# Clinical Supervision

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1

## Clinical Supervision

Supervision- A relationship in which a more senior clinician monitors and guide's a trainee's work in order both to facilitate development and ensure client care (American Psychological Association)

Feedback systems have been shown to improve quality of psychotherapy in part by identifying and preventing failing cases [3]

2

# Goals of Supervision[5]

| | |
|---|---|
| Explain and demonstrate | Explain and demonstrate models for effective practice (e.g. CBT, interpersonal psychotherapy, etc.) |
| Determine | Determine trainee's current level of understanding and opportunity for improvement |
| Provide | Provide corrective feedback and guidance in a manner accessible to trainee |
| Offer | Offer emotional encouragement to support growth and buffer against emotional challenges inherent in learning process |
| Teach | Teach trainee's how to work appropriately within various professional domains |

3

# Clinical Competencies [20]

1. Use of a theoretical or conceptual frame to direct therapy
2. Memory of the client's central issues
3. Skillful use of intervention techniques to promote desired change in behavior or to set the stage for conditions of change
4. Knowledge of when to apply (or not apply) these interventions
5. Knowledge of self and role of the self
6. Knowledge of the role of culture, ethnicity, gender, and variable of diversity of self, client and community in interaction

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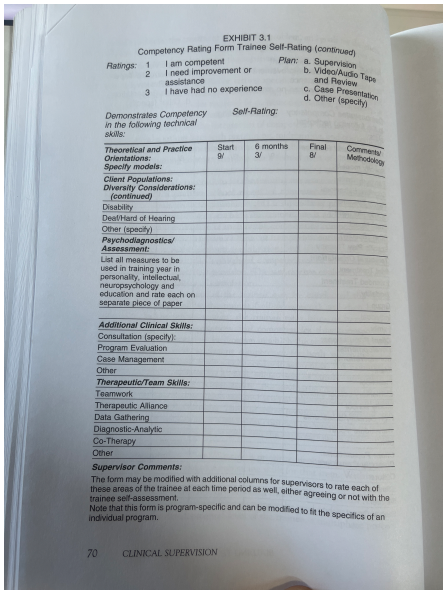


EXHIBIT 3.1
Competency Rating Form Trainee Self-Rating (continued)

Ratings: 1 I am competent
2 I need improvement or assistance
3 I have had no experience

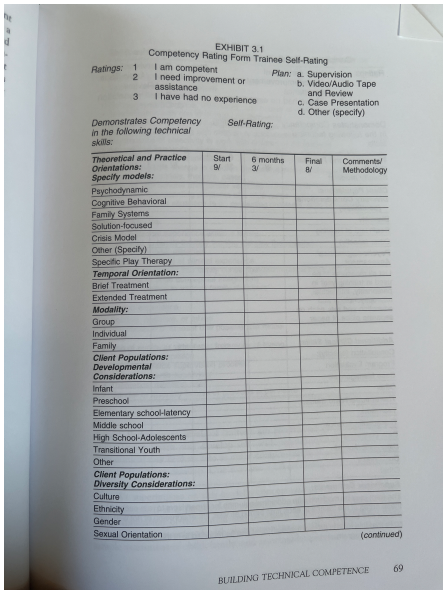
Plan: a. Supervision
b. Video/Audio Tape and Review
c. Case Presentation
d. Other (specify)

Demonstrates Competency in the following technical skills: | Self-Rating:

| Theoretical and Practice Orientations: Specify models: | Start 9/ | 6 months 3/ | Final 8/ | Comments/ Methodology |
|---|---|---|---|---|
| **Client Populations: Diversity Considerations: (continued)** | | | | |
| Disability | | | | |
| Deaf/Hard of Hearing | | | | |
| Other (specify) | | | | |
| **Psychodiagnostics/ Assessment:** | | | | |
| List all measures to be used in training year in personality, intellectual, neuropsychology and education and rate each on separate piece of paper | | | | |
| **Additional Clinical Skills:** | | | | |
| Consultation (specify): | | | | |
| Program Evaluation | | | | |
| Case Management | | | | |
| Other | | | | |
| **Therapeutic/Team Skills:** | | | | |
| Teamwork | | | | |
| Therapeutic Alliance | | | | |
| Data Gathering | | | | |
| Diagnostic-Analytic | | | | |
| Co-Therapy | | | | |
| Other | | | | |

**Supervisor Comments:**
The form may be modified with additional columns for supervisors to rate each of these areas of the trainee at each time period as well, either agreeing or not with the trainee self-assessment.
Note that this form is program-specific and can be modified to fit the specifics of an individual program.

70 CLINICAL SUPERVISION



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| Theoretical and Practice Orientations: Specify models: | Start 9/ | 6 months 3/ | Final 8/ | Comments/ Methodology |
|---|---|---|---|---|
| Psychodynamic | | | | |
| Cognitive Behavioral | | | | |
| Family Systems | | | | |
| Solution-focused | | | | |
| Crisis Model | | | | |
| Other (Specify) | | | | |
| Specific Play Therapy | | | | |
| **Temporal Orientation:** | | | | |
| Brief Treatment | | | | |
| Extended Treatment | | | | |
| **Modality:** | | | | |
| Group | | | | |
| Individual | | | | |
| Family | | | | |
| **Client Populations: Developmental Considerations:** | | | | |
| Infant | | | | |
| Preschool | | | | |
| Elementary school-latency | | | | |
| Middle school | | | | |
| High School-Adolescents | | | | |
| Transitional Youth | | | | |
| Other | | | | |
| **Client Populations: Diversity Considerations:** | | | | |
| Culture | | | | |
| Ethnicity | | | | |
| Gender | | | | |
| Sexual Orientation | | | | |

(continued)

BUILDING TECHNICAL COMPETENCE 69

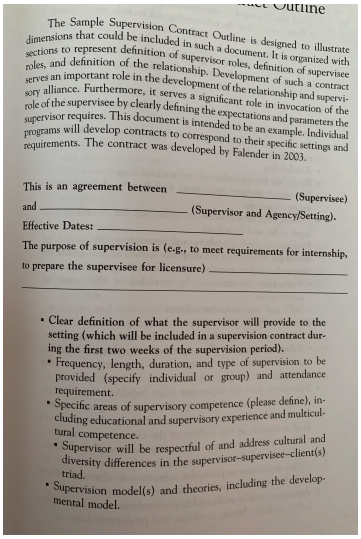
5

# Commitments of supervision[13]

1. Have obtained competence through formal training in both the provision of the services that are the focus of supervision and in the practice of supervision
2. Establish clear expectations about performance goals and about the responsibilities of each party in that relationship
3. Remain committed to resolving conflicts when they occur
4. Provide clear and ongoing feedback and evaluation
5. Demonstrate multicultural competence

6

# Sample Supervision Contract



Outline

The Sample Supervision Contract Outline is designed to illustrate dimensions that could be included in such a document. It is organized with sections to represent definition of supervisor roles, definition of supervisee roles, and definition of the relationship. Development of such a contract serves an important role in the development of the relationship and supervisory alliance. Furthermore, it serves a significant role in invocation of the role of the supervisee by clearly defining the expectations and parameters the supervisor requires. This document is intended to be an example. Individual programs will develop contracts to correspond to their specific settings and requirements. The contract was developed by Falender in 2003.

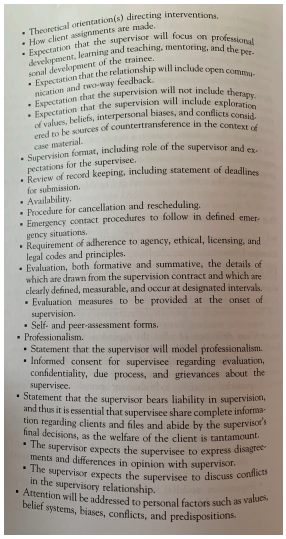
This is an agreement between _____ (Supervisee) and _____ (Supervisor and Agency/Setting).

Effective Dates: _____

The purpose of supervision is (e.g., to meet requirements for internship, to prepare the supervisee for licensure) _____

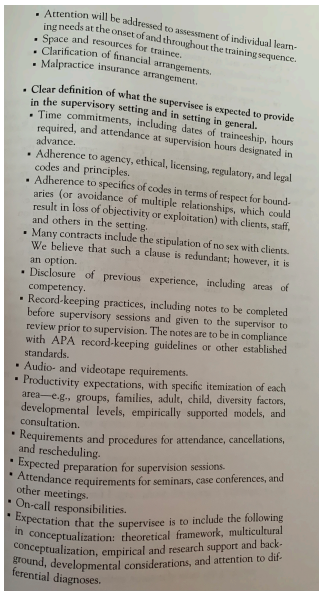
_____

- **Clear definition of what the supervisor will provide to the setting (which will be included in a supervision contract during the first two weeks of the supervision period).**
  - Frequency, length, duration, and type of supervision to be provided (specify individual or group) and attendance requirement.
  - Specific areas of supervisory competence (please define), including educational and supervisory experience and multicultural competence.
  - Supervisor will be respectful of and address cultural and diversity differences in the supervisor–supervisee–client(s) triad.
- Supervision model(s) and theories, including the developmental model.



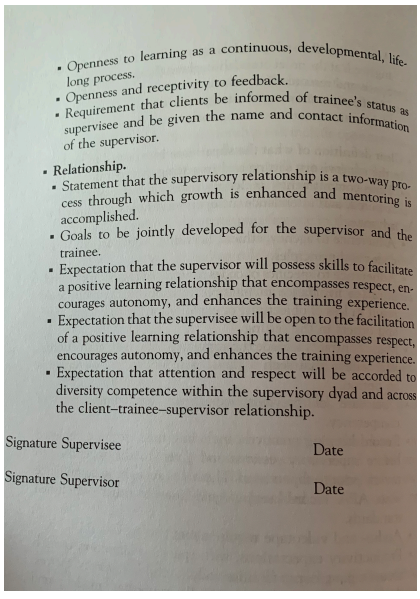
- Theoretical orientation(s) directing interventions.
- How client assignments are made.
- Expectation that the supervisor will focus on professional development, learning and teaching, mentoring, and the personal development of the trainee.
- Expectation that the relationship will include open communication and two-way feedback.
- Expectation that the supervision will not include therapy.
- Expectation that the supervision will include exploration of values, beliefs, interpersonal biases, and conflicts considered to be sources of countertransference in the context of case material.
- Supervision format, including role of the supervisor and expectations for the supervisee.
- Review of record keeping, including statement of deadlines for submission.
- Availability.
- Procedure for cancellation and rescheduling.
- Emergency contact procedures to follow in defined emergency situations.
- Requirement of adherence to agency, ethical, licensing, and legal codes and principles.
- Evaluation, both formative and summative, the details of which are drawn from the supervision contract and which are clearly defined, measurable, and occur at designated intervals.
  - Evaluation measures to be provided at the onset of supervision.
  - Self- and peer-assessment forms.
- Professionalism.
  - Statement that the supervisor will model professionalism.
  - Informed consent for supervisee regarding evaluation, confidentiality, due process, and grievances about the supervisee.
- Statement that the supervisor bears liability in supervision, and thus it is essential that supervisee share complete information regarding clients and files and abide by the supervisor's final decisions, as the welfare of the client is tantamount.
  - The supervisor expects the supervisee to express disagreements and differences in opinion with supervisor.
  - The supervisor expects the supervisee to discuss conflicts in the supervisory relationship.
- Attention will be addressed to personal factors such as values, belief systems, biases, conflicts, and predispositions.

7



- Attention will be addressed to assessment of individual learning needs at the onset of and throughout the training sequence.
- Space and resources for trainee.
- Clarification of financial arrangements.
- Malpractice insurance arrangement.

- **Clear definition of what the supervisee is expected to provide in the supervisory setting and in setting in general.**
  - Time commitments, including dates of traineeship, hours required, and attendance at supervision hours designated in advance.
  - Adherence to agency, ethical, licensing, regulatory, and legal codes and principles.
  - Adherence to specifics of codes in terms of respect for boundaries (or avoidance of multiple relationships, which could result in loss of objectivity or exploitation) with clients, staff, and others in the setting.
  - Many contracts include the stipulation of no sex with clients. We believe that such a clause is redundant; however, it is an option.
  - Disclosure of previous experience, including areas of competency.
  - Record-keeping practices, including notes to be completed before supervisory sessions and given to the supervisor to review prior to supervision. The notes are to be in compliance with APA record-keeping guidelines or other established standards.
  - Audio- and videotape requirements.
  - Productivity expectations, with specific itemization of each area—e.g., groups, families, adult, child, diversity factors, developmental levels, empirically supported models, and consultation.
- Requirements and procedures for attendance, cancellations, and rescheduling.
- Expected preparation for supervision sessions.
- Attendance requirements for seminars, case conferences, and other meetings.
- On-call responsibilities.
- Expectation that the supervisee is to include the following in conceptualization: theoretical framework, multicultural conceptualization, empirical and research support and background, developmental considerations, and attention to differential diagnoses.



- Openness to learning as a continuous, developmental, lifelong process.
- Openness and receptivity to feedback.
- Requirement that clients be informed of trainee's status as supervisee and be given the name and contact information of the supervisor.

- **Relationship.**
  - Statement that the supervisory relationship is a two-way process through which growth is enhanced and mentoring is accomplished.
  - Goals to be jointly developed for the supervisor and the trainee.
  - Expectation that the supervisor will possess skills to facilitate a positive learning relationship that encompasses respect, encourages autonomy, and enhances the training experience.
  - Expectation that the supervisee will be open to the facilitation of a positive learning relationship that encompasses respect, encourages autonomy, and enhances the training experience.
  - Expectation that attention and respect will be accorded to diversity competence within the supervisory dyad and across the client–trainee–supervisor relationship.

Signature Supervisee Date

Signature Supervisor Date

8

# Creating a Supervisory Alliance

- Lead by example
- Affirm your commitment and focus during supervisory sessions by limiting distractions
- Clearly and collaboratively identify the goals of each supervisory relationship and the tasks to achieve those goals
- Develop a sense of bond in supervision
- Be mindful of and discuss your own experiences and contribution to the supervision process
- Be engaged and active in the technique training at hand

9

# Worst Supervisors[20]

- Plays “games”
- Crosses boundaries
- Not focused on objectives during supervision
- Defensive
- Avoidant
- Poor modeling of professional and personal attributes
- Unclear standards of accountability
- Impose a personal agenda
- Unavailable
- Disregard theory

10

# Self- disclosure

- "statement that reveals something personal about the therapist" [20, p.88]
- Creates good supervisory alliance
- Influences emotional bond
- Model ethical self-disclosure with clients
- "self-disclosures relating to supervisors' emotional reactions to clients, their own counselling struggles and successes, personal feedback on the supervisory relationship, general professional experiences, and didactic mentoring providing vicarious experiences, all appeared to be facilitative." [20]

11

- Intentional self-disclosure
  - Remains client focused
  - Guidelines by Hill and Fox (2001)
    1. Generally disclose infrequently
    2. The most appropriate topic for therapist self-disclosure involves professional background, whereas the least appropriate topics include sexual practices and beliefs
    3. Generally use disclosures to validate reality, normalize client experiences, model appropriate behavior, strengthen the therapeutic alliance, or offer alternative ways to think or act
    4. Generally avoid using disclosures that are chiefly for their own needs, that remove the focus from the client, that interfere with the flow of the session, that burden or confuse the client, that are intrusive, that blur the boundaries, or that overstimulate the client
    5. Self- disclose in response to client self-disclosure seems to be particularly effective in eliciting client disclosure
    6. Observe carefully how clients responds to therapist disclosures, ask about client reactions, and use the information to conceptualize the clients and decide how to intervene next
    7. It may be particularly important for therapists to disclose with clients who have difficulty formation relationships in therapeutic settings

12

# Unintentional Self-disclosure

- Departure from appropriate practice and often results in discomfort due to the intrusion of personal influence
- Provide opportunities to understand the countertransference pressures within the relationship and to mitigate undue influence

13

# Ethical Perspectives

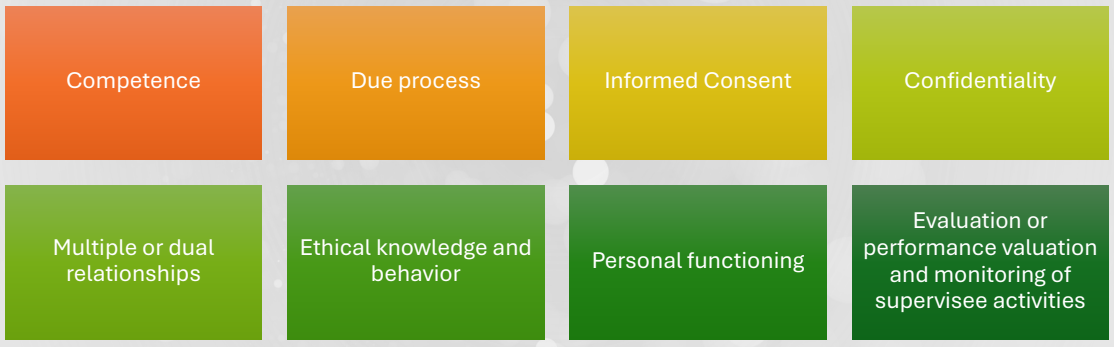
- Supervisors model professional values, principles, and ethics
- Awareness of countertransference of supervisor onto supervisee
- In Pope and Vetter's 1992 study with 703 ethical incidents:
  - 18% were breaches in confidentiality
  - 17% blurred, dual or conflictual relationships
  - 14% problems with payment sources, plans, settings or methods
  - 8% issues concerning academic settings, teaching dilemmas and training
  - 2% supervision issues

14

- Pope and Vasquez (1998) looked at reasons psychologists were sued
  - 20% sexual impropriety
  - 14% incorrect treatment
  - 11% loss from evaluation
  - 7% breach of confidentiality or privacy
  - 7% failure to diagnose or establishment of an incorrect diagnosis
  - 2% failure to supervise properly

15

## Areas of ethical competency




16

# Competence

- Practicing within scope of practice based on their education, training, supervised experience, consultation, study, or professional experience
- Central to supervision is the clinical practice of defining and supervising within one's own area of competence
- Self-assessment is a valuable competency for supervisors to model for supervisees

17

# Due process and informed consent

- Ensure supervisee's rights are not violated or ignored in supervision
- Informed consent including in regard to roles, expectations goals, and criteria for evaluation
- Define was signifies successful completion of training sequence
- Outline limits of confidentiality
- Guide supervisee in applying ethical principle of informed consent with client

18

# Informed consent for supervisee student

- Client consent to treatment by the supervisee and that the supervisor will supervise the case
- Supervisor and supervisee consent to the supervisory responsibility and relationship
- Institution consents to comply with the clinical, ethical, and legal dimensions of supervision
- Client must be informed that their therapist is a trainee under the supervision of a named individual, the provision of whose license and contact information may be required
- The client must consent that confidential information and the therapy process is shared with the supervisor

19

# Multiple or dual relationships

- Occur when a therapist or supervisor has a concurrent or consecutive personal, social, business or professional relationship with a client or supervisee in addition to the therapist-client or supervisor-supervisee relationships, and these roles conflict or compete [20]

20

# Documentation

- Just like practitioners maintain case records for clients, so must they provide documentation of their supervisory work [20]
- Measure of accountability
- Risk management
- Includes supervisory contract, supervisee's application materials, all performance evaluations, and a monitoring log
  - Log consists of a list of cases the supervisee is carrying; dates of supervision; presentation of problems and critical issues, directives or directions the supervisee is following in treatment, changes in diagnosis or treatment plan, discuss of case progress, details of safety, ethic, legal, and risk management concerns raised and their resolution; follow up reports on previous interventions or concerns; details of supervisee issues or concerns and their resolution

21

# Matching supervisee's development

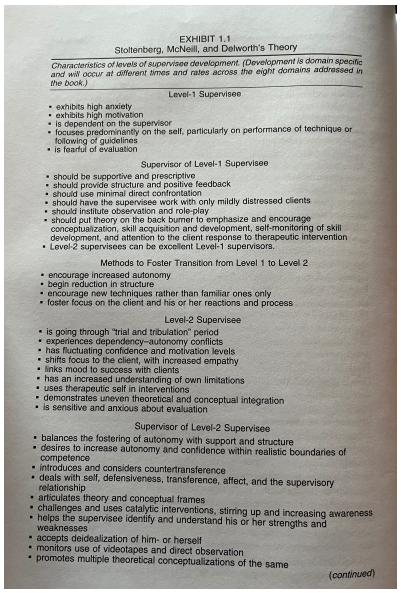


EXHIBIT 1.1
Stoltenberg, McNeill, and Delworth's Theory

*Characteristics of levels of supervisee development. (Development is domain specific and will occur at different times and rates across the eight domains addressed in the book.)*

Level-1 Supervisee

- exhibits high anxiety
- exhibits high motivation
- is dependent on the supervisor
- focuses predominantly on the self, particularly on performance of technique or following of guidelines
- is fearful of evaluation

Supervisor of Level-1 Supervisee

- should be supportive and prescriptive
- should provide structure and positive feedback
- should use minimal direct confrontation
- should have the supervisee work with only mildly distressed clients
- should institute observation and role-play
- should put theory on the back burner to emphasize and encourage conceptualization, skill acquisition and development, self-monitoring of skill development, and attention to the client response to therapeutic intervention
- Level-2 supervisees can be excellent Level-1 supervisors.

Methods to Foster Transition from Level 1 to Level 2

- encourage increased autonomy
- begin reduction in structure
- encourage new techniques rather than familiar ones only
- foster focus on the client and his or her reactions and process

Level-2 Supervisee

- is going through "trial and tribulation" period
- experiences dependency–autonomy conflicts
- has fluctuating confidence and motivation levels
- shifts focus to the client, with increased empathy
- links mood to success with clients
- has an increased understanding of own limitations
- uses therapeutic self in interventions
- demonstrates uneven theoretical and conceptual integration
- is sensitive and anxious about evaluation

Supervisor of Level-2 Supervisee

- balances the fostering of autonomy with support and structure
- desires to increase autonomy and confidence within realistic boundaries of competence
- introduces and considers countertransference
- deals with self, defensiveness, transference, affect, and the supervisory relationship
- articulates theory and conceptual frames
- challenges and uses catalytic interventions, stirring up and increasing awareness
- helps the supervisee identify and understand his or her strengths and weaknesses
- accepts deidealization of him- or herself
- monitors use of videotapes and direct observation
- promotes multiple theoretical conceptualizations of the same

*(continued)*

22

EXHIBIT 1.1
Stoltenberg, McNeill, and Delworth's Theory (*continued*)

Level-3 Supervisee

- exudes an attitude of "calm after the storm"
- exhibits stable motivation
- is secure with autonomy
- focuses on the client, process, and self
- has professional identity at the core of his or her treatment
- is not disabled by remaining doubts
- accepts own strengths and weaknesses
- exhibits high empathy and understanding
- uses the therapeutic self in interventions
- integrates client information, personal responses, theoretical information, and empirical information
- may find it a challenge to be flexible in approach
- has accurate empathy that is tempered by objectivity and processing of reactions, feelings, and thoughts
- has a high level of insight into personal strengths and weaknesses
- addresses areas of weakness with increased confidence and nondefensiveness

Supervisor of Level-3 Supervisees

- carefully assesses consistency in performance areas across domains
- works towards integration across domains
- continues careful monitoring
- emphasizes autonomy and growth
- avoids creating an intrusive and overly structured supervisory environment
- creates a supportive supervisory environment
- engages in confrontation
- devotes attention to parallel process, countertransference, and the supervisor–supervisee relationship
- focuses on leading the supervisee to make personal self-discoveries
- interacts with empathy and in a nonjudgmental manner, with encouragement of experimentation and exploration
- provides advice concerning professional development and job searches as needed

Methods to Foster Transition from Level 2 to Level 3

- encourage movement towards stable motivation across domains
- foster flexibility to autonomously move conceptually and behaviorally across domains
- encourage creation of a solid professional identity
- encourage development of a personalized understanding across domains
- encourage assessment of the impact of personal events on professional life

Summarized from Stoltenberg, McNeill, and Delworth (1998).

23

# Having difficult conversations

- Take a stance of curiosity, and orient supervisee's to do the same
- Supervisee's can be helped by focusing attention to [20]
  1. the states of mind and attributions that are being stimulated within the clinical interaction
  2. the mental states they are attempting to ward off
  3. the interventions applied and their effects on the interaction
  4. alternative behaviors
- Keep the goal in mind and consider what is effective

24

## Conflict resolution

- Areas of conflict
  - Style of supervision (direction and support)
  - Interpersonal issues
- Generally, supervisors take the lead in resolution
- Identify problem, verbalize problem, discuss solution
- Create safe environment for bringing up complaints
- Process with colleagues

25

## Ruptures

- Ruptures and impasses result from conflict in [20]
  1. Tasks and goals
  2. Problems in the bond dimension of the relationship
- A coconstructed cycle of misattunement can become established and deteriorate the alliance
- Avoid shame inducing comments
- The Working Alliance Inventory

26

- Emphasis on personal growth more than a technical skills orientation (Therapist effects)

The professional and personal characteristics of effective psychotherapists : a systematic review

Heinonen, Erkki

Routledge
2020-05-18

Heinonen , E & Nissen-Lie , H A 2020 , ' The professional and personal characteristics of effective psychotherapists : a systematic review ' , Psychotherapy Research , vol. 30 , no. 4 , pp. 417-432 . https://doi.org/10.1080/10503307.2019.1620366

27

# Diversity Competence in Supervision

- "Involves the deconstruction of the 'inescapable framework' of beliefs, assumptions, and morality that provides the implicit scaffolding of our sense of reality and identity." [20, p. 32]
- Identifying countertransference
- Multicultural competency- "therapist's awareness of assumptions about human behavior, values, biases, preconceived notions, personal limitations; understanding the worldview of the culturally different client without negative judgements; and developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with culturally different clients [21, p.481]

28

## Stages of effective multicultural supervision [22]


29

## What makes an effective psychotherapist?

- Most effective therapists average 50% better client outcomes and 50% fewer dropouts [1]
- Practitioner proficiency does not automatically increase with experience [2]
- Highly effective therapists devote 4.5 more hours to activities specifically designed to improve their effectiveness [4]
- In some more modern clinical trials, CBT appears to be less effective than was initially demonstrated in the 1970s [6]

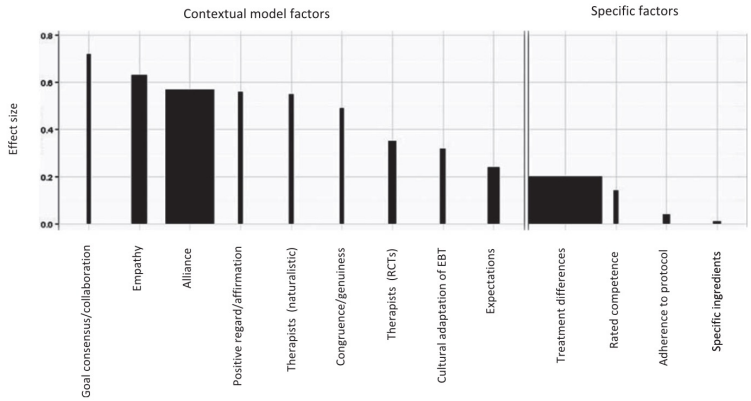
30

## What makes an effective psychotherapist?

- How one delivers a treatment is important, delivering an evidenced based treatment is not sufficient

31

## What makes an effective psychotherapist?

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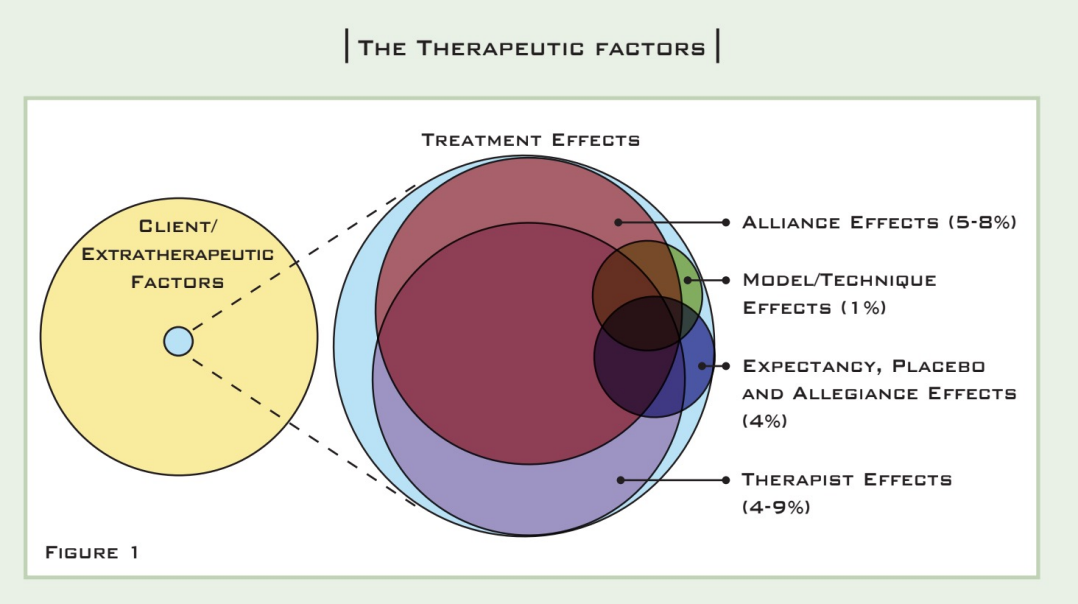


33

# Therapist Effects

- Preponderance of evidence indicates that there are important therapist effects (3-7% of variability)
- Therapist effects general exceed treatment effects
- What are the characteristics and actions of effective therapists?
  - Empathy
  - Authenticity (real relationship)
  - Ability to form strong alliances across the range of clients
  - Interpersonal skills (Higher linked to better client outcomes)
    - Verbal fluency
    - Interpersonal perception
    - Affective modulation and expressiveness
    - Warmth and Acceptance
    - Empathy
    - Focus on other
  - Reflective about practice

34

## General Effects

- Working alliance
  - Healthy, affectionate, and trusting feelings toward the therapist without transference
  - Agreement about the goals of therapy
  - Agreement about the tasks of therapy
  - Bond
  - Early symptom change may increase rates of alliance
- Placebo/ Expectation (Hope)
  - Desire to feel relief
  - Induction of an expectation that treatment can accomplish goal
  - Presence of emotional arousal
- Attribution
  - Client attributes changes to their own efforts (Self- efficacy increase)
  - Acquisition of the belief that one's efforts are responsible for improvement

Sunshine Coast Health Centre
A Non-12 Step Mental Health Program
Georgia Strait | Womens Clinic

35

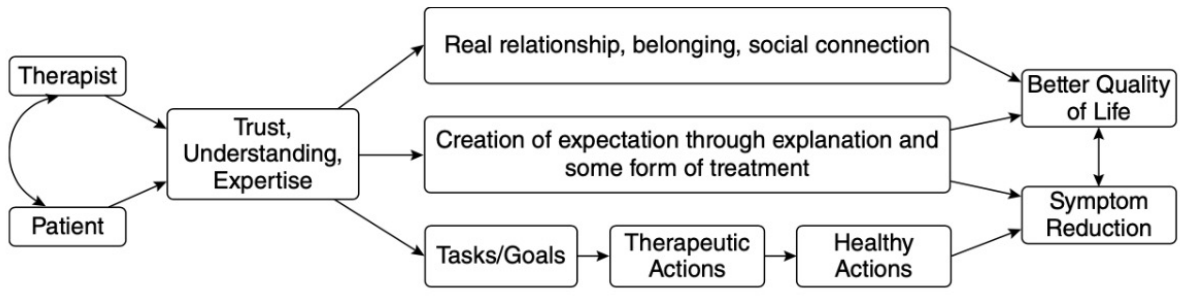


**Figure 3.1** Contextual Model.

Wampold & Budge, 2013; Wampold & Imel, 2015

36

*Table 9.2* Possible factors important to successful treatments of PTSD.

| |
|---|
| Cogent psychological rationale that is acceptable to patient |
| Systematic set of treatment actions consistent with the rationale |
| Development and monitoring of a safe, respectful, and trusting therapeutic relationship |
| Collaborative agreement about tasks and goals of therapy |
| Nurturing hope and creating a sense of self efficacy |
| Psychoeducation about PTSD |
| Opportunity to talk about trauma (i.e., tell stories) |
| Ensuring the patient's safety, especially if the patient has been victimized as in the case of domestic violence, neighborhood violence, or abuse |
| Helping patients learn how to avoid revictimization |
| Identifying patient resources, strengths, survival skills and intra and interpersonal resources and building resilience |
| Teaching coping skills |
| Examination of behavioral chain of events |
| Exposure (covert in session and in-vivo outside of session) |
| Making sense of traumatic event and patient's reaction to event |
| Patient attribution of change to his or her own efforts |
| Encouragement to generate and use social supports |
| Relapse prevention |

Note. Reprinted from "Determining what works in the treatment of PTSD," by B.E. Wampold, Z.E. Imel, K.M. Laska, S. Benish, S.D. Miller, C. Flückiger, . . . S. Budge, 2010, *Clinical Psychology Review, 30(8)*, p. 931. Copyright 2010. Permission from Elsevier.

[7]

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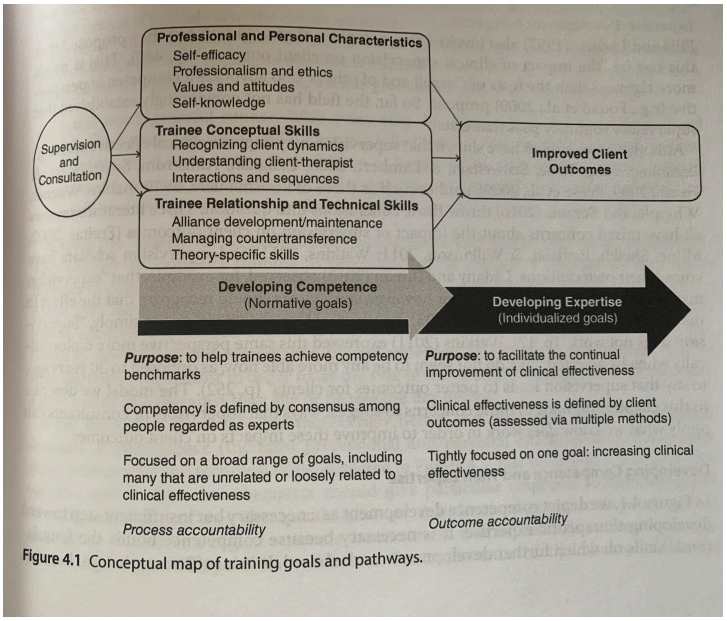



Figure 4.1 Conceptual map of training goals and pathways.

The Cyle of Excellence

38

# Creating Real Relationship

- Can the therapist understand me and my problems?
- Can I trust the therapist?
- Does the therapist have the capacity and expertise to help me?
- Most patients who drop out of therapy prematurely do so after the first session; second greatest after the second session
- Transference- free genuine relationship based on realistic perceptions [12]
- Authentic, open, honest, warm, caring and empathetic

39

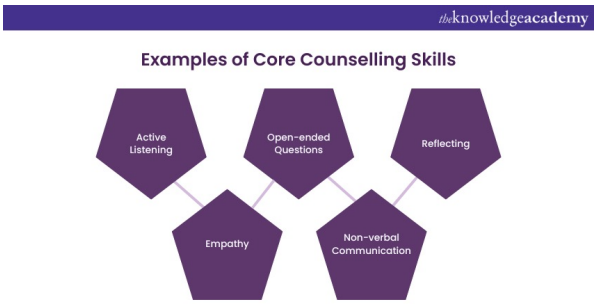
# Creating therapeutic alliance

Bond between therapist and client (Real Relationship)

Agreement about the goals of therapy

Agreement about the tasks of therapy

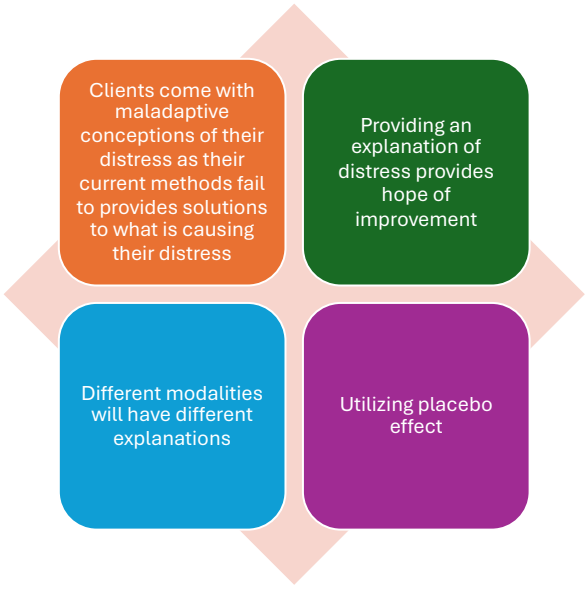
40


# Teaching empathy

41

# Utilizing expectation of treatment

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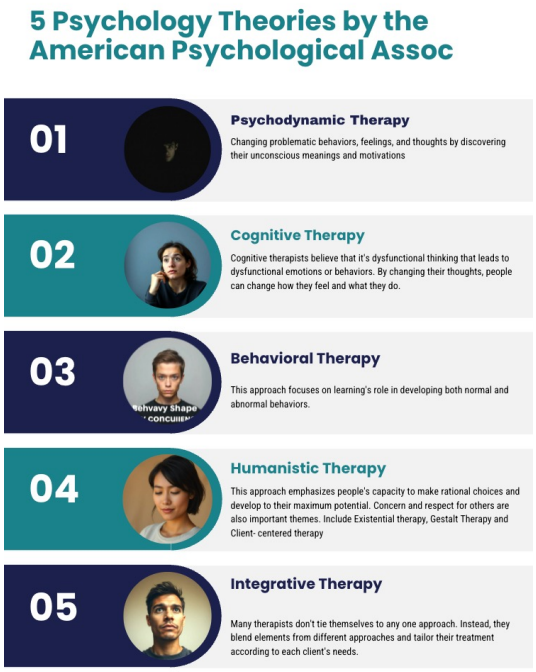



43

# Theories of therapy

**TABLE 3.9** The four forces of therapy, the relationship and traditional position of therapist

| | Methods | Position of therapist | Place of the relationship in therapy | Aim of therapy |
|---|---|---|---|---|
| **Psychoanalysis** | Interpretation of transference, countertransference and resistance | Expert<br>'Blank Screen'<br>Works with transference and interpretation | Working with the relationship in the here-and-now to resolve past issues | To adjust<br>To live more fully in the present reality based on the past |
| **Behaviourism and later Cognitive** | Deciding goals<br>Action plans<br>New ways of behaving and thinking | Expert<br>Educator<br>Trainer | Focus on practical, goal-based working alliance | To change maladaptive thoughts, feelings and behaviours |
| **Existential-humanistic** | Human encounter<br>In some cases particular techniques may be used | Facilitator or catalyst | Central<br>Focus on working in the here-and-now | To live a full life<br>Realization of potential<br>To live an authentic life |
| **Transpersonal Dialogue, Imagery,** | Dialogue<br>Imagery<br>Creative visualization | Guide<br>Facilitator<br>Educator | To facilitate holistic change | To achieve spiritual growth<br>To become integrated in mind, body and spirit |

[18]

44

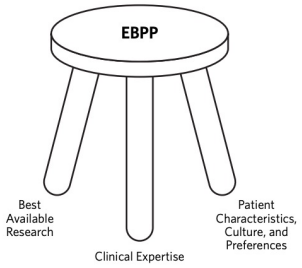
# Therapeutic Modalities

- Over 400 different modalities
- Evidenced based
  - Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

**Components of Evidence-Based Practice in Psychology (EBPP)**

APA's EBPP policy clearly identifies each of the three components of the tripartite model. The current professional practice guidelines illustrate *how* psychologists can apply these components to professional practice in health care. They provide a framework for integrating research evidence with clinical skill and patient identities and preferences. These guidelines seek to clarify and extend APA's EBPP policy by articulating practical considerations and providing illustrative examples of evidence-based psychological practice in health care.

*Figure 1. Components of Evidence-Based Practice in Psychology (EBPP)*




45

# Therapeutic Interventions

"Action on the part of a psychotherapist to deal with the issues and problems of a client. The selection of the intervention is guided by the nature of the problem, the orientation of the therapist, the setting, and the willingness and ability of the client to proceed with the treatment. Also called **psychological intervention**." (APA)

46

## Be Integrative, Not Eclectic [19, p.2]

- Theoretical integration- aims to bring together theoretical concepts from several different psychotherapeutic approaches and to develop a "Grand Unified Theory" of psychotherapy
- Assimilative integration- involves working primarily from one theoretical approach (e.g., cognitive behavioral therapy) but also incorporating techniques from other psychotherapeutic approaches as needed for any given client or context
- "An eclectic therapist chooses a technique because it may work or may be efficient, without concern for its theoretical basis or research evidence."

47

## Example: Psychodynamic Psychotherapy

- Individual Psychodynamic specific techniques
  1. Linking current feelings or perceptions to the past
  2. Focusing attention on similarities among patient's relationships repeated over time, settings, or people
  3. Identifying recurrent patterns in patient's actions, feelings, and experiences

48

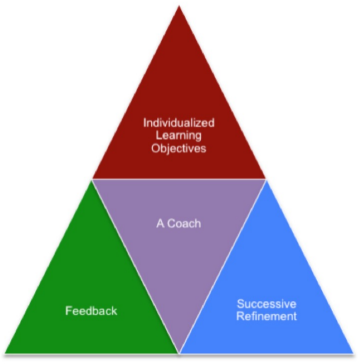
## Deliberate Practice

- Four Key Elements:
  1. A focused and systematic effort to improve performance pursued over an extended period
  2. Involvement of and guidance from a coach/teacher/mentor
  3. Immediate, ongoing feedback
  4. Successive refinement and repetition via solo practice outside of performance. (identify errors and then take steps to reduce errors during subsequent attempts)

49

Ericsson et al., 1993

## Deliberate Practice Framework

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# Taxonomy of Deliberate Practice Activities

- ../../Taxonomy of Deliberate Practice Activities Worksheets (TDPA)-v.6.0.pdf

51

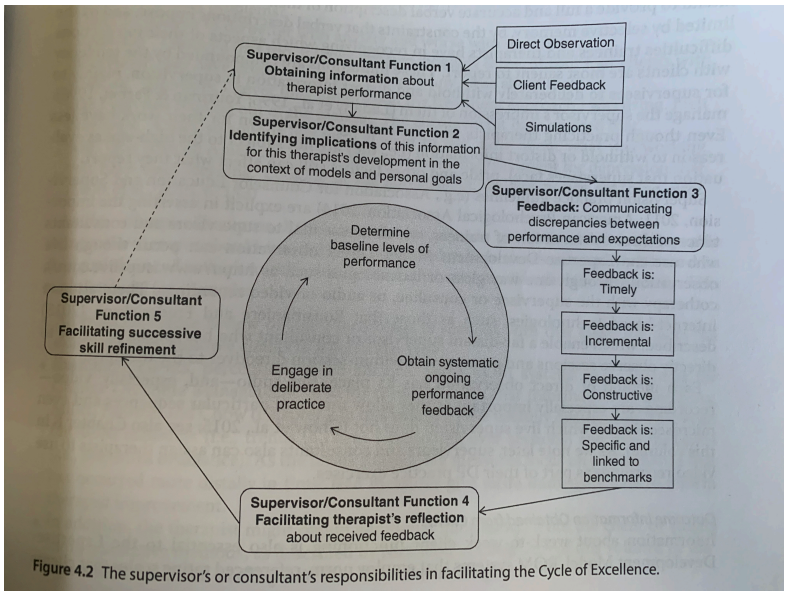


Figure 4.2 The supervisor's or consultant's responsibilities in facilitating the Cycle of Excellence.

52

# Cycle of Excellence [9]

1. Determine baseline of effectiveness
2. Obtain systematic, ongoing, formal feedback
3. Repeatedly engage in activities specifically designed to refine and improve performance.

53

# Step 1: Determine a Baseline

- Average psychotherapists overestimate their outcomes around 65% of the time [8]
- Measurement tools for outcomes
  - Partners for Change Outcome Management System (PCOMS)
  - Outcome Questionnaire Psychotherapy Quality Management System (OQ-Analyst)
- Lead versus Lag measures
  - - Lead measures most likely to aid in individual practitioner development
    Taxonomy of Deliberate Practice Activities Worksheet

54

# Function 1: Obtain Information

1. Direct Observation
   - Improved results over case presentation and narratives
   - Video ideal

2. Client feedback
   - Objective measures (e.g. FIT)
   - Focused on understanding psychotherapy impact including the therapeutic alliance
   - Not just symptom reduction scales

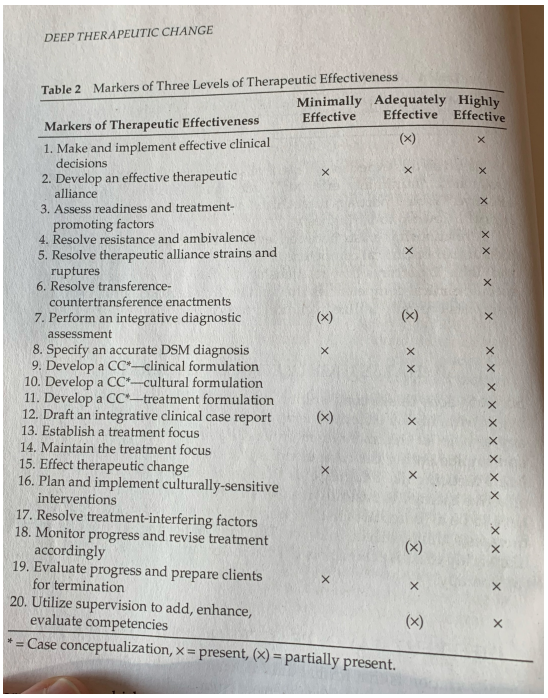
3. Simulations
   - Witness practicing through role-plays, sessions with actors, etc.

55

# Function 2: Identify Gaps

- Interpret data against industry benchmarks
- Consider competency standards
- Include individual goals

56



DEEP THERAPEUTIC CHANGE

Table 2 Markers of Three Levels of Therapeutic Effectiveness

| Markers of Therapeutic Effectiveness | Minimally Effective | Adequately Effective | Highly Effective |
|---|---|---|---|
| 1. Make and implement effective clinical decisions | | (×) | × |
| 2. Develop an effective therapeutic alliance | × | × | × |
| 3. Assess readiness and treatment-promoting factors | | | × |
| 4. Resolve resistance and ambivalence | | | × |
| 5. Resolve therapeutic alliance strains and ruptures | | × | × |
| 6. Resolve transference-countertransference enactments | | | × |
| 7. Perform an integrative diagnostic assessment | (×) | (×) | × |
| 8. Specify an accurate DSM diagnosis | × | × | × |
| 9. Develop a CC*—clinical formulation | | × | × |
| 10. Develop a CC*—cultural formulation | | | × |
| 11. Develop a CC*—treatment formulation | | | × |
| 12. Draft an integrative clinical case report | (×) | × | × |
| 13. Establish a treatment focus | | | × |
| 14. Maintain the treatment focus | | | × |
| 15. Effect therapeutic change | × | × | × |
| 16. Plan and implement culturally-sensitive interventions | | | × |
| 17. Resolve treatment-interfering factors | | | × |
| 18. Monitor progress and revise treatment accordingly | | (×) | × |
| 19. Evaluate progress and prepare clients for termination | × | × | × |
| 20. Utilize supervision to add, enhance, evaluate competencies | | (×) | × |

* = Case conceptualization, × = present, (×) = partially present.

Highly Effective Therapy by Len Sperry

57

# Step 2: Feedback

- Alerting therapists to cases most at risk for failure resulted in better outcomes and reduced rates of dropout and deterioration [10]
- Feedback delivered at the time of service had a considerably larger impact than when delayed by two weeks [11]
- One study considering using using objective monitoring tools for supervision indicated increased results when the tool was used
- Learning versus Performing Feedback
- Avoid criticism, break feedback in portions that are manageable and enable students to reach beyond their current comfort zones

58

- The unavailability of feedback contributes to therapists' overestimation of performance and poor judgement on adherence to intended treatment model [14, 15]
- Feedback must be:

1. Quality
   - Useful- Reduce gap between current performance and goal
   - Actionable to improve supervisee's performance
2. Timely
   - Regular and ongoing
   - Incremental, constructive, and specific

59

- Timely
  - Supervision and feedback 4 hours before a session was found to have greater impact on client outcome in session than feedback provided 2 days before a session [16]
  - Supervision after a session, coaching prior to a session
- Incremental
  - Bite size so as to not overwhelm
- Constructive [17]
  1. Ensure learner is aware of purpose of feedback
  2. Learners comment on goals they were trying to achieve
  3. Learners state whether they though they'd done well
  4. Supervisor stating what parts were done well
  5. Learners state what could be improved
  6. Supervisor state what should be improved
  7. Agree on action plan for improvement

60

## Step 3: Successful Refinement

- Setting aside time for self-reflection, identification of errors or deficiencies in one's performance, obtaining guidance, and then developing, rehearsing, executing, and continuously evaluating a plan for improvement based on PT and LF.

61

- Function 4: Facilitate critical reflection about feedback
  - Help supervisee's engage in the feedback process through reflection and critical thinking
- Function 5: Facilitate successful skill refinement
  - Behavioral repetition
  - Get supervisee to practice skills rather than teach or discuss skills and theory

62

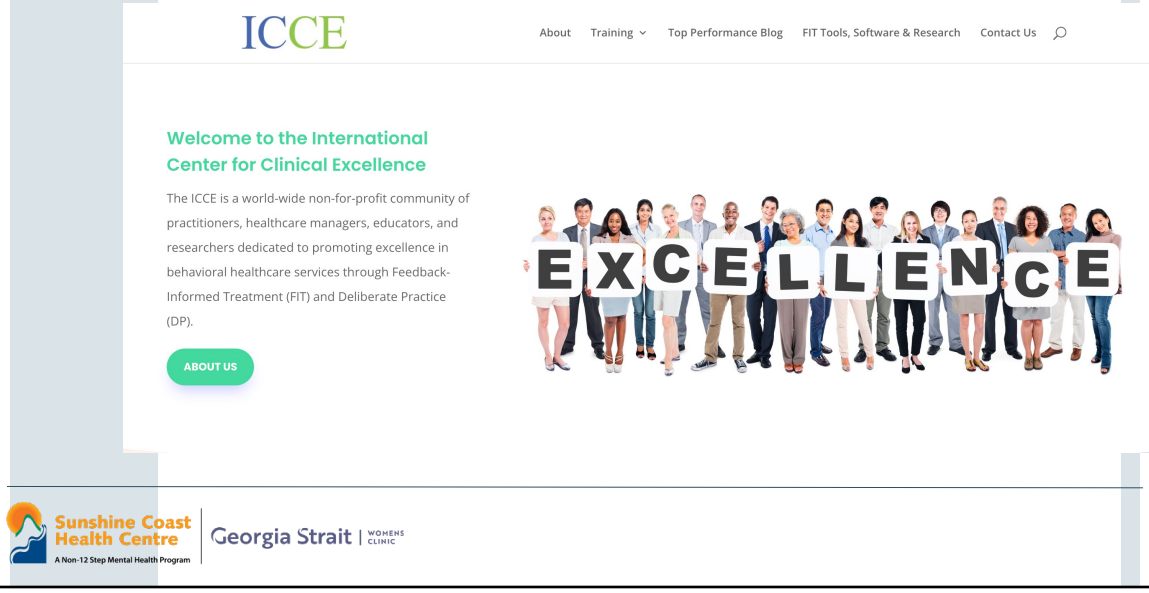
Table 4.2 Examples of tasks assigned to trainees or therapists to achieve particular training goals.

| Examples of Training Goals | Responses to Trainee or Therapist |
|---|---|
| *Build a stronger alliance with the client* | Notice each time the client breaks eye contact (taking into account possible cultural factors). |
| | Match the client's speech volume and pacing. |
| | Ask if the client thinks you understand what he/she just said. |
| *Help the client get in touch with feelings* | Ask the client to identify the emotion(s) he/she is having right now. |
| | Ask the client if any physical sensations accompany his/her emotions right now. |
| | Ask the client to notice if emotions are rising or falling in intensity or changing into other emotions. |
| *Become more aware of countertransference* | Notice if you have any feelings toward the client right now. |
| | Notice if there is anything about the client you wish you could change. |
| | Notice if the client reminds you of any people or situations in your current or past life. |

The Cycle of Excellence: Using Deliberate Practice to Improve Supervision and Training

63

## Feedback Informed Treatment




64

## Feedback Informed Treatment

- Pantheoretical approach for evaluating and improving the quality and effectiveness of behavioural health services
- Routinely and formally gathering feedback from clients regarding the working alliance and progress
  - Decreases deterioration by 33%
  - Reduces hospitalizations and shortens length of stay by 66%
  - Decreases drop out rates by around 50%
  - Session by session feedback more effective in improving outcomes and decreasing dropout
- Reliability and Validity

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65

## Feedback Informed Treatment

- In order to improve (not plateau) clinicians must:
  - Measure outcomes and determine overall effectiveness
  - Identify areas of growth
  - Develop and implement plan
  - Obtain training
  - Measure impact of plan
  - Adjust as needed
- Think, Act, Reflect

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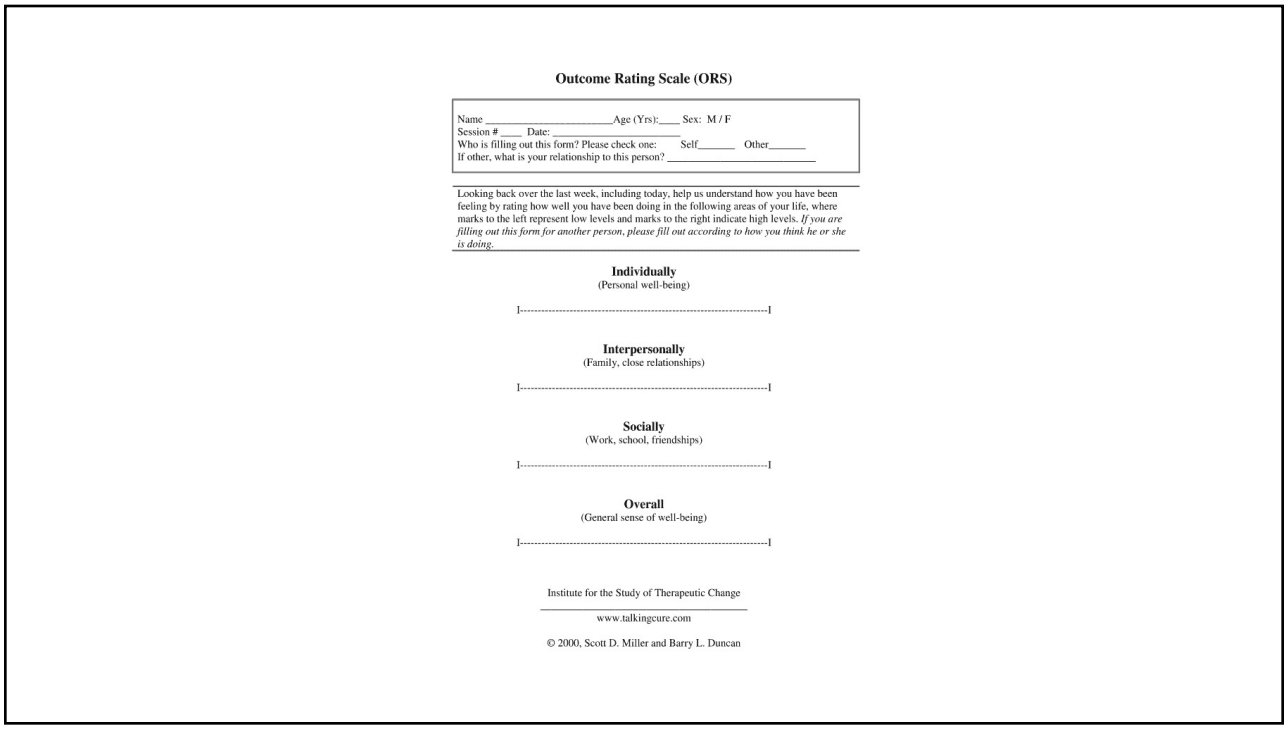
66



**Outcome Rating Scale (ORS)**

Name _____Age (Yrs):____ Sex: M / F
Session #____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

**Individually**
(Personal well-being)

I----------I

**Interpersonally**
(Family, close relationships)

I----------I

**Socially**
(Work, school, friendships)

I----------I

**Overall**
(General sense of well-being)

I----------I

Institute for the Study of Therapeutic Change
www.talkingcure.com
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67

# Outcome Rating Scale

- ORS- brief, client rated scale measuring client's experience of wellbeing
- Clinical cut off
  - Boundary between typical and clinical range
  - 25
- Reliable Change Index
  - Treatment success = increased score
  - RCI = chance that change is not due to random variation (a.k.a "clinically significant change)
  - 5 points
- Predictive trajectories

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68

**Session Rating Scale (SRS V.3.0)**

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

**Relationship**

I did not feel heard by the therapist, understood, and respected. — I felt heard by the therapist, understood, and respected.

**Goals and Topics**

We did *not* work on or talk about what I wanted to work on and talk about. — We worked on and talked about what I wanted to work on and talk about.

**Approach or Method**

The therapist's approach is not a good fit for me. — The therapist's approach is a good fit for me.

**Overall**

There was something missing in the session today. — Overall, today's session was right for me.

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69

## Session Rating Scale

- SRS- brief, client rated scale measuring client's experience of the therapeutic alliance
  - Quality of relationship bond
  - Agreement on goals, methods, and approach
- Clinical cut off
  - 36
  - Lower than cutoff indicates possible rupture and potential failure of alliance

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70

## Culture of Feedback

- Must work on creating an environment where clients can provide feedback without fear of retaliation and hope they can effect change
- Display attitude of openness and receptivity
- Introduce measures thoughtfully and thoroughly increasing client buy-in
  - Main purpose of forms is to help the practitioner stay on track and to avoid doing or saying things that are unhelpful or harmful
  - Commitment to accountability

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71

## Administration

- ORS
  - Beginning of session
  - Place X on the line
  - Average of week's feelings of wellbeing
  - Completed in presence of therapist
  - Can be used to elicit discussion about connection between their actions during the week and their score
- SRS
  - Just before the end of session
  - Framing in positive light can reduce client feeling pressured or uncomfortable
  - Identifies problem with alliance

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72

## Scoring

- ORS and SRS
  - Determine distance (in CM) between left pole and clients X
  - Add numbers from all 4 scales to obtain total score
  - Plot on graph paper
  - Software and electronic versions are available

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73

## Interpretation

- ORS
  - Average intake score for outpatient is 18 or 19
  - Below cutoff indicates there are things in their life they want to change
  - About 25-33% of clients will score above cutoff at intake
    - Mandated to treatment
    - Help with a very specific issue that does not impact overall quality of life\
    - May not have understood instructions
    - May be in denial
    - May lack self-awareness
- SRS
  - Majority of client will score 9 out of 10 on each line
  - Client may not yet feel safe to score honestly
  - Scores below 36 are causes of concern and should be discussed with clients
  - Since point declines session to session also cause of concern (even if above 36)

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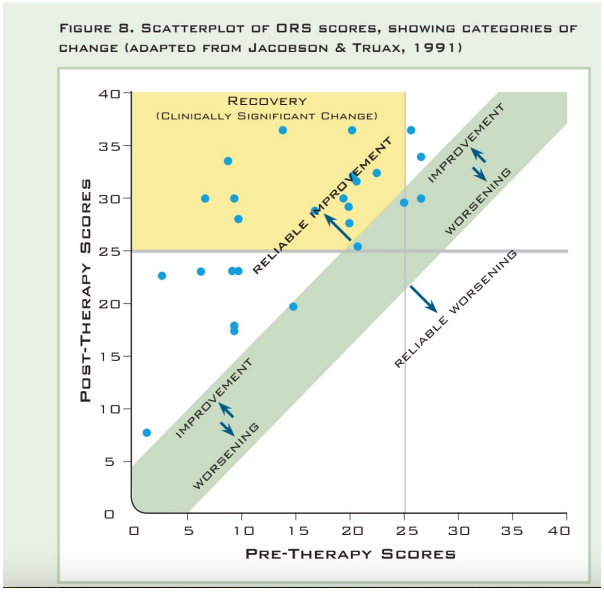
74

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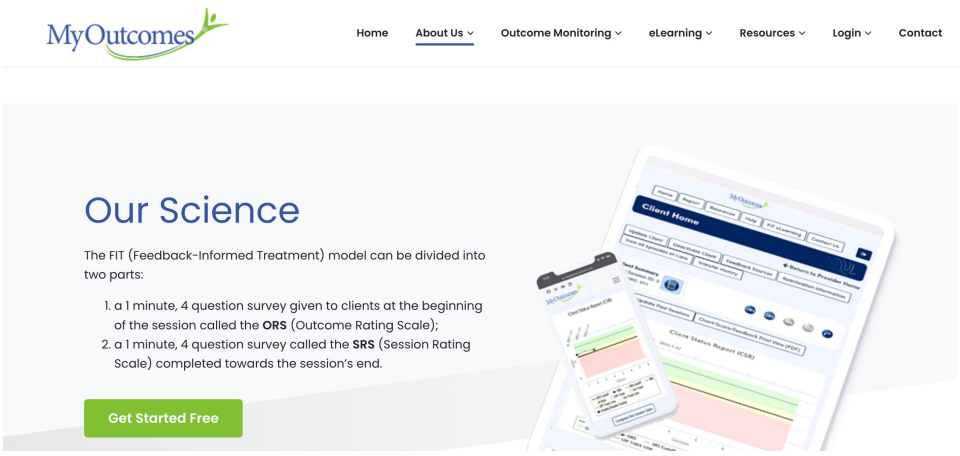
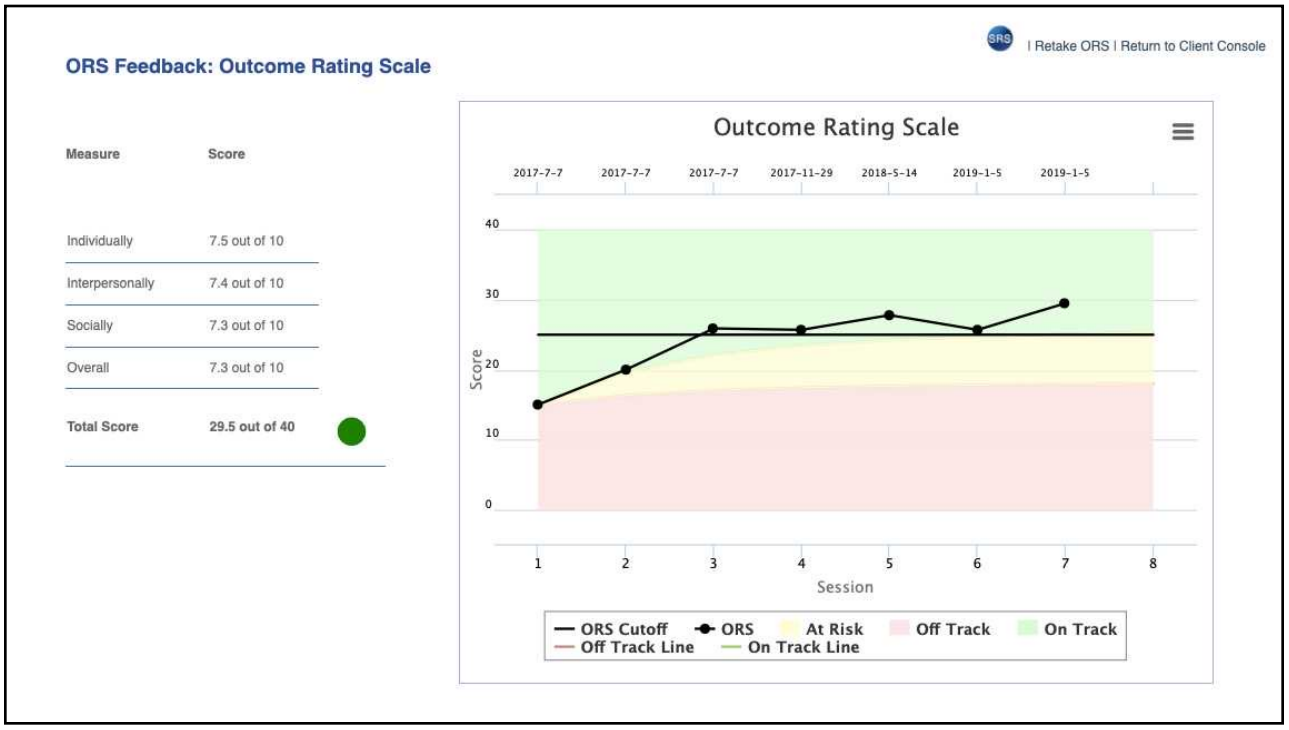
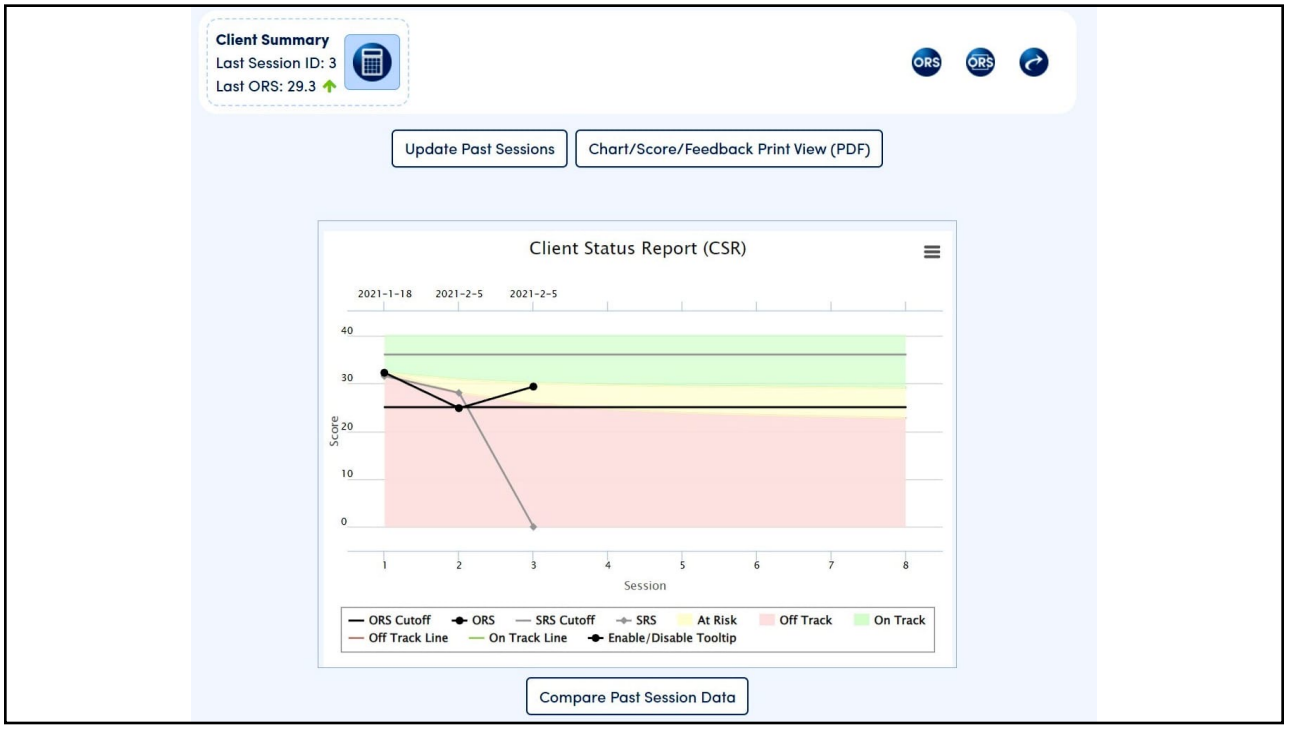



https://myoutcomes.com/outcome-rating-scale/

76


I Retake ORS I Return to Client Console
ORS Feedback: Outcome Rating Scale
Measure
Score
Individually
7.5 out of 10
Interpersonally
7.4 out of 10
Socially
7.3 out of 10
Overall
7.3 out of 10
Total Score
29.5 out of 40
Outcome Rating Scale
2017-7-7
2017-7-7
2017-7-7
2017-11-29
2018-5-14
2019-1-5
2019-1-5
Score
Session
ORS Cutoff
ORS
At Risk
Off Track
On Track
Off Track Line
On Track Line

77


Client Summary
Last Session ID: 3
Last ORS: 29.3
Update Past Sessions
Chart/Score/Feedback Print View (PDF)
Client Status Report (CSR)
2021-1-18
2021-2-5
2021-2-5
Score
Session
ORS Cutoff
ORS
SRS Cutoff
SRS
At Risk
Off Track
On Track
Off Track Line
On Track Line
Enable/Disable Tooltip
Compare Past Session Data

78

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