evangelista, & Probst, 2010). Self-reflection refers to the cyclical process a supervisor uses to critically evaluate and examine his affective, behavioral, and cognitive experiences. This critical examination yields greater insight and understanding, which are then applied to one’s conceptual framework and understanding. This greater insight and understanding leads to change (Orchowski, Evangelista, & Probst, 2010). Supervisors aim to become self-reflective supervisors who can autonomously engage in a critical analysis of the many complicated
relationship dynamics, clinical phenomena, and stressors that are present in
the supervision experience. There are innumerable factors to attend to, and
supervisors, with practice, become increasingly skilled at efficiently making
sense of voluminous amounts of information.

Supervisors engage in self-reflection for the betterment of their perform-
ance as a supervisor; additionally, supervisors model reflectivity so that their
supervisees may learn and develop the same self-reflective and analytic
skills in their own clinical work. Ideally, a supervisee, with time and prac-
tice, becomes readily able to self-monitor and manage his work with greater
autonomy. Eventually, a supervisee becomes increasingly capable of self-
supervision and is ready for fully autonomous clinical practice. Autonomous
practice does not mean practicing alone or in isolation; rather, autonomous
practice means having the skill and insight to be able to make in-the-moment
corrections to one’s work. Clinical autonomy means having the competence
to recognize legal and ethical dilemmas as they occur and knowing how
and when to access consultative assistance and support. Clinical autonomy
means having an understanding of one’s professional standards of practice,
and being able to accurately evaluate one’s performance in relation to those
standards. For supervisors to move their supervisees to such proficiency in
their clinical work, it is necessary for supervisors to move to proficiency in
their competence as a clinical supervisor.

**COMPETENT SUPERVISION**

Many of the major theorists and leaders in the supervision field have
contributed to the collective understanding of what makes supervision
“good” (e.g., Stoltenberg, McNeill, & Crethar, 1994; Worthen & McNeill,
1996). In that same spirit, many of these contributors have also examined
what makes supervision “lousy” or ineffective (e.g., Magnuson, Norem, &
Wilcoxon, 2000; Nelson & Friedlander, 2001; Wulf & Nelson, 2000). While the
literature provides a fairly comprehensive and at times humorous account of
the many features of good and bad supervision, supervisors must concern
themselves first with providing *competent* supervision. Competent supra-
vision is supervision that aligns with the knowledge, skills, and attitudes
described by the Standards for Counseling Supervisors (Supervision Inter-
est Network/SINACES, 1993). A supervisor who aims to practice competent
supervision builds his knowledge about supervision as a discrete field of
practice, gains experience in providing supervision in a self-reflective man-
ner, and actively works to identify as a member of the clinical supervision
profession.

This book assists supervisors in these crucial tasks. While reading this
book, supervisors will collect knowledge about the field and practice of cli-
rical supervision. As they gather knowledge, supervisors will think critically
and reflectively about their own experiences as a supervisee and, perhaps, as
a supervisor. These recollections will help shape and inform current thinking about the supervision process and one’s developing practice as a clinical supervisor. Finally, this book helps supervisors gain familiarity with the many key features of the clinical supervision profession: the methods and approaches, the standards and competencies, the code of ethics, the roles and functions, and the many interrelated tasks and features of the supervision process.

This book is an instrument to gain knowledge, develop skills, and form the habit of self-reflective practice. Supervisors should complete the readings and exercises in the order they are presented, as many of the components build upon prior experiences and reflections. Most importantly, supervisors should recognize that this book, while experiential and interactive, is only a book. It is not a substitute for the valuable learning and development that can be gained by supervisors who invite a more experienced and trained supervisor to oversee their work through supervision-of-supervision. Supervisors may use this book as a tool to develop knowledge and to form their professional plan and identity as a clinical supervisor; this book, combined with supervision-of-supervision, will assist supervisors in providing competent, effective, and impactful clinical supervision services.