Self-Evaluation Paper

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This paper will provide a personal examination of my supervisory notions, expectations, strengths, areas of growth, questions, and suspicions. The following issues will be addressed: how I evaluated my work; what my supervisees say about my supervision style and practice; my role as supervisor; how well I did overall; any ethical or legal issues that were raised; cultural issues that arose during the supervision; and transference/countertransference issues that arose. A biblical worldview was not overtly addressed given the nature of the clinical setting (e.g. a community behavioral health center); however, a biblical worldview was implicit in the supervision and will be discussed.

At the onset of the class I was aware that my supervision included both areas of strength and weakness. My strongest areas are being supportive, encouraging, and modeling skills and professionalism for my supervisees. My areas of improvement are the use of one model to guide the supervision process and ensuring that my supervision balances clinical and administrative supervision effectively. One question that I had was how to balance provision of quality clinical supervision with my administrative responsibilities as a manager.

I evaluated my work through the Supervisor Evaluation Form, developed by Susan Hall-Marley (2001). This tool allowed my supervisee to rate areas of my performance on a likert scale of 0 to 3 (0 is satisfactory and 3 is much more of this area is needed). In hindsight, it would have been prudent to give my supervisee this scale early in our supervision and then again at the end to compare my growth as a supervisor; however, I only had him complete the rating form at the end of our work together.

Currently I have twelve supervisees, and they report that my supervision style is positive and motivating. One area that I can improve is my availability for regular supervision. We are

required to have weekly supervision for residents in counseling and biweekly supervision for licensed staff at my agency. Unfortunately, there are times when I have management meetings and other mandatory meetings that pre-empt supervision. Of course, I try to proactively reschedule supervisions, but this can be challenging given that the clinicians schedule 30 clinical sessions per week. Most of the time, it is difficult to find mutual availability. One solution that I have found is to say no when I am asked to take on extra duties or projects at work. This is challenging for me because I like the variety that extra projects provide; however, I recognize that this should not be of more importance than the needs of the clinical staff. A second area of improvement is making sure that I am checking with my supervisees on their needs. At times, I may assume that I know what their needs are and they may have a different perspective. For example during supervision with Scott Bradley, I assumed that his needs were to work on specific clinical skills using a CBT approach but the area that he identified was self-care. Thus, we focused on this area during our supervision work together and I focused a little less on his clinical skill set.

I see my role as supervisor to be the champion and supporter of each staff that I supervise. My role is to assist them with identification of goals and development of a collaborative plan in our work together. I like to serve as a coach and mentor as well, guiding their development. I am very proud of my supervisees when they accomplish goals, both minor and major (e.g. getting licensed, obtaining a promotion, facilitating a training, etc). In particular with my supervisee, Scott Bradley, I think I did well in providing support and feedback. I think I could have improved my work with him by making sure that I was attune to his overall needs, not just improvement in his clinical skill set.

During my work with Scott, we encountered a potential ethical and legal issue with regard to a mandated client for substance use treatment. The client disclosed information to Scott

regarding a relapse and asked Scott not to share this information with the referral source (probation). While the client had initially signed a release of information to share treatment information with the referral source, ethically and legally she was able to rescind the release. Therefore, Scott and I discussed that he was not able to share this information with the referral source. However, we discussed the importance of reviewing the relative limits of confidentiality. Given that this case had court involvement, a judge could potentially subpoena treatment records, in which case information regarding the client's substance use can be shared with the court. Scott and I discussed the importance of informed consent and reviewing the relative privileges and limits of confidentiality at the onset of treatment and reviewing them as needed throughout the course of treatment. As it turned out, the judge did not subpoena treatment records.

There were no overt cultural issues that arose during supervision. This is another area of weakness for me as I need to remember to specifically probe for potential issues. While a biblical worldview was not formally discussed during supervision, Scott and I are both grounded in our faith and use this grounding to guide our work with clients specifically treating each client with grace. Finally, the role of transference was addressed as we discussed a client of Scott's that dressed in a provocative manner and engaged with Scott in a manner that could be interpreted as seductive. We discussed how her history and interactions with men in her life in the past likely contributed to her presentation in session. We also addressed how to set appropriate boundaries and provide feedback in a manner that is caring and straightforward with the client.

Overall, this course reinvigorated my passion for clinical supervision. A review of the supervision models helped to ground and guide my supervision sessions with intentionality. An ongoing challenge that I will need to address is balancing clinical and administrative supervision in my role as a clinical supervisor and manager in community behavioral health.

Appendix 1 Supervision Notes

Date	Topics	Homework
6/26/20	Review of informed consent, my supervision model, emergency procedures, supervision goals, establishing of meeting dates/times	Talk to Angie (Bedford clinical supervisor) about supervisory coverage/emergency protocols
7/3/20	Case conceptualization strategies	Identify four elements of case conceptualization and how these are used in two clinical sessions during the next week
7/10/20	Work sample review; Provided positive and constructive feedback on an audio recorded session; role-play of assigning client homework	Identify self-care activity (book to read for pleasure)
7/13/20	Self-care; what does this mean to the supervisee; how and when to recognize the need for self-care; how to balance work/life obligations	Engage in identified self-care activity at least twice in the next week for 30 minutes each
7/17/20	Self-care; review of testing materials and practice scenarios for NCE	Engage in at least two self-care activities in the next week for 30 minutes each
7/22/20	Case conceptualization, diagnostic formulation, and issue of potential release of substance use information	Review 42 CFR (federal code that governs release of substance use information)
7/31/20	Shared supervisee evaluation; supervisee completed supervisor rating form	Confirm supervision time with Angie (Bedford supervisor) for ongoing clinical supervision

Appendix 2 Supervisee Evaluation

Core Areas of Counselor Development

John C. Thomas, Ph.D., Ph.D.

Does Not Meet Expected Level	Meets Expected Level	Exceeds Expected Level	Not Applicable	Insufficient Information
1	2	3	N/A	IS

Core Competency	Student Rating	Supervisor Rating
1. Self-Other Awareness (e.g., emotional awareness, differentiation)	**2**	3
2. Basic Skills (e.g., listening, empathy, confrontation, goal & agenda setting)	**2**	3
3. Knowledge (e.g., cull from academic training to clinical situations)	**2**	2
4. Professional Role (e.g., insight & understanding of counseling role)	**3**	3
5. Multiculturalism	**3**	3
6. Individual Counseling Core Domains:		
a. *Theoretical Orientation and Insight into philosophical assumptions*:	**2**	2
b. *Individual Assessment Techniques and Skills*:	**2**	2
c. *Individual Client Conceptualization consistent with theory*:	**2**	2
d. *Advanced Techniques consistent with theory*:	**2**	2
7. Couple & Family Core Domains	**N/A**	N/A
a. *Particular Systems Theory*		
b. *Systemic Skills (e.g., Joining, etc.)*		
c. *Case Conceptualization consistent with theory*		
d. *Systemic Techniques consistent with theory*		
8. Group Counseling	N/A	N/A
a. Psychoeducation		
b. Group Process Groups		
c. Stages of Group		
9. Ethics and Legal Issues	**3**	3
10. Integration/Biblical Worldview	**N/A**	N/A
11. Ability to Write a Biopsychosocialspiritual Intake	**3**	3
12. Ability to Write Progress Notes	**3**	2
13. Ability to Develop a Treatment Plan	**3**	2
14. Ability to Self-Supervise	**2**	2

Student Comments: When completing things of this nature, I am often reminded of the many areas of growth that is still required of me as a therapist. I greatly appreciate the supervision time that I have with Jennifer which allows me to process each of the areas listed above – identifying areas of strength while also identifying areas in which I must improve as a therapist

Supervisor comments: Scott demonstrates an excellent awareness of his strengths and areas of growth. His commitment to his clients, care for their well-being, and strong engagement skills make him a valued counselor in our agency. His clinical areas of strength are case conceptualization and diagnostic formulation. He continues to grow in his knowledge and delivery of evidence-based treatment models with fidelity. He is open to feedback and seeks to improve his clinical skills. His ethical and legal decision-making skills are solid as he uses the ACA Code of Ethics to guide decision-making. His documentation is accurate and timely. He is a pleasure to work with!

Appendix 3 Personal Journal

Intensive

- June 15: First day of intensive; I read 1.5 textbooks prior to the intensive so I felt as though I had a fair grasp on the supervision practices and models. I vaguely remembered them from graduate school back in the 1990s. Interestingly, I graduated from UNC-G where Dr. DiAnne Borders was a professor in the CES department and I had her for a class or two. I felt that I came full circle, in a way, reading her textbook.
- June 16: Second day of intensive: I learned from Louis' and Jeremy's presentations; they were well-done and thorough; I began to realize that in my current position, my supervision practice has become more administrative than clinical, although I provide a fair amount of clinical supervision. My current role seems to be more aligned with administrative supervision. I am hopeful that this course will reawaken and add to my clinical supervision skills.
- June 17; Third day of intensive; I am starting to feel more immersed in the clinical supervision world while stepping away from the administrative supervision role a bit. However, I am already thinking about how I will sustain an increase in clinical supervision in my job role. It is doable, but the job definitely pulls me in many administrative directions in terms of my time management.
- June 18: Fourth day of intensive; I presented my model (Feminist Supervision); many of the components of the model aligned with my personal theory of supervision but some areas are not a dedicated focus. Nonetheless, it was a good learning experience. The presentation was not my best; however, it was definitely not my worst either and the class was a very kind and non-judgmental group. I experienced some technical malfunctions

on the videos I prepared. Overall, I see how the developmental approach to supervision is a common thread across supervision models.

- June 19: Last day of intensive: I thoroughly enjoyed the intensive and the interactions that it offered (even through video conference). I do realize that over the years I have drifted from a well-defined supervision model. My model is a cognitive-behavioral model which parallels my therapy model. My biggest take away from the intensive is the need to understand the different supervision models while intentionally using my own model as I work with the clinicians I supervise. I also understand the importance of using a developmental approach to supervision regardless of the model used.

Supervision with R.S. Bradley

- June 26 - First supervision. Reviewed informed consent, supervision model, goals, expectations. Because I have worked previously with the supervisee, we already had a rapport and he appeared to respond well to the expectations of supervision and provided valuable insights on his areas of strength and areas of growth. His therapy model is CBT so it aligned well with my CBT supervision model. I felt as though I dominated the conversation a bit which I did acknowledge in the supervision.
- July 3 – Reviewed homework (follow up with Angie on supervisory emergency contact); Discussed case conceptualization strategies. I tried to use more reflective statements and general attending skills to encourage a more balanced dialogue between me and the supervisee.
- July 10 – Provided feedback on a session that supervisee conducted. Offered praise and constructive feedback; as homework was assigned supervisee wanted to work on self-

care. I used techniques including offering specific praise and constructive feedback on a session that I reviewed. We also did a role-play in supervision to assist the supervisee with improving his homework assignment by thoroughly addressing obstacles toward completion of the assignment. I thought the role-play went well. Like many supervisees, role-plays are not always comfortable at first; however, the supervisee appeared to benefit from the practice.

- July 13 – Discussed self-care and validated/normalized supervisee's challenges with managing job stressors; came up with specific strategies to increase self-care, including reading for pleasure, playing golf, and hiking/walking on trails. We addressed potential obstacles (heat/inclement weather) for the latter two activities. I spent some time processing the supervisee's feelings about feeling a little drained from the intense caseload that he is currently seeing. He has many mandated clients with significant needs.
- July 17 – Continued discussion on self-care; I feel that I am not always a good model in this area as I tend to work a lot on the weekends and evenings; I could have brought this up in the supervision with Scott but I missed an opportunity to self-disclose which I think would have supported relationship building and normalization of his feelings.
- July 22 – Reviewed a challenging case of a co-occurring adult with MH/SUD; discussed case conceptualization, treatment planning, and diagnostic formulation; checked in on self-care activities; discussed potential release of information to court on client's self-reported substance use

- July 31 - Reviewed evaluation; supervisee completed Supervisor Rating Form (Hall-Marley, 2001); discussed steps to attain unmet/continuing supervision goals with Angie (supervisor)