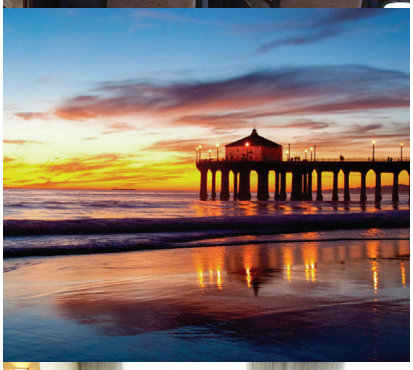
WWW.CAMFT.ORG/SUPERVISION16



Supervision Workshop Series: Deconstructing the Supervisory Relationship

Presented by
Ellen Kinoy, MA, LMFT

Saturday, July 16, 2016

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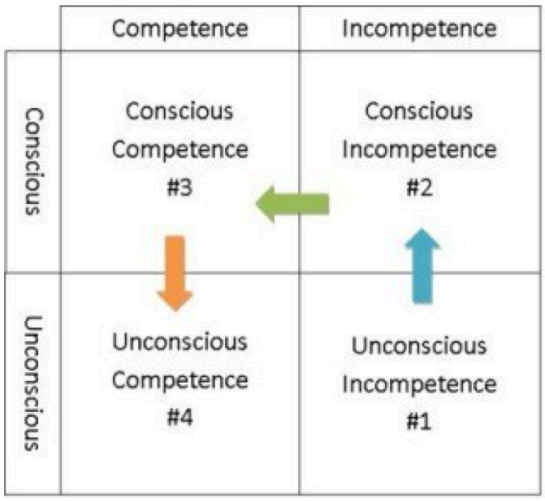
Deconstructing the Supervisory Relationship

July 16, 2016

9:00 – 9:10	Introductions
9:10 – 10:10	Developmental Model of Supervision
10:10 – 10:20	*Break*
10:20 – 11:20	The Supervisee/Supervisor Relationship
11:20 – 12:00	Contextual Issues Part 1
12:00 – 1:15	*Lunch*
1:15 – 1:45	Contextual Issues Part 2
1:45 – 2:45	Theory of Psychotherapy & Philosophy of Supervision
2:45 – 3:00	*Break*
3:00 – 4:00	Supervisory Interventions
4:00 – 4:30	Supervisory Techniques Wrap-up

Conscious Competence Matrix



Conscious Competence Matrix

	Competence	Incompetence
Conscious	**3 - Conscious Competence** • the person achieves 'conscious competence' in a skill when they can perform it reliably at will • the person will need to concentrate and think in order to perform the skill • the person can perform the skill without assistance • the person will not reliably perform the skill unless thinking about it - the skill is not yet 'second nature' or 'automatic' • the person should be able to demonstrate the skill to another, but is unlikely to be able to teach it well to another person • the person should ideally continue to practise the new skill, and if appropriate commit to becoming 'unconsciously competent' at the new skill • **practise** is the singlemost effective way to move from stage 3 to 4	**2 - Conscious Incompetence** • the person becomes aware of the existence and relevance of the skill • the person is therefore also aware of their deficiency in this area, ideally by attempting or trying to use the skill • the person realises that by improving their skill or ability in this area their effectiveness will improve • ideally the person has a measure of the extent of their deficiency in the relevant skill, and a measure of what level of skill is required for their own competence • the person ideally makes a commitment to learn and practice the new skill, and to move to the 'conscious competence' stage
Unconscious	**4 - Unconscious Competence** • the skill becomes so practised that it enters the unconscious parts of the brain - it becomes 'second nature' • common examples are driving, sports activities, typing, manual dexterity tasks, listening and communicating • it becomes possible for certain skills to be performed while doing something else, for example, knitting while reading a book • the person might now be able to teach others in the skill concerned, although after some time of being unconsciously competent the person might actually have difficulty in explaining exactly how they do it - the skill has become largely instinctual • this arguably gives rise to the need for long-standing unconscious competence to be checked periodically against new standards	**1 - Unconscious Incompetence** • the person is not aware of the existence or relevance of the skill area • the person is not aware that they have a particular deficiency in the area concerned • the person might deny the relevance or usefulness of the new skill • the person must become conscious of their incompetence before development of the new skill or learning can begin • the aim of the trainee or learner and the trainer or teacher is to move the person into the 'conscious competence' stage, by demonstrating the skill or ability and the benefit that it will bring to the person's effectiveness

http://www.businessballs.com/consciouscompetencelearningmodel.htm

Developmental Fit Between Supervisee and Supervisor

Supervisee \ Supervisor	Unconscious Incompetence	Conscious Incompetence	Conscious Competence	Unconscious Competence
Unconscious Incompetence				
Conscious Incompetence				
Conscious Competence				
Unconscious Competence				

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Clinical Supervision Contract

Supervision is a forum for supervisees to gain clinical, emotional and administrative support for their development as mental health professionals. Supervision will remain confidential except when there are risks of liability to the supervisor, the program and/or Lincoln.

Supervisee responsibilities include:

1. Supervisee will identify reasonable goals and training needs with Supervisor.
2. Supervisee will attend weekly individual and group supervision as scheduled. Supervisor and supervisee will include in this contract how supervision will be made up if supervision is missed.
3. Supervisee will plan to use and utilize the allotted individual and group supervision sessions by coming prepared with a clinical agenda. Clinical supervision will focus on the Supervisee's clinical interventions and/or countertransference.
4. Supervisee is expected to follow the directives and suggestions of the individual and group supervisor regarding clinical issues, legal obligations and ethical responsibilities.
5. Supervisee is expected to be on time to individual and group supervision.
6. Supervisee will submit the Summary of Experience logs to the Supervisor for review and signature on a monthly basis. The Summary of Experience logs and Experience Verification forms should be an accurate reflection of the Supervisee's actual services provided. All Board of Behavioral Sciences and/or Board of Psychology documentation will be completed prior to the Supervisee's departure from Lincoln.
7. Supervisee will inform Supervisor of any ethical or legal issues that arise in therapy with the client and/or family in accordance with LCC policies and procedures.

Supervisor responsibilities include:

1. Supervisor will provide supervision according to the rules and regulations of the Board of Behavioral Sciences and/or Board of Psychology.
2. Supervisor will provide individual and/or group supervision.
3. Supervisor will assess the Supervisee's developmental and skill level and provide constructive feedback to support Supervisee's professional growth.

4. Supervisor will provide Supervisee with guidance on both the content and process of his/her clinical work. This will include concrete directives and suggestions for therapeutic strategies, theoretical frameworks for conceptualizing the clinical work and analysis of countertransference and issues of human diversity.
5. Supervisor will raise issues of job performance and prepare a plan of improvement if deemed necessary. Supervisor will accordingly recommend additional personal support as deemed necessary to enhance clinical work performance.
6. Board of Behavioral Sciences and/or Board of Psychology paperwork submitted by Supervisee will be completed prior to Supervisee's departure from Lincoln.
7. Supervisor will document a summary of content of individual and/or group supervision and track Supervisee's attendance.
8. Supervisor will follow the Risk Management Communication policy and expeditiously address all risks of liability to the program or agency. Supervisor will inform the Supervisee of the extent of what are identified as liability issues.

Other agreements and/or expectations:

I have reviewed and agree to the above Clinical Supervision Contract:

_____ _____
Supervisee Dated

_____ _____
Individual Supervisor Dated

_____ _____
Group Supervisor Dated

Guidelines for Utilizing Parallel Process, Transference & Countertransference Successfully in Clinical Supervision

1. Supervisor must have a well-developed sense of self-awareness.

2. Supervisor must be able to attend equally well to external interpersonal and intersubjective material, as well as intrapsychic data and internal stimuli.

3. Supervisor must be able to sort through incoming data quickly and efficiently.

4. Make the link explicit between what you are absorbing from the supervisee and the parallel experience with the therapist and the client.

5. Use the supervisee's own words to understand the client's experience.

6. Mobilize empathy.

Parallel Process, Transference and Countertransference Worksheet

What was your intersubjective experience of the narrative?

What was your affective reaction? What sensations did you feel in your body and where?

What images or pictures popped into your head?

What narratives, words or thoughts bubbled up for you?

Cultural Humility Framework Video

Cultural Humility and Clinical Supervision Resource List

1. Cultural Humility Framework
   a. Cultural Humility Video Parts 1-4
   https://www.youtube.com/watch?v=SaSHLbS1V4w

   b. Article
   Reference
   Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9 (2), 117-125.

   Link
   http://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf

   c. Cultural Humility v. Cultural Competence

	Cultural Competence	Cultural Humility
Goal	To build an understanding of minority cultures to better and more appropriately provide services	To encourage personal reflection and growth around culture in order to increase awareness of service providers
Values	○ Knowledge ○ Training	○ Introspection ○ Co-learning
Strengths	○ Allows for people to strive to obtain a goal ○ Promotes skill building	○ Encourages lifelong learning with no end goal but rather an appreciation of the journey of growth and understanding ○ Puts professionals and clients in a mutually beneficial relationship and attempts to diminish damaging power dynamics
Shortcomings	○ Enforces the idea that there can be 'competence' in a culture other than one's own ○ Supports the myth that cultures are monolithic ○ Based upon academic knowledge rather than lived experience ○ Believes professionals can be "certified" in culture	○ Challenging for professionals to grasp the idea of learning with and from clients ○ No end result, which those in academia and medical fields can struggle with

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2. Strategies to Use in Supervision
   a. Modeling within the Supervisory Relationship
      ○ Begin the supervisory relationship by acknowledging the power differential and naming the differences/similarities that exist.
      ○ Demonstrate the courage to have difficult relational conversations. For example, initiate a dialogue about late documentation, missed supervision sessions, or contextual differences and how they may be impacting the therapeutic relationship.
      ○ Ask questions that highlight the importance of identity in clients and identity in the clinician.
      ○ Discuss the difference between intention and impact.
      ○ Be vulnerable, transparent, and act with integrity. Disclose relevant information about yourself for the purpose of deepening the connection.

   b. Harvard Implicit Association Test (HIAT)
   Website with the HIAT
   https://implicit.harvard.edu/implicit/takeatest.html

   Dateline video about reactions to HIAT results
   https://www.youtube.com/watch?v=n5Q5FQfXZaq

   Articles about the efficacy of the HIAT
   https://www.psychologytoday.com/blog/beautiful-minds/201101/does-the-implicit-association-test-iat-really-measure-racial-prejudice

   http://www.scientificamerican.com/article/the-implicit-prejudice/

   c. Cultural Genogram
   Article
   Reference
   Hardy, K. V. & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. Journal of Marital and Family Therapy. 21 (3), 227-237.

   Link
   http://swrtc.nmsu.edu/files/2013/10/Cultural-genogram-hardy-laszloffy-1995.pdf

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d. Discussion about privilege and intersectionality
Videos
Chimamanda Ngozi Adichie "The Danger of a Single Story"
https://www.youtube.com/watch?v=D9Ihs241zeg

Tiffany Jana "The Power of Privilege"
https://www.youtube.com/watch?v=N0acvkHIiZs

e. "I Am From.." Poems
Examples:

Anonymous September 24, 2009 at 11:12 AM

I am from thick blonde hair
From health food and organic everything's
I am from free Irish and Spanish spirits
(who taught me how to become an individual)
I am from candle sticks being thrown into doors
From loving and hating my sister
fighting, screaming and carrying her drunk up the stairs as if it were yesterday

I am from death metal
from guitars, double bass, and growls
I am from "Let's get stoned!" to "no, I quit"
from gauged ears and rainbow hair
I am from love, gay pride and acceptance
from tattoos, blood and gore

I am from Oregon and New Mexico
From Portland to Taos
from painful divorces and strength
(I will never forget that day)
I am from headbanging and screaming "Fuck yeah!"
From long hair and walls of death
I am from experience and ignorance
From crying for hours and partying until the break of dawn
I am from photographs, videos, and memories
Of long lost friends, new friends, and the family i will always have.

-Mackenzie Nielsen

http://nuhspoetry.blogspot.com/2009/09/where-im-from-poems.html

Where I'm From
Kelly G.
I am from the Sanbos and Pachincletas
From Sula and Gorditos
I am from the smell of Azistin and the noise of the rooster and the dogs
I am from the cornfield and the beautiful mountain
I am from the times that you have to wear new clothes on Christmas and long black hair, from Abuelita Tina and Abuelito Juan and Abuelito Rene
I am from the noisy family tendencies and popularity
From *El que mancha paredes y mesa da a conoser su bejesa* and *Dime con quien andas y te dire quien eres*
I am from going to church every Sunday
I'm from Incas and Mayas in the beautiful Siguatepeque and tortillas de arina, and the fried fish
From the time when Tia Chelo got pregnant, the family tried to hide it and forced her to get married.
I am from a family that likes to fight but when you need them they will be there for you.

Where I'm From
By Loran M.
I am from Coco coffee, hibiscus tea, green pigeon peas, vevine, black stage, fever grass, lime bud teas
From fiber grass mattress & pillows and cokia brooms from coconut leaves
I am from the village of relatives, cousins
I am from the coconut trees, corn fields, plums, sugar cane, sorrel, pineapple, grapefruit and orange trees. From pumpkins, field watermelon, ginger field, yam and dasheen plants and fruit
I am from thanksgiving yearly and Curtains Old year's night, from black fruit cake and cassava pone and Agatha
I am from the curry goat, chicken, bodi, roti, fried plantains and cassava bread, sweet bread, tarts, homemade jams, bread, baked coconut drops
From Breeze – "Never let someone's money burn your eyes." and "Jacob climb the ladder" Jesus saw "Faith is the key to survival."
I am from Pentecostal, Baptist, Catholic, Jewish
I'm from Trinidad & Tobago, Port-of-Spain and mangos & banana trees
From the Fabien George Edwards Jr., the Masa George Edwards and the slaves, Indians and Irish, Spanish grandmother. Irish – Great, Great Grandfather and Indian – Great, Great Grandmother
I am from leaders, doctors, judges, teachers from Tobago, Grenada, Venezuela.

Managing Stress to Improve Learning nelrc.org/managingstress

http://www.nelrc.org/managingstress/pdfs/lessons/Where%20I'm%20from%20poems%20-%20Project%20Hope.pdf

Questions to Consider While Preparing for the Cultural Genogram Presentation

Please consider these questions for *each* group constituting your culture of origin, as well as considering the implications of the answers in relation to your overall cultural identity.

1. What were the migration patterns of the group?
2. If other than Native American, under what conditions did your family (or their descendants) enter the United States (immigrant, political refugee, slave, etc.)?
3. What were/are the group's experiences with oppression? What were/are the markers of oppression?
4. What issues divide members within the same group? What are the sources of intra-group conflict?
5. Describe the relationship between the group's identity and your national ancestry (if the group is defined in terms of nationality, please skip this question).
6. What significance does race, skin color, and hair play within the group?
7. What is/are the dominant religion(s) of the group? What role does religion and spirituality play in the everyday lives of members of the group?
8. What role does regionality and geography play in the group?
9. How are gender roles defined within the group? How is sexual orientation regarded?
10. a) What prejudices or stereotypes does this group have about itself?
    b) What prejudices and stereotypes do other groups have about this group?
    c) What prejudices or stereotypes does this group have about other groups?
11. What role(if any) do names play in the group? Are there rules, mores, or rituals governing the assignment of names?
12. How is social class defined in the group?
13. What occupational roles are valued and devalued by the group?
14. What is the relationship between age and the values of the group?
15. How is family defined in the group?
16. How does this group view outsiders in general and mental health professionals specifically?
17. How have the organizing principles of this group shaped your family and its members? What effect have they had on you?
18. What are the ways in which pride/shame issues of each group are manifested in your family system?
19. What impact will these pride/shame issues have on your work with clients from both similar and dissimilar cultural backgrounds?
20. If more than one group comprises your culture of origin, how were the differences negotiated in your family? What were the intergenerational consequences? How has this impacted you personally and as a therapist?

From: Hardy, K. V. & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. Journal of Marital and Family Therapy. 21 (3), 227-237.

Questions to Answer in Synthesis Paper

1. What are your family's beliefs and feelings about the group(s) that comprise your culture of origin? What parts of the group(s) do they embrace or reject? How has this influenced your feelings about your cultural identity?
2. What aspects of your culture of origin do you have the most comfort "owning," the most difficulty "owning"?
3. What groups will you have the easiest time working with, the most difficult?
4. What did you learn about yourself and your cultural identity? How might this influence your tendencies as a therapist?
5. Was the exercise valuable, worthwhile? Why or why not?

Questions for Facilitators to Consider During the Presentation

1. a) What does the content of the presentation teach about the presenter's culture of origin?
    b) What does the process of the presentation teach about the presenter's culture of origin?
    c) What parallels, if any, exist between the presenter's style and the cultural content disclosed?
2. Are family-of-origin and culture-of-origin issues appropriately differentiated?
3. Do the colors and symbols chosen by the presenter have special cultural relevance? How were these chosen?
4. Is there a disproportionate number of pride or shame issues? What is the presenter's rationale for the schism?
5. When there are multiple groups comprising a trainee's culture of origin, how are they presented/negotiated?
6. How comfortable is the presenter in engaging in an open dialogue about inter- and/or intragroup prejudices and stereotypes?
7. What issues appear too uncomfortable for the presenter to discuss?
8. What impact did the presentation have on other trainees? What are the hypotheses regarding why such reactions were generated?
9. What relevance or insights did the presenter have as a result of this experience?
10. What was the process by which the information for the cultural genogram was gathered?

From: Hardy, K. V. & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. Journal of Marital and Family Therapy. 21 (3), 227-237.

Diversity Informed Infant Mental Health Tenets Workshop

I Am From Poem Exercise

Participants Instructions: We are inviting you to write a short poem called "I am from" as away to open a door to self-exploration and awareness in the light of Tenet #1. You have 10 minutes to write it and draw from your own experience: you may include statements about where you are from regionally; geographically; ethnically; socioeconomically; religiously; and family composition wise. You may also include memories of different points of your life; mottos; credos; family traditions and customs and any other aspects that define who you are.

Reflect on how these have shaped your identity and how they have influenced your closely held beliefs about child rearing and child development, parenting, caregiving, psychotherapy, facing and recovering from adversity, etc. Reflect on how they have shaped your realm of practice. If you wish to, you may introduce yourself to the person sitting next to you and read your poem to them. You also have the option to share how it felt for you to write the piece, or to not share at all.

_____
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CRN/6/16 Adapted from: Diversity and Social Justice Training Activities Education and Arizona State Residence Life Residential Education and Social Justice Education Department

Learn more about the Tenets at http://imhdivtenets.org/ #imhtenets

Selected Attachment Theory Concepts Applied to Clinical Supervision

Attachment Theory Concept	Definition	Application to Supervision
Secure base	A securely attached child is able to go out into the world to explore and try out new things and ways of being using the attachment figure as a touchstone.	The securely attached supervisee is able to function independently as a psychotherapist, checking in when necessary with the supervisor for support and guidance.
Optimal parenting	Children thrive when they receive both nurturing and appreciation for their wonderful and unique qualities and limit-setting that provides them a sense of safety and structure.	Supervisees thrive when they are given clear expectations and strength-based feedback and support to be able to successfully fulfill those expectations.
Attachment-promoting activities	Memory-building; rupture and repair; emotional and collaborative communication; reflective dialogue – all these contribute to the child's ability to form healthy attachments.	Memory-building; rupture and repair; emotional and collaborative communication; reflective dialogue – all these contribute to the supervisee's ability to become healthy attachment figures for clients.
Internal working model (IWM)	Through early experiences in relationship, children develop ideas about their worth and lovability, what can be expected from others, and shift their behavior accordingly.	Supervisees have also developed an IWM that they bring into their work as psychotherapists that tells them if they are worthwhile or unlovable, if people in authority are trustworthy and reliable, and has shaped their behavior in the world. This will impact both their relationship with the supervisor and their interactions in therapy.
Coherent narrative & traumatic reminders	The ability to make meaning from your experiences even when painful and create a story that makes sense, is linear, and has insight. When you can do this the likelihood of being activated by triggers from past trauma is decreased.	The ability to make meaning from your experiences even when painful and create a story that makes sense, is linear, and has insight. When you can do this the likelihood of being activated by triggers from past trauma is decreased.
Interpersonal neurobiology	The structures of the brain can be changed through important relationships and attachment-promoting activities.	The structures of the brain can changed through the supervisory relationship and attachment-promoting activities.

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What Is Your Philosophy of Change?

Insight/awareness_____Action

There-and-then_____Here-and-now
(the past) (the present)

Focus on personality_____Focus on problem

Changing the person_____Solving specific problems

Heredity_____Environmental factors
(Biology)

Feelings_____Behaviors_____Thoughts

Importance of feelings_____Importance of thoughts

Emotional catharsis_____Cognitive restructuring

Therapist centered_____Client centered

Therapist is the expert_____Client is the expert

Individual_____Integrated_____Systems

Universals_____Situation specific

Relationship important _____Technique important

Medical model_____Phenomenological Model

From: Campbell, J. (2000). Becoming an effective supervisor: A workbook for counselors and psychotherapists. Ann Arbor, MI: Taylor & Francis.

Applying Psychotherapeutic Theory to Clinical Supervision

Theory Concept	Definition	Application to Supervision

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Supervisor/ Consultant Guide

Case Selection

Use This:

To guide selection of cases or events to discuss as part of supervision or consultation.

Objective:

- To apply deliberate decision-making strategies to identify a subset of cases for review

Strategies:

☐ **Consider relevant factors for case selection**	Identify the client, practitioner, and contextual factors that could influence which cases are prioritized during supervision. Determine priorities so as to achieve the desired balance across these multiple factors. Example factors include: • *Client factors:* Client progress, practice history, time since last review, newly identified case • *Practitioner factors:* Each practitioner's professional development history (e.g., experience and competence), practitioner's need for support and feedback • *Contextual factors:* Relevant quality initiatives in the organization, program development, staffing issues (e.g., vacations)
☐ **Apply one or more case selection rules**	Purposefully apply one or more specific case selection rules, which may tie to the factors identified above. Example rules include: • *Poor progress*: Cases are selected when their case-specific evidence shows that clinical gains are not meeting expected benchmarks over time or that the cases are deteriorating • I*dentified risk*: Cases are selected based on a known history of particular risk (e.g., history of suicidal behaviors) representing the need for increased surveillance and review • *Practitioner nomination*: Cases are selected based on each practitioner's stated need for review (e.g., by prioritizing therapist ratings of urgency) • *Random subset*: A random case or set of cases is selected to ensure adequate representation and/or to prevent systematically avoiding a set of cases over time. Random subsets can be used to supplement other systematic strategies listed above
☐ **Maintain comprehensive caseload review**	As multiple case selection rules are employed, ensure that there is also a regular review of *all* cases within a regular time interval (e.g., all cases get reviewed at least once per month).
☐ **Balance breadth and depth**	Review the cases selected to balance broad monitoring coverage with in-depth focus. For example, it can be helpful to pick a single case or clinical event for the purpose of intensive supervisory attention that promotes practitioner learning and professional development goals, whereas many cases may need only a brief review.

Strategies:

☐ **Vary criteria from time to time**	Case selection rules can and should be varied across supervision events, in order to maintain a certain degree of novelty and complexity and to prevent supervision/consultation from becoming monotonous or overly routine.

Sample Caseload

	Major area of challenge	Current level of crisis (1-10 scale)	Documentation due in	Clinician expression of urgency (1-10 scale)	When last discussed in supervision
Ana	Parenting overwhelm	5	One month	7	Two weeks ago
Brittany	Depression & suicidality	6	One week	9	Last week
Carlos	Anxiety & trauma	8	Two months	5	Last week
Drew	Relationship break-up	7	Seven months	7	One month ago
Ebony	Depression & identity issues	6	Two weeks	4	Two weeks ago
Francisco	Career & financial concerns	3	Six months	4	Three months ago
Gabriella	Chronic health issues	9	Four months	3	Six weeks ago
Hana	Grief at loss of mother	2	Three weeks	8	Three weeks ago
Isolde	Anger at work	4	One week	7	Two months ago
Jing	Depression & suicidality	3	Two weeks	9	Last week

Adapted from: www.practicewise.com Ellen Kinoy, MFT / July 16, 2016

Case Selection Exercise

1. Utilizing the Case Selection Supervisor Guide, apply a case selection rule to the caseload described on the worksheet.

2. What are the top three clients you would discuss in your supervision session and why?

   a. _____ b. _____ c. _____

3. Now apply a different case selection rule and determine three clients to discuss.

   a. _____ b. _____ c. _____

4. Were the clients the same or different?

   _____

5. Which factors are most prominent in your decision-making? Client, clinician, or organization?

   _____

Supervisor/ Consultant Guide

Instruction

Use This:

To teach new skills or concepts to supervisees

Objective:

- To help supervisees develop expertise with new skills or concepts

Strategies:

☐ **Organize materials**	Organized, structured materials are useful for teaching. Consider multiple media, and develop activities or exercises (e.g., games, tests) that will enhance participation in the learning processes.
☐ **Use rehearsal and coaching**	Don't just explain: practice new skills in context when possible, or use simulated rehearsals (e.g., role play) as a substitute. Correct mistakes when they happen, and give opportunities to try again.
☐ **Pair and partner**	Consider having supervisees work in teams, perform co-therapy, or work together in role-plays to learn new skills. This can reduce anxiety, and allows additional modeling and feedback to occur naturally.
☐ **Praise and shape**	Regularly praise supervisees for attempts at skill development, regardless of the specific performance outcome. Shaping refers to the notion that even partial successes should be noticed and acknowledged. Delivering praise in public contexts is encouraged, as it can have enhanced impact.
☐ **Leave the comfort zone**	Develop a thorough understanding of which activities are comfortable for supervisees, which activities are a stretch, and which activities are (for the moment) not possible. The aim is to keep supervisees working in the middle zone, where they are challenged but not overwhelmed.
☐ **Aim for "overlearning"**	Emphasize the importance of learning a skill to the point of automaticity habit (like driving a car). Such a level of performance frees cognitive resources for other important activities (e.g., monitoring client mood while teaching a skill; planning or selecting a subsequent activity).
☐ **Assign homework**	Because rehearsal is a critical part of learning, be sure to assign activities for practice or homework between supervision sessions. Follow-up on these assignments is very important.
☐ **Establish public commitment to learning**	Obtain public commitments from supervisees when you are seeking to have them attempt a new skill or activity or pursue a particular course of action (e.g., "who is going to practice this with a client this week—raise your hand?").
☐ **Return to key points**	Once a new skill or concept is covered, be sure to emphasize those points continually going forward, always looking for opportunities for repetition. Often, examples of key concepts will arise naturally in the course of supervision, and these should be explicitly framed and connected to the curriculum to help supervisees better understand the concepts and how they manifest in practice.

Rehearsal Exercise Skills

1. Talking to your client about confidentiality and its limits.
2. Providing psychoeducation to a caregiver about how trauma impacts their child's brain e.g. being on high alert all the time and reacting to all triggers with the same intensity.
3. Introducing the idea of ending therapy because it is the end of the school year to your 4th grade client.
4. Providing psychoeducation to a teen client about the impact of using alcohol on their mental health.
5. Using tracking statements in non-directive play therapy.
6. Talking to a couple about the Five Languages of Love (Words of Affirmation, Acts of Service, Receiving Gifts, Physical Touch and Quality Time).

Designing A Rehearsal Worksheet

Set Up	• Select concept, resource or application: _____ • Clarify rehearsal activity and objective: _____
Kick Off	• How will you kick off? _____
Inspect	• Active observation task: _____ _____
Talk Through	• How will you debrief? _____ _____

www.practicewise.com

MAP Agency Supervisor Portfolio: Promotion Review

SUPERVISION EVALUATION FORM

Supervisor's Name: Supervisee Number: Today's Date:

Registered Agency: Months of Supervision:

Instructions: Please complete this form with respect to your experiences in receiving supervision or consultation services from the named Supervisor over the previous three (3) months.

Overall Impression	**Seldom**	**Sometimes**	**Frequently**	**Usually**	**Don't Know**
1. The supervision and consultation that I received was useful.	☐	☐	☐	☐	☐
2. I have a good relationship with my supervisor.	☐	☐	☐	☐	☐

Please rate your agreement with each item	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Don't Know**
3. I am confident that I can use the MAP system successfully.	☐	☐	☐	☐	☐
4. I believe that the MAP system can help my clients and improve our services.	☐	☐	☐	☐	☐
5. My knowledge and skills have improved as the result of the supervision and consultation that I received.	☐	☐	☐	☐	☐
6. Supervision helps me identify specific things that I can do to help particular clients.	☐	☐	☐	☐	☐
7. I have clear, specific, and achievable goals for learning and using the MAP system.	☐	☐	☐	☐	☐
8. I have the opportunity to practice and use new MAP skills in my daily work.	☐	☐	☐	☐	☐
9. I am reminded and encouraged to use my MAP skills by my colleagues.	☐	☐	☐	☐	☐
10. The feedback I receive helps me know how well I am doing with my MAP skills.	☐	☐	☐	☐	☐
11. Using the MAP system has helped my clients and improved my practice.	☐	☐	☐	☐	☐

Please rate your supervisor	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Don't Know**
12. My supervisor prepares me to learn skills by telling me what to expect and what is important.	☐	☐	☐	☐	☐
13. My supervisor teaches, demonstrates, and practices MAP skills with me.	☐	☐	☐	☐	☐
14. My supervisor and I regularly review my progress and performance.	☐	☐	☐	☐	☐
15. My supervisor reminds and encourages me to use my MAP skills.	☐	☐	☐	☐	☐
16. My supervisor helps me plan and supports my professional growth.	☐	☐	☐	☐	☐
17. My supervisor helps create a supportive work environment.	☐	☐	☐	☐	☐

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Comparison of Supervisory Techniques

Evaluation of Usefulness for Implementation

Technique	Logistical Factors	Benefits for the Supervisor	Benefits for the Supervisee	Pitfalls for the Supervisor	Pitfalls for the Supervisee	Supervisor Familiarity Level (1-4 Scale)
Record review						
Process notes						
Audio or videotape review						
Role play						
Live Supervision						
Expressive arts activities						

Adapted from: Campbell, J. (2000). Becoming an effective supervisor: A workbook for counselors and psychotherapists. Ann Arbor, MI: Taylor & Francis.
Ellen Kinoy, MFT / July 16, 2016

LINCOLN

School-Based Services
Group Supervision Case Presentation Format

1. Why this client is being presented. What questions do you have about the work you are doing?
2. Identifying information. Age, gender, grade, ethnicity, socio-economic status, language.
3. Family constellation. Significant family members, living situation, and relevant family history. May include genogram.
4. Strengths. Academics, likeability, multiple intelligence, temperamental style.
5. Presenting problem. Who referred this client to HOPE and why?
6. Focus of treatment. Needs, goals, assessment issues.
7. Course of treatment. How many sessions so far? What services are being/have been provided? Has there been any change?
8. Conceptualization of case. Intrapsychic, interpersonal, and systemic.
9. Therapeutic interventions and their outcome. What have you tried? What has been successful and why? What has been unsuccessful and why? Report of therapy session.
10. Transference and countertransference issues.
11. Group discussion.

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