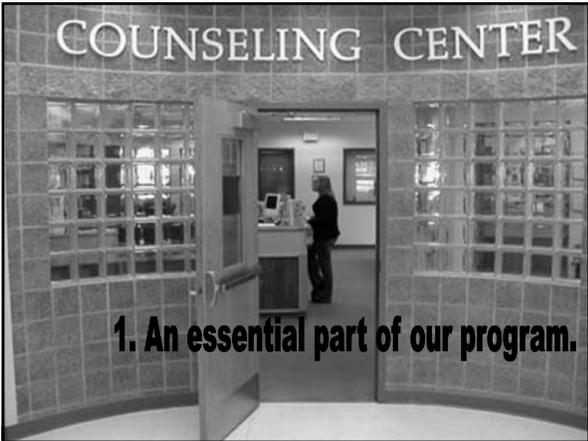




Recommendations



COUNSELING CENTER

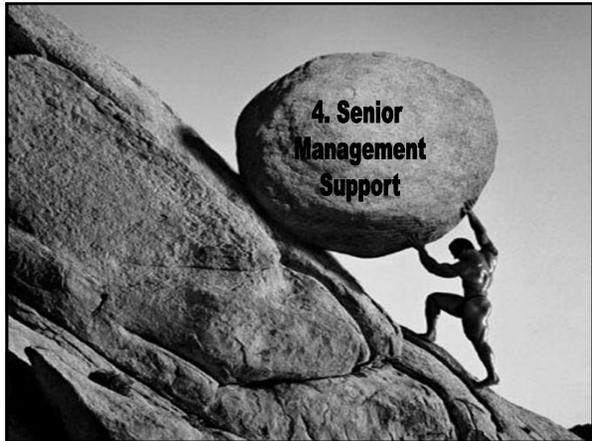


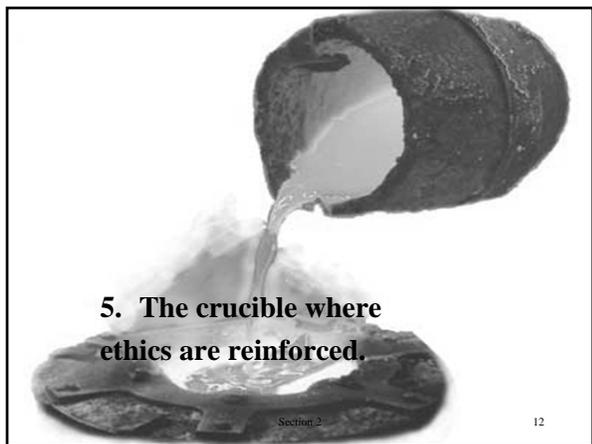
1. An essential part of our program.

2. Supervision enhances retention & morale.





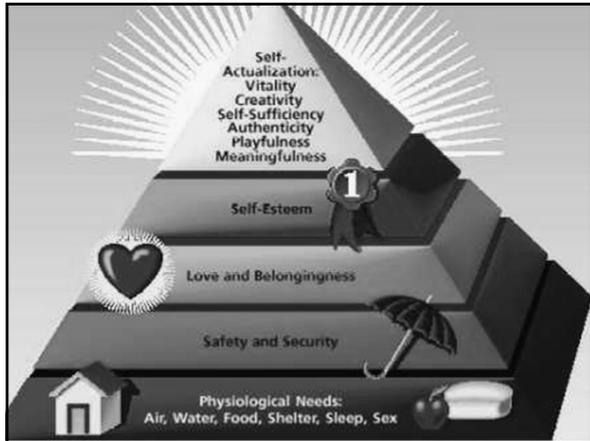




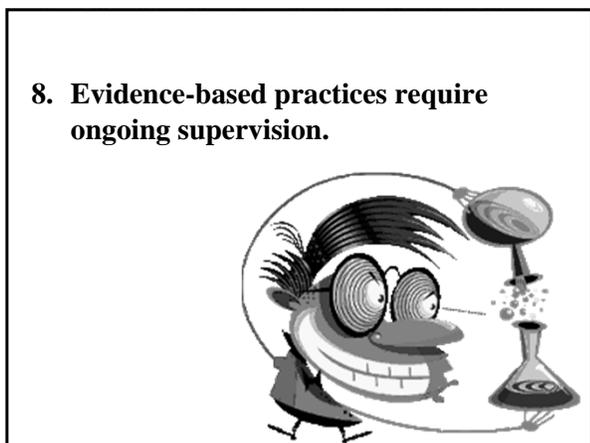


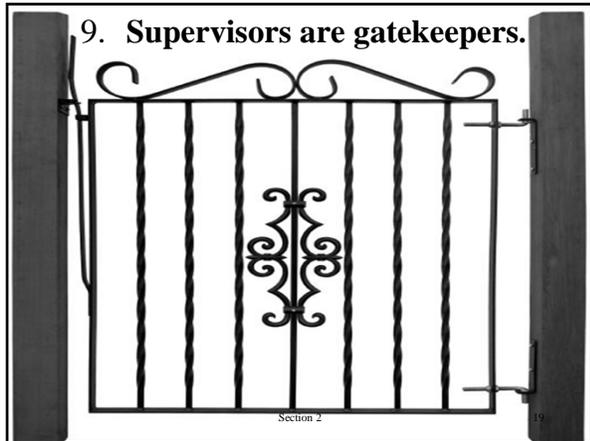




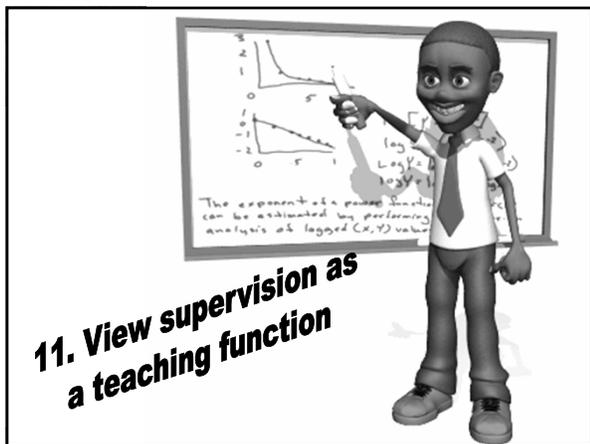












**Supervisors are often blamed
but seldom trained**



Section 2

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**Goal -- to ensure competency.
DOES IT WORK?**

Section 2

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Session Rating Scale*

Relationship

I wasn't heard,
understood & -----
respected

I was heard
understood &
respected

Goals & Topics

We didn't talk
about what I -----
wanted to
talk about

We talked about
what I wanted
to talk about



Approach or Method

The approach isn't a good fit ----- The approach is a good fit

Overall:

Something's missing in the session today ----- The session was right today

super-vision

**“A disciplined tutorial process
on 4 dimensions:
Administrative, Evaluative,
Supportive, & Clinical.”**



TOMORROW'S CLIENTS

- ✓ Adolescents
- ✓ Criminal Justice
- ✓ Gender, Age-specific treatment
- ✓ "Minorities"
- ✓ Chronically Ill & Aging



Cyber-Therapy



Rationale

Requires Constant Supervision

- ✓ What a way to learn!
- ✓ It improves morale & care
- ✓ We have legal & ethical need to supervise

30

CASE MANAGEMENT & CLINICAL SUPERVISION

Case Management

- Focus on patient
- Continuum of Care
- Multiple Reviews



Clinical Supervision

- Focus on therapist
- Skill Development
- 1 Case Presentation



Types of Supervisors

1. Mental health professional-direct reporting
2. Not a mental health professional, i.e., hospital administrator
3. Not directly reporting, i.e. Preceptorship
4. Onsite practicum/internship supervisor
5. Supervising for licensure

Types of Supervisees

1. Supervisee in training/intern
2. Pre-certified/licensed
3. Post-degree, post-licensure
4. "Long-term" professional

University of Georgia, 2009

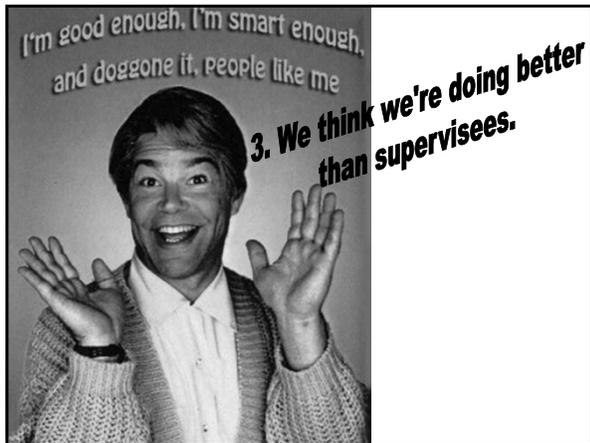
1. Counselors & supervisors *only moderately satisfied* with supervisory relationships.

2. Both report negative experiences in supervision.



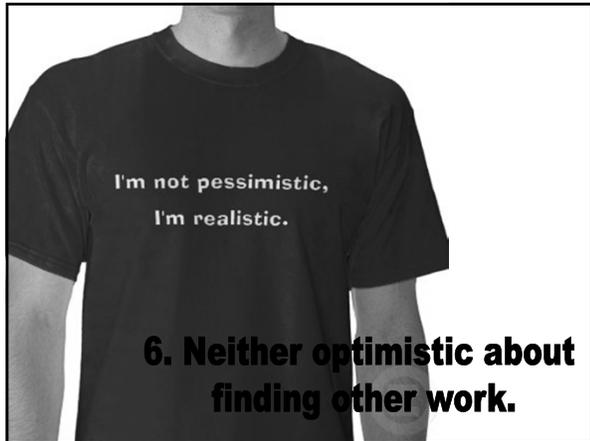
Stand up if Good Supervision Stand up if Bad Supervision



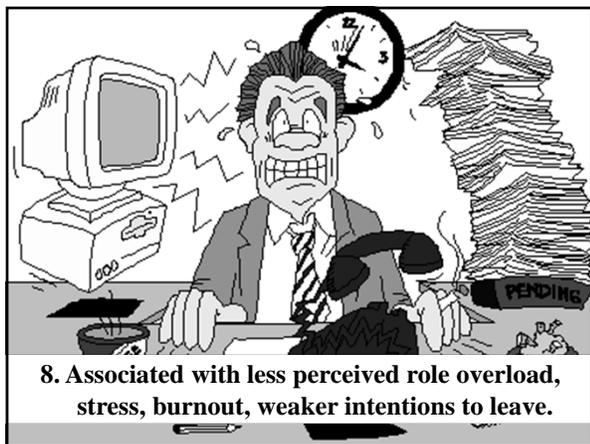














9. Non-recovering counselors--significantly lower job satisfaction, organizational commitment, higher turnover intentions.

You've been assigned to redesign the supervision program for a treatment program moving to an integrated system of supervision. Staff has a broad range of training backgrounds, from entry level certified addiction counselors to LCSWs & LPCs. Despite this range of experience, all do basically the same job.

In the past staff received mostly administrative supervision with an emphasis on meeting standards for job performance. You want to make the supervision more clinical, utilizing direct methods of observation.

The vignette begins with you meeting with the agency's CEO to get her support to do more clinical vs. administrative supervision, including direct observation of counselors.



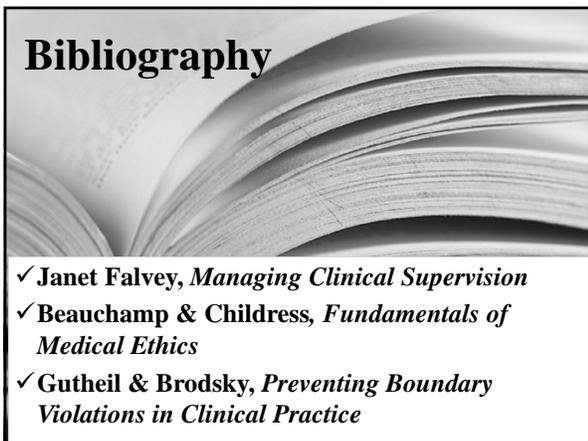


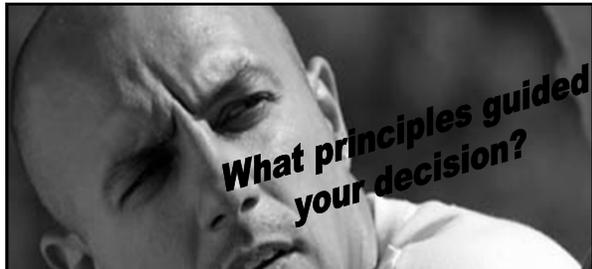












What principles guided your decision?

Ray, a recovering counselor, has a 2 day relapse after his wife's death. He goes to AA, sees his sponsor & a counselor. Your agency policy requires 2 yrs of continuous sobriety. No one knows of his relapse. He fears he will lose his job. He seeks your advice as a friend.



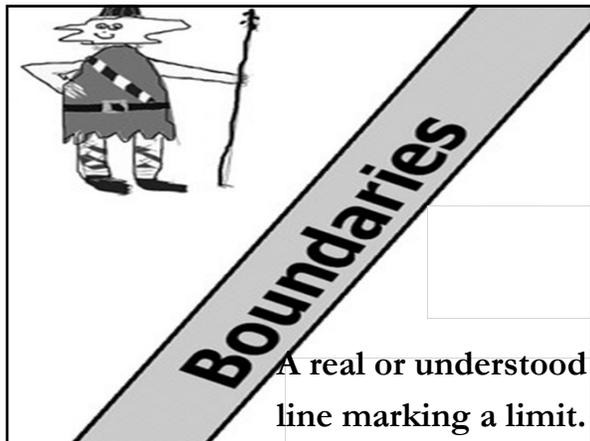
The Puzzle

- **Legal:** Minimal level of acceptable practice in profession
- **Ethical:** Highest ethical standards
- **Moral:** Personal Values



Ethics Check List

1. Is it legal?
2. Is it ethical?
3. How will I feel about myself?



Boundary: a real or understood line

- ✓ **Boundary crossing = benign deviations from standards, harmless, non-exploitative, advances therapy**
- ✓ **Boundary violation = significant deviations from standards, harmful, exploitative**

Section 2 56

Boundaries

1. **Clinical**
2. **Ethical**
3. **Legal**

Where's the line?

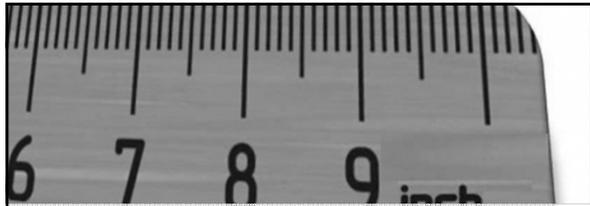
- ✓ Repetitive pattern
- ✓ Out of context, culture
- ✓ Outside therapeutic frame
- ✓ Role reversal: advice
- ✓ Time, place, purpose

Boundary Issues

- Time: longer sessions, odd hours, contact between sessions
- Place: out of office, home visit
- Self-disclosures: role reversal

Clues

- Therapy adrift, repetitive
- Discrepant record
- Avoidance, aversion
- Client is "friend"
- Fantasies, dreams
- "Special" treatment



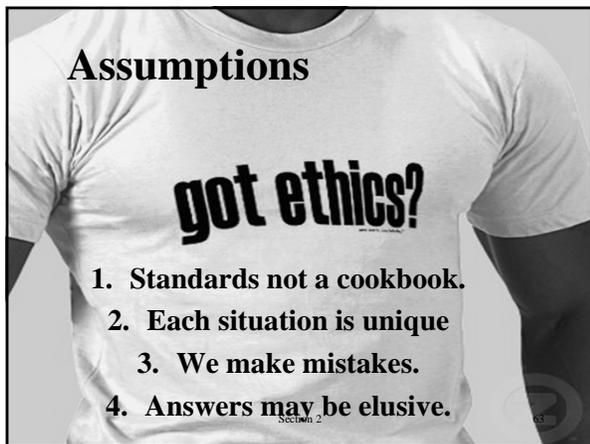
1. Responsibility *always* belongs to counselor.
2. Don't blame client for boundary violation.
3. Boundary testing can lead to violations.
4. But, testing is an important part of growth.

AXIOM Section 2 61



New Frontier of Technology

- ✓ Emails
- ✓ Social networking sites
- ✓ Internet information
- ✓ Websites



Assumptions

got ethics?

1. Standards not a cookbook.
2. Each situation is unique
3. We make mistakes.
4. Answers may be elusive.

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In my private practice, I treat people from diverse socio-economic backgrounds. I do not participate in any insurance plans but I routinely use a downward-sliding scale to help patients in financial difficult afford care. Some patients have extremely high incomes. A friend suggested I charge them more. Is it ethical to use the sliding scale in both directions?



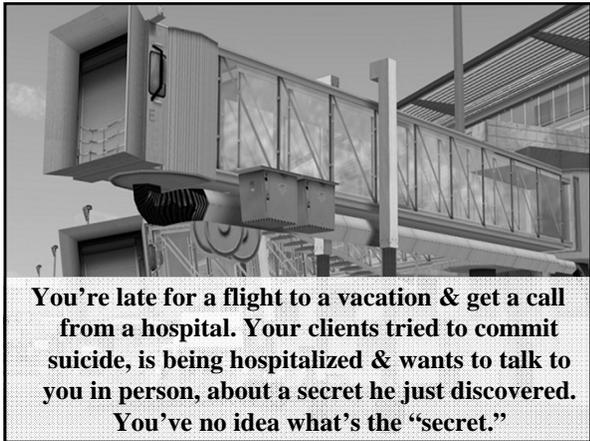
“Ds” of Wrongdoing

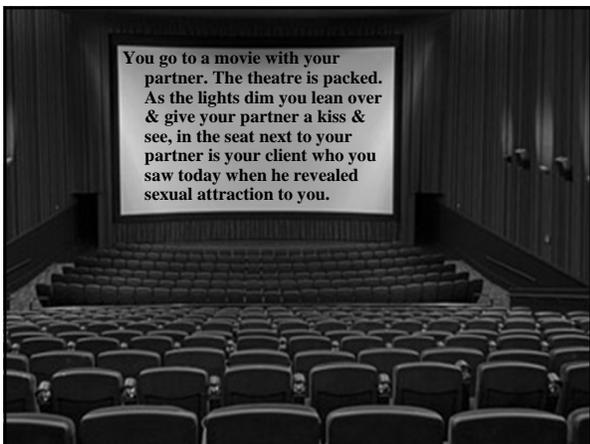
1. Duty
2. Derelict
3. Damages
4. Directly

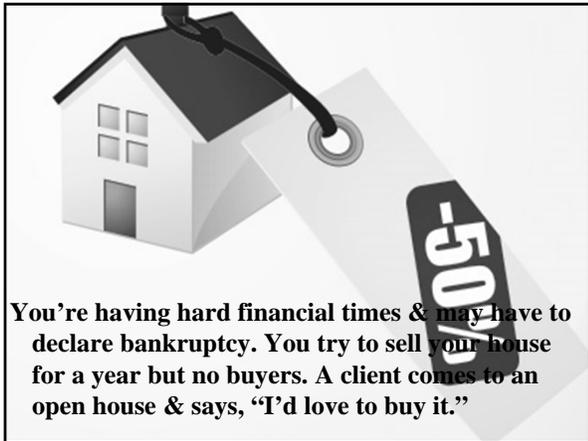
- Therapeutic frame, standards of care
- Ethical slippery slope,

Cliff









You're having hard financial times & may have to declare bankruptcy. You try to sell your house for a year but no buyers. A client comes to an open house & says, "I'd love to buy it."

Congratulations! You're being sued

Top reasons for suits

1. Sexual impropriety (20%)
2. Incorrect treatment (14%)
3. Breach of confidentiality (7%)
4. Incorrect diagnosis (7%)

A cartoon illustration of a doctor in a dark suit, holding a briefcase and a sign that says "You're Being Sued".

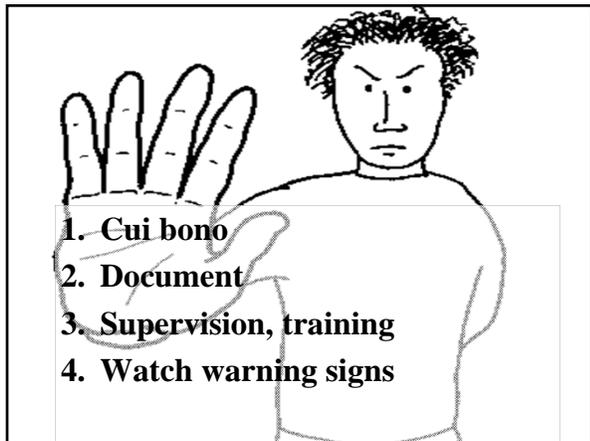
Claims to Ethics Boards

A black and white photograph of a group of doctors in white coats sitting around a table, looking at documents.

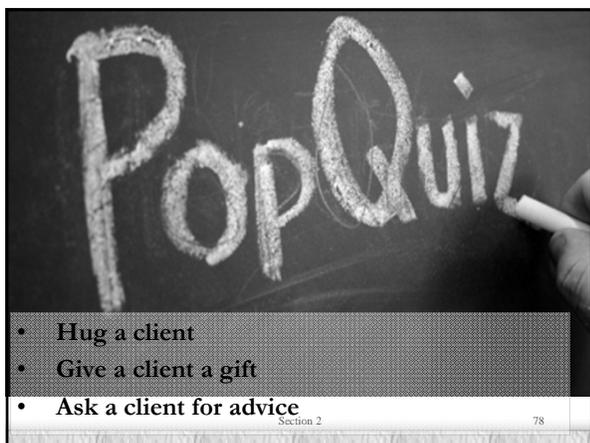
1. Dual relationship— 35%
2. Unprofessional-- 29%
3. Impairment—4%
4. Credential fraud—2%

Negligent Intervention

- High risk techniques
- Inadequate training or expertise
- Abrupt termination of services = abandonment



1. Cui bono
2. Document
3. Supervision, training
4. Watch warning signs



- Hug a client
- Give a client a gift
- Ask a client for advice

Section 2 78

USE YOUR IMAGINATION™

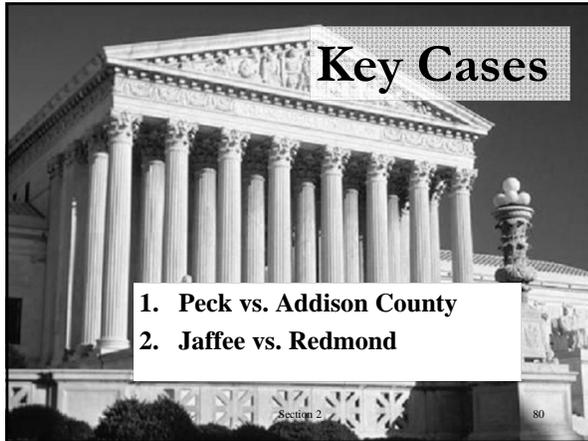
Blue Book

EXAMINATION BOOK

- Indigent client bus fare home
- Give client a peck on cheek
- Go to funeral of client's mother
- Attraction to client
- Practicing when tired, distressed

Section 2

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Key Cases

1. Peck vs. Addison County
2. Jaffee vs. Redmond

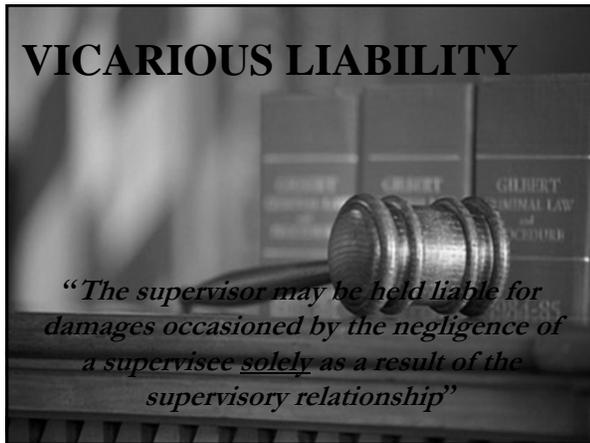
Section 2

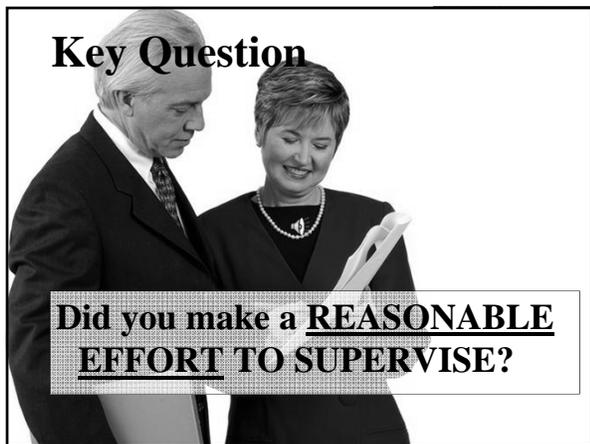
80



1. Boundary Issues
2. Respondeat Superior
3. Confidentiality





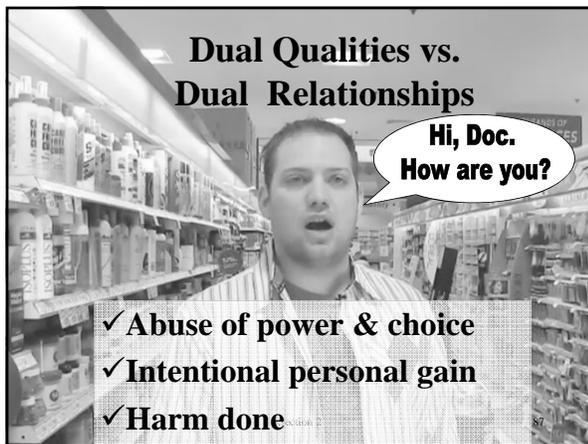


Questions

- ✓ Maximum # of supervisees
- ✓ Maximum # of clients of supervisees
- ✓ Should a supervisor supervise only in areas they have experience?







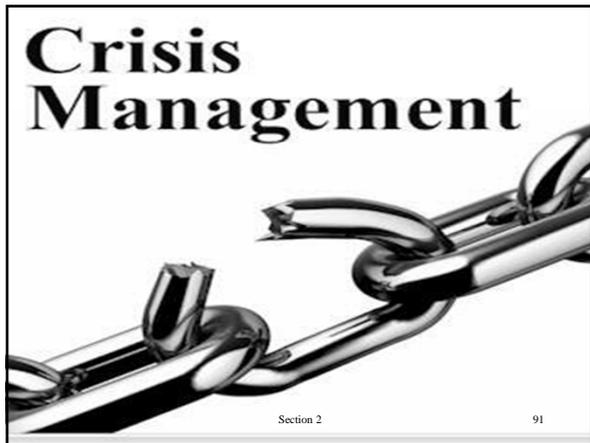
A client saw her former counselor at a class reunion. They were both from the same state & discovered they were at the same campgrounds as teens. They laughed a lot about this, went to dinner together. After a year they married.

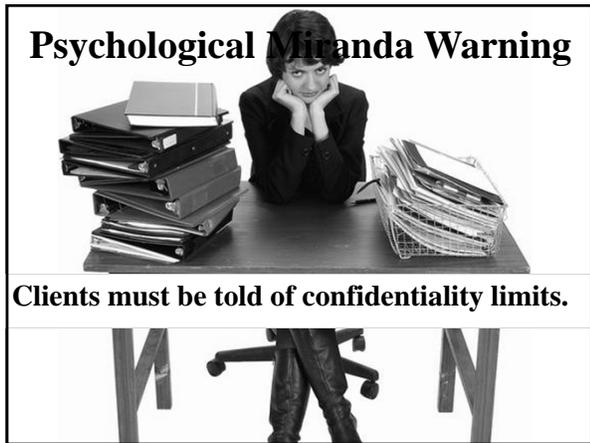


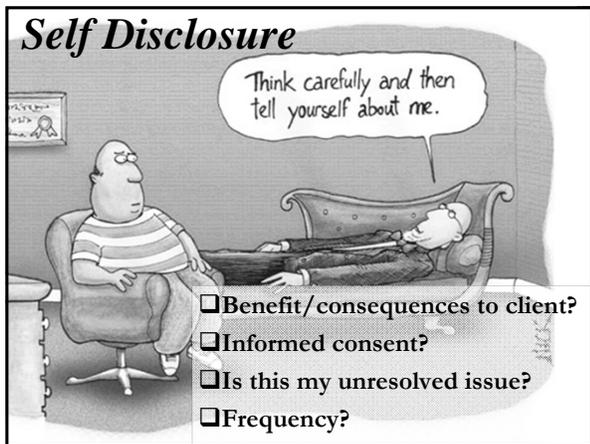


There is a statewide proposition that, if passed, would significantly cut the funding for alcohol and drug abuse agencies, including your facility. Should you advocate your patients & co-workers vote against the proposition.









- ✓“Notice of Privacy Practices:” how information may be used.
- ✓HHS has access to medical records



USA PATRIOT ACT

Law enforcement can examine records without patient's knowledge or consent

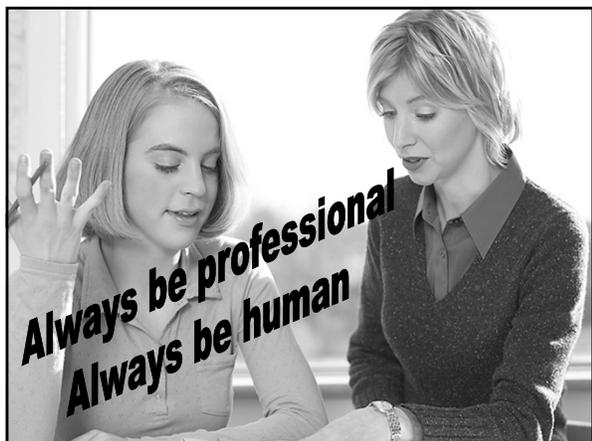
The logo for the USA PATRIOT ACT. The word "USA" is at the top, "PATRIOT" is in the middle with a stylized eye icon where the letter 'O' is, and "ACT" is at the bottom. Below the text, there is a small line of text: "THE CONSTITUTIONAL RIGHTS FOUNDATION".

**When in doubt,
be human!**

A road sign on a wooden post. The sign is tilted and has two sections. The top section says "High Road" with a white arrow pointing to the left. The bottom section says "Low Road" with a white arrow pointing to the right. The sign is set against a dark background.

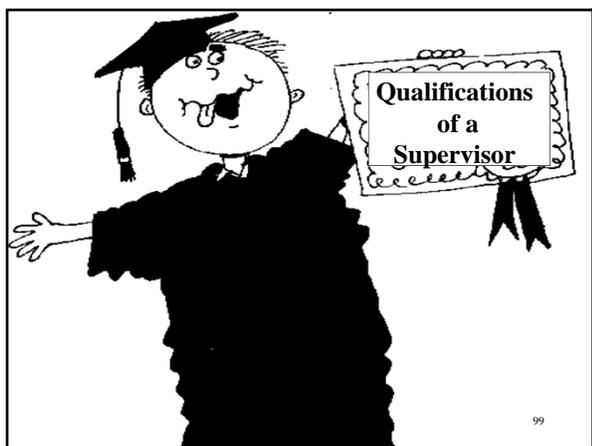
Section 2

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**Human first, counselor second.
Easy to remember, hard to do.**



- Reinforcement, authority
- Positional, your title
- Referent, your experience
- Expertise, your competence

POWER

✓ If you don't know the names of your employees' children, you're not managing.

✓ If you are not creating community, you're not managing



Qualities of Supervisors



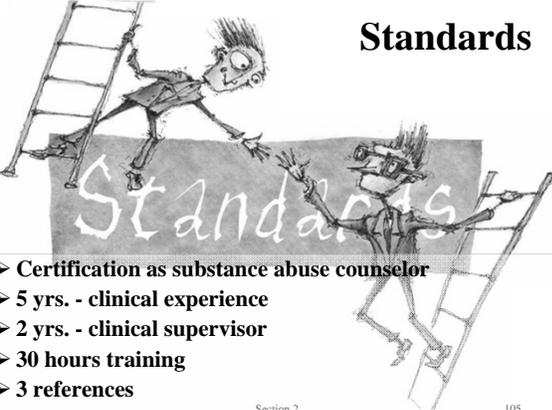


Performance Domains

- Performance Evaluation
- Counselor Development
- Professional & Ethical Standards
- Administration
- Program Development/Quality Assurance
- Treatment Knowledge



Standards



- Certification as substance abuse counselor
- 5 yrs. - clinical experience
- 2 yrs. - clinical supervisor
- 30 hours training
- 3 references
- Written exam

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Supervision Models



Section 2

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Blended Model



- ✓ Focus on changeable
- ✓ People change constantly
- ✓ Change occurs by insight & behavioral change
- ✓ We needn't know causation to resolve a problem
- ✓ People have "true self"

Section 2

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Overview of Models

1. Competency-based models, Discrimination
2. Treatment-based models, MI, CBT
3. Developmental models, Stoltenberg
4. Discipline-specific models, MSW, MFT
5. Integrated models, Blended Model

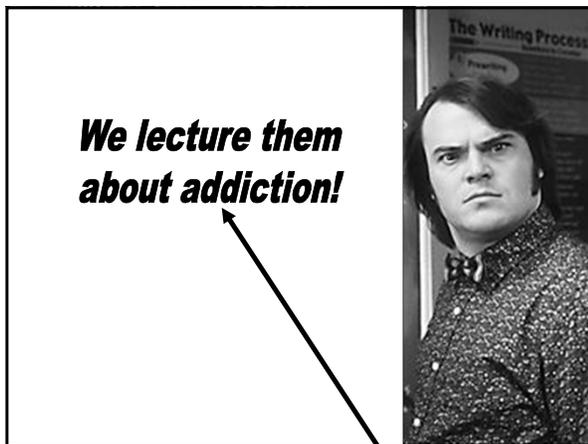


Substance abuse is rooted in pain.

- We confront patients
- Tear down their defenses
- Have them see price of addiction
- Break through denial

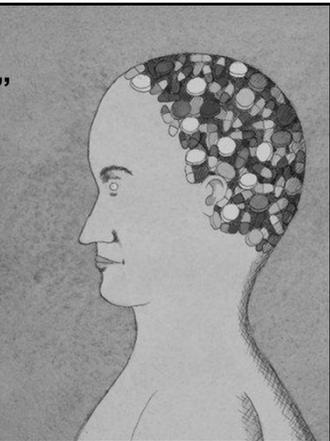




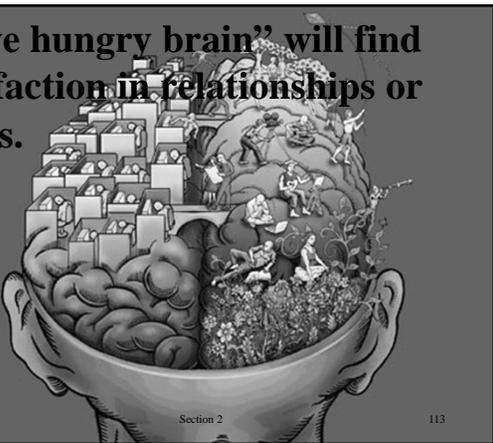


**“Drug of choice”
as if volition
was issue.**

**Drug of
Addiction**



**“Love hungry brain” will find
satisfaction in relationships or
drugs.**

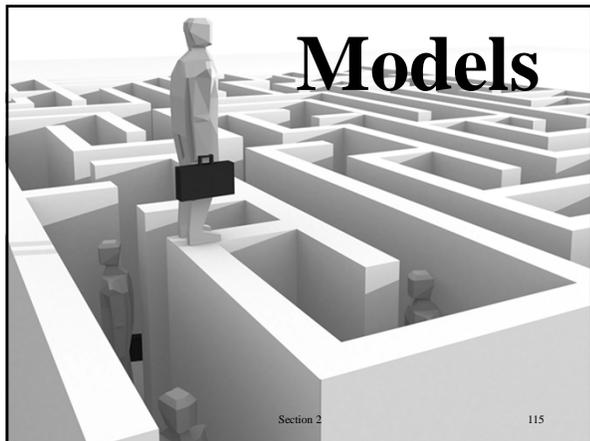


Section 2 113

5 CUPS of Treatment



Insight **Education** **Awareness** **Skills** **Wisdom**



1930s-60s

- Psychoanalytic
Transference/Counter-Transference
Intrapsychic conflicts
- Client-Centered
Non-directive
Personal growth

Section 2 116

- ✓ Behaviorism
- ✓ Supervision-practice skills

Section 2 117

Sensitive 60s & 70s

- Humanistic Psychology:
BioEnergetics, Gestalt,
Rolfing, Marathons
- Supervision? What's that?



I'm hitchhiking
my way to
self-actualization

My new therapy technique-
Naked Om Chanting



1970s-80s

- ✓ Skill-based
- ✓ Adult Children
- ✓ Co-Dependency



1970s & 1980s

- ✓ Task-Oriented, Skill-based
- ✓ Adult Children
- ✓ Co-Dependency



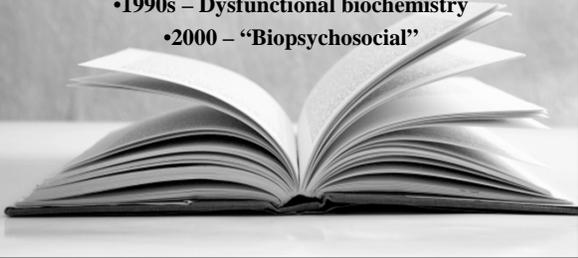
21st Century

- The Blended Model
- Developmental Approach
- Blending affective, behavioral, spiritual aspects



Summary

- 1960s – Affect, feelings
- 1970s – Cognition
- 1980s – Dysfunctional families
- 1990s – Dysfunctional biochemistry
- 2000 – “Biopsychosocial”

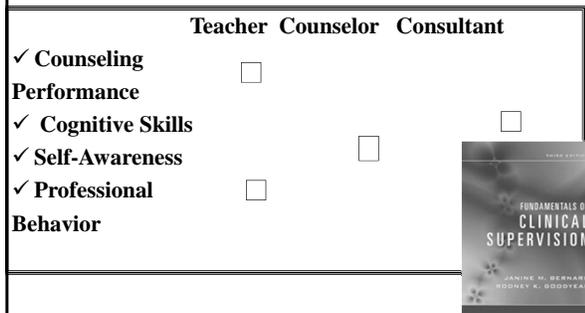


Lessons from Yalom

1. Avoid diagnosis-self-fulfilling, limits vision
2. Acknowledge your errors
3. Use your feelings as data
4. Blank screen? Forget it! Be real!
5. Be transparent

- 6. Do home visits
- 7. Don't place too much emphasis on insight
- 8. Do touch, as grist for the mill.
- 9. Non-validated therapies aren't necessarily invalidated therapies.
- 10. Cherish the occupational privilege.

Bernard & Goodyear's Discrimination Model



Mead's Task Model

- ☞ "A process of learning core competencies & refining skills for the betterment of the client"
- ☞ "...the intent to change a therapist's behavior to resemble that of the experienced therapist"



Haley's Strategic Model

“No research study shows a therapist who’s had therapy or understands personal family issues has better outcomes as a therapist”



Kagan's IPR Model

- ✓ Highly structured, directive
- ✓ “What are you thinking/feeling?”
- ✓ Audio-taping

Communications

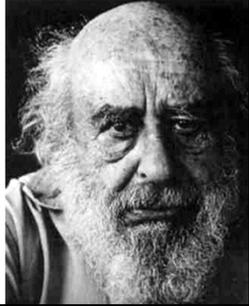
IPR Questions

- 📄 What were you thinking? Feeling?
- 📄 How did that make you feel?
- 📄 Any physical sensations for you?
- 📄 What did you want to say?

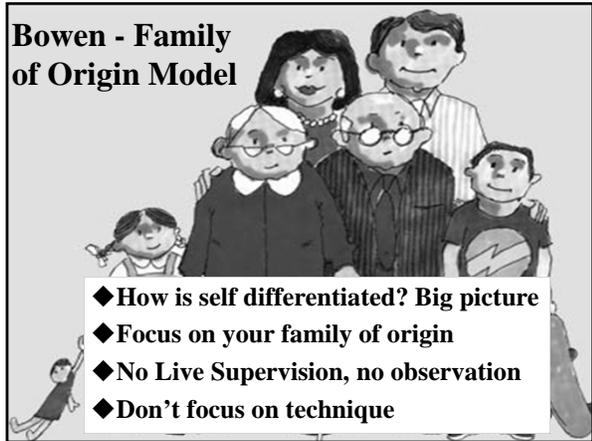


Conflict Model

- ✓ “A therapeutic process focussing on intra & interpersonal dynamics of counselor & others”
- ✓ Focus on inter & intra-personal conflict, affect, conflicts, feelings, impasses, transference, counter-transference

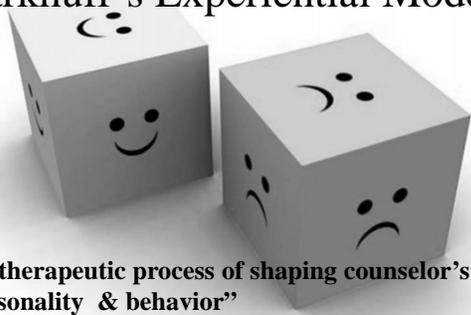


Bowen - Family of Origin Model



- ◆ How is self differentiated? Big picture
- ◆ Focus on your family of origin
- ◆ No Live Supervision, no observation
- ◆ Don't focus on technique

Carkhuff's Experiential Model

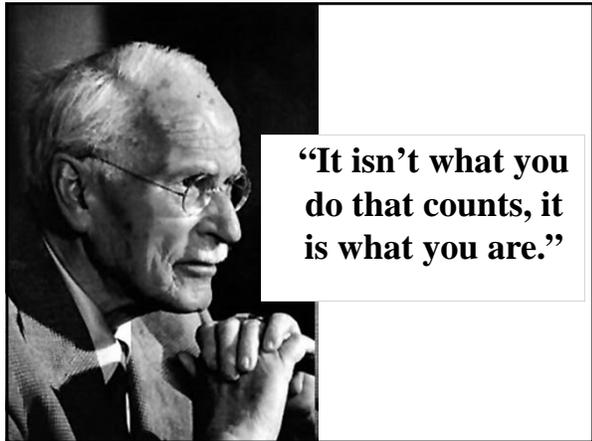


- ✓ “ a therapeutic process of shaping counselor's personality & behavior”
- ✓ Focus on personal growth

Psychoanalytic Model

“Supervision is internalizing an analytic attitude & refining listening”





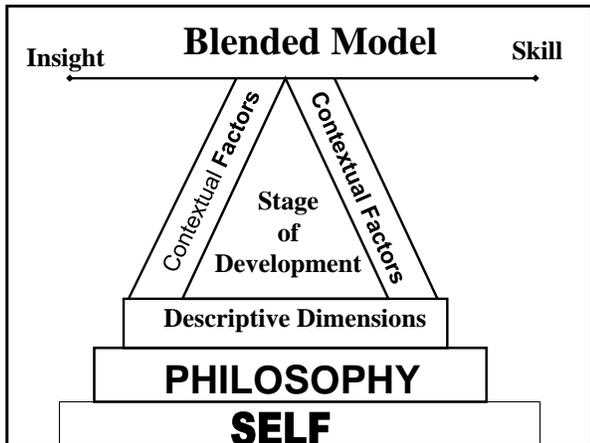
“It isn’t what you do that counts, it is what you are.”

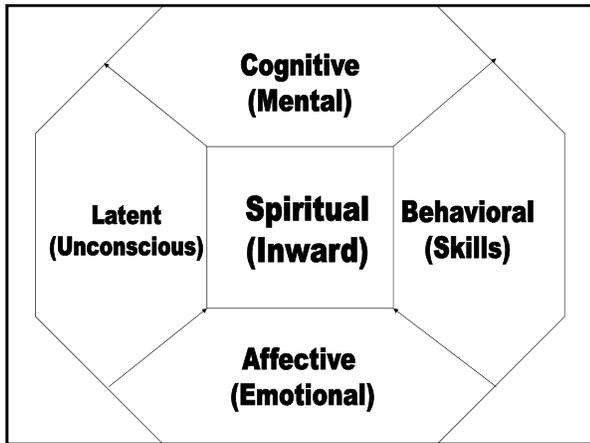
Psychoanalytic Supervision

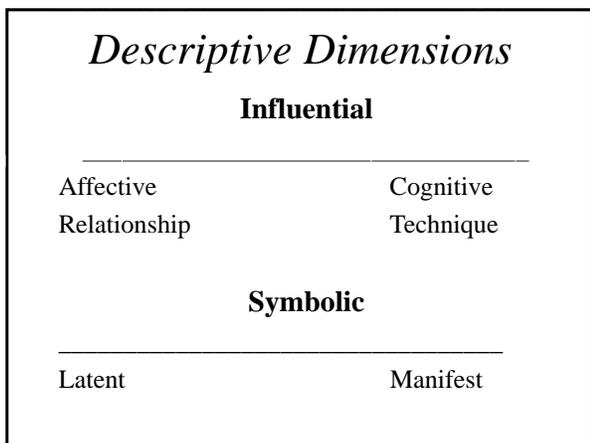
“...the dyadic pre-oedipal area of narcissistic vulnerability and oedipal issues in relation to triadic aspects.”

Carruth









Structural	
Reactive	Proactive
Strategy	
Theory	Technique

Counselor in Treatment	
Required	Not Required
Information Gathering	
Indirect	Direct

Jurisdiction	
Therapist	Supervisor
Relationship	
Facilitative	Hierarchical
Consultative	Managerial



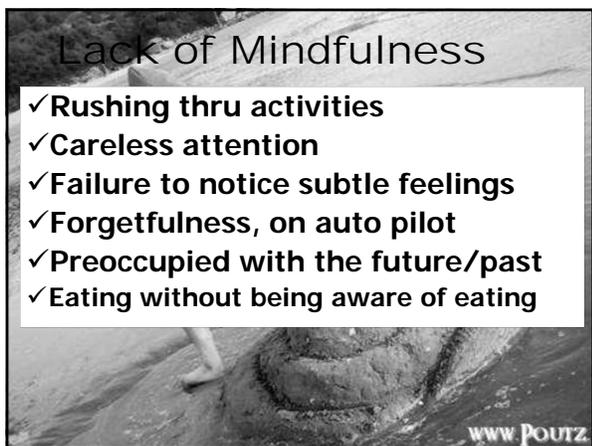
Colorful History of Presence/Mindfulness

Carl Jung, Erich Fromm, Karen Horney, Ram Dass, Herbert Benson, Jon Kabat-Zinn, Marsha Linehan



Lack of Mindfulness

- ✓ Rushing thru activities
- ✓ Careless attention
- ✓ Failure to notice subtle feelings
- ✓ Forgetfulness, on auto pilot
- ✓ Preoccupied with the future/past
- ✓ Eating without being aware of eating



--Average adult attention span--
22 seconds
--We remember ½ of what was
heard
--Within an hour we recall 20%





WHAT DOES IT MEAN TO REALLY LISTEN?

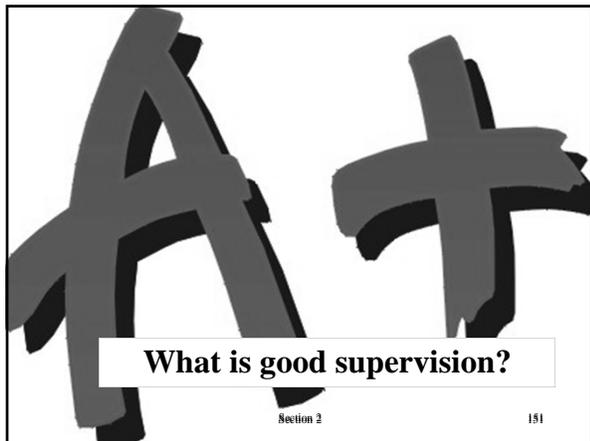
Empathy

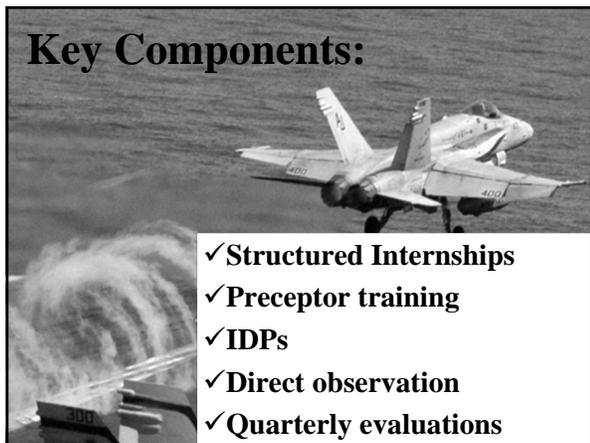


Accurate understanding of other's world seen from inside.

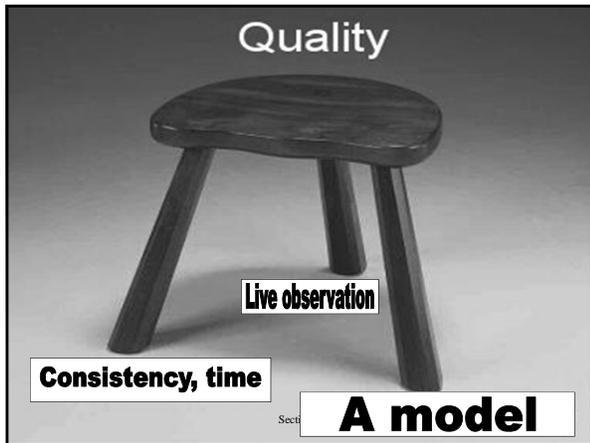


Would you rather be 20% more attentive in therapy or have 20% more techniques?

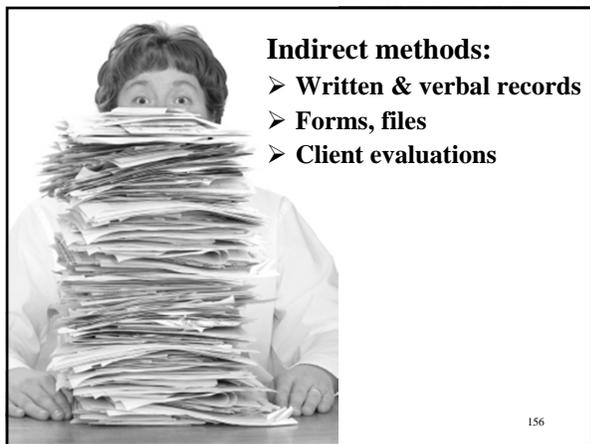


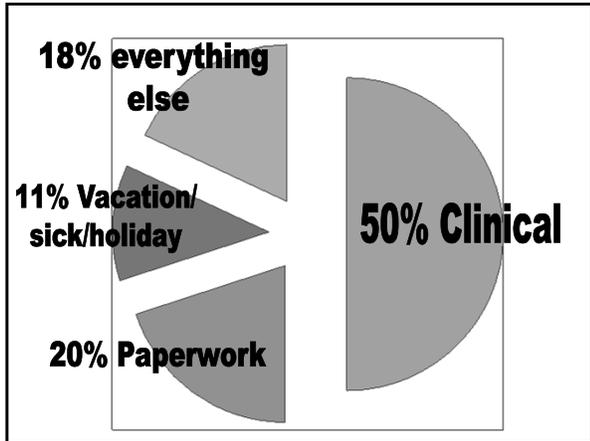




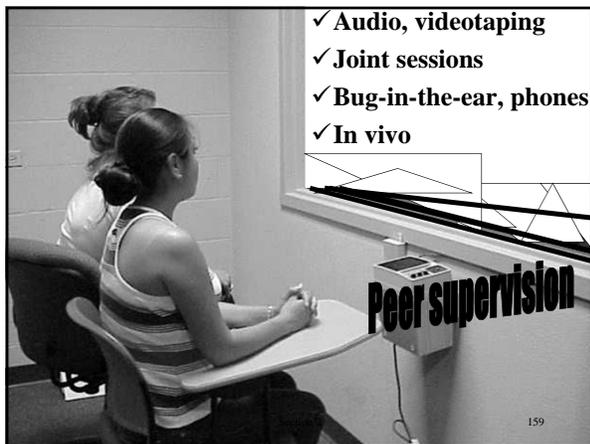








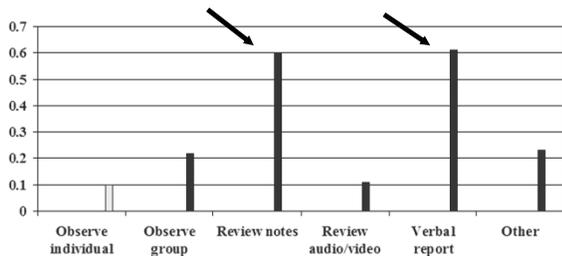




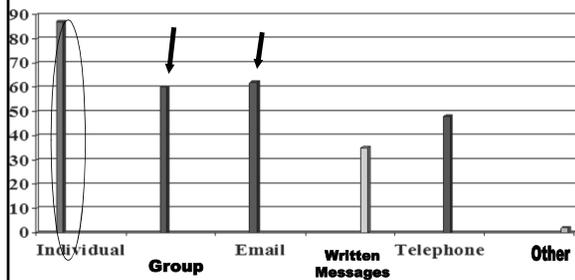
Primary Methods Used --

	1980	1990	2000
✓ Process Reports	40.1%	20.1%	15%
✓ Audio-tape	28.8%	22.4%	18%
✓ Video-tape	5.1%	13.7%	21%
✓ Co-Facilitation	6.2%	26.7%	31%

Modes of Supervision in Substance Abuse Field



Modes of Interaction



Keys in Supervision

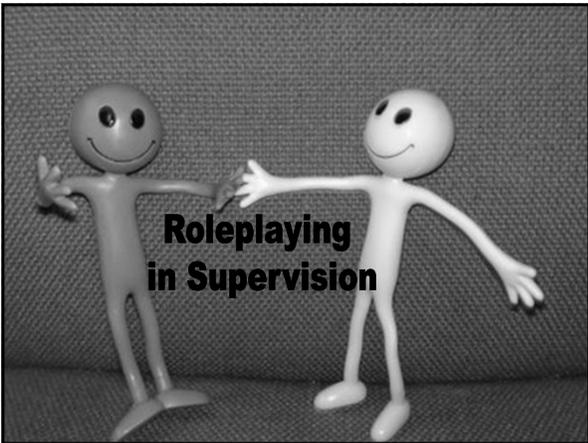
**Case management
vs. Clinical Supervision**

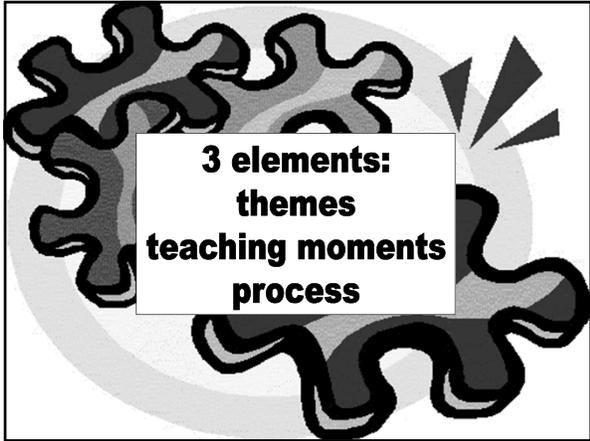


**Direct
Observation**



**Roleplaying
in Supervision**





**3 elements:
themes
teaching moments
process**

Have an IDP



Make Sandwiches



(Don't just take orders)

The flow of this page is important if you are counting the number of “f”s. If, on the other hand, the force is with you, it is easier for you to force yourself to forget what you are going, and count the “f”s your facing in this format. For that reason, it is important, regardless how you feel about it, for you to face the fact that it is, quite often, a formidable function for you to force yourself to fabricate the number you see, even if you try. So, based on what you just faced, how do you feel?

Focus on skills



© 1987 by Randy Glasbergen. E-mail: randyg@norwich.net
http://www.norwich.net/~randyghoon.html



& affect

GLASBERGEN

“You always complain that I don’t know how to show my emotions, so I made these signs.”

Chunking





Structure for Supervision

- Goals of session
- Include supervisee in planning
- “What do you need from our time?”
- Create a structure, sandwich
- Wrap up
- Document the session



- ✓ “What are your responses to this client? How was it for you to sit with this client?”
- ✓ “What is your plan for working with this client?”
- ✓ “What does client want?”
- ✓ “Concerns you have about this client?”



- ✓ Buttons being pushed?
- ✓ Why do you react to client this way?
- ✓ What do you want to do differently with client?



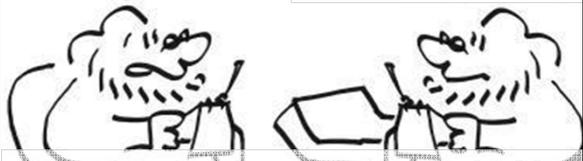
What to talk about?



What to talk about?

Section 2 177

Transference



"An *irrational* attitude not evoked by present but from other relationships."

"You have a very bad case of transference."

Section 2 178

Counter-Transference



- Mirror image of transference
- Therapist projecting her unresolved issues on patient

Stress Reduction Kit



- ✓ Not all counter-transference is harmful
- ✓ Are there unresolved issues?
- ✓ Key is it a healthy or unhealthy response

Counter-transference?

“I’m a middle-aged, never-been-married woman. I rarely, if ever, bring up an interest in men during my therapy sessions. Still, my therapist often diverts the conversation to cross-examine my efforts to find a husband. I am unsure whether my therapist’s matchmaking focus is because she believes I would be more fulfilled with a partner or because, in her culture, women are less whole without one. Is it unethical for a therapist to project their cultural values onto her client?”

Counter-Resistance

Tacit agreement between patient & therapist to avoid a topic

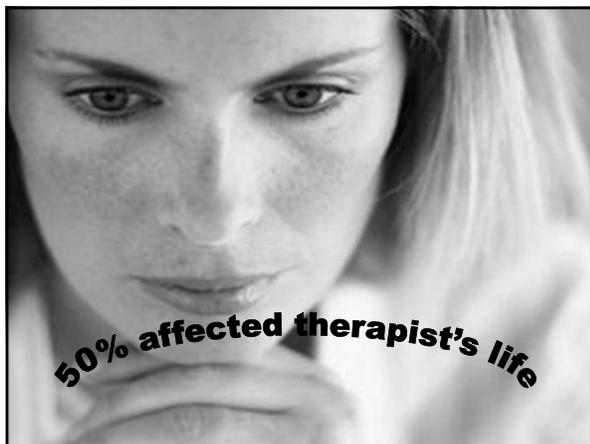




97% feared patient would commit suicide













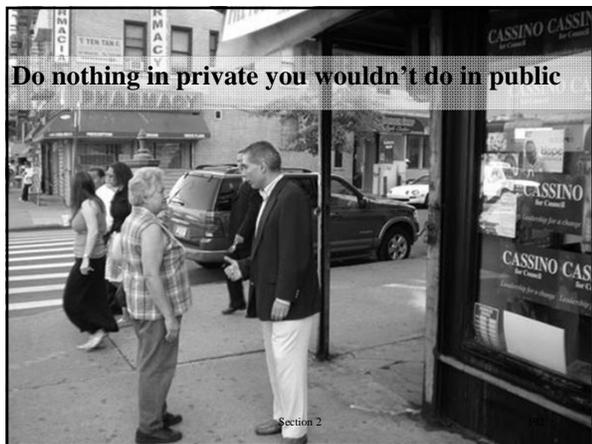


- Neutrality decreases
- Sessions more social
- Client is "special"
- Counselor self-disclosure increases
- Touch, leading to embrace



- Extra sessions begin
- Counselor manipulates transference
- Sessions scheduled at end of day, longer
- Counselor stops billing
- Social time





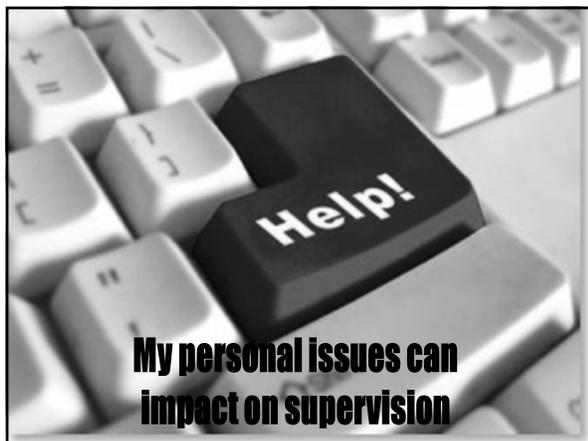
“To feel attraction to a client is not unethical. Rather it is unethical not to address the attraction in supervision.”

K. Pope





Transferring a client because of excessive counter-transference

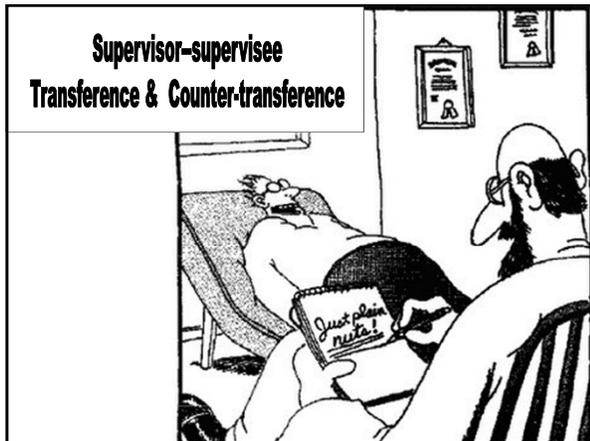


My personal issues can impact on supervision

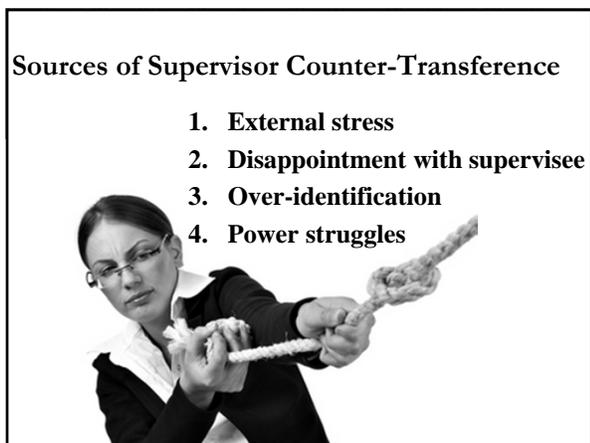


Disclosure

What's my hypothesis of what's going on in this session that makes me think self-disclosure is appropriate?



**Supervisor-supervisee
Transference & Counter-transference**



Sources of Supervisor Counter-Transference

- 1. External stress
- 2. Disappointment with supervisee
- 3. Over-identification
- 4. Power struggles

Cues to my Counter-transference

- ✓ Strong +/- feelings when with a supervisee
- ✓ Different feelings about a supervisee than others
- ✓ Gradual changes in feelings
- ✓ Discussion with colleague
Always talking about
a supervisee





Mary is a new counselor, having just completed her Masters degree in counseling. She works with male/female clients, some who have had trauma in their lives. Mary repeatedly comes to work with necklines you deem too low, & tight-fitting, short skirts. She wears high heels & a lot of makeup. You feel you need to address this in supervision.





Matt is a 55 yr. counselor, with 20 yrs experience. He works with teens & wants to be seen as understanding them. He comes to work wearing a tie die tee shirt & tight jeans. He says “the kids relate better to me when I wear such clothing.” You want to address this issue with him but he is very resistant, saying “You’re “old fashioned.”

Talking about Attire

- 1. Own your feelings. “I am uncomfortable talking to you about this.”**
- 2. Remind supervisee of supervision goals.**
- 3. Empathy. “You may hear this feedback as criticism/maybe think I am just old-fashioned.”**



- 4. State issue clearly from your perspective. Avoid character or motives.**
- 5. Give specific examples.**
- 6. Ask supervisee their thoughts.**



1. Supervision, training
2. A limited intake
3. Guidelines on gifts, touch, dual relationship



Stages of Development



Assumptions

- ⌚ There's a beginning point but no end point
- ⌚ The order is approximately the same
- ⌚ Advanced have different needs



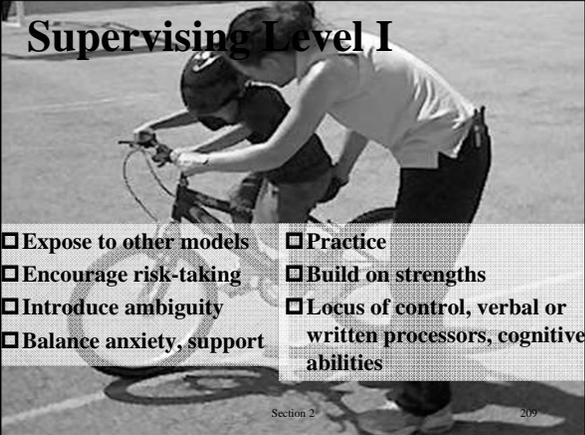
Level I



<ul style="list-style-type: none"> <input type="checkbox"/> Basic skills <input type="checkbox"/> Anxiety & enthusiasm <input type="checkbox"/> Follows role model <input type="checkbox"/> Cookbook answers <input type="checkbox"/> Probing, confrontation, self-disclosure 	<ul style="list-style-type: none"> <input type="checkbox"/> The right way to counsel? <input type="checkbox"/> Dependent <input type="checkbox"/> Anecdotal, categorical vs. conceptual thinking <input type="checkbox"/> Doesn't know what she doesn't know
--	--

Section 2 208

Supervising Level I



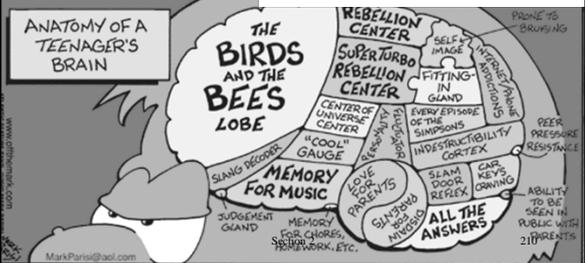
<ul style="list-style-type: none"> <input type="checkbox"/> Expose to other models <input type="checkbox"/> Encourage risk-taking <input type="checkbox"/> Introduce ambiguity <input type="checkbox"/> Balance anxiety, support 	<ul style="list-style-type: none"> <input type="checkbox"/> Practice <input type="checkbox"/> Build on strengths <input type="checkbox"/> Locus of control, verbal or written processors, cognitive abilities
--	--

Section 2 209

Level II

- Frustrated with difficult clients
- Wants autonomy but still dependent

- Knows something's broken, lacks skills to fix it
- Doesn't imitate supervisor
- Doesn't want recommendations



Mark Parisi@aol.com

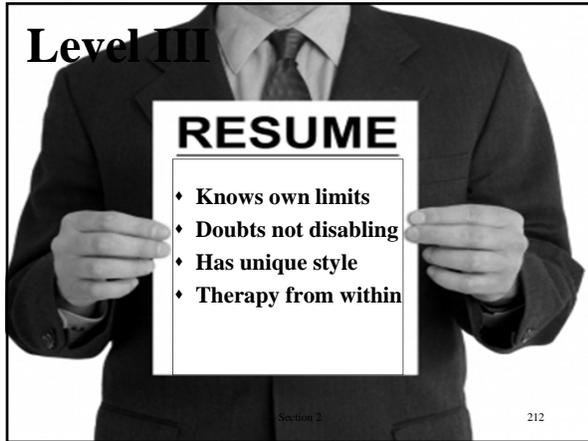


Supervising Level II

- ≈ Focus less on technique
- ≈ Wear flack jacket
- ≈ Challenge your competence
- ≈ Blends clients
- ≈ Promoted up- they know what you don't know

2

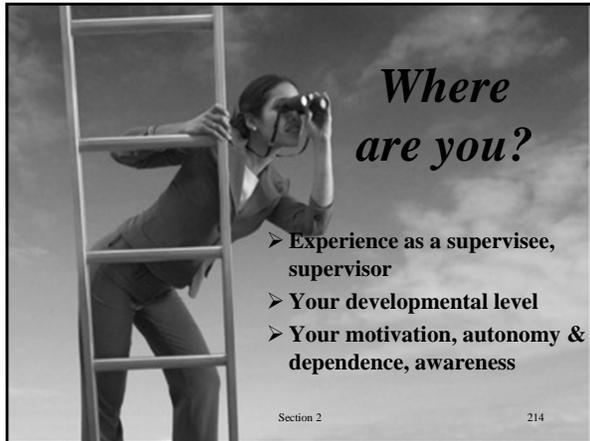
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212



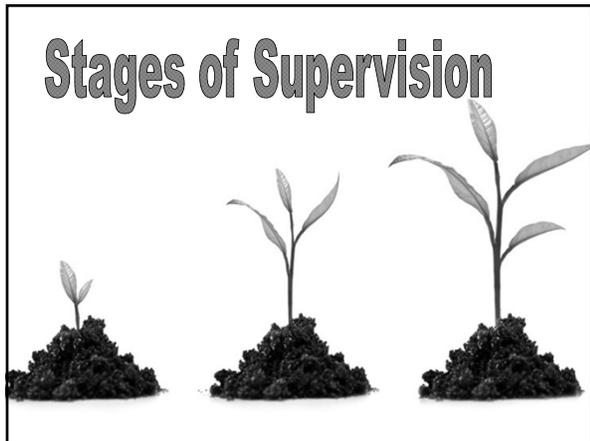
213



Where are you?

- Experience as a supervisee, supervisor
- Your developmental level
- Your motivation, autonomy & dependence, awareness

Section 2 214



Stages of Supervision



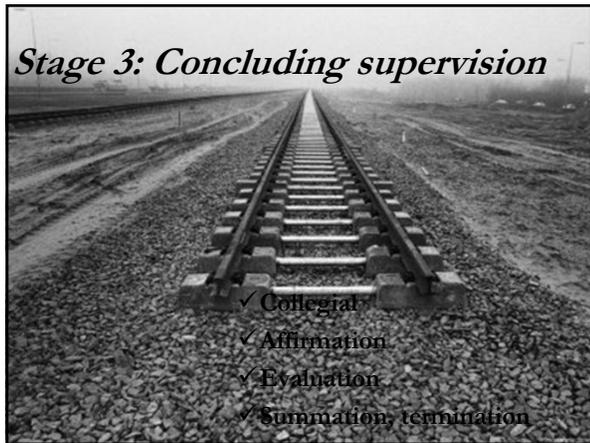
Stage 1: Building an Alliance

- ✓ Acceptance
- ✓ Openness
- ✓ Forming contract
- ✓ Trust building



Stage 2: Working Alliance

- ✓ Parallel process
- ✓ Skill acquisition
- ✓ Self-awareness
- ✓ Ethical sensitivity



Stage 3: Concluding supervision

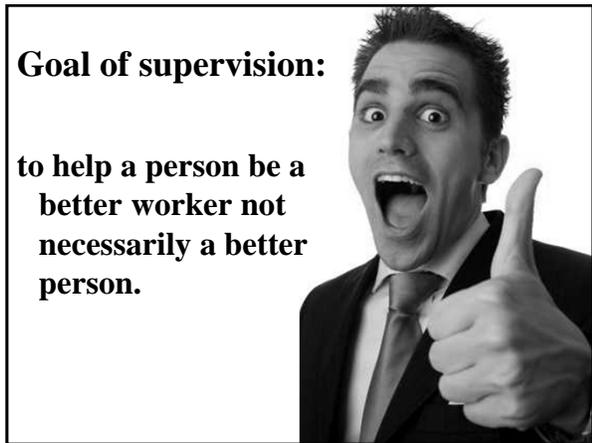
- ✓ Collegial
- ✓ Affirmation
- ✓ Evaluation
- ✓ Summation, termination

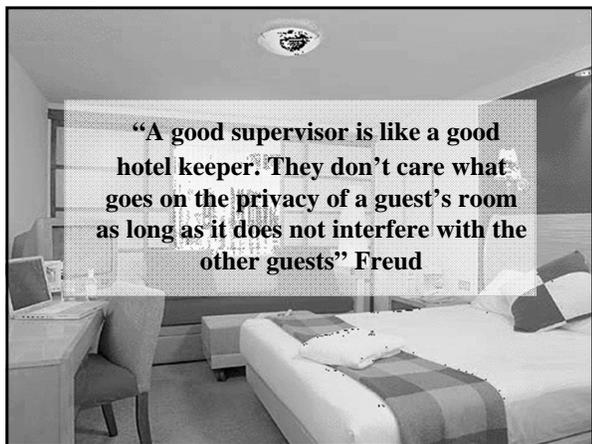


1st Session

- What to expect
- Licenses/certification
- Backgrounds
- How supervision works
- What to do is disagreement
- Confidentiality
- Boundaries









Supervision looks like therapy not because a supervisor does therapy with a supervisee but because a therapist does supervision



Is there a time for counseling in supervision?

- ✓ Potential harm to client
- ✓ Transitory issues
- ✓ Events are so intense it's impossible to respond



Abuse at work

- o Know personnel law & your lawyer
- o Have an EAP. Use it!
- o Legal & illegal drugs
- o Eating disorders, smoking, overwork

Warning signs of Impairment

- Change in affect
- Withdrawal
- Withholding vital information
- Excessive counter-transference
- Changes in patient visits
- Attire
- Absenteeism/tardiness
- Inappropriate self-disclosure



Problematic Supervisees

- Inadequately trained
- Unaware of counter-transference
- Excessive need for approval
- Organic impairment
- Impaired judgment
- Psychopathology
- Emotionally needy



Paperwork



1. Client notes are public records/can be subpoenaed.
2. Don't write anything you don't want read in court.
3. Good notes are important, necessary.
4. Don't leave out key information (this is fraud).
5. Use behavioral descriptors, avoid emotions, subjective impressions.

6. Be concise, brief, avoid excessive quotes, lengthy descriptions.
7. Avoid disparaging remarks about clients, their lifestyle, parentage, culture, race, diagnosis.
8. Take notes right after each session, if possible.
9. Lock files. Password protected. Control access.
10. Know legal requirements/regulations, HIPAA.
11. Randomly check files



Basics of Hiring

- If not pleased start over. Never settle
- Make it hard to get a job, hard to leave
- Interview a lot, hire a few



- There are few hiring emergencies, take time
- Hire in teams, at different times
- Listen to staff's impressions
- Don't fall in love



High Satisfaction

1. Hire cheerful, empathic people
2. Teach staff to actively solicit patient needs
3. Teach staff to show concern for privacy
4. Brief patients on their condition, status, delays
5. Teach staff how to defuse anger



1. Is she happy?
2. Is he smart?
3. Does she like people?



S.H.A.R.E.

S- Sense people's needs (Initiative)

H- Help each other out (teamwork)

A- Acknowledge people's feelings (empathy)

R- Respect the dignity & privacy of staff (courtesy)

E- Explain what's happening (communication)





- Never pass another employee in the hall without greeting them with a smile
- Avoidance violates corporate culture.

Firing

- Did you follow progressive discipline?
- Is it documented?
- Did you use a standard criteria?
- Have you talked to HR? Lawyer?
- Discrimination?
- Work in male/female team
- When to fire?





✓ Make it quick. Help them
leave, safety first. Get
everything back
offer EAP
leave them some dignity
except you'll be sued
anyway
answer no questions.
respect their privacy
Reference?



Solution Focussed

“If you find yourself
in a hole, the first
thing to do is stop
digging.”
Will Rogers



“When I focus on what’s good today I have a good day. When I focus on what’s bad, I have a bad day. If I focus on a problem, the problem increases, if I focus on the answer, the answer increases.”





Solutions
NEXT EXIT →

- ✓ No approach works for everyone
- ✓ Solution & problem may bear little resemblance
- ✓ Simplest, least invasive approach is oft best
- ✓ Focus on strengths, resources not weaknesses
- ✓ Focus on future rather than past

KISS & SMART





- How have you been successful with this type of client in past?
- In a bad session what were good moments?
- What did you do well?





What would you like to do differently?
When you act as you want to, what's different?

The “Miracle Question”

If you woke up tomorrow & a miracle happened, all was better, how would you act differently?



Externalizing the Issue

- Make the problem an “it.”
- How have you allowed *it* to not bother you at other times?



1  

2  

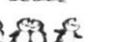
3  

4  

5  

6  

7  

8  

9  

10  

Boundary Profiling

On a scale of 1-10, how'd you rate this?

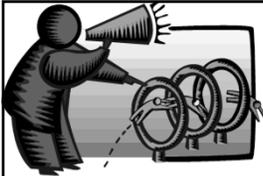
What will I notice if you were a 10?

To go to 8, what do we need to do?

Identifying Exceptions

How have you stopped it from occurring?
What's different about the situation before,
when you were effective?





Cheerleading

- I know this case is difficult. It's for most!
- That's great! Keep doing that!
- You should be pleased with how went it went. That's good for a difficult case!
- How did you do that? How'd you stay in the room so long? I felt like leaving.

Future Oriented

What would we notice if it was better tomorrow?
What do you want to look for now to improve?
Where are you getting better?

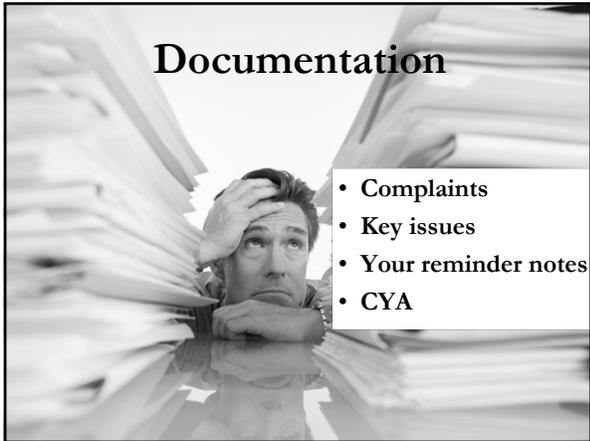


Encouraging Change

- Do more of that. It worked. Do it again.
- What'd it be like if that happened always?
- What else in your life can you draw on to continue doing that?



Documentation



- Complaints
- Key issues
- Your reminder notes
- CYA

Evaluating Counselors





Formative

- ✓ Enabling process, regular, feedback on competencies,
- ✓ “Are you going in the right direction?”
- ✓ The quality of relationship determines success of process

Assessments

Summative

- ✓ How does the supervisee measure up?
- ✓ Formal evaluation
- ✓ Job rating, Fitness for duty

Assessments

What ha Summative

- Authority, power, hier
- As a supervisor you r
your authority
- When you evaluate a
evaluate yourself
- Brings up emotions: r
criticism, performanc



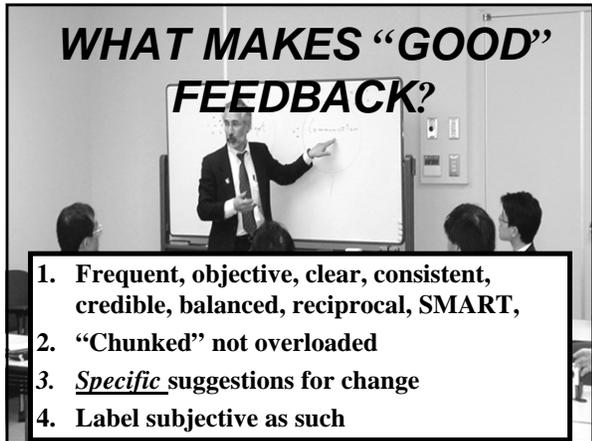
Issues in Summative Evaluation

- We remember the negatives
- Not owning our value-based judgments
- Not always clear or direct
- Tackling too many problems
- Giving only negative criticism



WHAT MAKES “GOOD” FEEDBACK?

1. Frequent, objective, clear, consistent, credible, balanced, reciprocal, SMART,
2. “Chunked” not overloaded
3. *Specific* suggestions for change
4. Label subjective as such





- 5. Supervisor demonstrates expertise
- 6. Direct information through observation
- 7. Supervisee able to offer alternatives
- 8. In supportive, trusting relationship



Least Preferred Feedback by Supervisees

Unannounced observations, no feedback, vague, no suggestions or specificity for improvement, perfunctory or indirect feedback, withholding information, hurtful delivery



Problems in Assessment

- What is a “good counselor?”
- Non-specific personal qualities
- Few (if any) evaluation instruments have psychometric validity or reliability



#1 complaint by supervisees of ethical violation by supervisors: Improper, inadequate, unfair assessment procedures

1 Rule of Feedback

Catch them doing something right!



How to give useful feedback

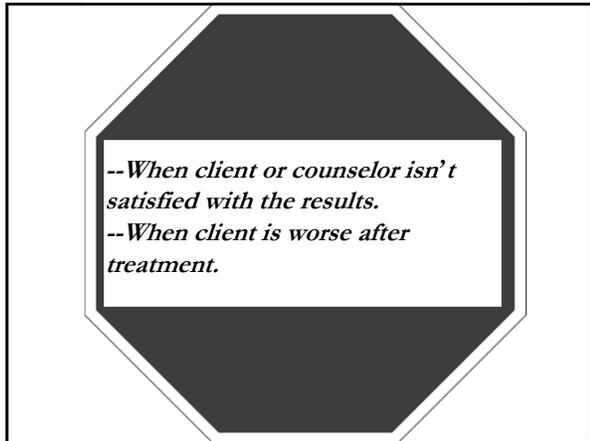
- Describe don't judge
- Be SMART
- Deal with changeable behavior
- Don't pile on too much
- Check it out
- Do not discipline when giving feedback



Individual Development Plans

- ✓ Define roles & responsibilities
- ✓ Identify desired knowledge & skills
- ✓ Be flexible, it's a work in progress
- ✓ Do it together!





What Patients say

- Passive, un-empathic counselor.
- A waste of time, feels unsafe.

A cartoon illustration of a doctor's office. A doctor is sitting at a desk with a computer monitor. A sign on the wall reads "PLEASE DON'T WASTE THE DOCTOR'S TIME WITH QUESTIONS". The doctor is looking at a patient who is standing and talking. The doctor's name "MD" is written above the desk. The cartoon is signed "VOTKO" at the bottom.

- Counselor doesn't listen, follows own agenda.
- Does same thing over & over again.
- Inflexible, reluctant to make needed adjustments.

A black and white photograph showing the back of a person's head. Two hands are pointing to the person's ears, symbolizing that the person is not listening.

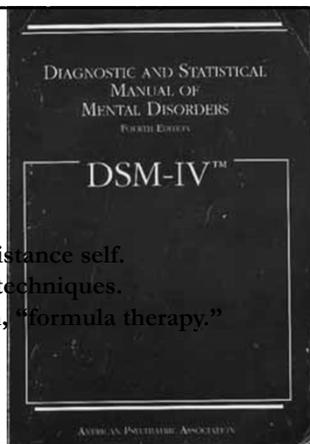
- ✓ Not sure where you're going.
- ✓ Arrogant, overconfident, "infallable". We're not as smart as we think we are!
- ✓ Counselor's lazy, punishing, disrespectful, impatient



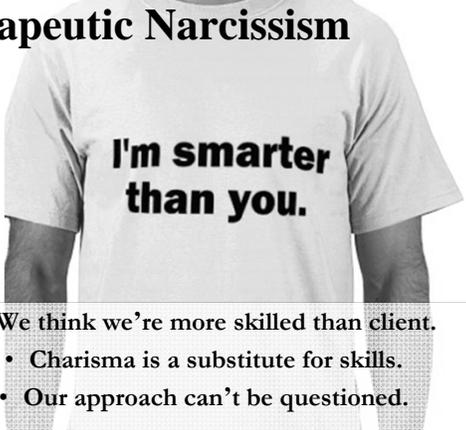
- Fails to create therapeutic alliance.
- Excessive counter-transference; boundaries.
- Invalid assumptions; trusts intuitions solely.



- Uses DSM labels to distance self.
- Uses unproven fancy techniques.
- Stuck with 1 approach, "formula therapy."

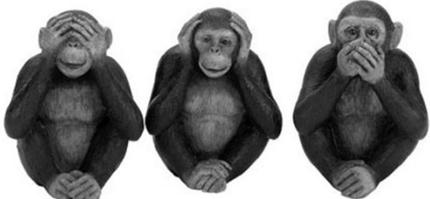


Therapeutic Narcissism



- We think we're more skilled than client.
- Charisma is a substitute for skills.
- Our approach can't be questioned.

How to ruin the therapeutic alliance



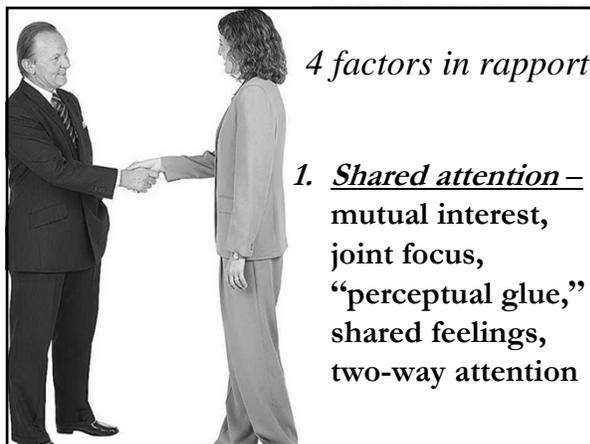
1. Emphasize technique over relationship.
2. Don't elicit feedback about the alliance.
3. Respond defensively to negative client feedback.



- Your worst therapy session? What happened?
 - What was so awful for you? The client?
 - What's it like to talk about it now?
 - What would you have done differently?
 - What did you learn from that experience?







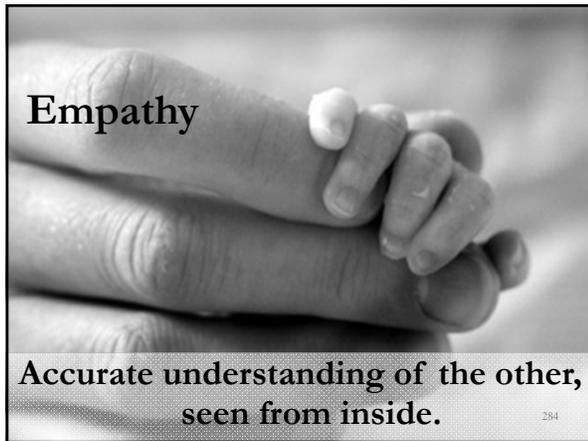
2. Mutual empathy – people experience being experienced.

GIVING EMPATHY

Social ease = comfort

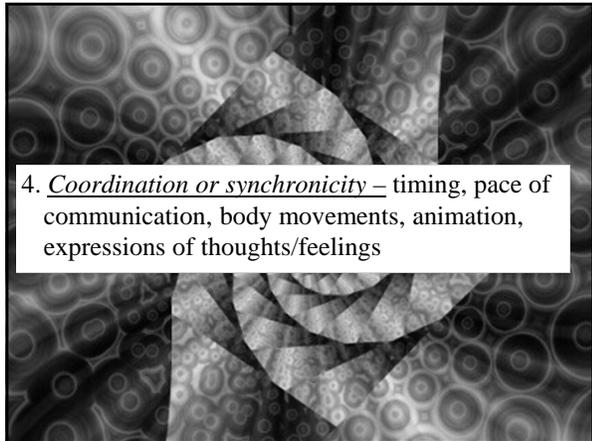
Rapport = attuned to feelings



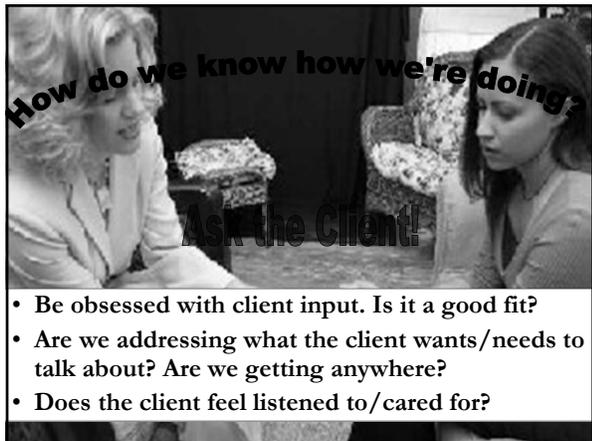


3. Good feelings – tone of voice, facial expressions, non-verbals, sense of positivity, warm feelings towards each other





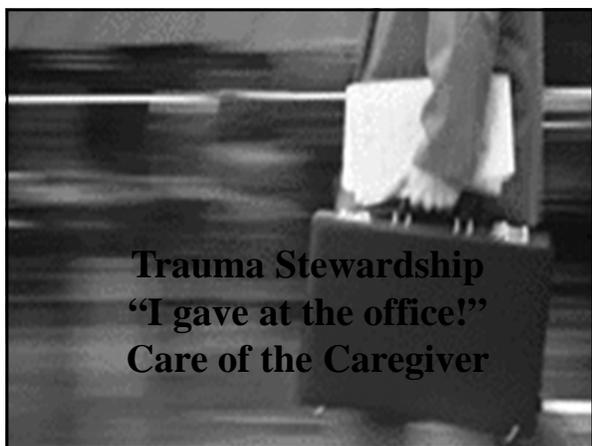
4. *Coordination or synchronicity* – timing, pace of communication, body movements, animation, expressions of thoughts/feelings



How do we know how we're doing?

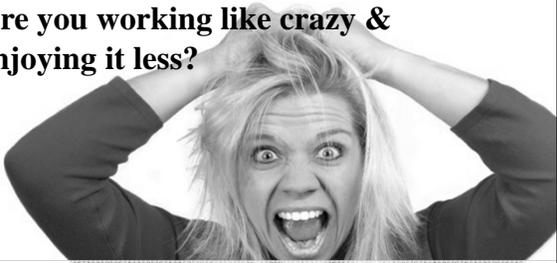
ASK the Client!

- Be obsessed with client input. Is it a good fit?
- Are we addressing what the client wants/needs to talk about? Are we getting anywhere?
- Does the client feel listened to/cared for?



**Trauma Stewardship
"I gave at the office!"
Care of the Caregiver**

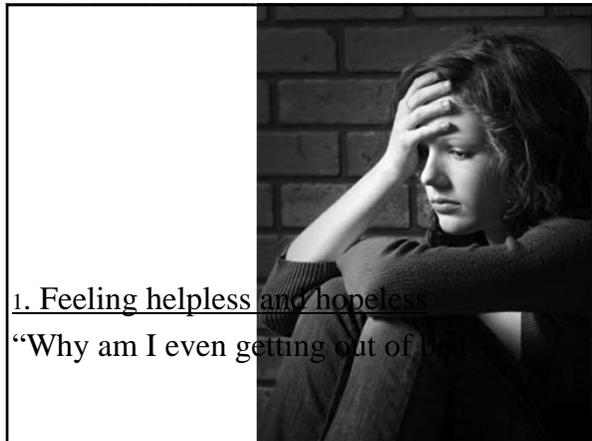
Are you working like crazy & enjoying it less?



- “I should have left an hour ago.”
- “Between work & family, I don’t have a minute for myself.”
- “There has to be more to life than work.”



Warning Signs
Erasmus B. Dragon



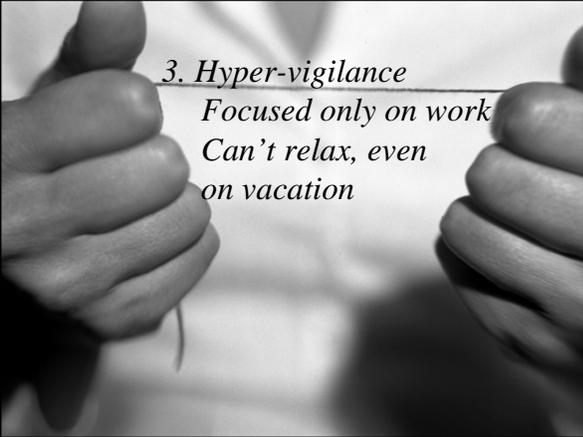
1. Feeling helpless and hopeless
“Why am I even getting out of bed?”

2. I can't do enough

- "I should be doing more."
- Expect scarcity.

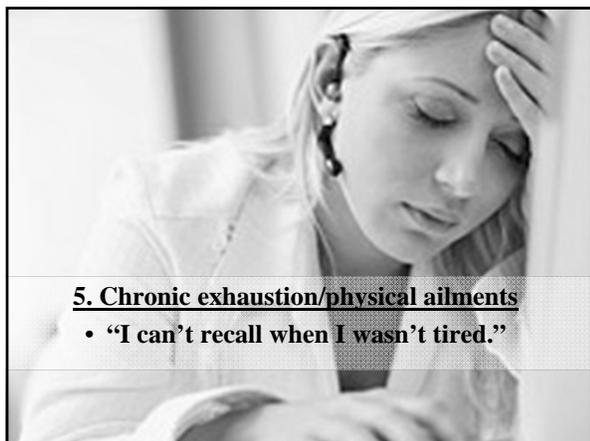


3. Hyper-vigilance
*Focused only on work
Can't relax, even
on vacation*



4. Minimizing
Trivializing
"You had a hard day? Let me tell you about pain."



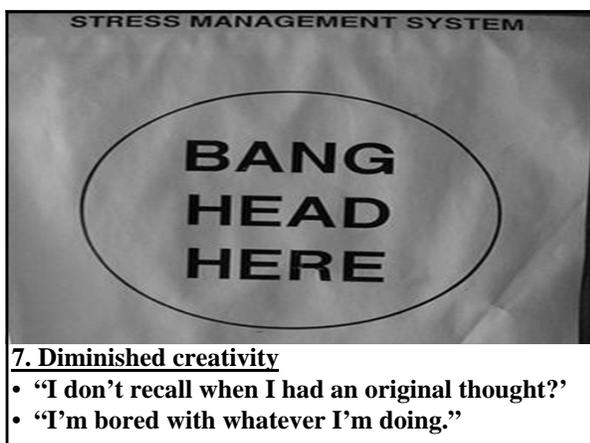


5. Chronic exhaustion/physical ailments

- “I can’t recall when I wasn’t tired.”

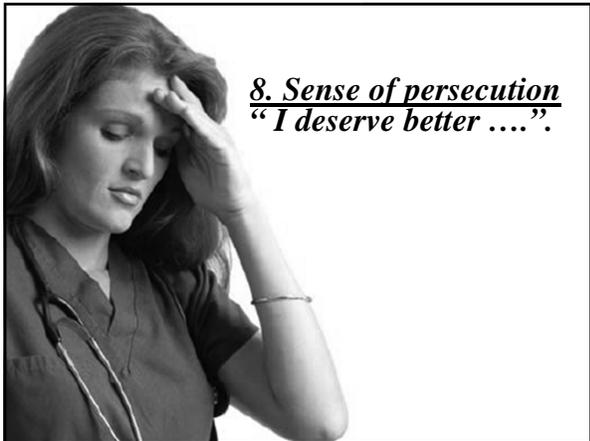


6. Inability to listen



7. Diminished creativity

- “I don’t recall when I had an original thought?”
- “I’m bored with whatever I’m doing.”

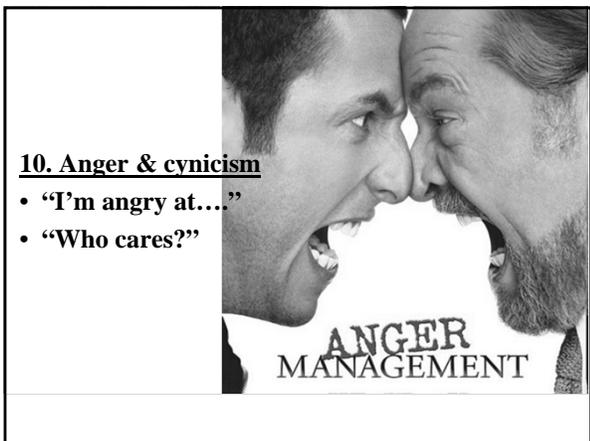


8. Sense of persecution
"I deserve better".



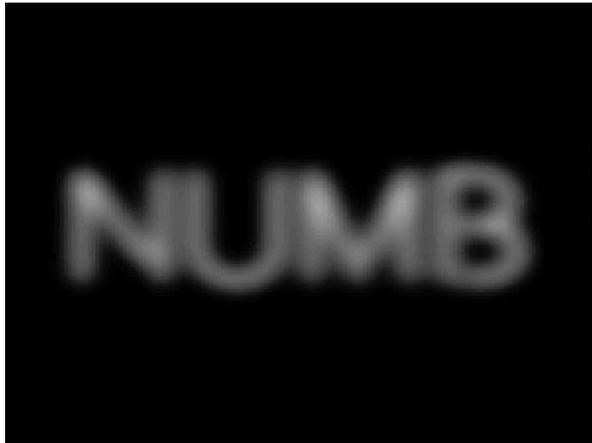
9. Guilt

- "I shouldn't feel good about my job after seeing patients' lives"
- "I feel guilty because I can leave at any time"



10. Anger & cynicism

- "I'm angry at..."
- "Who cares?"



ME

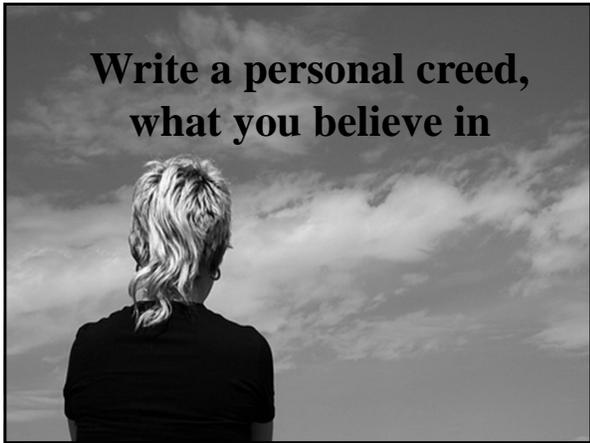
12. Inflated self importance

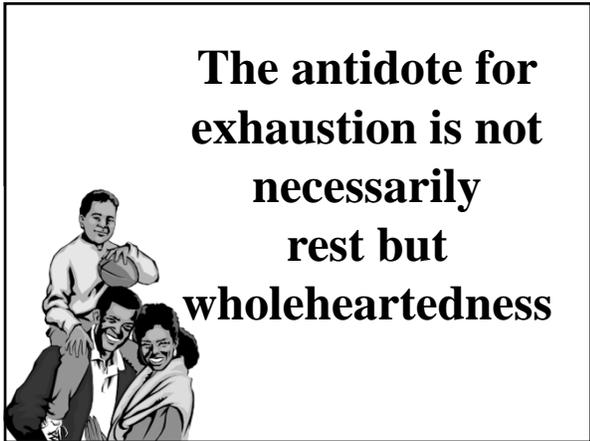
- “It would fall apart without me.”
- “If I weren’t here, it wouldn’t get done.”

1. Create Space for Inquiry

Why am I doing this?

He who has a “why” can bear almost any “how.”





2. *Choosing your focus*

- “What went well today? What should I leave behind today?”
-



Everyone Needs a Plan B!

- “Let yourself be silently drawn by the stronger pull of what you really love.” Rumi
- “If I weren’t doing this, what would I love to do?”



3. Build community

Self-help group, sponsor. How does your community nurture you? Do you need stronger models?

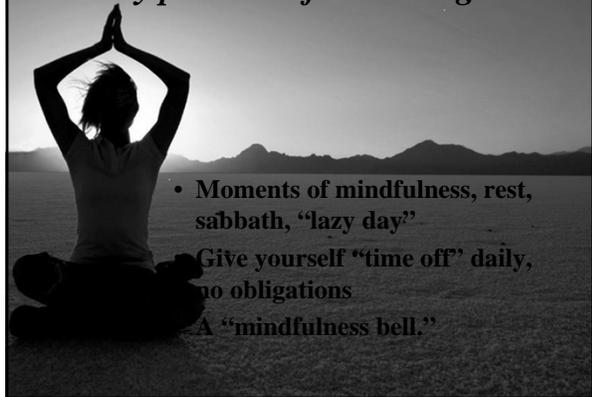
4. Finding Balance: life outside work



- 3 minutes between meetings.
- Make an appointment with sleep
- Write down all your time off. **Use it.**



5. A daily practice of Centering

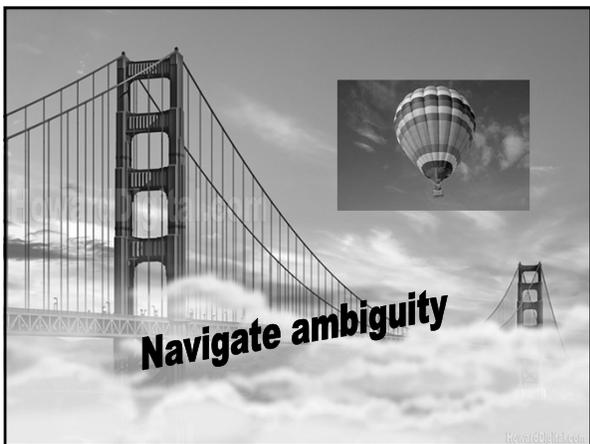


- Moments of mindfulness, rest, sabbath, “lazy day”
- Give yourself “time off” daily, no obligations
- A “mindfulness bell.”

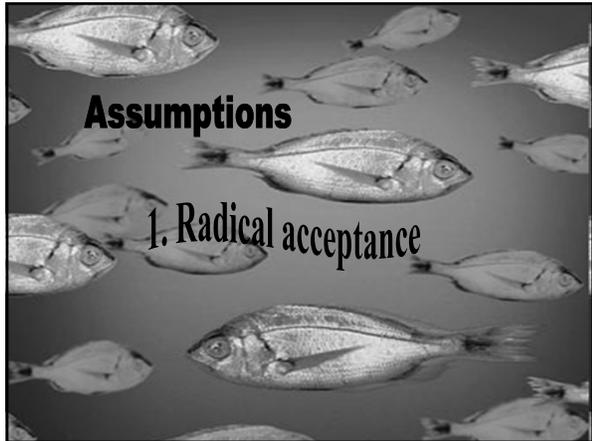




















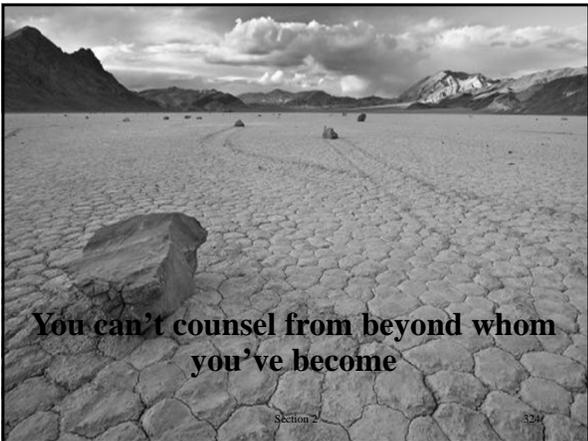
Longest trip you'll take is the journey from head to the heart.



The way to connect with others is to experience them, not think about them.



You can't counsel from beyond whom you've become



3 Principles of Healing

1. If we don't transform pain we transmit it!
2. Transformed people transform people
3. Love transforms people

Section 2

“My teacher said, ‘You have fine technique, great virtuosity, but you haven’t found yourself yet.’

I finally saw that musicianship is not about technique but love, giving, generosity.”

