Questions Asked During Live Webinar Broadcast on 12/07/2016

Clinical Supervision for a Skill-Based, Client-Centered Program

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I am in my first supervisory position, new to an agency with a senior and well-experienced staff who have been largely unsupervised for the past several months/years. They are often defensive and resistant to any changes and frequently point out how experienced they are, as if to say they don't need/want supervision, especially by me (someone much younger and less experienced than most of them). I feel at a loss for how to respond to this without becoming harsh or demanding, as I want a positive work environment and there are very needed changes I'm tasked with bringing about. How can I encourage their respect and cooperation?

A: I experienced something very similar early in my career as a supervisor. I approached it by letting those I supervised, who had more experience than I did, know that I looked forward to learning from *them* – I saw it as a bi-directional relationship. Also, *everyone* has professional growth needs. Ask your supervisees to identify their growth needs and help them determine how those needs can be met perhaps by you, but likely by sources other than what you provide in supervision. The supervisory relationship is key – let them know you value their expertise and you see the relationship as mutually beneficial. That could be one step toward gaining their respect.

I was just given a person to supervise and add to the addictions clinical team that is highly codependent to our clients and has very poor boundaries. She does not have any education in substance abuse treatment. She has been a social worker.

A: Similar to my first answer, this may be an opportunity to learn from each other. Also, what can she, as a social worker, add to the staff (for example, she might be more ethically grounded and has better defined boundaries). You have something to offer her (your expertise and knowledge in addictions) – find out what she can offer you and the rest of the staff (from her social work perspective). This could be a win-win relationship.

Can you provide a summary of top clinical issues in the field that typically require the closest supervision?

A: The number one issue that comes to mind is ethics. Supervisors are in a position to contribute greatly to quality care by being role models for ethically professional behavior and by closely monitoring staff relationships with clients. Some ethical issues are quite clear (such as confidentiality) while others are not (such as ethical boundaries – see my answer below about self-disclosure). Of course, professional development and the enhancement of clinical skills are also crucial and relate to ethical behavior (for example, is a counselor attempting interventions or other actions without the proper training or experience?). The best way to know what the counselor is doing and to ensure ethical and professional behavior are being performed is to observe the work of counselors. The best way to do this is to provide occasional co-therapy where the supervisor can both observe and model therapeutic behavior. Co-therapy can also enhance the supervisory relationship by building mutual trust and respect merely by working together with a client.

Please tell me the actual benefits of Group Supervision. In my many years of experience, I have found that it is great when teaching new policies/paperwork, but not at all as a methodology to "get all the supervision done at once, & I'm done."

A: The greatest benefit to group supervision is the fact that there are multiple supervisors in the room. The best

approach to take is to acknowledge the vast and likely diverse expertise in the room. You might even consider taking off your "supervisory hat" and make it more of a peer supervisory approach. This works best when there is mutual respect among all members of the group where there is an attitude of openness to new ideas when working with clients. One suggestion is to rotate case presentations such that 2 or 3 members are prepared to present a case each session and then receive input and ideas from others in the group on working with the client presented. If you do this, always leave time for urgent issues that come up with clients that members want input and advice on.

What do you feel is the most important aspect of making a change from co-worker to clinical supervisor in re-defining the relationship?

A: This is a common occurrence, so it's a good question to pose. It becomes even more complicated when a counselor is promoted to a position where he/she is supervising someone they have a social relationship with. In either case a new relationship now exists and a new level of understanding regarding the change must be acknowledged and discussed between the two individuals. What complicates things when a new supervisor is supervising a friend is a possible *appearance* of favoritism by other staff members. Also, in this case, a dual relationship has been formed and, although the social relationship may continue, there is still a potential for problems if the two individuals cannot separate the two relationships (which is often a very difficult task). In the matter of making a change from co-worker to supervisor, there could also be jealousy (especially if a former do-worker competed for the promotion), but through openness and a genuine support by the new supervisor (and a demonstration of how this can benefit the new relationship), much of the tension and discomfort can be overcome.

What suggestions do you have for counselors who are overly disclosive of their own personal issues and life with clients, despite coaching at length on this problem?

A: My simple advice to counselors who overly disclose is this: Who is it for? If the counselor is self-disclosing for their own benefit, then what they are doing is highly unethical. Self-disclosure should only be used if there is no other way for the client to gain insight to a particular area or dilemma (and used sparingly if at all). Otherwise, it may be used to manipulate a client or to gain unhealthy attachment by the client. It is a boundary issue and can be seen as a dual relationship (where the counselor is developing a secondary dependent or social-type relationship with the client). It is unprofessional, unethical, and ultimately may be doing the client more harm than good.

I am working in an environment that is not to open to allowing clinical supervisors to utilize there office space to supervise provisional clinicians for licensure. Are there any suggestions?

A: I assume what you are referring to is offering clinical supervision to counselors not officially assigned to supervisors by the agency (or perhaps they don't even work at the agency?). In either case, the supervisor may be providing the service above and beyond their job responsibilities. If my interpretation is correct, then I suggest the supervision be held on the supervisor's own time (and maybe even outside of the clinic). However, if these are staff members who need supervision for licensure, my suggestion is to work with management to find a way to allow this to occur as this would ultimately benefit the agency by increasing the number of licensed clinicians (however, I'm not sure if I totally understand the situation).

What was meant by "double standard of self-care"?

A: This simply has to do with the fact that if we, as supervisors, encourage good self-care by those we supervise, we need to be good role models and model such self-care in our own lives in and outside of work. Those who emphasize self-care, but don't "practice what they preach" are examples of this double standard.