A Comprehensive Framework for Clinical Supervision

Course Agenda

- Introduction & overview
- Goals & challenges of middle management
- Models of supervision
- Anxiety management
- Learning styles
- Learning problems vs. problems about learning
- Leadership styles
- Covey time management
- Parallel process
- Relationship triangle
- The big 6: What to do when you get stuck
- 4 stages of professional development
- 4 supervisory mistakes you never want to make
- Ethics, liability, recordkeeping
- Challenges of new supervisors / interns
- Methods of clinical training
- Diversity competence
- Supervision vs. therapy
- Use of groups: When & how
Goals & Challenges of Middle Management

Goals

- Maintain quality control
- Develop / maintain staff
- Adhere to / develop budgets
- Develop programs / coordinate with other teams / community

Challenges

- Supervising staff you have not hired
- Supervising staff at different experience levels
- Nurturing staff to become generalists rather than specialists
- Limited funds
- In the Middle: Represent management, advocate for staff, buffer / filter information from above

Qualities of Good Managers

- **Be the role model you are** – you can’t not be a role model – be aware and deliberate

- **Demonstrate leadership & proactivity** – be in charge, set the pace, the culture, the priorities, the vision; set goals, let others help with means; don’t be reactive

- **Be realistically optimistic** – emotional climates are contagious; speak the truth, but provide energy & solutions; don’t need to have all the solutions (read Leading at the Edge, Perkins)

- **Think individual, think team** – what do individuals need to develop; how can you create a sense of team (cops in the car, same goals & missions); when / how do individual problems reflect team problems
  
  - **Fundamental Attribution Error**: Assume people problem rather than a situation problem
Learning Problems vs. Problems About Learning: Skill vs. emotional over-ride

- **Have clear expectations, standards, & actions** – clear communication; make directives concrete, specific & behavioral – creates trust, safety, reliability

- **Treat everyone equally & fairly** – need to adjust to style to help individuals develop but have same expectations among peers; no favorites
  (read *Leading At the Edge*, Perkins)

Models of Clinical Supervision

Models Grounded in Clinical Theory

**Psychodynamic Supervision**

- Budapest School – supervision as continuance of analysis, therapeutic
- Viennese School – supervision as focus on supervisor – clinician relationship, educational
- Supervisor focus – clinician, client, or supervisory relationship
- Use of parallel process, supervisor as expert imbedded in relational process

**Person-Centered Supervision**

- Follow the lead of therapist
- Help therapist grow in self understanding and skill
- Supervisor give input on their own approach
- Teaching relationship building as skill

**Cognitive –Behavioral Supervision**

- Potential of clinician as potential to learn
- Focus on skills and strategies rather than personality
- Skills are behavioral; use of role playing, imagery exercises
- Assessment and monitoring of supervision essential; challenging of cognitions

**Systemic Supervision**

- Active, directive, collaborative
- Focus on boundaries, transference as family or origin dynamics
Use of live supervision, reflecting teams

Constructivist Approaches – Narrative, Solution-Focused
- Consultative role of supervisor, focus on strengths, downplay of hierarchy
- Curiosity rather than knowing, supervisor as editor of evolving script
- Use of questions to guide interactions

Developmental Models of Supervision

Stage Models (Loganbill, Stoltenberg, Taibbi)
- Clinicians move through levels – increase in skills, independence, self awareness over time
- From unawareness – doing right, blindspots, black and white thinking, dependency – to confusion, conflict – pulling away from supervisor, erratic behavior, more self awareness – to integration – new understanding, balanced view of supervisor, flexibility

Process Models – Reflective (Ward, Driscoll)
- Focus on trigger event that creates discomfort or confusion; reflect upon skills, self, theory; re-evaluate situation; gain new perspective
- Move from feedback-oriented supervision (supervisor as teacher) to reflectivity-oriented supervision (self-supervision, supervisor as consultant)

Life-Span Models (Ronnestad and Skovholt)
- Changes over career: Lay-helper, beginning student, advanced student, novice professional, experienced professional, senior professional (characteristics of each stage)

Social Role Models of Supervision (Bernard, Ekstein, Holloway, Kadushin)
- Supervision moves among teacher, counselor, consultant, administrative roles
- Choose roles that fit workplace and clinician abilities, with each role comes specific tasks

Anxiety Coping Styles

- **Approach:** Feels anxious but sees as part of learning new skill or need to solve problem – able to move forward, take risks, is creative.

- **Avoid:** Feels anxious and feeling is the problem – tries to get rid of feeling by distraction, use of drugs and medication. Easily overwhelmed; looks to others to fix.

- **Bind:** Does not feel anxious by staying within rigid patterns, using control of self and others, or blocks out potentially anxiety-producing topics or situations.

**Goal:** Supervisor as approacher; assess clinician’s style, move towards approaching

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**Learning Problems vs. Problems About Learning**

- **Learning Problems:** What don’t know; lack of information / skills.

- **Problems About Learning:** Have skills, but emotional reactions keep from using

**Goal:** Assess which is which, use as basis for supervisory plan

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**Learning Styles – NLP**

- **Visual:** Thinks in terms of pictures; use pictures, videos, diagrams; talk in terms of scenes; use visual words – look, see; eyes move upwards.

- **Auditory:** Thinks in terms words; use lectures, audiotapes; use auditory words – sounds like, hear; eyes move to side.

- **Kinesthetic:** Thinks in terms of emotions, feelings, experiential; use hand-on; demonstrations, observations; use words like – handle, grasp; eyes look down

**Goal:** Assess learning style, incorporate into supervision process

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**Types of Leadership Styles**

*Drill sergeant* – clear, control, little nurturance, danger abusive role model, create dependency, encourage passive aggressive behavior
*Mother hen* – warm nurturing, difficulty with confrontation & boundaries, create dependency

*Inconsistent* – shift from micro managing to absence based upon stress and emotion, creates confusion, pushing of limits, replication with clients

*Crisis oriented* – responsive to biggest, latest crisis; good with emergency skills, difficulty with ongoing relationship, gets bored, terminates suddenly

*Neglectful* – provides little supervision, rationales that don’t need it, overstressed or difficulty with relationships, encourages peer support

*Balanced* – nurturing and able to confront and set limits; level of supervision dependent on immediate needs and level of skill

**Goal: Be balanced**


**Covey Time Management**

**Four Types of Work Tasks**

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**Urgent / Not Important**

Task may be important to some other department, but are not reflective of major job tasks – e.g., administrative tasks on short deadlines, non clinical tasks.

If significant amount of supervisory or staff time is spent on these tasks, need to develop better infrastructure and admin support.

**Urgent / Important**

Task is related to job duties and has deadline – e.g., clinical crisis.

If supervisor or staff is spending significant time on these tasks and not essential to job description, e.g. not crisis service, then need to look at staff skill and training, or work environment that is reactive rather than proactive.

**Not Urgent / Important**

No deadlines but essential proactive duties of job – longer range planning, treatment planning, productive client contact.

This should be majority of work for clinicians and supervisors. Priorities are clear, tasks essential, less reactive so less danger of burnout.

**Not Urgent / Not Important**

Time for brainstorming, for creativity regarding work. Small amount of time but valuable for staying creative over the long haul.

**Goal: Assess how you & staff use time; move towards not urgent / important**

Parallel Process

Parallel process – reflected in both behavioral patterns & language.

- Patterns – how client is perceived by therapist is often replicated when therapist talks about client with supervisor. Therapist can also replicate supervisor when talking to client. Important that supervisor treat therapist the way therapist needs to treat client.

- Language – projection: Therapist will project on client own emotions. As supervisor be curious about what the therapist reports about client, look for themes – is what she saying about client true for her as well?

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Parallel process can come from above – management – and below – clients. Good supervisor is a buffer between both and does not replicate dysfunctional process.

Personal and professional overlap. The challenges of each stage of professional development can raise personal issues of each stage. This is particularly strong in the 3rd stage.

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**Professional Relationship**

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**Clinicin Personal History**

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**Goal:** Be aware of parallel process unfolding in session, correct process; listen for parallel statements and address
• **Rescuer** = shoulds, hypervigilant, manages anxiety by fixing the other, unassertive, martyr; shoulds lead to expectations, resentment, disappointment.

  Goal – increase assertiveness, be aware of wants, stop being over-responsible, use emotions (especially anger) as information of needs / problems rather than internalizing

• **Victim** = overwhelmed, expects others to make better, eventually resents control.  
  Goal – increase self confidence and self-responsibility, manage anxiety, problem partialize

• **Persecutor** = abusive, intimidating.  Goal – contain anger, give up control, talk about fear, use anger as information about needs rather than exploding, increase emotional range

• **Adult** = able to self regulate, responsible for own problems, can help but not control others, aware of wants, no power differential, able to take acceptable risks, has emotional range, able to use emotions as information
Goal: Help clinicians move out of rescuer role; move supervisory relationship towards adult-adult

The Big 6

1. How you do anything is how you do everything
   - Process trumps content
   - Keep doing the same thing, keep feeling the same way
   - Change anything and you change everything

2. Look for the holes

3. Problems are bad solutions

4. Empathize with emotions not behaviors

5. There are no mistakes

6. Be honest

Goal: Assess what clinician needs to do different to solve problems; move outside comfort zone; encourage creativity; hold accountable; model honesty

Stage 1: Supervisor as Teacher

Characteristics

- Know what don’t know – aware of inadequacies not competencies
- Fear / anxiety, performance pressure, good-kid syndrome
- Overwhelmed by content – difficulty knowing what important, seeing bigger picture
- Reactive – not solid enough to set own pace or be proactive
- Looking competent while feeling incompetent
- Struggles with:
  - setting structure, using power
  - establishing trust
  - ideal vs. practical – want to “help others”
  - vague vs. specific – goals tend to be vague
Supervisory Needs and Goals

- Assess skills and knowledge – ask directly, uncover in clinical work, set 3/6 month learning goals
- Assess anxiety management – understand how clinician copes in new situations, how uses internal and external resources, how quickly recovers, how well can think on feet
- Assess learning style / problems about learning – try then talk, talk through then do, how rigid, how flexible, what problems / clients particularly difficult
- Assess response to supervision – how open, how closed, how active; expectations – spoon-feeding, perfectionist, how sensitive to power – begin to move towards holes
- Determine how to create more openness – need more structure, less; more direction, less; more self disclosure, less
- Provide job orientation / clinical training as necessary
- Provide structure (e.g., regular supervision), clarify job expectations, set boundaries
- Create success experiences – reduce anxiety, create trust and safety
- Correct distortions / impressions of each other and process; be seen as real person who is also strong leader, reliable, knowledgeable, supportive
- Provide quality control, assure clients get good service – check as needed

Supervisory Tasks

- Provide own place, tools, help settle into agency family
- Define open door policy – open door, no door, unlocked door
- Provide positive feedback informally and formally, reward creativity
- Have clinician tag along with another staff or self
- Use self disclosure to model openness, reduce anxiety
- Be honest, acknowledge double bind
Assign reading, taping of sessions

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**Dangers -- Clinician**

- Fear – stop learning – anxiety gets in the way of learning or taking risks
- Rigidity / Anxiety binding – narrow thinking to avoid anxiety; one problem, one theory, one solution; over-control of process, not see complexity of problems
- Over-responsibility – too directive with clients or doing too much; pressure to have answer to every problem rather than helping client find answers or determine priority of problems; feeling should be able to read client’s mind, rather than asking client what need to know
- Helplessness, feeling overwhelmed, taking reactive stance, often replicating client’s crisis

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**Dangers – Supervisory Process**

- Spoon-feeding – falling into pattern of doing clinical work through clinician – clinician passive, reactive, uses supervision to get filled up
- Remains anxious, remains good
- Little trust – afraid to be open, afraid to use supervisor for support, covers problems – primarily supervisor’s responsibility
- Little self awareness – doesn’t see limits of style or knowledge; rationalizes what does, not admit mistakes, supervisor does not confront, takes on face value and enters binding relationship
- To transfer to another supervisor or not – how much does supervisory process carry over to clinical work

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**Ethical Dangers**

- Incompetence – taking on cases / problems / clients beyond capabilities – supervisor’s responsibility, quality control issue
- Blurred boundaries – over-responsibility, idealism, good-kid pattern of wanting to be liked by clients
Stage 2: Supervisor as Guide

Characteristics

- **Don’t know what know** – has gained skills but not confident or able to use consistently or effectively

- **Settling down** – initial anxiety and performance pressure reduced as passes probation and trust is created in supervisory relationship

- **Self reflection** – because better able to control and screen information coming in, because more proactive, because some clients have moved away from crisis, time for both clients and clinician to look at self

- **Individual vs. family, past vs. present** – questions arise re: focusing on individual in context of family issues, how much to focus on past as means of dealing more effectively with present

- **Managing impasses** – growing awareness of patterns of stuckness with clients

- **Dependency** – because of settling down, increased intimacy both clinician and clients can grow dependent on supervisor or clinician.

Supervisory Needs and Goals

- **Content vs. process** – see how the problem and treatment are replicated in the process of the room; be able to shift focus more effectively from content to process

- **Increase awareness of anxiety** – more openly talk about anxiety, identify triggers, begin to understand parallel process

- **Increase awareness of self** – shift towards using relationship as medium for change rather than only focusing upon fixing the problems out there

- **Greater confrontation** – clinician and relationship less fragile – can be more confrontive, discuss more fully the supervisory process in the room

Supervisory Tasks

- **Explore patterns in cases** – what is successful, where get stuck, when too controlling or too overwhelmed, etc.
- **Help separate personal issues from skills / theory** – as patterns become clear and more aware of inner process, clarify and address learning problems from problems about learning

- **Teach experiential techniques**, intergenerational models, new skills – now that clinician has a base and less anxious, more open to new skills

- **Increase use of taping**, observation, co-therapy – more trusting, more able to use effectively

- **Written exercises**, empty chair work to clarify thinking, get through impasses

- **Serve as role model, guide** – clinician more self motivated, need guidance rather than firmer direction setting and settling

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**Dangers**

- **Dependency** – in both clinical and supervisory relationships – because intimacy can be seductive, clinician may encourage dependency in clients or continue cases too long; may be parallel process with supervisor who encourages dependency in supervisory relationship

- **Impasses** – clinician finds self treading water or reaching limits of relationship and has difficulty going further – reflects personal limits with power and intimacy, limits of skills, parallel process of supervision where both supervisor and clinician have fallen into rut

- **Over-identification with children**, vulnerable clients – being sensitive to own vulnerabilities makes sensitive to that in vulnerable clients – creates imbalances in relationships with families

- **Burnout** – having worked so hard to appear good, survive probation, exhausted

- **Supervision as therapy** – as intimacy increases between supervisor and clinician, supervisor may blur line between therapy and supervision

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**Ethical Dangers**

- Encouraging dependency in clients

- Blurred boundaries – does too much, less from being good or idealism, more because of over-identification with clients
Comic Relief
Zen for those who take life too seriously...

1. A day without sunshine is like night.
2. On the other hand, you have different fingers.
3. 42.7% of all statistics are made up on the spot.
4. 99% of lawyers give the rest a bad name.
5. Honk if you love peace and quiet.
6. Remember, half the people you know are below average.
7. He who laughs last thinks slowest.
8. Depression is merely anger without enthusiasm.
9. The early bird may get the worm, but the second mouse gets the cheese.
10. I drive way too fast to worry about cholesterol.
11. A clear conscience is usually the sign of a bad memory.
12. Change is inevitable, except from vending machines.
13. Get a new car for your spouse. It'll be a great trade!
14. Plan to be spontaneous tomorrow.
15. Always try to be modest, and be proud of it!
16. If you think nobody cares, try missing a couple of payments.
17. How many of you believe in psycho-kinesis? Raise my hand...
18. OK, so what's the speed of dark?
19. How do you tell when you're out of invisible ink?
20. If everything seems to be going well, you have obviously overlooked something.
21. When everything is coming your way, you're in the wrong lane.
22. Hard work pays off in the future. Laziness pays off now.
23. Everyone has a photographic memory. Some just don't have film.
24. If Barbie is so popular, why do you have to buy her friends?
25. How much deeper would the ocean be without sponges?
26. What happens if you get scared half to death twice?
27. I couldn't repair your brakes, so I made your horn louder.
28. Why do psychics have to ask you for your name?
29. Inside every older person is a younger person wondering what happened.
30. Just remember - if the world didn't suck, we would all fall off.
31. Light travels faster than sound. That is why some people appear bright until you hear them speak.

Stage 3: Supervisor as Gatekeeper

Characteristics

- Don't know what don't know – empowered, can become overconfident
Anger / Power – as move out of reflective stage, become aware of anger in self and clients; more clear about style and values

Exploration / Experimentation – now that feel confident in own skills, time to try new approaches

Counterdependence – beginning to separate from supervisor in orientation and interests; questioning of older approaches

Desire for change – feel contained within job, desire for other duties /tasks; frustrated with clients who are slow to change or uncommitted

Termination / Loss / Grief / Identity Issues – as clinician pulls away from supervisor, stirs personal / professional issues re: separation, loss, identity; time when supervisor – clinician breakups, e.g., Freud / Jung

Supervisory Needs and Goals

Support exploration and separation – challenge to maintain relationship while encouraging differentiation

Help deal with anger – use appropriately with clients, use to clarify goals, separate personal from professional issues

Maintain boundaries, quality control

Increase awareness of strengths, style, intuitions

Supervisory Tasks

Consider using group supervision or transfer supervision to another

Teach adjunct approaches, send to training programs

Help develop career path – increase responsibilities based on interests and talents

Dangers

Over-identify with adolescents

Truncate relationships – act out anger, impatience, see client as unmotivated

Move too quickly for families / clients, too confrontive, terminate poorly
- Rebellious – acting out with supervisor, questioning policies and procedures, acting too independently
- Supervisor encourages acting out as way of expressing own frustrations about agency
- Cynicism – often leave job, field

**Ethical Dangers**


- Abuse of power – time of highest risk for client abuse, e.g., dual relationships, sexual abuse, premature termination, over-controlling of treatment – rationalizes behavior
- Stealing clients – siphon off clients to private practice, etc. – feels like doesn’t need to follow rules

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**Stage 4: Supervisor as Consultant**

**Characteristics**

- **Know what know** – clear about strengths, weaknesses, style
- **Supervisor as peer**, consultant, brainstormer, problem solver
- **Individuation, integration** – power differential and struggling over
- **Respect each other’s expertise** – appreciation of each other’s strengths / skills

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**Supervisory Needs and Goals**

- Problem solve around specific case problems
- Help develop integrated therapeutic model
- Support personal and professional self
- Expand professional role – find place in organization that uses skills / strengths

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**Supervisory Tasks**

- Expand job responsibilities
- Help develop new goals
- Begin supervisory training
- Encourage exploration and integration of self

Dangers

- Boredom – settling into job rut, going on auto-pilot, staleness, coasting – with clients and in supervision
- Unresolved issues – limit relationship, certain issues not discussed, limited openness or clinician sees self as more skill than supervisor and uses only in administrative way
- Unresolved issues from Stage 3 cause supervisor to be unable to respect differences, still needing to assert power, holds clinician back

Ethical Dangers

- Collegial relationship interferes with administration / quality control – supervisor fails to confront, lets poor judgment go unchallenged
- Dual relationships between supervisor and clinician – both rationalize unethical behavior regarding larger agency or dual relationships interfere with supervisor’s administrative responsibilities

Stages & Experienced Clinician

Challenges:
- Start at Stage One because new to you and agency – will move through stages more quickly
- Less experienced supervisor – easy to feel intimidated and not hold accountable or challenge
- Difference clinical orientation – need to translate approach into clear treatment goals and success
- Don’t do windows – some experienced clinicians feel more entitled and less cooperative – set expectations and boundaries
Four Common Supervisory Mistakes

- **Spoonfeeding:** Teaching, directing clinician; relieves anxiety but creates dependency.
- **Focus on client:** Bypass supervision & instead becomes case management; reduces anxiety; common among new supervisors.
- **Ignore parallel process:** Miss projections; replicate dysfunctional process.
- **Unclear goals / tasks; not use stages:** Crisis-oriented or therapist driven; scattered, replicating how clinician feels; lacks leadership; clinician remains anxious, do same with clients; not accommodate changing needs of clinician.

Clinician Assessment & Supervisory Plan

- **What are the clinician’s skills?** Gaps in knowledge, specific techniques, strengths & weaknesses with certain populations and problems.
- **What stage is the clinician at?**
- **How does clinician manage anxiety / stress?** Approach / avoid / bind? Withdraw, clingy, over-responsible, angry, assertive? What is anxiety level? How self-aware?
- **How does clinician learn?** Visual / kinesthetic / auditory?
- **Strength / weakness of supervisory relationship?** Open / closed? Dependent / independent? Controlling / flexible?
- **What are the holes?** What is not in room, not in sessions? What doesn’t clinician talk about, do?
- **What are reasonable 3-6 month goals?** What skills to learn, populations / problems to work with? Changes in supervisor process?

Ethics & Liability

Code of Ethics – NASW, APA, ACA

**Primary Issues:** Competence; confidentiality; dependence; abandonment

**Self determination:** clients set own goals but can limit rights of self determination when actions or potential actions pose a serious, foreseeable, and imminent risk to self or others.
Informed Consent: Staff inform clients of

- Purposes of treatment
- Risks of treatment
- Limits of service due to insurance
- Relevant costs
- Reasonable alternatives
- Rights to refuse or withdraw consent
- Time frame covered by consent
- Obtain clients’ informed consent before audio or videotaping or permitting observation

Competence: provide services within education, training, license, certification, consultation, supervision, or other professional experience. New experiences only with appropriate training and supervision.

Cutting edge practice: careful consideration, proper training and supervision to protect clients from harm.

Cultural Competence and Social Diversity: Understand clients’ cultures, be sensitive, seek education and seek to understand social diversity and oppression.

Conflict of Interest: Avoid conflicts, keep clients’ interests in forefront; no dual relationships; clarify role, clarify who is considered client in multi-client relationships.

Privacy and Confidentiality:

- Keep information to minimum for situation
- Discuss with clients limits of confidentiality
- Multiple clients – seek to preserve confidentiality among each individuals. Inform that cannot guarantee that all participants honor agreements (groups).
- No disclosure to third parties without permission
- Not discuss confidential information in non-secure setting

Subpoenas – request that court withdraw order or limit order as narrowly as possible or maintain their records under seal

Electronic records – secure confidentiality

- Secure records, protect confidentiality in event of social worker termination of practice, incapacitation or death
- No identifying info in teaching / training or when in consultation
- Protect confidentiality of deceased clients
Access to Records

Make available; if concerned about interpretation, interpret for them; Limit access if serious harm to clients; protect information of others in records

Sexual Relationships

- Set boundaries with clients and client relatives or others where there is potential harm to client.
- No services to those who have had sexual relationship.
- No sexual conduct with former clients. Therapist responsible for demonstrating that client no exploited, coerced, or manipulated, intentionally or unintentionally.

Physical Contact: No contact if possibility of harm – need to set clear, appropriate and culturally sensitive boundaries.

Language: No derogatory language – verbal or written

Payments: ensure fair, reasonable, consideration to ability to pay; no bartering – assume responsibility that not detrimental to relationship.

Advertising: No false advertising, proper credentials, no use of clients for testimonials.

Interruption of Services: Make reasonable efforts to ensure continuity of services in event of unavailability, relocation, illness, disability, or death.

Termination of Services:

- Terminate when no longer required or no longer serve client needs or interests
- Avoid abandoning clients who still in need of services – make arrangements for continuation of services
- Not terminate to pursue a social, financial or sexual relationship with clients
- May terminate for non payment if financial arrangements made clear and client not pose imminent danger to self or others.
- If leaving employment should inform clients of appropriate options for the continuation of services and benefits and risks of the options.
Laws & Liability Issues

Advertising

- No false statements, no misleading
- Use exact title – be careful of using psychotherapist
- Expert – if stated, set self at higher standard
- Sliding scale – if advertise can be misconstrued
- No claims of professional superiority

Referrals to Physician

- Failure to refer – medical symptoms, psychiatrist for meds = negligent
- Consider physical exam to rule out possible physical causes
- Document

Referrals: No remuneration for any referrals

Partnerships: Spilt profits and losses – both liable for negligent acts of other partners
Check legalities in state to form partnership with staff of different disciplines

Corporations

- Get clear legal advice about forming corporation – be careful about mixing types – e.g., non-profit vs. profit
- Corporation may not limit liability for professional negligence

Common Errors

- Failure to renew license – your responsibility, don’t wait on licensing board
- Failure to renew malpractice insurance – cost, insurers won’t cover sessions
- Failure to obtain mandatory continuing education credits
- Failure to obtain business license – check with attorney / city if work out of home
- Failure to file fictitious business name

Child Abuse
• Mandated reporter child abuse, neglect – failure = disciplinary action and possible malpractice liability
• Domestic violence – mandated if child dysfunction – longer term impact
• Abuse across states -- report to home state, they will report to other state – if you contact other state could be breach of confidentiality
• Be aware of timelines for reporting and mode requirements – within 72 hrs, okay by phone, call local or State Hotline, must supply written documentation if requested
• Medical neglect – doctor must diagnose a condition that if not treated will lead to physical harm
• When in doubt call protective services, ask, and document
• Reported abuse by adult re: his past abuse as child – no mandate, client may report

Child Custody / Visitation Disputes
• Avoid writing opinions regarding custody / visitation requested by client lawyer – danger other parent claim provided info on children without his consent, violated confidentiality of children = possible improper conduct – instead ask to be subpoenaed
• If subpoenaed state limits of exposure, no opinion without independent and objective evaluation, opinions based upon reporting of client / children, not other parent
• Joint custody – check if need consent of both parents, generally need one parent, be safe require consent of both parents; need 2 parents re: entrustment of child to social services
• If both parents agree, then one wants to terminate, consider impact of abandonment
• Sole legal custody – that parent can decide on treatment

Court Testimony – Guidelines
• Tell the truth – don’t slant for benefit of client or case
• Don’t guess – okay to say don’t remember
• Prepare – check notes, find out in advance what is likely to asked, cross examination, have information on license, ceu’s etc re: credibility
• Focus on answering question, not worrying about effects
• Answer specific question, don’t volunteer information

Minors

• Parent Access to Records of Minor – varies from state to state – if harm to child may limit

• Emancipated minor is treated as adult – full rights to confidentiality, no child abuse mandate

• Age 14 (varies among states) can consent to birth control, STD treatment, substance abuse, mental health services

• Pregnant teen – consent re: delivery, no consent re: abortion

Death of Client: required to disclose records to coroner; confidentiality survives death, privilege passed to executor of estate

Authorization Forms: written, have copy, if client revokes authorization get it in writing

Disclosing “Fact of Relationship”: Obtain permission re: communication with others regarding therapy – phone messages, mail at start of relationship, document

Confidentiality and Groups: some therapists require contract with patients, up to therapist to discuss at onset and be sensitive to any violations

Confidentiality and Dangerous Clients

Danger to self and others – specific and immediate threat

Duty to Protect Options:

• TDO client
• Reasonable attempts to warn potential victims or parents if under 18
• Reasonable efforts to notify police
• Reasonable steps to prevent violence – e.g., call police who takes custody
• Provide therapy in session until provider believes that client no longer threat

Confidentiality and Unexpected Caller
Someone wants to share information about client – say that not promise confidentiality of what said and will tell the client, don’t admit that you are treating client

Confidentiality and Search Warrant

See warrant, object, ask that file be placed in sealed envelop and brought to a judge, ask them to document your requests and you document your requests, notify client

Confidentiality -- Couples

Consider the couple as the client – records belong to clinician but authorizes releases requires both

Secrets – decide on policy and state at the start – consider “no secrets” rule, place secrets in context of couple problem

Treating Multiple Family Members

- Be clear who is the patient – define it – patient hold privilege
- Someone drops out – document changes
- Obtain consultation re: handling multiple family members if in doubt
- Confidentiality – be careful not to “leak” information to other family members

Dual Relationships

- Attendance at client event (wedding, graduation, etc) – okay, request must come from client, act discreetly, be careful of disclosure of confidential information, gifts – clinical rationale
- Dual relationship – in a professional role and at same time in different role with client. Need to set “clear, appropriate, and culturally sensitive boundaries with client” (NASW) – not impair objectivity, competence, effectiveness
- Don’t terminate in order to start different relationship – VA SW Board requires 5 years before start sexual relationship – generally a 2 yr rule about personal relationships

Self Disclosure: make sure it has a clinical, not personal, purpose

Use of client information in public presentations: okay if mask details of case; for books, best to get permission of family – discuss with publisher / attorney
Home visits: be clear about auto insurance and liability; clear policy and procedures re: secure case records

Fees

- Raising fees – best to notify at start of relationship in writing about possible fee changes – give plenty of notice and discuss – midstream raises could cause client to feel exploited
- Do not tie releasing of records to payment of back fees – keep separate; be careful of large balances – could be construed as dual relationship problem, where you are creating a debtor-creditor relationship
- Sliding scale – better to set fees based on what think time is worth rather than source of payment; sliding scale usually incompatible with insurance board contracts; consider set-aside pro bono work or reduced fee for certain number of clients rather than sliding scale
- Do not bill insurance company for no-shows. If reduce co-payment for clients, should reduce fee to insurance company.

Videotaping: make clear voluntary, tell client how tapes used, stored, get signed informed consent, provide secure storage, destroy old tapes on regular basis, be aware they can be subpoenaed.

Termination of Treatment

- Be careful termination not interpreted as abandonment. Best to clarify in disclosure statement (given to clients prior to treatment) conditions under which treatment can be terminated (not paying bills, client not getting better, problems beyond clinician competence).
- Make a referral to other practitioner or facility.
- Document termination process.

Supervision as Outside Vendor

If supervising clinician who works for agency, you are normally outside the administrative chain of command. In event of clinical issues arising in supervision that have legal or liability connotations (e.g., suicidality of client):

- Write in your notes your specific directives to clinician
- Tell clinician to inform administrative supervisor of problem and supervisory discussion
• Call admin supervisor and let her know of case, concern, your recommendations, and directive that clinician contact her
• Have plan to follow up with clinician and document
• Consider writing Memo of Understanding with workplace supervisor

Closing a Practice

• Notify clients – 60-90 days, longer for long-term clients
• Document in record
• Treatment records – where kept, how to access, confirm w/ letter if necessary
• Publish notice in paper
• Keep up malpractice insurance post closing
• Notify insurance panels, community contacts
• Inactivate license

Ethics & Liability Guidelines

When in doubt:

• Make / document decisions based on sound clinical reasoning
• Do best to uphold confidentiality
• Disclose policies, limits, areas of concern in advance and in writing
• Obtain client written consent
• Document in records your actions / recommendations
• Obtain consultation

Useful Websites: Center for Ethical Practice; CPH & Associates – Archives on Liability

Recordkeeping

Clinical Records – Guidelines
- Include identifying information, diagnosis and treatment plan, progress notes for each activity, information from collaborate contacts
- Objectives and goals need to behavioral, specific, and measurable (GIRP, BIRP)
- Progress notes can be short – ideally, goal for session, your intervention, client response, plans for next session – 3rd parties more concerned about your actions than client details
- Include telephone contacts collaterals, phone or written outreach to client, etc.

**Supervisory Notes – Guidelines**
- Keep notes of each session
- Document cases discussed, administrative issues
- Document any behavioral-performance concerns; any specific recommendations for particular case, any directives re: specific clinical interventions; any planned follow up
- Document any action plans re: specific performance concerns
- Document any contacts with administrators, HR, consultants, etc.


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**Groups: When & How**

**Benefits of Group Supervision**
- Economy of time, cost, expertise
- Opportunities for vicarious learning
- Breath of client exposure
- Greater quantity, diversity, quality of feedback to clinician
- More comprehensive picture of clinician
- Opportunity for clinicians to learn supervisory skills
- Normalizing of clinician experiences

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**Limitations of Group Supervision**
- Not enough individual attention
Confidentiality related to clients and other clinicians less
Less opportunity to observe parallel process
Group dynamics (competition, scapegoating) can interfere with learning
Group may devote too much time to issues of limited relevance or interest to some

Supervisory Tasks
- Define the goal(s) of group
- Define parameters, expectations, process, tone
- Assume active stance; redirect focus, impose time limits, etc
- Provide feedback about group development and process

Supervision Group Checklist

What is the main purpose of the group?
Is the group to be the primary or secondary source of supervision for the members?
Will you be the primary supervisor for both individual and group supervision?
What is the composition of the group?
How large a group do you want?
Is the group time-limited or ongoing, open or closed?
What logistical problems do you need to consider?

Types of Groups

<table>
<thead>
<tr>
<th>Case- Focused Group</th>
<th>Focus on specific cases; helps translate skills to new situations; opportunities for leadership &amp; training; interaction of staff of different levels / stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Group</td>
<td>Focus on specific skills; bringing together of staff of similar levels</td>
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</table>

Challenges: Make certain able to present; clear session format; not for Stage 1


| **Staffing Group** | **Challenges:** Homogenous, trainer primary focus  

  | Decide on disposition of new cases, initial assessment; opportunities for learning  

  | **Challenges:** Triage of cases; accomplishes end-goals  

| **Staff Support Group** | Focus on support & connection; helps reduce isolation, increases staff morale  

  | **Challenges:** Become easy alternative to supervision for staff; becomes complaint sessions affecting morale  

| **Supervisory Group** | Meeting of supervisors; focus on disposition of cases, middle management support; opportunities for improved coordination & communication among services  

  | **Challenges:** Become gripe session, lose focus  

| **Administrative Group / Meeting** | Staff meetings around administrative issues; keeps staff updated; opportunities for informal staff interaction  

  | **Challenges:** Finding right structure so both informative and safe for sharing of ideas  


**New Supervisors**

**Challenges:**

- Tendency to think as senior clinician – talk about clients rather than supervisee
- Developmentally back at Stage One – need to develop trust, teach new skills
- Supervisor needs to help new supervisor develop a clear plan / goals for developing supervisory skills
- Taping / observation of supervisory sessions useful to help new supervisor become aware of own process and presentation

**Promotion of peers** – promoting a staff person to supervisor from group of peers creates difficult sibling-type reactions. The new supervisor struggles with stepping up to role with peers, easily falls into peer-consultant role and awkward about using power.

In order to help with the transition:

- Consider assigning new staff to new supervisor (fresh start and opportunity for success)
- Get the awkwardness on the table – bring up with new supervisor and rest of staff
• Be clear about your support and backing of new supervisor re: supervisory power and decision-making (line staff may test boundaries and try and go around new supervisor to avoid awkwardness)

• Coach new supervisor on handling problems with individual staff as arise

Interns / Students

• Essentially at Stage 1 unless have longer-term placement

• Focus on teaching, building skills & self confidence

• Help integrate into staff as much as possible – include in meetings, buddy-up

• Be careful matching skill and clients – challenges not incompetence

• Coordinate closely with school

• Give lots of positive feedback – needed to offset insecurity and self-doubt

Diversity Competence

• Need to be sensitive to different cultural / ethnic differences; sensitize staff

• Need not be an expert in different cultures but be sensitive – ask clients to explain at start of treatment about their culture

Supervision vs. Therapy

• Supervision focuses on work performance – the bottom line is whether the individual can perform her work tasks

• Because of the nature of the work, it is easy for the personal and professional to cross: one goal of supervision is to help supervisees realize when personal issues are affecting their perceptions

• Supervision is making the supervisees aware and helping them adequately perform work tasks; the goal of therapy is to treat the personal issues themselves

Supervisory Tools and Techniques
Evaluations and Goal Setting

Useful to include a self-evaluation as basis for discussion and separate from the standard agency form

Topics include:

- Theory of Clinical Work
- Evaluation of skills and knowledge
- Evaluation of use of self
- Evaluation of use of supervision
- Goals for next evaluation period

Goals should be specific and incorporate training needs / supervisory changes

Taping / Observation

- Useful to look at micro-process, develop third ear; intimidating for new staff – get lots of fuzzy tapes in beginning – important to be extremely supportive at start; have clinician analyze tape first

- Outline for tape processing: Goal of session; beginning, middle, end of session in terms of process and content; how session fits into overall goals; evaluation of self re: accomplishing goal; goal for next session

- Observation: can use mirror or live; be clear about purpose and process; have clinician observe supervisor first to reduce anxiety

Role Playing

- Useful for skill training and reducing anxiety over new situations

- Play role of clinician to model

- Debrief – discuss how you felt as clinician and why you did what, hear response from “client,” emphasize technique, skills

Empty Chair

- Have clinician visualize client in empty chair; talk to client about feelings, about being stuck, etc; have switch roles, as client respond to comments, go back and forth as needed
• Helps clarify counter-transference issues; separate out personal from professional reactions; helps understand client better; support for taking risk