



# Below The Waterline, Part 1

Deeper Clinical Supervision –

Cultivating the next generation of LPC's beyond models & manuals.

Paul B. Williams LPC

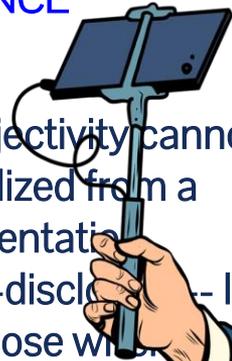
# Supervisory Equivalency Course: Peer Reviewed Literature, Texts + Personal Experience

## PEER REVIEWED LITERATURE + TEXTS

- Literature deep dive of 113 articles.
- 5 texts on clinical supervision.

## PROFESSIONAL EXPERIENCE

- Subjectivity cannot be sterilized from a presentation
- Self-disclosure -- I will disclose what I know. My idea is my personal

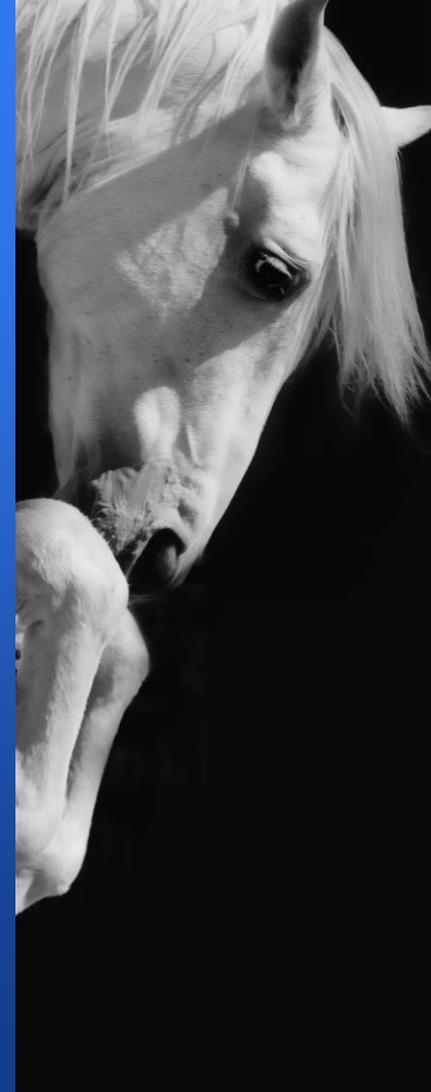




# The gravitas of clinical supervision

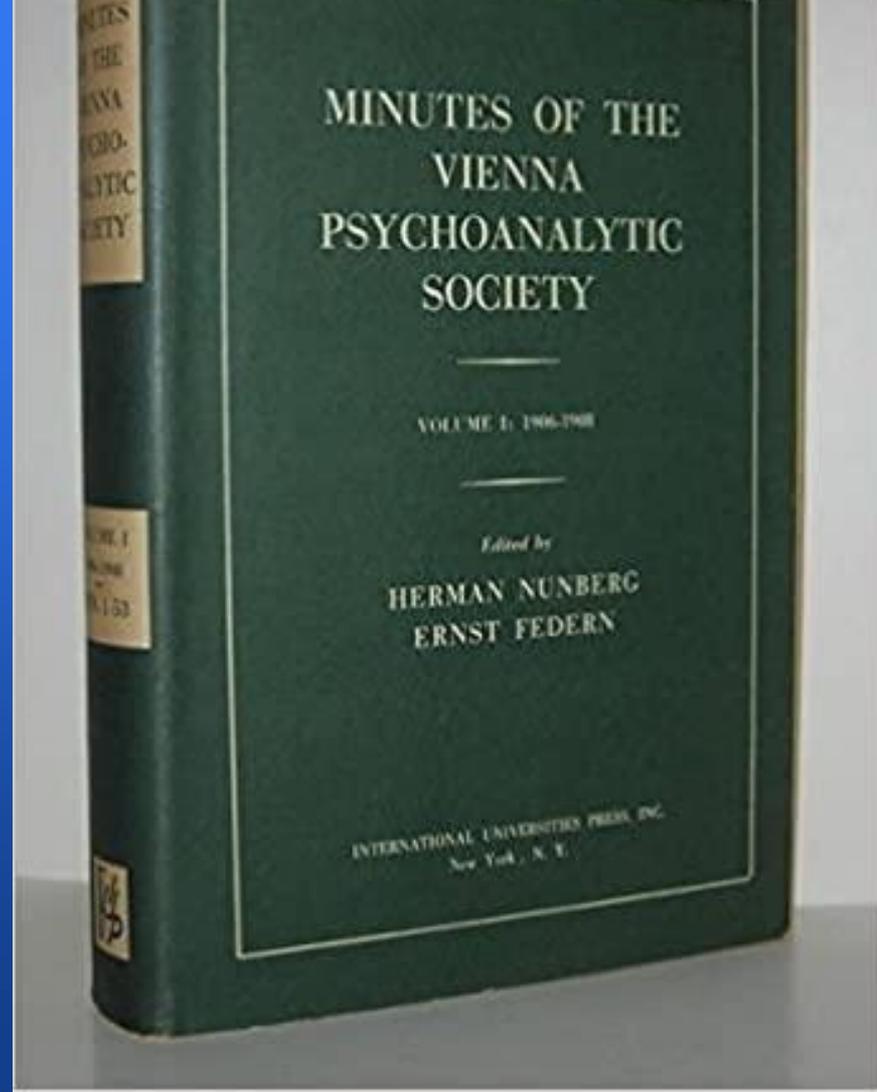


## Freud & The Case of Little Hans



# Psychologische Mittwochs-Gesellschaft

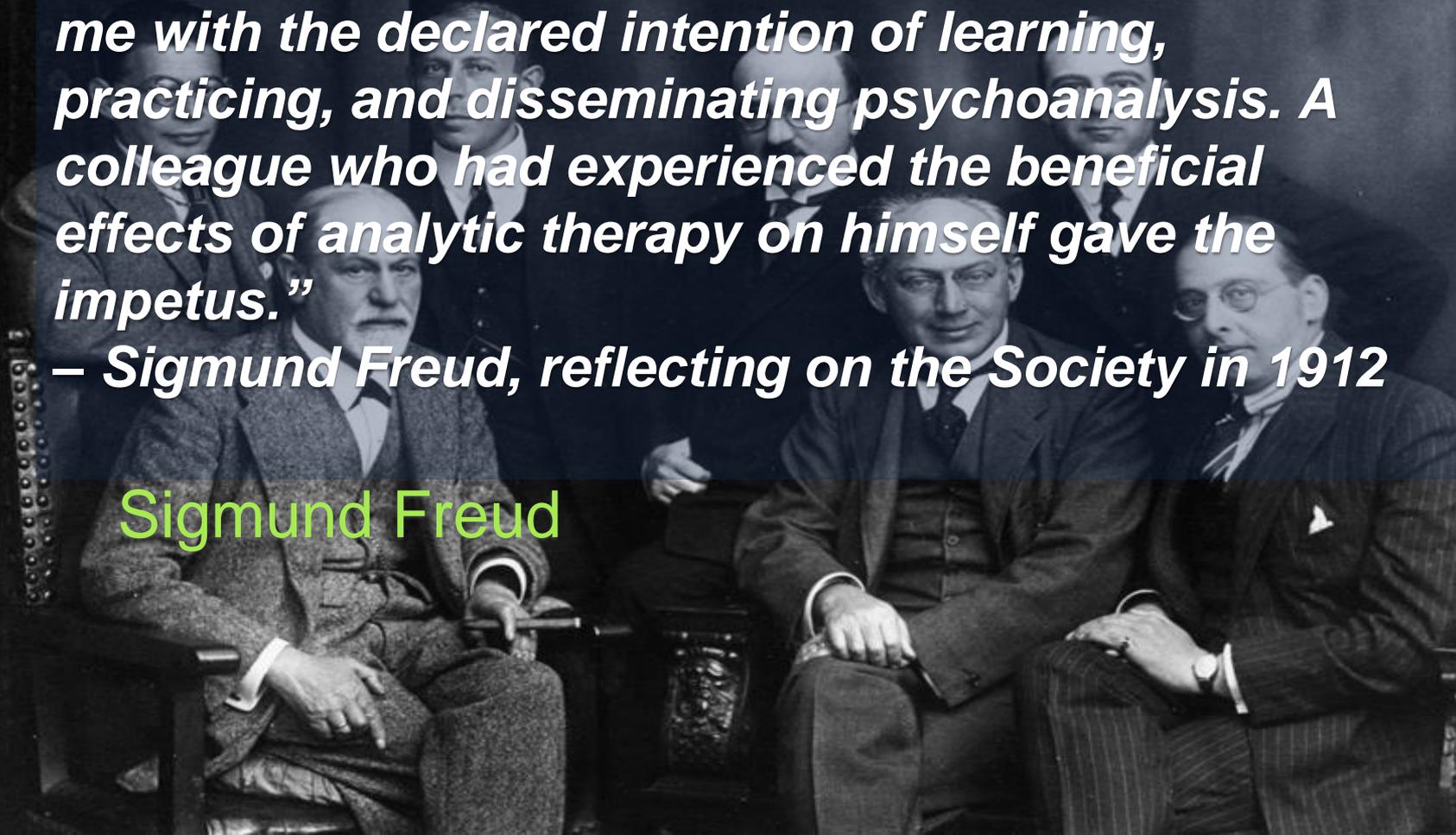
- Vienna 1902
- **The Wednesday  
Psychological Society**
  - **Group Supervision**
- *The International  
Psychoanalytic Society*



***“A number of younger physicians gathered around me with the declared intention of learning, practicing, and disseminating psychoanalysis. A colleague who had experienced the beneficial effects of analytic therapy on himself gave the impetus.”***

***– Sigmund Freud, reflecting on the Society in 1912***

**Sigmund Freud**





# Group Discussion

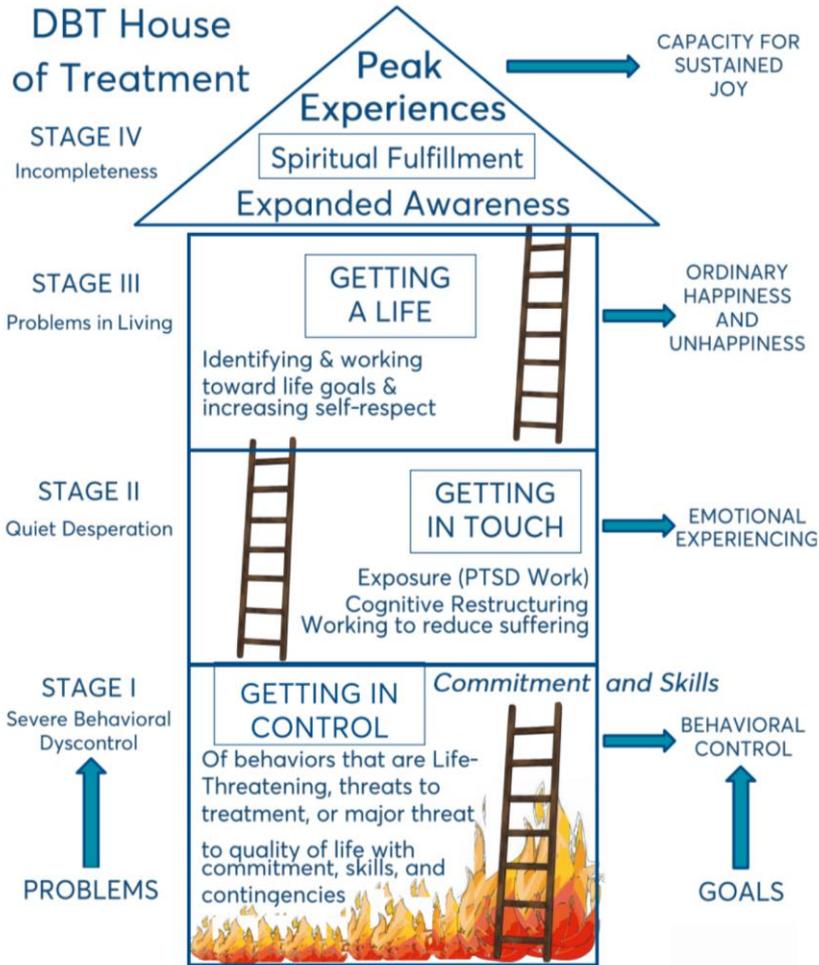
What was your Clinical Supervisory “childhood” like?  
How were you supervised?

# Before We Supervise: Why do Psychotherapists Exist?

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- Relieve human suffering.
- Increase mental/emotional/behavioral hygiene.
- Facilitate growth.
- Help make meaning.
- Presumably, we're the **Puzzle Pieces** for the public consumers.
- **How do you prepare these Puzzle Pieces?**

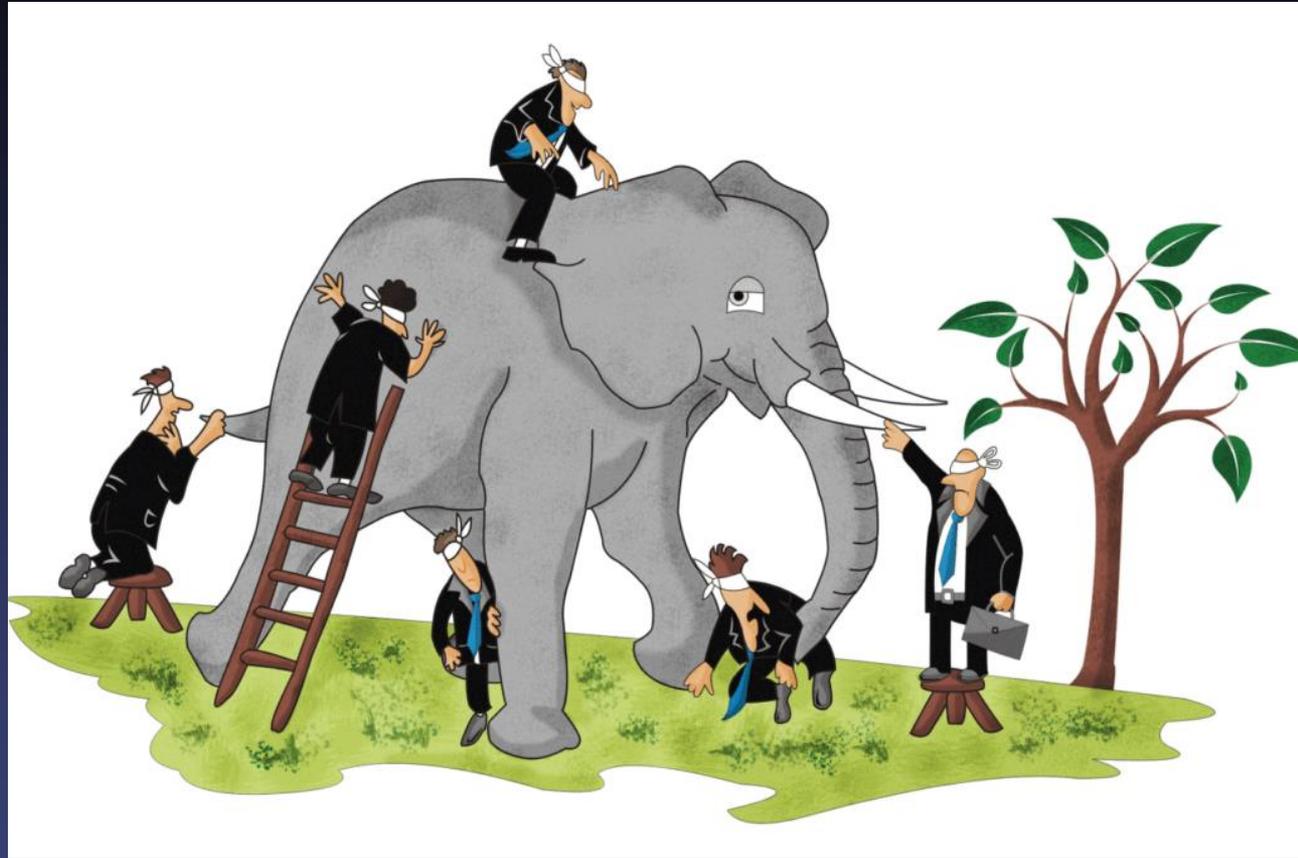




SHAWL: Suicide and Hospitalization As a Way of Life  
DBT House concept credited to Marsha Linehan, PhD & Charles Swenson, MD

# A tall order: Supervise the whole house







The supervision candidate  
as **green**.



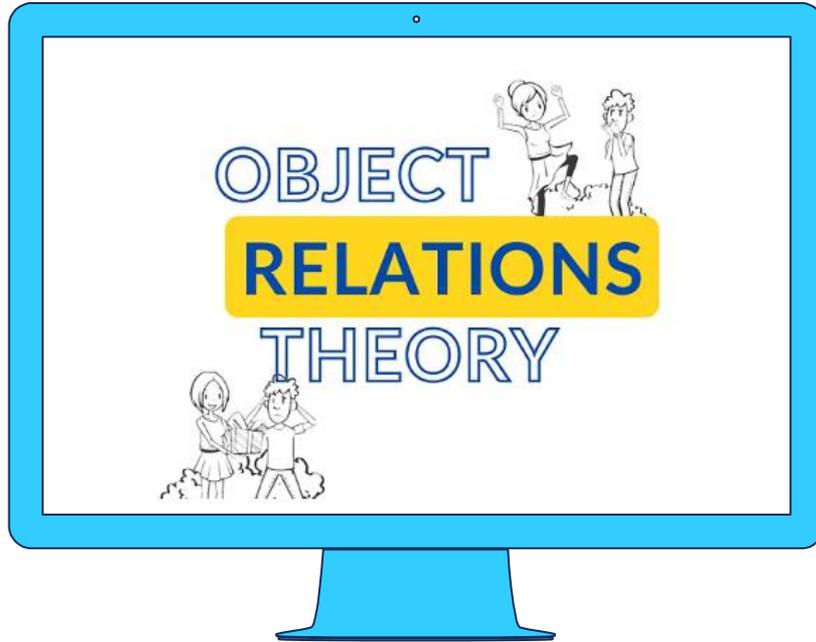
# Green

- Green in knowledge.
- Green in DEI maturity.
- Green in psychological maturity.
- There is no insurance that our candidates have addressed psychological neuroses or even their own psychopathologies.

## What About My Supervisee's "Baggage"?



# Object Relations, Simply Explained



# Use of Transference & Countertransference



Client's Past Person  
Candidate

Therapist's Past Person  
Supervisor



## Personal Therapy or Supervision?

### School A ~ The HR Dept. Approach

- Candidates get own therapy.
- Process countertransference in *personal* therapy.
- Show up to supervision needing technical guidance, not personal guidance.

School A

- Doing therapy is getting therapy.
- Processing countertransference in supervision is essential.
- Technical guidance might be indigestible if countertransference is unprocessed

School B

# The Holding Environment

- Child Psychoanalyst:  
Winnicott

- Letting Nature take its course
- The “good enough” parent
- The “holding environment”

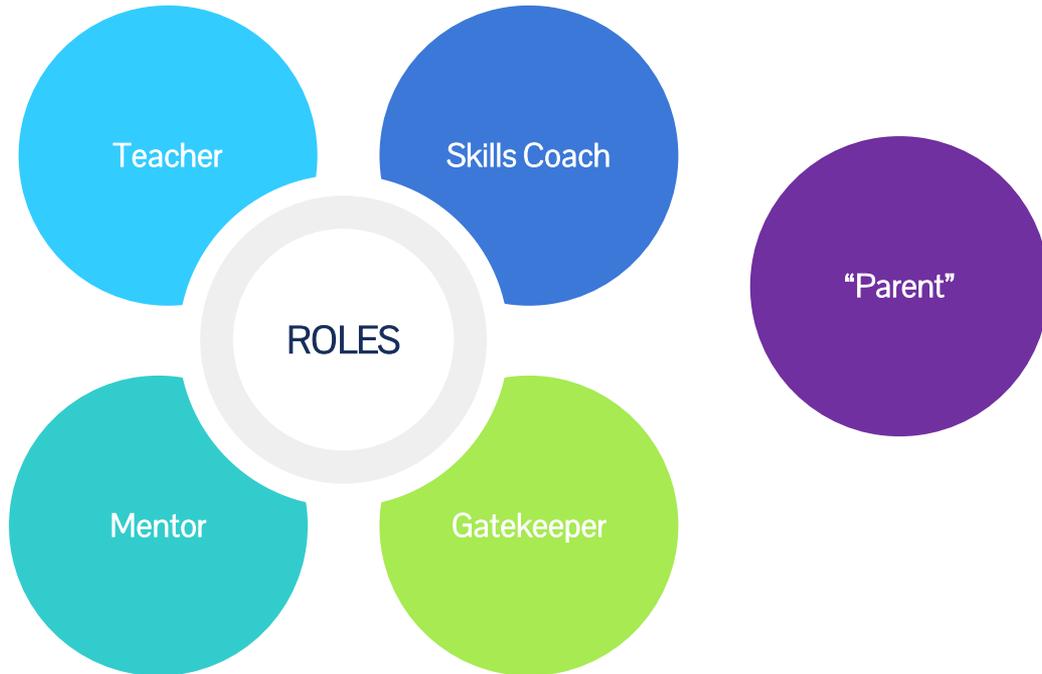


# Winnicott's Holding Environment

- Insulate “baby” from too much stress.
- Adapt to “baby’s” needs.
- Allow emotional processing with soothing. Babies cannot self-soothe in the beginning.
- Gradually increase of response delay between expression of need and meeting of need.
- **How do Supervisors keep this from turning into Psychotherapy?**



# The Roles of a Clinical Supervisor



# Psychodynamic Roles of the Supervisor (McWilliams, 2021)

- **Psychological support** for a very stressed candidate
- Reinforcing fundamental **counseling processes** (universal across models)
- Processing transference & countertransference (rarer these days with "techniq" counseling models)
  - **Countertransference to supervisor**
- Illuminating **defense mechanisms**
- The relating of the client to the supervisee vs. Content-focused.

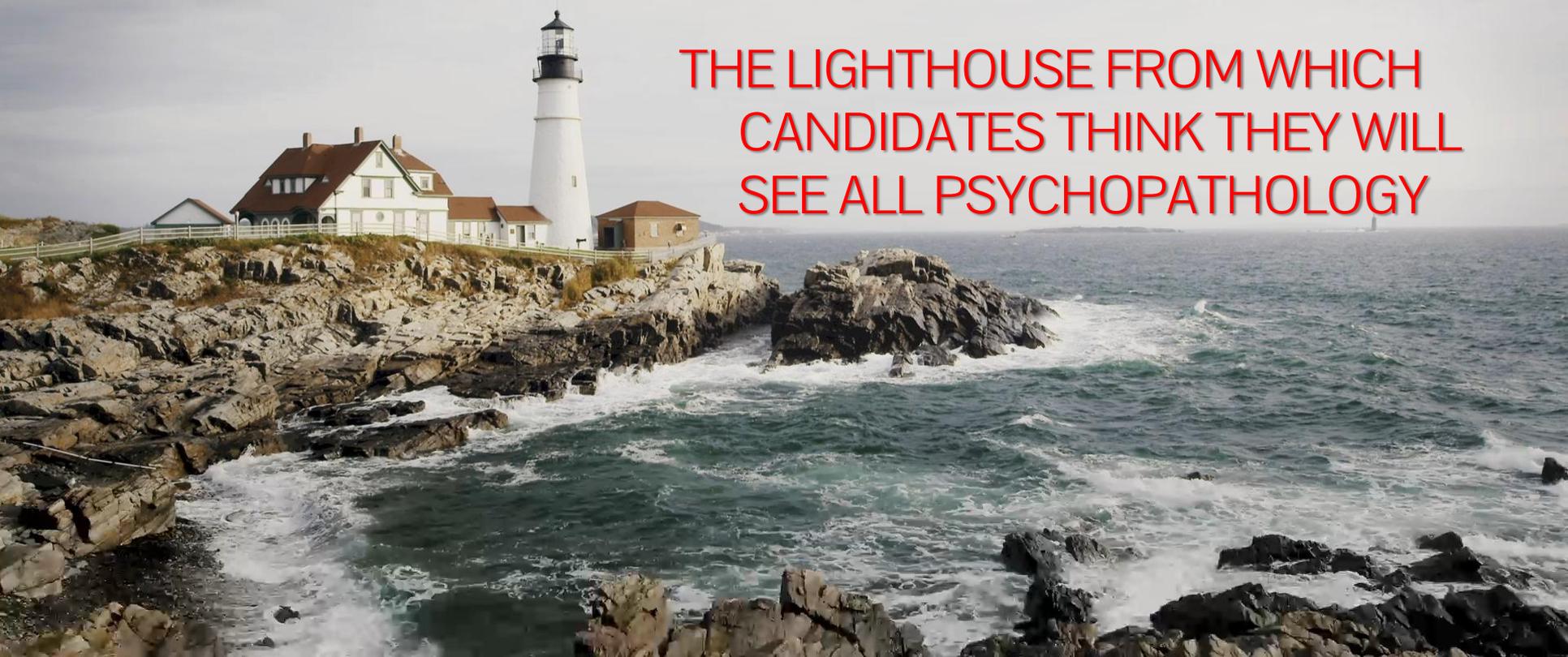


# And While Parenting... Clinical Supervisor as **Overseer**

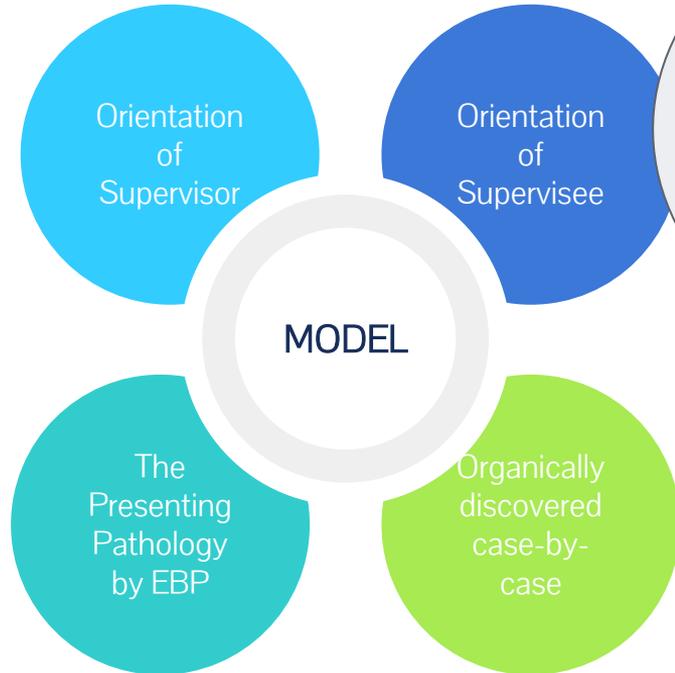


# The Almighty Theoretical Orientation

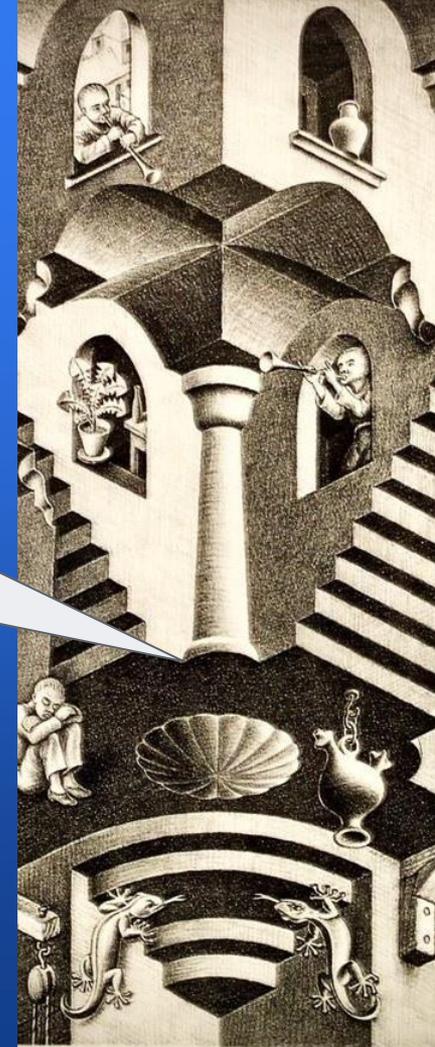
THE LIGHTHOUSE FROM WHICH  
CANDIDATES THINK THEY WILL  
SEE ALL PSYCHOPATHOLOGY

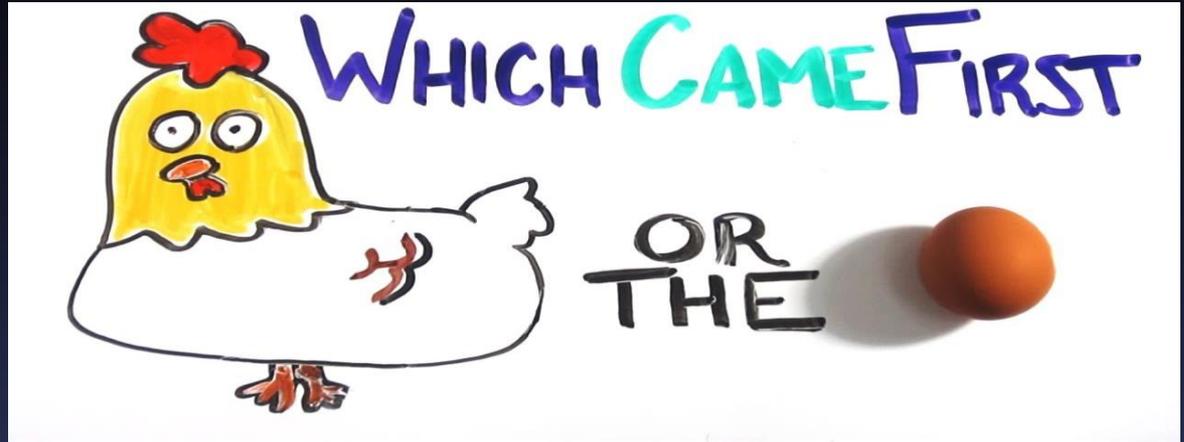


# Beginner Supervisees Ask: What is the “right” Modality for this case?



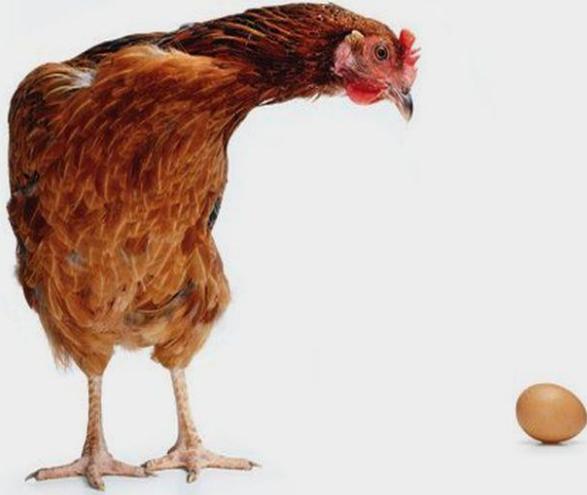
To Supervisees, the right model is like an Escher drawing, optically confusing staircases, each equally plausible.



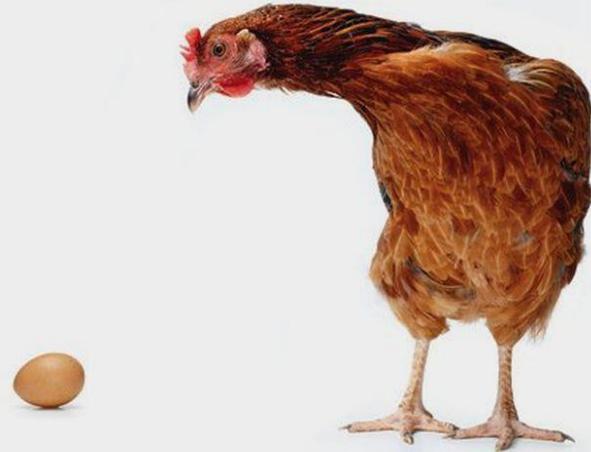


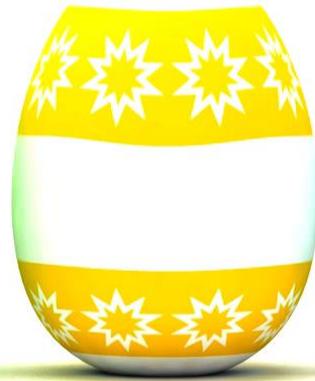
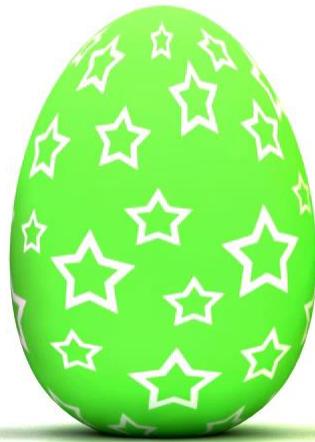
- Does your Candidate fall in love with the Theoretical Orientation 1<sup>st</sup> and then goes and “lays an egg” in session? Or, does your Candidate lay an egg and then say, “Wow! I love this model!”

Let Candidates choose their favorites, then lay their eggs.



Push Candidates to lay an egg, and then evaluate the model.





# What is the “right” Modality for this case?



MODEL

The Presenting Pathology by EBP

Organically discovered case-by-case

Harder

Hardest

- You wear the bigger crown.
- Supervisees often finish Grad School with a little crown.
- A favorite model.



# Harder

## By Presenting Pathology (EBPs)

### Spectrum of Models

The supervisor must know a wide spectrum of models to advise the supervisee, until this becomes intuitive.

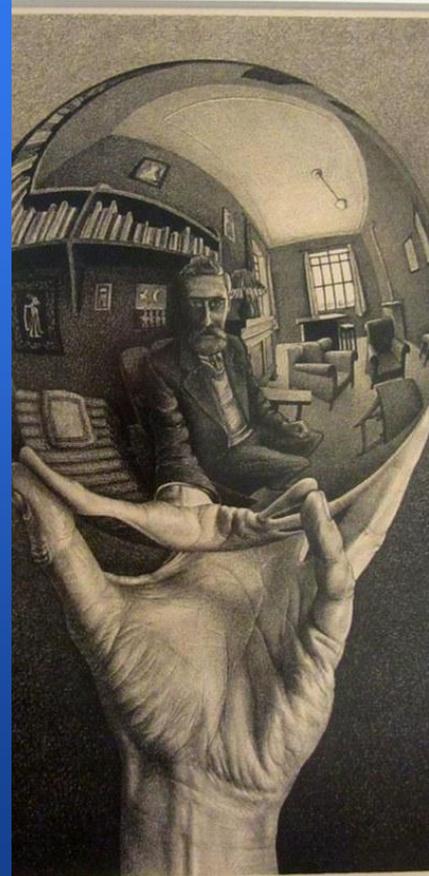
### Know the literature

The supervisor must constantly learn from the clinical literature what models are considered “evidence-based” for any pathology.

### Teach the Model

The supervisor must teach the model (if qualified) or send the supervisee to appropriate training.

Discuss insights from the training with the supervisee. Connect with other psychotherapy theories and techniques.



# Hardest

## By Presenting Case (Organic)

### Spectrum of Processes

Know the literature

Teach Multiple Processes  
on the Same Case

The supervisor must  
know a wide spectrum  
of Processes  
(transtheoretical) to  
advise the supervisee.

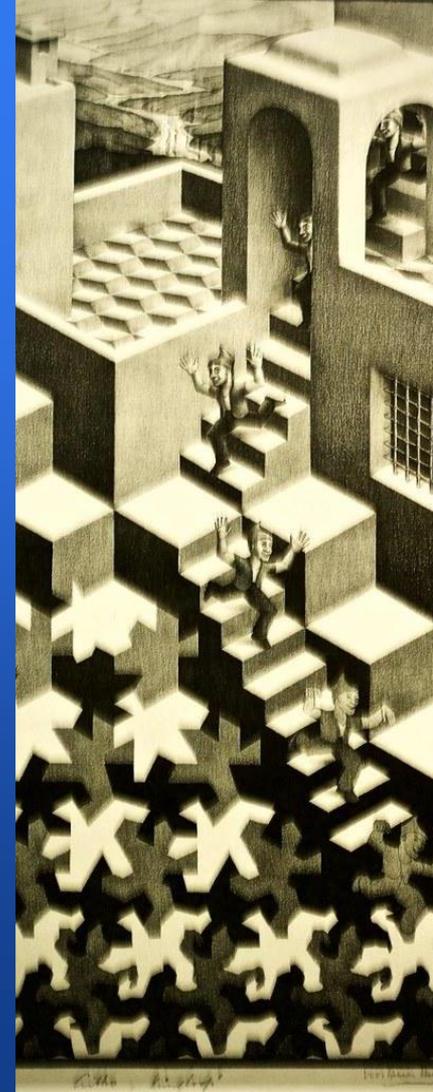
Process-Based  
Psychotherapy.

The supervisor discusses  
the same case **from  
multiple theoretical  
orientations** and openly  
identifies those processes  
across Models.

ACA Competencies

“Common Factors”

Technical interventions are  
discussed from **multiple  
theoretical orientations**.



## Effective Therapy-- The Dodo Bird Verdict

Despite differences in therapy models, the models yield similar outcomes via **Common Factors**.

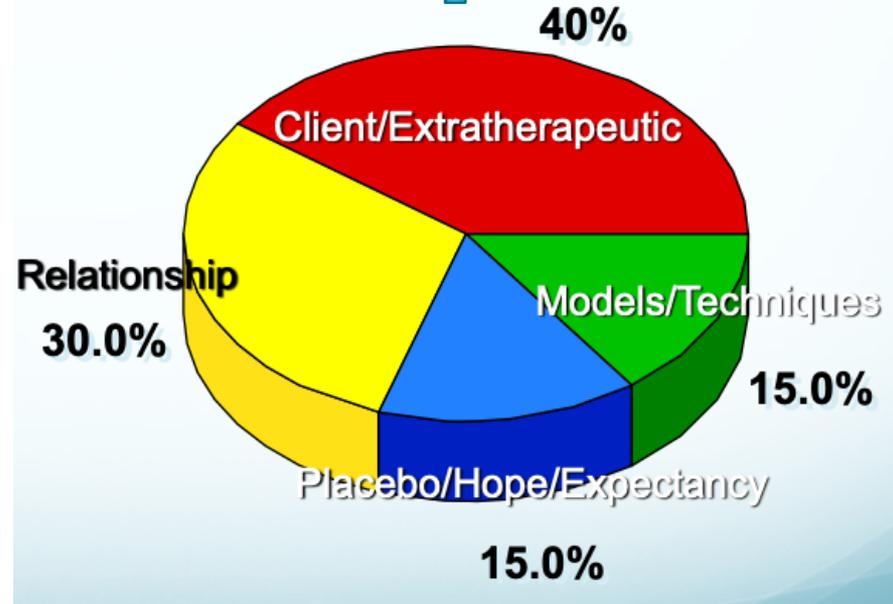
**"Everybody has won and all must have prizes."**



# Client-reported

## Common Factors? vs. Processes

- **Common Factors** = Client Reported
- **Processes** = Therapist Reported



# Therapist-reported

## Then, What are You Teaching?

- Teach **multiple models**.
  - Multiple tools will be needed.
  - Identify each model's focus & purpose.
  - Identify their limits-- there is no one-size-fits-all for any issue.



## Research Outcomes

- Higher **fidelity** to a Theoretical Orientation does not predict effective outcomes.
- What predicts higher outcomes is the Supervisee's and Supervisor's **BELIEF, CONFIDENCE** in the efficacy of the techniques.

## Then, What are You Teaching?

- Teach **Competencies**.
  - Ensure your supervisees can do all of the Competencies of the ACA.



## Then, What are You Teaching?

- Teach **Processes (PBA)**.
  - Ensure your supervisees can do all of the Bouillabaisse processes competently.



# PBA: Castles and Stones

→ Castles are the Therapy Models.

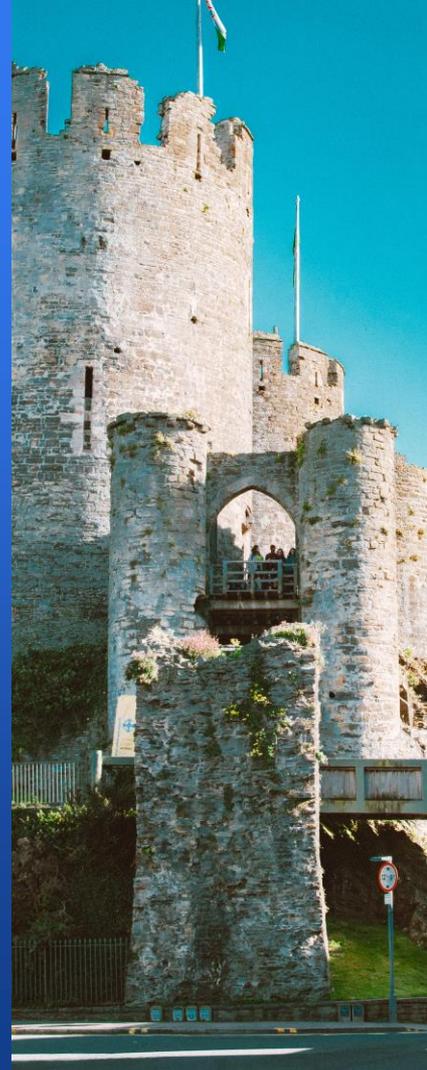


→ Castles are built by stones.



→ Stones are the therapeutic processes, no matter the castle.

→ AKA “techniques”





Clinical Supervision is **NOT**  
**solely** Clinical Consultation in  
1 therapy model for 2 years.

Clinical Supervision raises a “child”  
therapist to an “adult” therapist, beyond  
models.

Clinical Consultation in a model raises a  
therapist to follow a model across case  
presentations & varying case complexities.



ONE TRICK PONY

In the research, a common complaint of supervisees is that their supervisors are One Trick Ponies, teaching a model of psychotherapy.

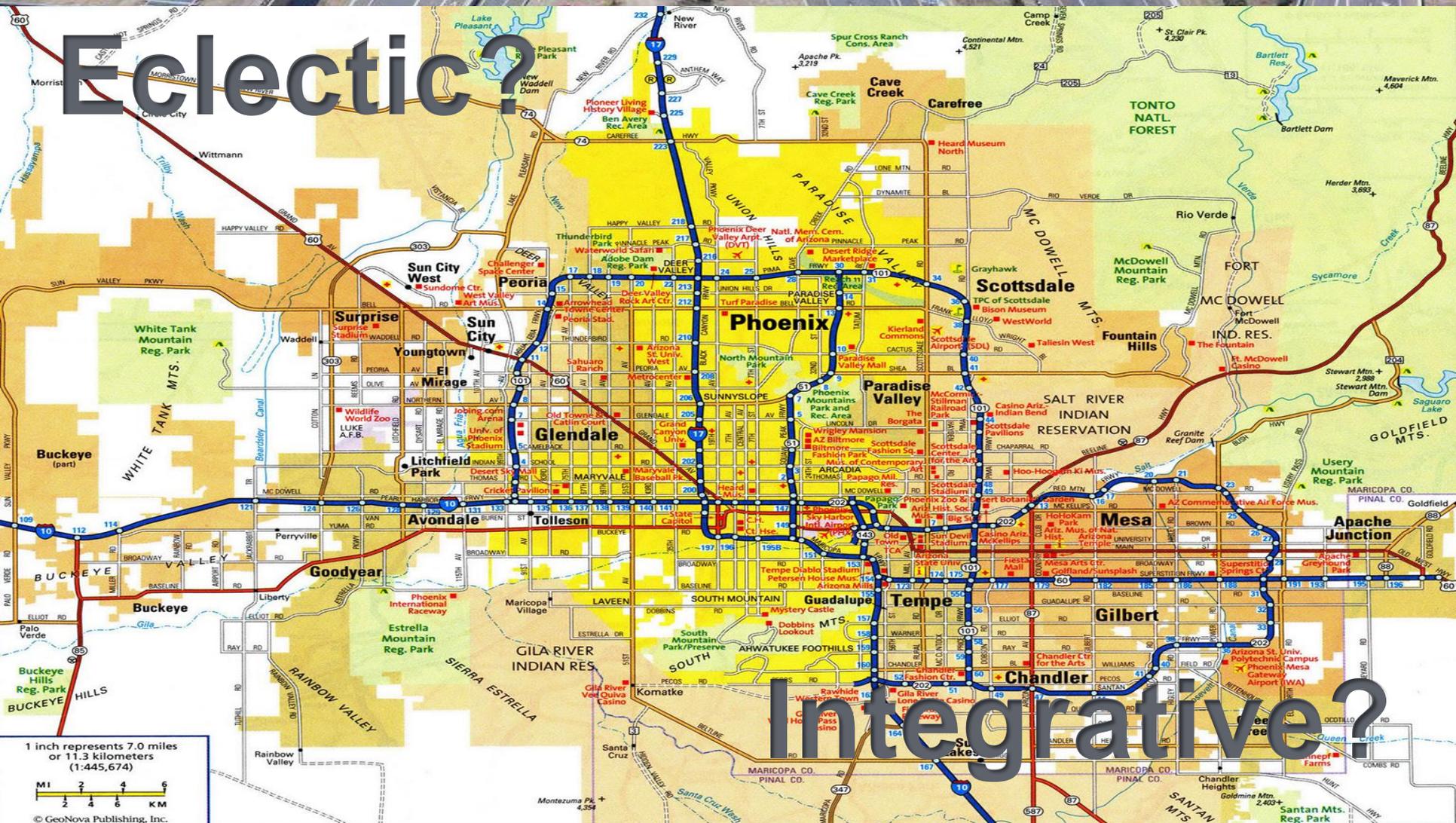
Complaint: Supervisors are not raising therapists, but raising followers of **their favorite model**.

# The Eclectic Candidate?

- **Eclectic** = You're not actually testing a theory of change. You are spontaneously reacting to session events.
- **Integrative** = You've decided on a theory of change, integrating different pathways.
- All Supervisees must operate, for a moment, from a Theory of Change.



# Eclectic?

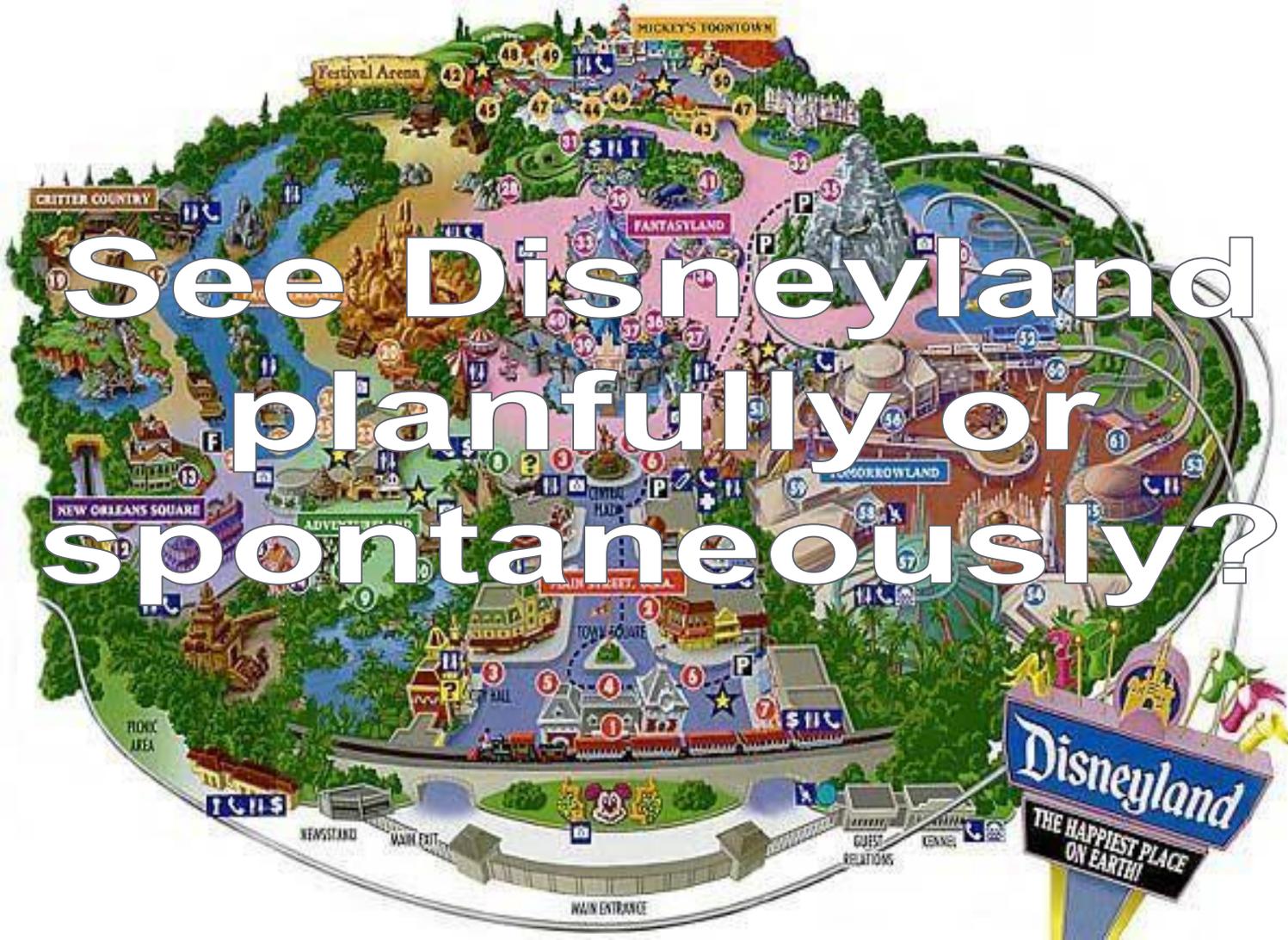


# Integrative?

1 inch represents 7.0 miles  
or 11.3 kilometers  
(1:445,674)

MI 2 4 6  
KM

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**You are teaching your candidate HOW to learn, not simply WHAT to learn.**

**In the Disneyland of Psychotherapy “rides,” you are teaching candidates how to approach the Disneyland of our industry.**





# Group Discussion

What are the Therapy “rides” that are essential for your candidates to do?



# Pragmatics of supervision

→ Supervisory  
Paragigm



→ Supervision  
Agreement



→ Evaluations



→ On-site Supervisor  
collaboration

→ Documentation of  
Weekly Supervision

**Setting up a  
productive  
experience  
(not necessarily  
positive)**

# Supervision Paradigm

Combo platter of:  
Professional Biography +  
Philosophy of treatment & supervision.



# Supervision Agreement

- The Board Form
- Your Own Form(s).
- Please do not rely solely on the Board's supervision, which is an agreement between signatories.
- Your Supervision Agreement is anticipatory and memorializes your expectations.

	Licensed Behavioral Practitioners Licensed Marital and Family Therapists Licensed Professional Counselors	State Board of Behavioral Health Licensure 3815 N. Santa Fe, Ste. 110 Oklahoma City, OK 73118 Telephone: (405) 522-3696 Fax: (405) 522-3691 www.ok.gov/behavioralhealth
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### SUPERVISION AGREEMENT

Please check appropriate license:       LPC       LMFT       LBP

I the undersigned have read and agree to comply with the requirements set forth in Subchapter 11 of the LPC Regulations, Subchapter 9 of the LMFT Regulations, or Subchapter 13 of the LBP Regulations. I understand that a violation of these requirements may result in a loss of supervision hours and/or disciplinary action against both the candidate and the supervisor.

Name of Candidate: \_\_\_\_\_

Candidate's Employing Agency (The location listed below must reflect the location in which you are accruing supervised experience hours. You must have an approved agreement for each location where you are accruing hours):  
\_\_\_\_\_

Address of Employing Agency: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Candidate's Phone #: \_\_\_\_\_ Candidate's Email Address: \_\_\_\_\_

Candidate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ License #: \_\_\_\_\_

I will be acting as (please check one):     Primary Supervisor       Secondary/Back-Up/Alternate Supervisor

Supervisor's Employing Agency: \_\_\_\_\_

Supervisor's Phone #: \_\_\_\_\_ Supervisor's Email Address: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of On-Site Supervisor: \_\_\_\_\_

License Type: \_\_\_\_\_ License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

On-Site Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Are you requesting the use of technology-assisted supervision?     Yes       No

Factor to be considered (Please choose one): \_\_\_\_\_

HIPAA compliant service to be used: \_\_\_\_\_

..... (For office use only).....

Approved: Yes    No    Date Approved/Disapproved: \_\_\_\_\_ PCL Staff Initials: \_\_\_\_\_

# LPC Evaluations

- The Board Form
  - Key features
- Use your own additional tools to *inform* your evaluation, but do not attach.
- Guidelines on “Additional Supervisor Comments”

## LPC EVALUATION OF SUPERVISED EXPERIENCE

Name of Supervisee: \_\_\_\_\_

Board Approved Supervisor: \_\_\_\_\_

Is the Board Approved LPC Supervisor also acting as the Board Approved On-site Supervisor? Yes:  No:

Name of Candidate's Employing Agency: \_\_\_\_\_

Was 100% percentage of experience listed below accrued in accordance with §59-1902 (3)(4)(5)(6)(7)? Yes:  No:

On a scale of 1-5, please provide the supervisor's rating of the supervisee's professional activity: \_\_\_\_\_

Work Week Beginning Date	Date(s) met with Supervisor	Dates of Observation (Live or Taped)	Date of Supervisor Consult w/ On-site	Total Face-to-Face Supervision Hours		Total Direct Client Contact Hours	Total Supervised Experience Hours
				GRP	IND		

### Additional Signature(s) (Optional, use only if applicable):

If the candidate was supervised by more than one supervisor during this 6-month period, you may add as many signatures as required to page one of this evaluation form. You may also use to space below for any additional required signatures:

SUPERVISOR SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

SUPERVISOR SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

### Supervision Rules and Regulations:

Please refer to Subchapter 11 of the Regulations to review all Supervised Experience Requirements. You may download the Regulations from the Board's website at [www.ok.gov/behavioralhealth](http://www.ok.gov/behavioralhealth).

### Additional Supervisor comments (Optional, use only if applicable):

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**Additional Signature(s) (Optional, use only if applicable):**

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**Additional Supervisor comments (Optional, use only if applicable):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Additional Comments:

## The Dialectical Dilemmas

- Too Much Information vs. No Information
- Only Positives vs. Only Negatives
- Problematic behaviors and no comments?

# Additional Supervisor Comments

**Additional Signature(s) (Optional, use only if applicable):**

If the candidate was supervised by more than one supervisor during this 6-month period, you may add as many signatures as required to page one of this evaluation form. You may also use to space below for any additional required signatures.

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

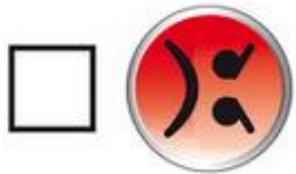
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## Tips on “negative” notations (critiques):

- Do not include any private information revealed in clinical supervision.
- Only objective and measurable as related to counseling/therapy competencies.
- Avoid “psychic swami” comments:
  - Avoid intuiting internal states, character, motivation, attitude, etc.
- Candidate should NEVER be surprised by a critique!
- Reframe lite/moderate critique into *encouragements* for enhancements.
- Articulate more significant critique as simple & direct statements of needs.
  - State what you want to see.
- Avoid statements like “*this has been reviewed many times...*” It sounds aggressive. The fact that it’s in your review implies you’ve reviewed the expectation sufficiently. You also have your shadow notes, if needed.

# How do I remark on a negative without sounding too negative?

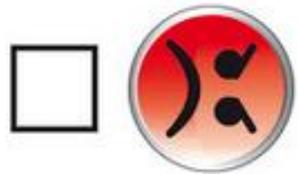
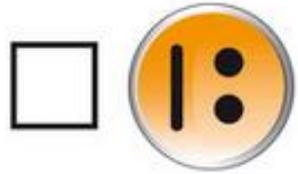
## THE IMPLICATION TECHNIQUE



“encouraged to”

“needs to”

- You imply that something is **NOT** being done by remarking that it needs to be done.
- Or, you remark on a specific Board Regulation to imply that it **needed to be emphasized** this review period.



# How do I remark on a negative without sounding too negative?

## THE WHY IS IT IMPORTANT TECHNIQUE

- You state the reason(s) **why it is important**, to imply that the candidate is not demonstrating appreciation for its importance.

## Pandora's Box – Evaluations



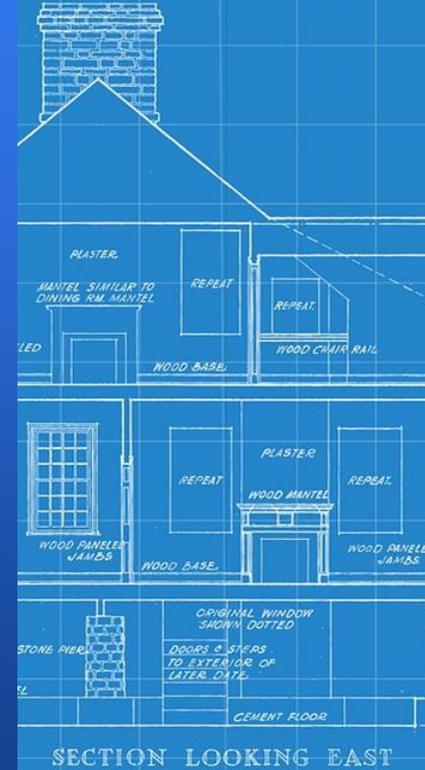
- Keep critique-comments tightly bound to therapy behaviors.
- No surprises—If you never brought it up, then it doesn't go on the review. (Bring it up verbally on the review and own you've not brought it up.)
  - **Transference/Countertransference: Supervisees will understandably wonder:**
    - If there are other observations you've kept to yourself.
    - What is your Countertransference that led to you concealing your observation?
    - Rationalizing concealment as "protective" or "{Supervisee} wasn't ready or doesn't handle feedback well" opens a Pandora's Box of anxieties in Supervisees.

# DOCUMENTATION

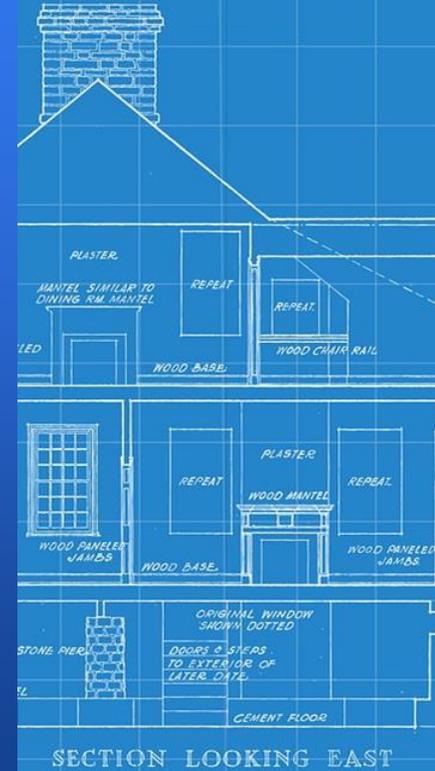


Where do they get the vocab?

Does the Progress Note sound CLINICAL?

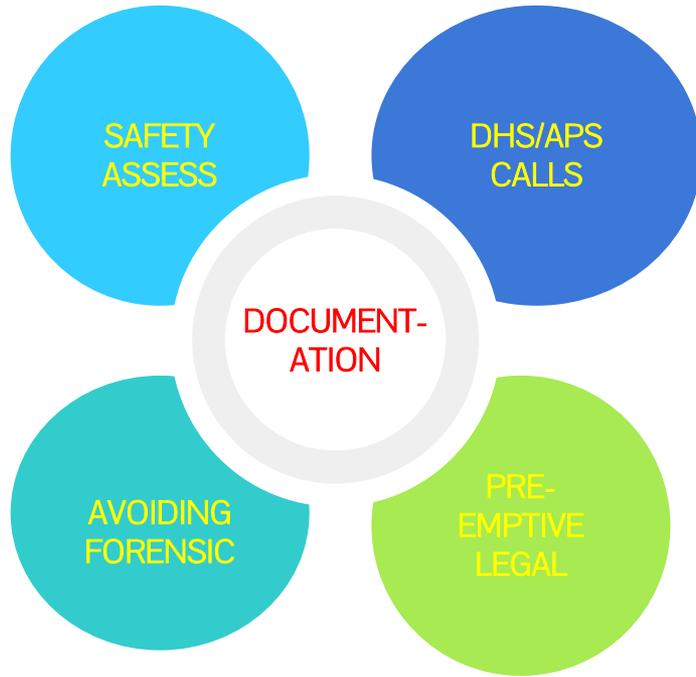


# Where do they get the vocab? How do they talk like the Modality?

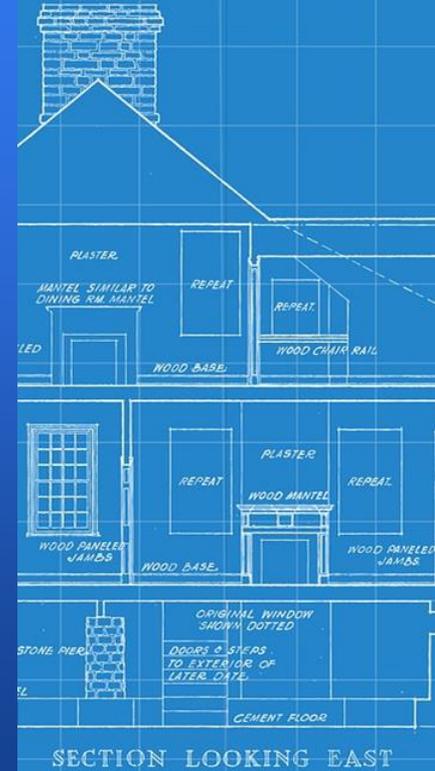


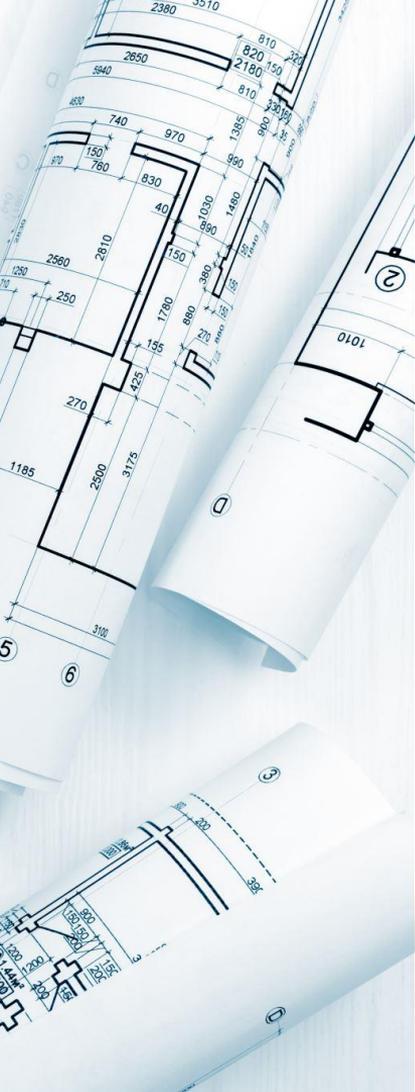
Does the Progress Note sound like the Modality?

# DOCUMENTATION –RISK MANAGEMENT



Don't wait.  
Teach early

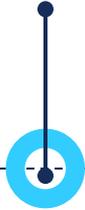




# Models of Supervision

# Modern Supervision Models

1983-1995



## DEVELOPMENTAL MODELS

Presumes new therapists are developing on similar trajectories, with similar needs along that timeline.

1996-2011



## PSYCHODYNAMIC MODELS

Focuses on the supervisory relationship, transference/counter-transference, and what is needed to foster a new “self-aware” therapist.

2012 - Now



## COMPETENCY MODELS

Focuses on key skills and competencies that all therapists must master.

# Modern Supervision Models

1983-1995



DEVELOPMENTAL  
MODELS



1996-2011



PSYCHODYNAMIC  
MODELS



2012 - Now



COMPETENCY  
MODELS



# Developmental Models

## Metaphor of Cook → Chef

- Supervisor adjusts supervisory approach to the developmental level of the candidate.
- New therapists need “**recipes**”.
- Seasoned therapists integrate & transcend recipes to become “**chefs in the kitchen**”.



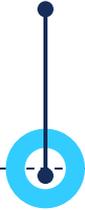
## *Do You Mean I Tell Them What to Do?*



- **Yes.** They actually don't have the answer within.
- Psychotherapy is sophisticated; we cannot expect newbies to already have sophistication.
- They need **recipes** of the model to avoid technical chaos.
- **Handing down on Theoretical Orientations.**
- **Pedagogical.**

# Modern Supervision Models

1983-1995



DEVELOPMENTAL  
MODELS

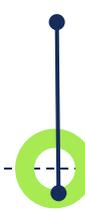
Pedagogical  
Give Recipes  
Teach case  
conceptualization  
Teach Models (Theoretical  
Orientations)

1996-2011



PSYCHODYNAMIC  
MODELS

2012 - Now



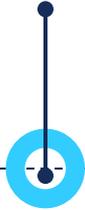
COMPETENCY  
MODELS



Part 2

# Modern Supervision Models

1983-1995



## DEVELOPMENTAL MODELS

Pedagogical  
Give Recipes  
Teach case conceptualization  
Teach Models (Theoretical Orientations)

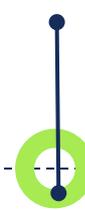
1996-2011



## PSYCHODYNAMIC MODELS

Client and therapist are interpreted.  
Therapist/Supervisor interpreted.  
“Self-aware” therapists is the goal.

2012 - Now

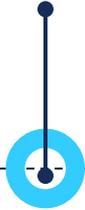


## COMPETENCY MODELS



# Modern Supervision Models

1983-1995



## DEVELOPMENTAL MODELS

Presumes new therapists are developing on similar trajectories, with similar needs along that timeline.

1996-2011



## PSYCHODYNAMIC MODELS

Focuses on the supervisory relationship and what is needed to foster a new therapist.

2012 - Now



## COMPETENCY MODELS

Focuses on key skills and competencies that all therapists must master. Also focus on manualized treatment.

# Core Competency Models

Supervisee as “technician” Or “gymnast”

- **Competencies** are taught and monitored.
- **Coaching** is focused on skills.
- **Competency** is adherence to manualized treatment.
  - Fidelity Checklists





AMERICAN COUNSELING  
ASSOCIATION



## Core Competencies of Therapist in Training

- The huge pluralism of therapy has resulted in associations focusing on shared skills and competencies across models.



National Association of Social Workers



NAADAC

THE ASSOCIATION FOR  
ADDICTION PROFESSIONALS



AMERICAN COUNSELING  
ASSOCIATION



American Association for Marriage and Family Therapy

## Core Competencies of Therapist in Training

- Therapy attitudes, skills, abilities: **Professional organizations**
- Review at start and at reviews.



National Association of Social Workers



NAADAC

THE ASSOCIATION FOR  
ADDICTION PROFESSIONALS

# Process-based Model for Supervisees

- We look at what the problems are, irrespective of Labels.
- We don't worry about Everyone; we worry about You.
- We embrace Complexity, not Simplicity.
- We identify processes to change that are transtheoretical- although the vocabulary may be borrowed.





Marseille



# La Bouillabaisse

2 kg de poissons à chair ferme (trascaso, congre, lotte, grondin, vive).  
 1 kg de poissons à chair tendre (St-Pierre, merlan, loup, girelle).  
 1 kg de poissons de roche pour le bouillon.

Hachez 2 blancs de poireau, 2 oignons, 3 gousses d'ail et le persil. Réservez en la moitié pour la bouillabaisse et mettez le reste à revenir dans un peu d'huile avec le poisson de roche. Ajoutez 1 cuil. de concentré de tomate, safran, laurier, fenouil; salez, poivrez. Couvrez avec 2 litres 1/2 d'eau et laissez bouillir 20 mn. Passez le tout à la moulinette. Vous aurez entre temps mis le reste du poisson à mariner avec les ingrédients réservés.

2 tomates concassées, les pommes de terre tranchées, l'huile d'olive, le safran et le fenouil.  
 20 mn avant de servir déposez dans le feu et ébullition les tranches de pommes de terre. À mi-cuisson ajoutez le poisson à chair ferme puis le poisson à chair tendre qui cuit plus vite. Disposez le tout sur un plat garni de pommes de terre. Servez avec le bouillon très chaud, les croûtons grillés frottés d'ail et la rouille.

La rouille traditionnelle se prépare dans un mortier avec : 300 g de pain trempés dans du lait, 3 piments rouges forts, 3 gousses d'ail pilées, une pomme de terre cuite, du safran, le tout lié à l'huile d'olive et réduit en une purée onctueuse.

BOIL  
 2 kg  
 angl  
 1 kg  
 bass  
 1 kg  
 1 kg  
 Chop  
 clove  
 Keep  
 for t  
 other  
 half in  
 a little  
 oil with  
 the rock  
 fish.  
 Add 1  
 tablespoon  
 of tomato  
 paste, saffron,  
 laurel, fennel; then salt and pepper. Cover  
 with 2 1/2 litres of water and let boil for  
 20 minutes. Pass everything through a  
 masher. Meanwhile, leave the rest of the fish to



The traditional rouille is prepared in a mortar with: Soft part of the bread soaked in milk, 3 strong red pimentos, 3 cloves of smashed garlic, one cooked potato and saffron, all blended with olive oil and reduced to an oily paste.



# Processes for your Psychotherapeutic Bouillabaisse

- Contingency management
- Stimulus control
- Shaping
- Self-management
- Arousal reduction
- Coping and emotion regulation
- Problem solving
- Exposure strategies
- Behavioral activation
- Interpersonal skills
- Cognitive reappraisal
- Modifying core beliefs
- Cognitive defusion
- Experiential acceptance
- Attentional training
- Values choice and clarification
- Mindfulness practice
- Enhancing motivation
- Crisis management and treating suicidality





# Which Supervisory Overall Model is Best?

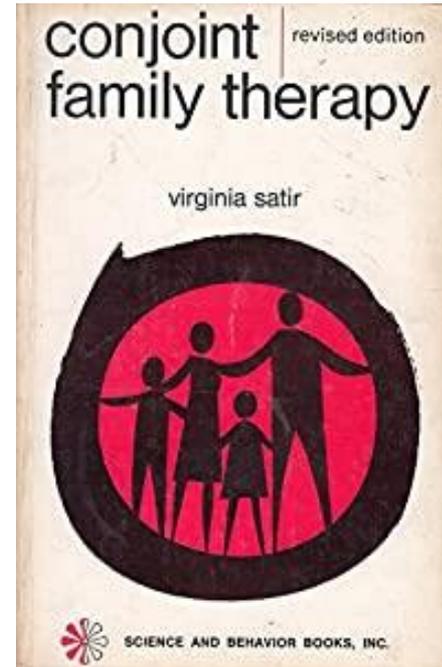
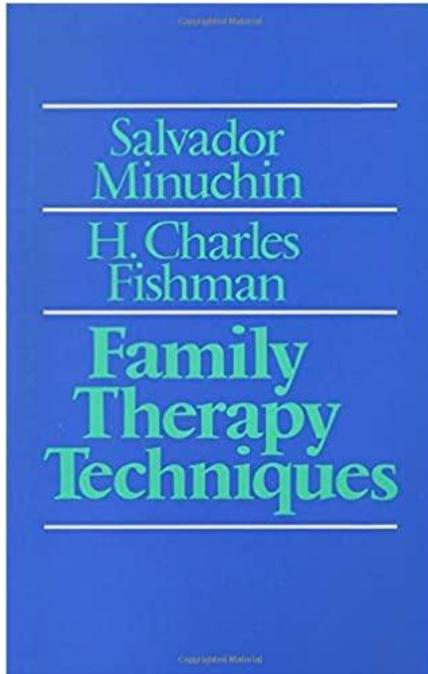
- Highly subjective
- Candidate-dependent
- Supervisor-dependent  
(what's **your** range?)



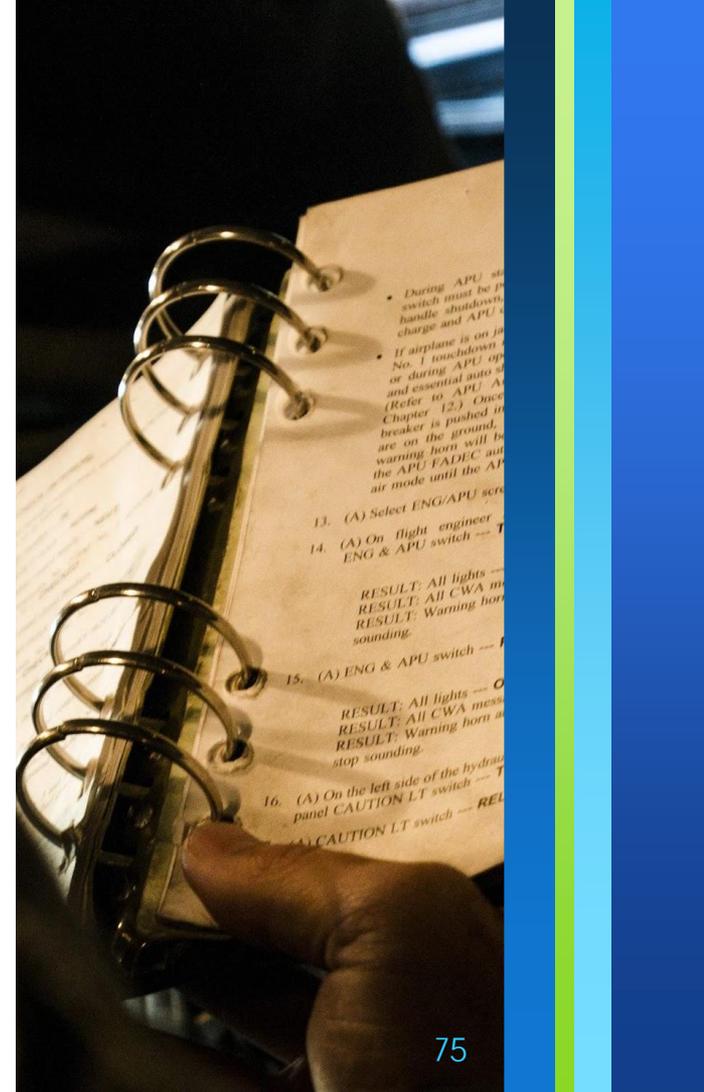


# Supervising Treatment Manuals?

**The Masters used to write books on their models,  
demonstrate on stage. We imitated.  
Now everyone wants a manual, session-by-session.**



# Our industry seems to be chasing Manuals



Acceptance and Commitment Therapy for Depression  
Acceptance and Commitment Therapy for Chronic Pain  
Acceptance and Commitment Therapy for anxiety disorder  
Acceptance and Commitment Therapy for coping with psychosis

Applied Relaxation for Panic Disorder  
Assertive Community Treatment for Schizophrenia

Behavior Therapy/Behavioral Activation for Depression

Behavioral Couple Therapy for Depression

Behavioral and Cognitive Behavioral Therapy for Chronic Low Back Pain

Behavioral Weight Loss Treatment for Obesity and Pediatric Overweight  
Biofeedback-Based Treatments for Insomnia

Cognitive Adaptation Training for Schizophrenia

Cognitive Behavioral Analysis System of Psychotherapy for Depression

Cognitive Behavior Therapy for Insomnia  
Cognitive Behavioral Therapy for Anorexia Nervosa

Cognitive Behavioral Therapy for Binge Eating Disorder

Cognitive Behavioral Therapy for Bulimia Nervosa

Cognitive and Behavioral Therapies for Generalized Anxiety Disorder

Cognitive Behavioral Therapy for Panic  
Cognitive and Behavioral Therapies for Social Phobia/Public Speaking Anxiety

Cognitive Behavioral Therapy for Chronic Headache

Cognitive Behavioral Therapy for Schizophrenia

Cognitive Processing Therapy for Post-Traumatic Stress Disorder

Cognitive Remediation for Schizophrenia  
Cognitive Therapy for Bipolar Disorder  
Cognitive Therapy for Depression

Cognitive Therapy for Obsessive-Compulsive Disorder

Dialectical Behavior Therapy for Borderline Personality Disorder

Emotion-Focused Therapy for Depression  
Exposure and Response Prevention for Obsessive-Compulsive Disorder

Exposure Therapies for Specific Phobias  
Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder

Family-Based Treatment for Anorexia Nervosa

Family-Based Treatment for Bulimia Nervosa

Family Focused Therapy for Bipolar Disorder

Family Psychoeducation for Schizophrenia

Healthy-Weight Program for Bulimia Nervosa

Interpersonal Therapy for Depression  
Illness Management and Recovery for Schizophrenia

Interpersonal Psychotherapy for Binge Eating Disorder

Interpersonal Psychotherapy for Bulimia

Interpersonal and Social Rhythm Therapy for Bipolar Disorder

Multi-Component Cognitive Behavioral Therapy for Fibromyalgia

Multi-Component Cognitive Behavioral Therapy for Rheumatologic Pain

Paradoxical Intention for Insomnia

Problem-Solving Therapy for Depression

Prolonged Exposure for Post-Traumatic Stress Disorder

Psychoanalytic Therapy for Panic Disorder

Psychoeducation for Bipolar Disorder

Psychological Debriefing for Post-Traumatic Stress Disorder

Relaxation Training for Insomnia

Reminiscence/Life Review Therapy for Depression

Schema-Focused Therapy for Borderline Personality Disorder

Self-Management/Self-Control Therapy for Depression  
Self-System Therapy for Depression

Short-Term Psychodynamic Therapy for Depression  
Sleep Restriction Therapy for Insomnia

Social Learning/Token Economy Programs for Schizophrenia

Social Skills Training for Schizophrenia

Stimulus Control Therapy for Insomnia

Supported Employment for Schizophrenia

Systematic Care for Bipolar Disorder

Transference-Focused Therapy for Borderline Personality Disorder

# Protocols for Everything?

- You must read a manual that applies a Therapy Model to a Syndrome.
- If the Syndrome changes, you must read another manual.





**Our Industry has become  
Sport-dependent.**

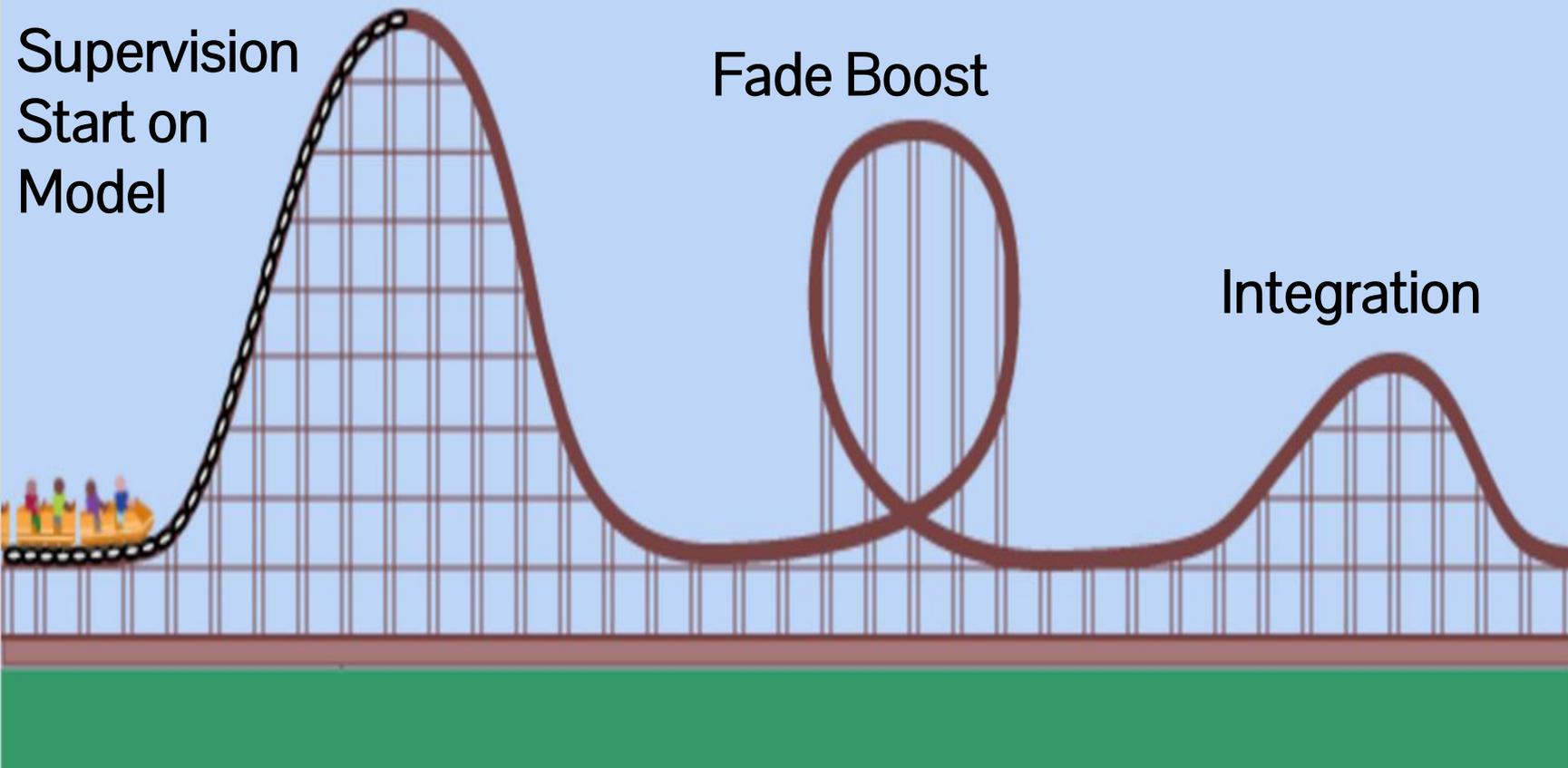




# What do New Supervisees say of Manuals?

Thank you!

# The Story Arc of Manualized Treatment Adherence & Clinical Supervision





Pedagogically, what  
should I be teaching my  
**green** supervisees?

# Pedagogy vs. Andragogy



Supervisee as CHILD



Supervisee as ADULT



## 1st Session Tasks Supervisees May Avoid

- Disclosure of training and experience.
- Personal disclosures when asked by clients or families.
- Explaining how therapy works.
- Anticipatory Boundaries:
  - Attendance
  - Crises
  - Course of treatment
  - Potential testimony and its limits
  - Potential letters of advocacy and its limits
  - School meetings
  - Couples sessions

# Mise en Place



- Rapport
- How to answer personal questions elegantly and to further the clinical relationship
  
- Explaining diagnoses
- Informed consent, confidentiality (complexities of)
- Pre-treatment stance
- Attendance, payment
- Quietude
- Limit-setting
- Treatment interfering behaviors
- Burnout inoculation
- CE-CERT®



# Thank You!

Evals & CEU's

Part 2...



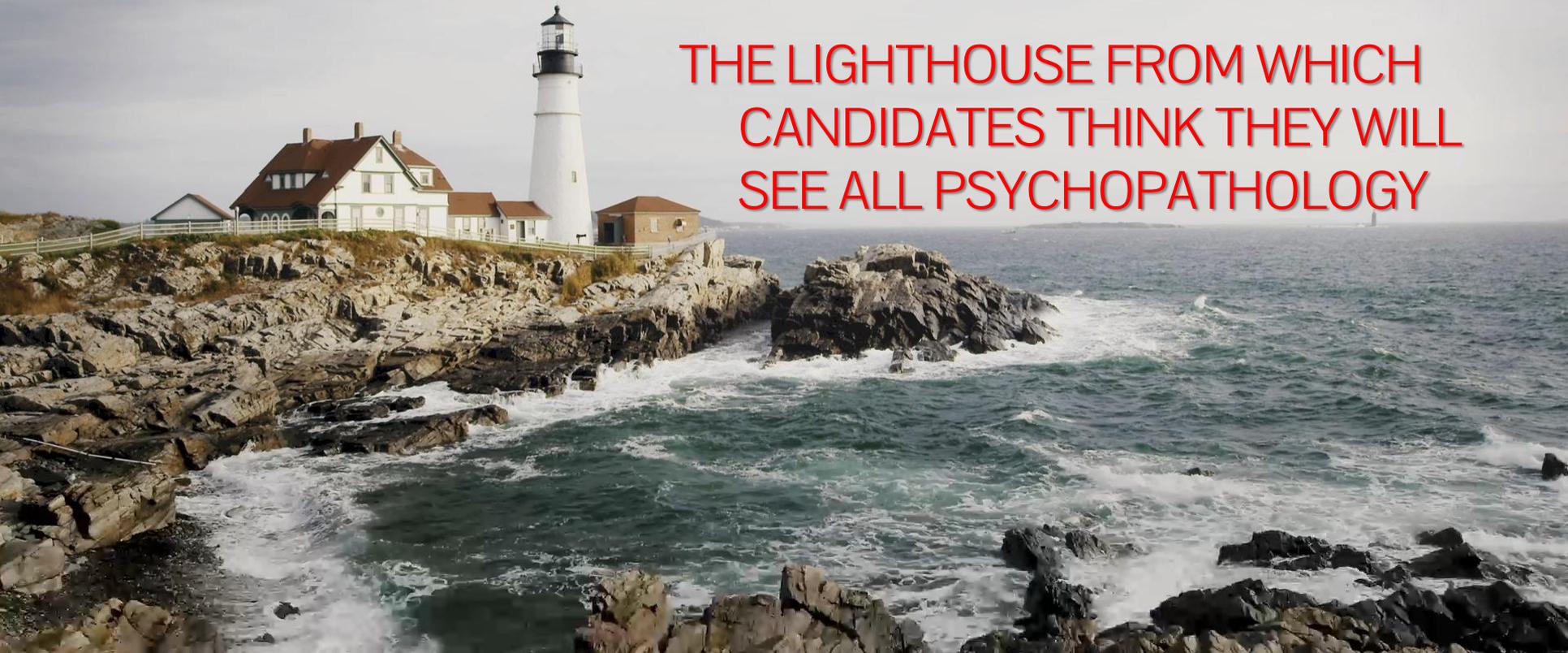
# Below The Waterline, Part 2

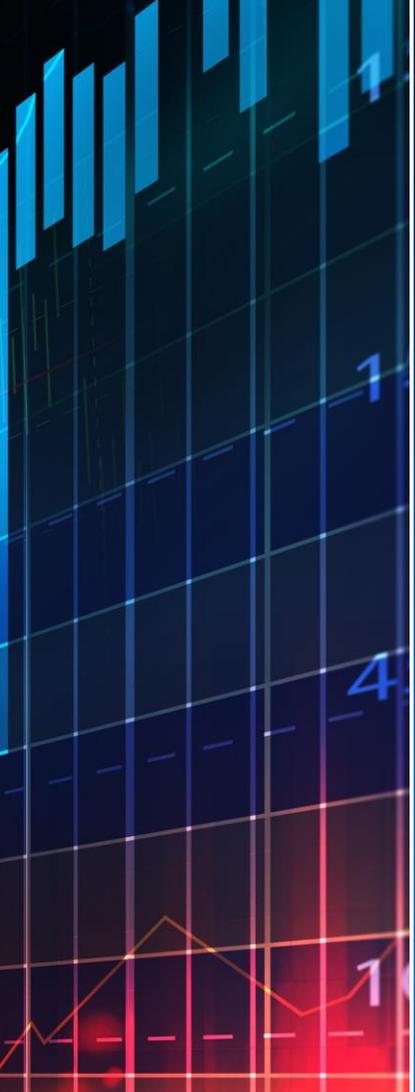
**Deeper Clinical Supervision –  
Cultivating the next generation of LPC's beyond models & manuals.**

**Paul B. Williams LPC**

# The Almighty Theoretical Orientation

THE LIGHTHOUSE FROM WHICH  
CANDIDATES THINK THEY WILL  
SEE ALL PSYCHOPATHOLOGY





# Outcomes from Supervision

**Supervisor as “Attending Physician”**

**The patients of your supervisee should be getting better, right?**

**What about patient outcomes?**

**Does Supervision Change Patient Outcomes? Should it?**

# Supervisee



Supervisor



Client





**“THE reason for providing supervision and the ethical justification for requiring it are that it makes a difference with respect to client outcomes...**

**... If we cannot show that supervision affects patient outcome, then how can we continue to justify supervision? The benefits of supervision on supervisees alone are not necessarily sufficient; while valuable, they at best only provide us with an indirect link to patient outcome.”**  
Lichtenberg, 2007.



**The “acid test”: 24k gold  
resists all but the strongest  
of acids.**

**“The impact of clinical  
supervision on client outcome  
is considered by many to be  
the acid test of the efficacy of  
supervision” (Ellis & Ladany,  
1997)**



## The Brilliant Artist... ... Who doesn't sell any art?

**PICASSO:** “It’s often been said that an artist ought to work for himself, for the ‘love of art,’ [and] that he ought to have contempt for success.

**Untrue! An artist needs success.” 1944.**

## The Picasso Test Are you selling art?



# How can YOU determine if your Supervision changes patient Outcomes?

EACH AGENCY HAS ITS OWN DATA ANALYTICS:

Patient Outcomes, No Shows/Cancellations, Planned Discharges vs. Unplanned Discharges.

Is it **fair** to the Supervisee?



# Evaluating Candidates Skills

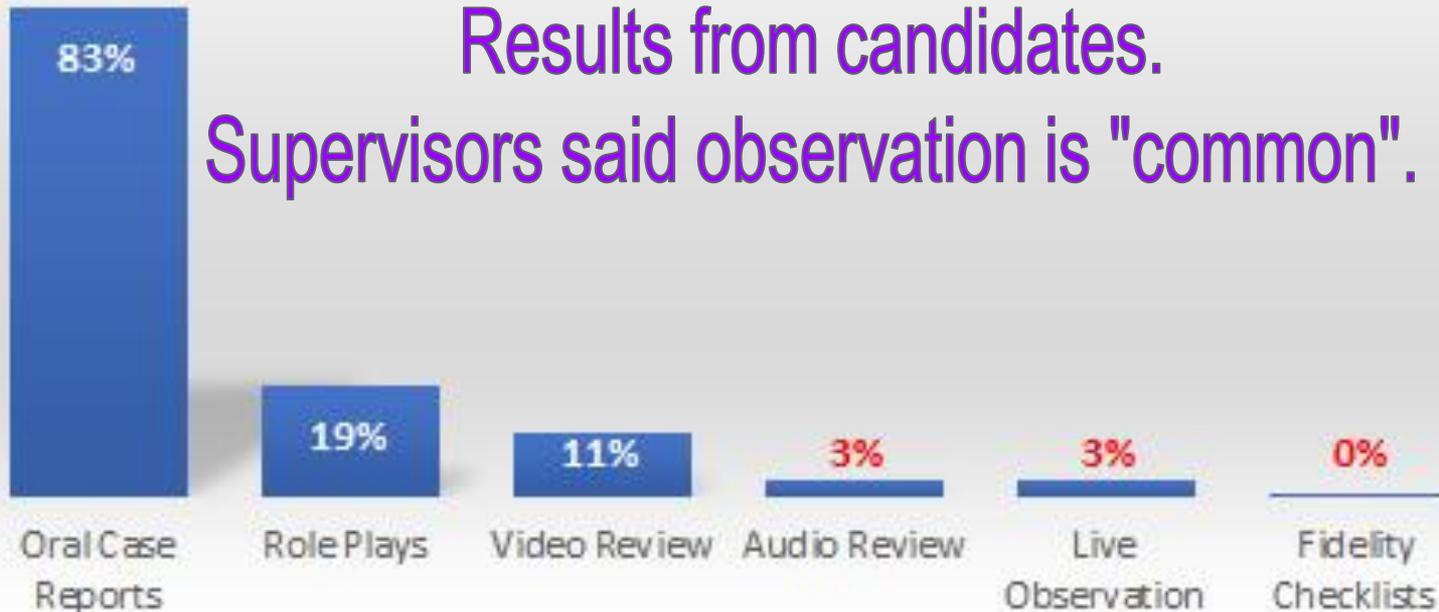
Multiple Models  
Common Factors  
Competencies  
Processes

## Survey Says! **Houston... We have a problem.**

- Least popular function of clinical supervisors.
- Not done informally before the required 6 month formal deadline.
- Tapes are often rushed in at the last minute (this suggests important deficits in direct observations).
- Use of direct observation is alarmingly low, low on role play, low on fidelity checklists.

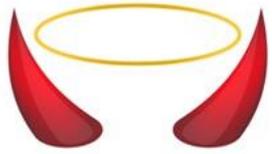


## Evaluative Forms of Clinical Supervision





- **Too much to cover each session.**
  - Even the Board seems to recognize this.
- **Belief that honest candidates adequately represent themselves.**
  - Some truth to this in the research regarding the “horn” effect (opposite of “halo” effect).
- Candidates hate being taped and procrastinate.



- **HALO EFFECT vs. HORN EFFECT**
  - Candidates tend to give themselves “horns” regarding their work.
  - Supervisors tend to give their candidates “halos”.

## LENIENCY EFFECT

- Supervisors go too easy on candidates and rate them higher than they really are.
  - Often, Supervisors tell themselves, “based on her developmental stage, she’s o.k. at that!”
- LPC Board has rating 1-5.

Do you rate that according to Developmental Stage or “within the current Developmental Stage”?



## CENTRAL TENDENCY BIAS

- Grading on the Curve:
- Supervisors are biased to the middle, reluctant to give scores that are too high or too low.
  - Too high → *“But what will he work towards?”*
  - Too low → *“I don’t want to discourage her.”*
    - *“I don’t want that permanently on her Board review.”*



## RECENCY BIAS

- Supervisors rely on recent impressions, rather than rating the candidate over the prescribed period of time.
  - Recent improvements = total improvement?
  - Recent problems = chronic problems?



## THE STRUGGLE BUS EFFECT

- Struggling Supervisees:
  - Withhold information, only revealing difficult information if asked.
  - Evade information, diverting the discussion to other topics or issues on the case.
  - Pretend to know, using affirmation or agreement with the Supervisor as a means to pretend to know what one is doing.
    - *"Did you do a safety assessment?"*
      - *"Mmm hmm."*
    - *"So, you then called DHS?"*
      - *"Oh, I absolutely thought of that, but I'm bringing it here first."*
    - *"It seems that Chain Analysis would be helpful here."*
      - *"Oh, absolutely, I was thinking the same thing.:"*



## THE SELF REPORT EFFECT

- Evaluations seem to be based on mostly Supervisee's **self-reports** of what's happening in sessions.
- Even if the **2 tapes/6 months formula** is used (Oklahoma), this is **a tiny percentage of the candidate's body work**.

## Paul's Solutions to Supervisory Evaluation Issues

- Prescribe tapes monthly.
- Use varying forms of evaluation: Client feedback sheets, Fidelity Checklists, Consider no-show/cancellation rates.
- Have “evaluation check-ins” monthly.
- Prescribe Self-Evaluations to Candidates (use professional association Competency guides).
- Be aware of Biases.
- Role-Play interventions to test understanding (not just intellectualization of the understanding).
- Ask open-ended questions to prevent Evasive responses.
- Understand that any critical observation is your responsibility as Gatekeeper to the profession. Given multiple reviews will occur, candidates have opportunities to grow.



## Compassionate Taping vs. Cheerleading a Child

- Evaluating a Tape is excruciatingly vulnerable for the candidate.
- Be mindful of not accidentally devastating the candidate.
- The expected **hardiness** of the Old Days has disappeared.
- **However!** Don't swing too far and never critique. Candidates actually become exasperated with Supervisors who only praise.
- Supervisees want critique.

## Feedback

- Giving only positive feedback (cheerleading) is like telling a blindfolded basketball player that he made every shot.





Play → Pause → Play





## Categories of Supervision Models



DEVELOPMENTAL

- PSYCHOTHERAPY



MODEL-BASED

COMPETENCIES

- POSTMODERN APPROACHES

# Psychotherapy-Based Models

- The Supervision Approach is informed by the theoretical orientation(s) of the Supervisor.
- The Supervisor is not exactly teaching the psychotherapy model, but living it in session with the candidate.
- What the Supervisor attends to and ignores is informed by the theoretical orientation of the Supervisor in regards to psychotherapy of patients.

# Modern Supervision Models

1983-1995



DEVELOPMENTAL  
MODELS



1996-2011



PSYCHODYNAMIC  
MODELS



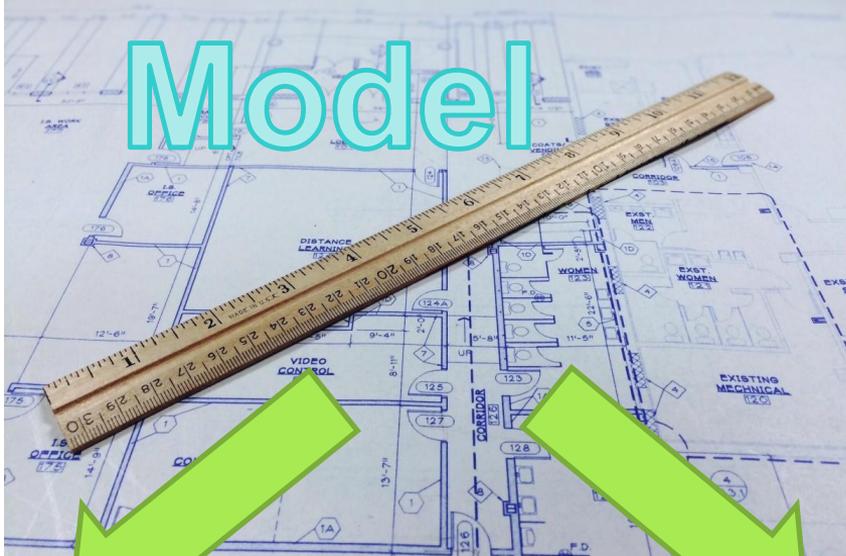
2012 - Now



COMPETENCY  
MODELS



# Model





# So, am I then providing psychotherapy for my supervisee?

- The psychotherapy approach is being applied to the supervisee **ONLY in relation to the client... or in relation to you.**
  - Psychodynamic → The supervisee's transference/countertransference.
  - CBT → The supervisee's core beliefs, schemas, cognitive distortions about the client (or you).
  - Gestalt → The genuineness of the Supervisor, fostering honest awareness of “background” sensed reactions in the supervisee.

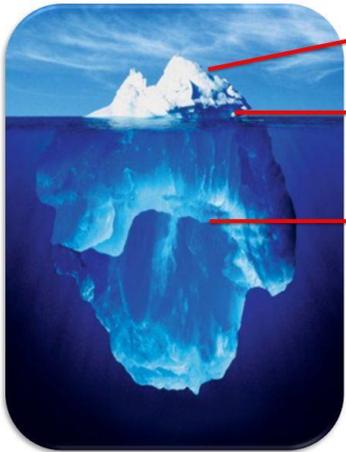
## Psychodynamic Can be Blurry

- A **dynamic** connection between:
  - Psyche of the past + present
  - Unconscious + Conscious
  - Trauma + non-trauma contexts
  - Client's relationships + relationship with the therapist
- An **unconscious** use of:
  - Defense mechanisms
  - Transference
  - Projection
  - Templates from the past & trauma



# Psychodynamic Processes are Classic for a Reason

## Psychodynamic Perspective



**Conscious:** things we are aware of

**Preconscious:** things we can be aware of if we think of them

**Unconscious:** deep, hidden reservoir that holds our “true” self—all of our fears and desires.

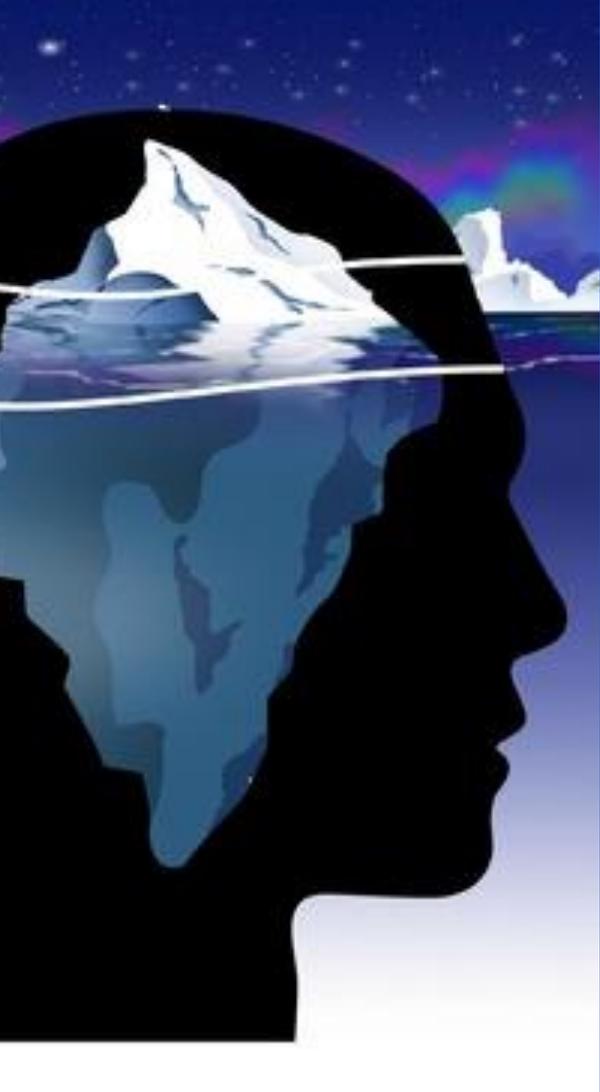
- Unconscious-to-awareness
- Object Relations (early relationships as template)
- Transference
- Countertransference
- Defense Mechanisms
- Interpretations key technique



## Psychodynamic Supervision Metaphor: Jedi Training

- Supervisee Self-awareness of emotions.
- Focus on process, less on content. **Yoda had to address Luke's internal emotional process, not just teach him Jedi skills or philosophy.**
- Transference/ Countertransference is analyzed regularly.
- Interpretation of the Supervisee **vis-à-vis the client.**
- Supervisor & Supervisee are also in a relationship,
  - That relationship is analyzed.





→ Transference/  
Countertransference



→ Projection / Projective  
Identification

→ Defense Mechanisms



“ Now that a considerable number of people are practicing psychoanalysis and exchanging their observations with one another, **we have noticed that no psychoanalyst goes further than his own complexes and internal resistances permit**; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his own observations on his patients. Any one who fails to produce results in self-analysis of this kind may at once give up any idea of being able to treat patients by analysis. ” (Freud, 1910, pp. 144–145).

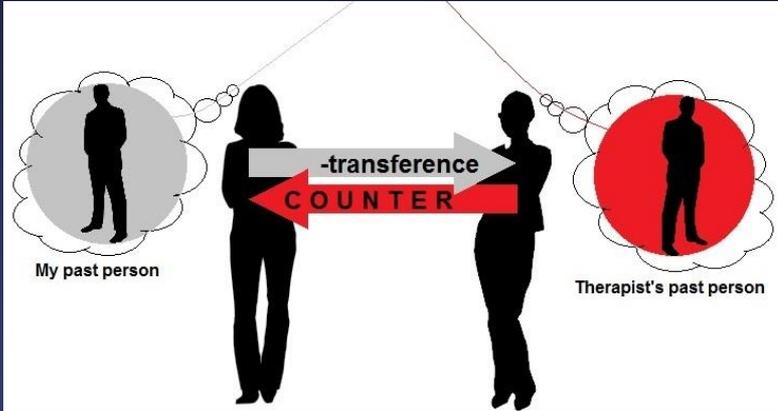


# VIDEO

Transference  
A primer

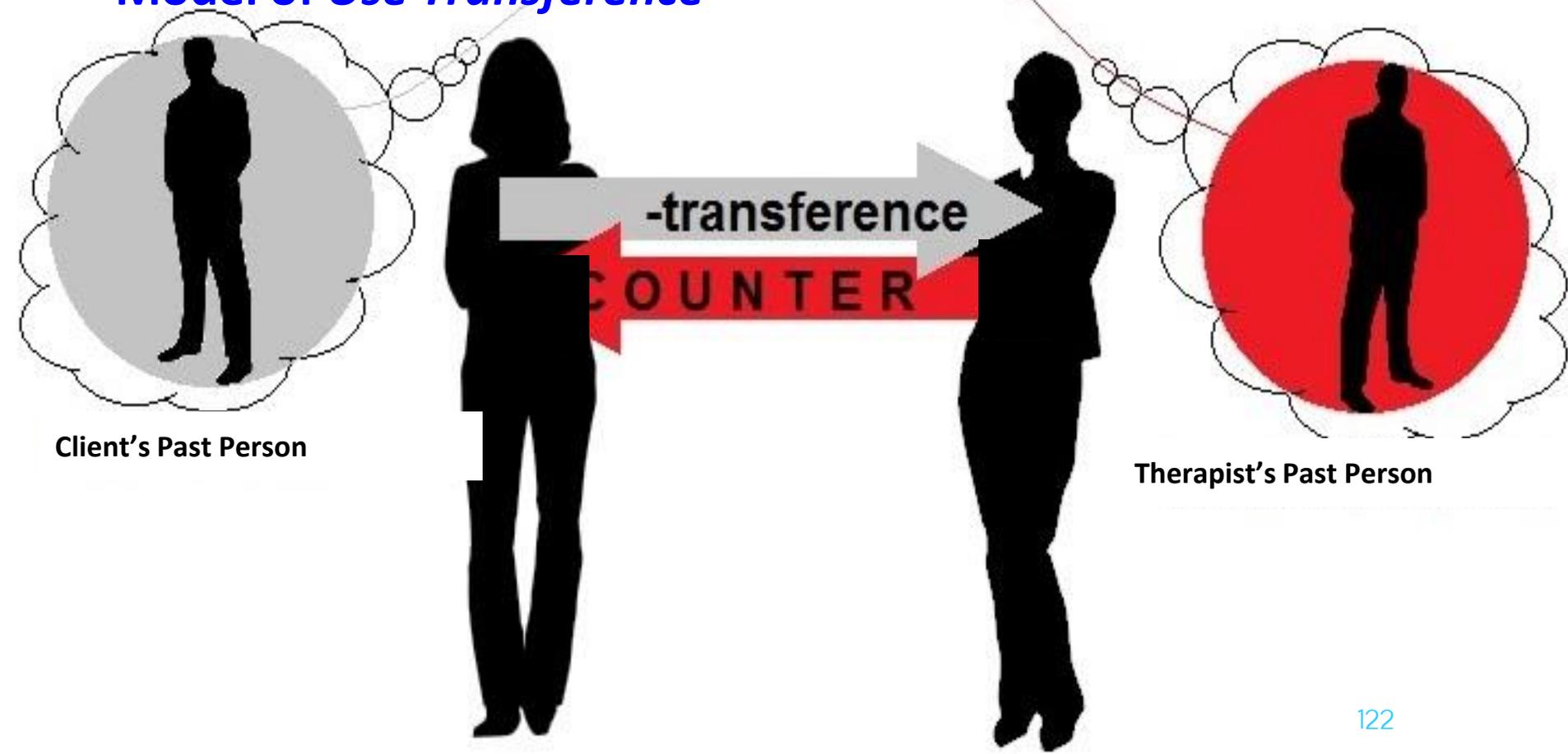


# There's a lot of... Countertransference



- Countertransference of supervisee to client.
- Countertransference of supervisee to Supervisor.
- Countertransference of Supervisor to supervisee.
- Countertransference of Supervisor to client.

## Model of Use Transference



# Object Relations “fancier” language:



Client's Object Relations

Candidate



Therapist's Object Relations

Supervisor

# Should I use Transference & Countertransference?



# Use it or it'll use you.



## VIDEO

Using the  
Countertransference  
In Supervision

Also Defense  
Mechanism:  
“Introjection”



5:50- 20



## Categories of Supervision Models

- ✓ DEVELOPMENTAL
- PSYCHOTHERAPY
- ✓ MODEL-BASED
- ✓ COMPETENCIES
- POSTMODERN APPROACHES

## PostModern Psychotherapy Models

- Modernism = “I can know” + Objectivism
- Post Modernism = “I cannot know” + Subjectivism
- Models of Psychotherapy are pure projection.
- No truth more valid than any other, including the patient.
- Rules of Psychotherapy are discarded (except safety).

# Piccino





# PostModern Supervision

- No right way to do counseling (although, there are some wrong ways).
- Knowing the client through the lens of diagnosing & theoretical orientations is a delusion.
- Anxiety is good for candidates; only possible without the safety net of an expert supervisor or manual.
- Supervisees explore and create their own models by forgetting everyone else's models.
- Sacred Cows of Psychotherapy are questioned.
- Supervision becomes the support of the candidate's own self-discovery.
- Generally, new candidates despise PostModern Supervision.
- More seasoned candidates may enjoy PostModern.





## Categories of Supervision Models

- ✓ DEVELOPMENTAL
- PSYCHOTHERAPY
- ✓ MODEL-BASED
- ✓ COMPETENCIES
- POSTMODERN APPROACHES



# Psychotherapy Ethics

Most difficult clinical decisions are tradeoffs, rather than a discovery of the one way of wisdom.

## Ethical Issues noted by Supervisees. My supervisor...

- Is a One Trick Pony: Doesn't know many models beyond the favorite.
- Didn't give me feedback until my Review, and I was surprised.
- Didn't keep what I said confidential; my admin supervisor learned private stuff.
- Was not available.
- Invited self-disclosure of vulnerable stuff, then evaluated me on it.



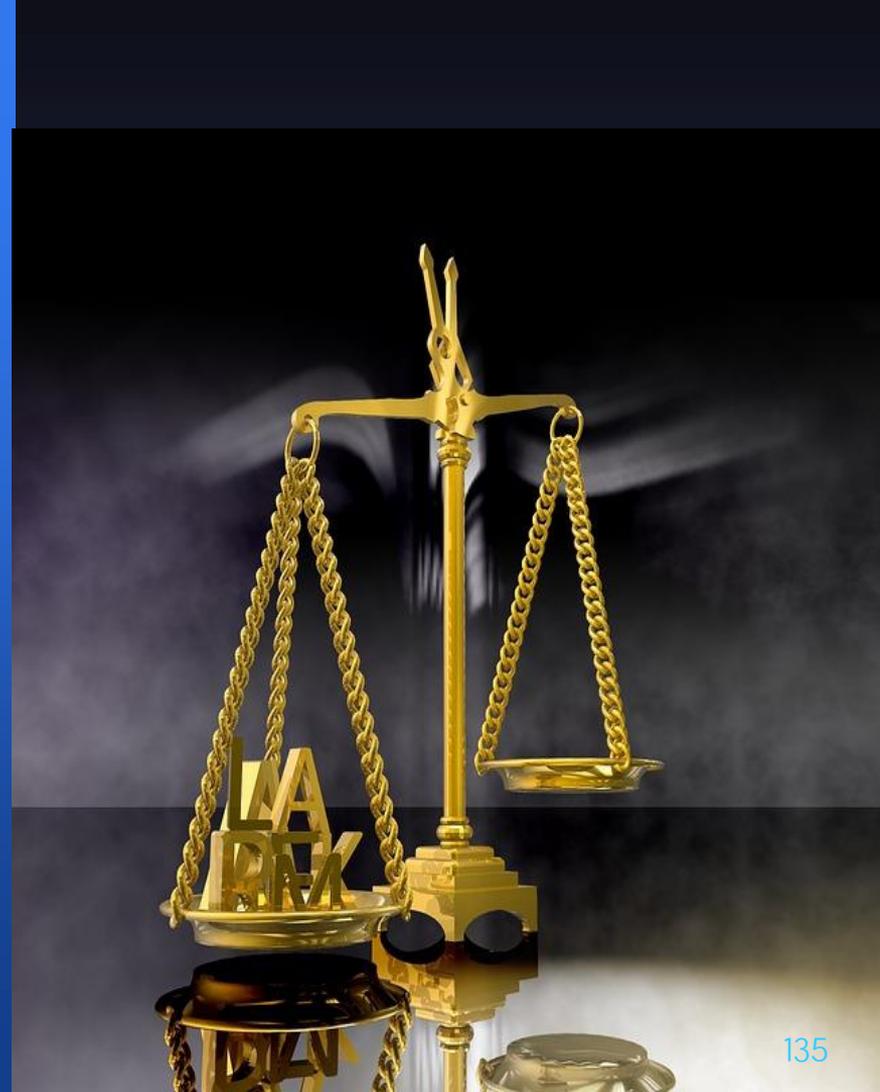
## Ethical Issues noted by Supervisors. My supervisee...

- Won't try new models.
- Won't tell me the truth.
- Didn't consult with me on a legal/safety issue.
- Won't do tapes.
- Won't read or watch anything.
- Has poor documentation, even on legally sensitive issues.
- Needs their own therapy.



# LPC Legal & Ethical Concerns

- 86:10-3-2 Specialist Competence
  - Counseling, Specialist?
  - Testing
  - Assessment
  - Forensics
  - Custodial concerns
  - Fact-witness testimony\*



## Child/Families

- **Candidates are especially unprepared for Child/Family minefields.**
- **Opening Sessions tasks change for child/family cases:**
  - **Confidentiality**
  - **Individual vs. Family Therapy**
  - **Custodial concerns**
  - **Hidden agendas**
  - **DHS Calls**



## Directly Rehabilitating a Supervisee...

- Be honest with Supervisee.
- Communicate with Admin Supervisor.
- Use Fidelity Checklists.
- Increase taping.
- Assign reading & videos, document (lack of) follow-through.
- Increase review of documentation.
- Explore Supervisee Transference around rehabilitation.





## Diversity: The Great Existential Question

- Chess Game = Candidacy
- Checkmate = Specialization
- Candidacy = Just a few winning moves, the candidate will be done and specializing?

# Diversity, Equity, Inclusion?

- **Diversity:** **Your candidates will treat a diverse population.**
  - Specialization is highly unlikely (and not advised) in candidacy.
  - Supervisors will have diverse candidates.
- **Equity (differs from Equality):** Takes into account unique circumstances, adjusting treatment and even practices to ensure an equal result.
- **Inclusion: The IMAX® effect—**
  - Candidates must become aware of degrees of communication of inclusivity or otherwise in their speech, clothing/costuming, offices, etc.



# VIDEO

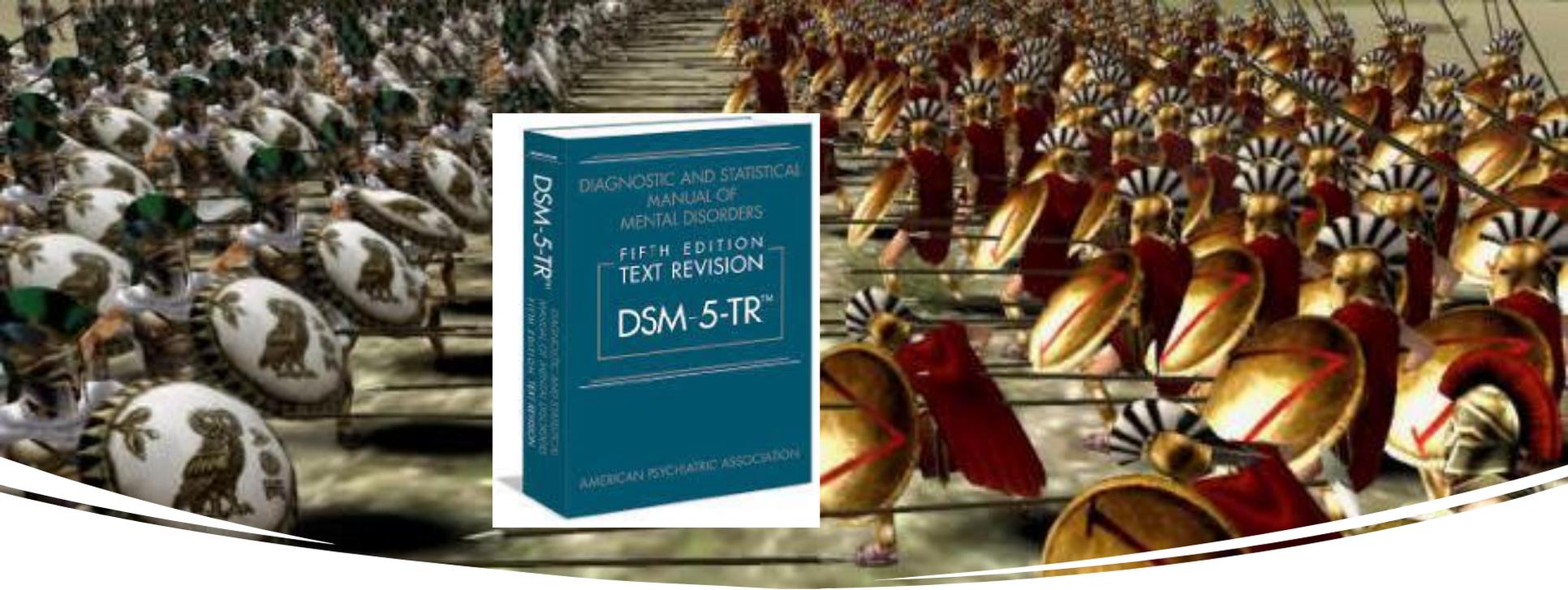
## Cultural Humility



A pair of black-rimmed glasses is resting on a stack of books. A red bookmark is visible in the bottom book. The background is a blurred blue and white.

## Screening for DEI

- Screening the profession
- Screened for in graduate schools?
- Screened for in State Boards?
- The Pre-Supervision Interview



## Culture Wars

- **Dialectic:**
- Our candidates must be “conscientious objectors” + Our candidates must stand up for what our profession stands for.

# POLITICAL



5 PUBLIC POLICY SUMMIT • APRIL 11, 2005 • UNIVERSITY OF ILLINOIS AT SPRINGFIELD

# RELIGION

## But, Political & Religious Neuroses?

- Supervisees are often unprepared for navigating political & religious ideals that appear to be supporting neurotic behaviors.
- This creates an impasse in the candidate who maintains that **until the belief changes, the client/family cannot possibly progress.**

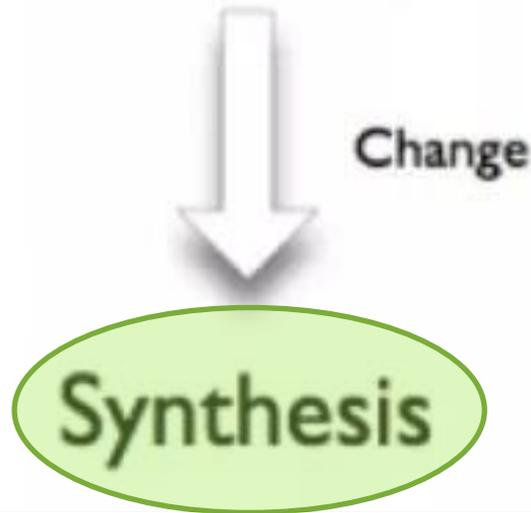


Validate the Valid  
Invalidate the Invalid

Refrain from debating the validity of the  
religious/political belief, per se.

Debate the validity around the **impact** of the  
**behaviors** on the **psychology & relationships**.

We may not be experts in any given political  
belief, but we are legitimately experts in what  
we are licensed to provide.



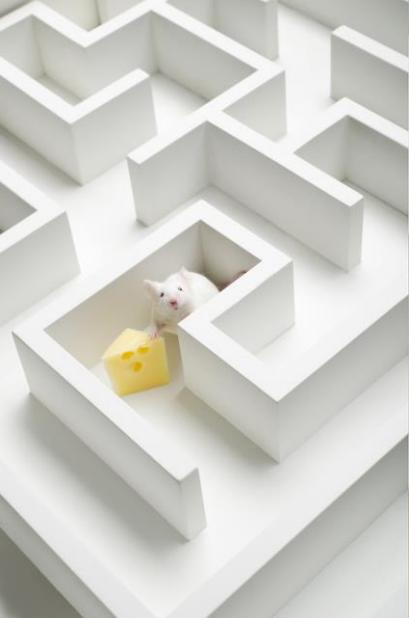


Stance A

Stance B

Common  
Ground

Do not negotiate beliefs.  
Negotiate behaviors.



## Supervision Interfering Behaviors

Is this a Motivational deficit?  
Or, a Skill deficit?  
Or, a Defense Mechanism?



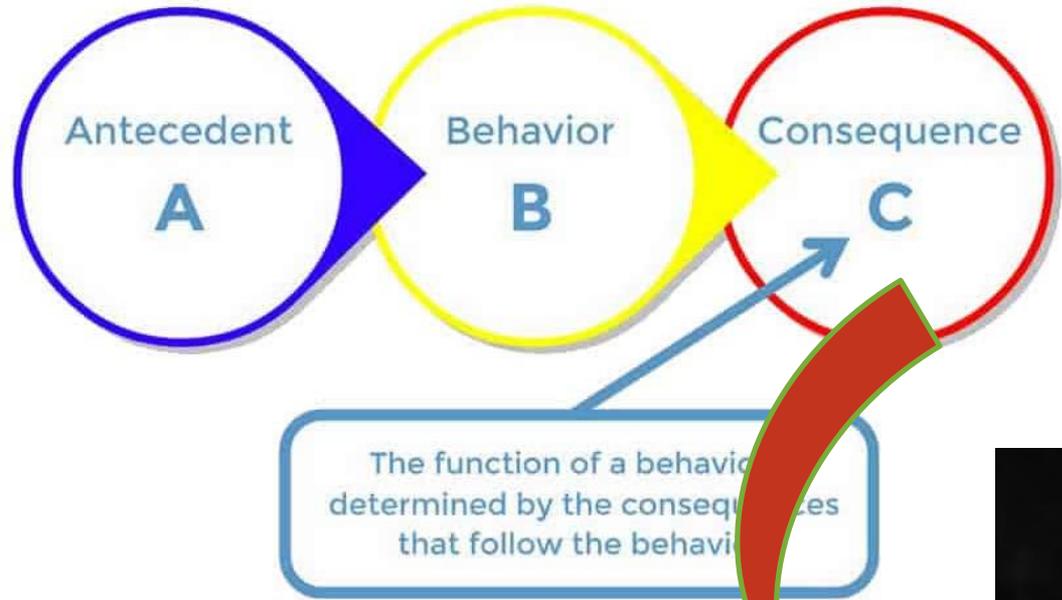


Behavioral

Cognitive

Emotional

Psychodynamic



# Behaviorism

FUNCTIONAL ASSESSMENT  
MARSHA LINEHAN "TALK IT TO DEATH"



# Cognitive

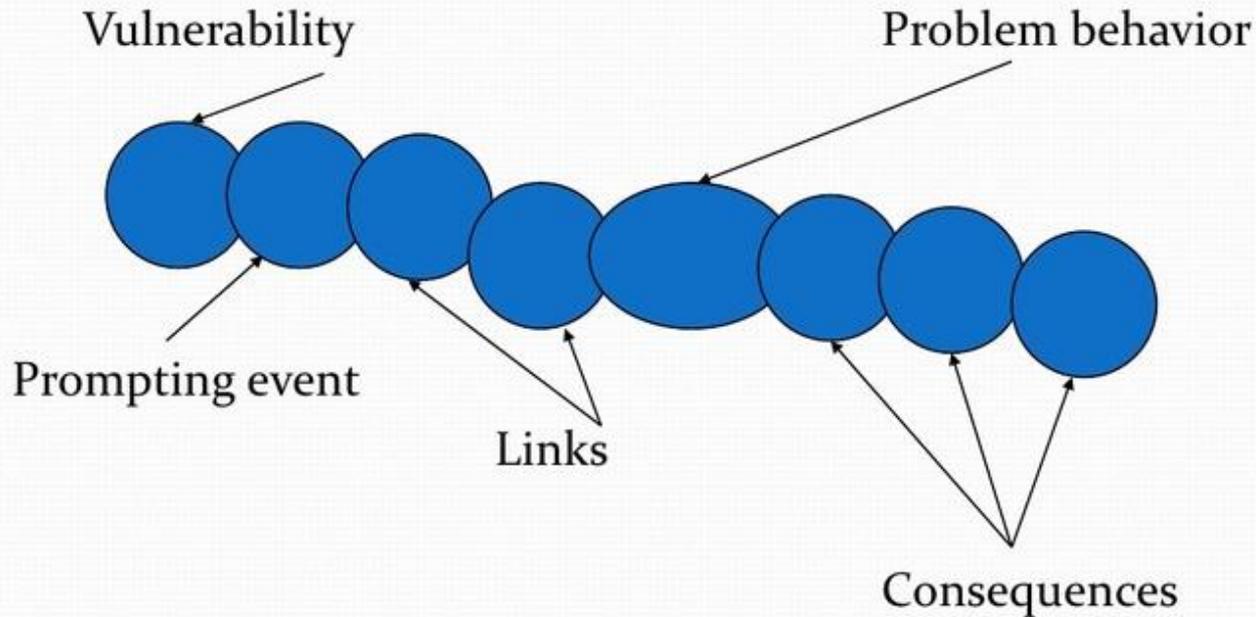
EXPLORING CORE BELIEFS  
GUIDED DISCOVERY (SOCRATIC QUESTIONING)



# Emotional

DIALECTICAL BEHAVIOR THERAPY:  
VALIDATING THE VALID, INVALIDATING THE INVALID

# Chain Analysis



DBT

(Combines  
all 3)

CHAIN  
ANALYSIS

An iceberg floating in the ocean. The tip of the iceberg is visible above the water, while a much larger portion is submerged below the surface. The sky is blue with some clouds, and the water is a deep blue.

# Psychoanalysis / Psychodynamic

## Clarification

- Asking clarifying questions with the intention to not just get information, but to help the client see a defense mechanism in play.

## Confrontation

- Pointing out a defense mechanism currently in play.

## Interpretation

- Summarizing an overall schema of how particular defense mechanisms are used by the client to defend against anxiety.

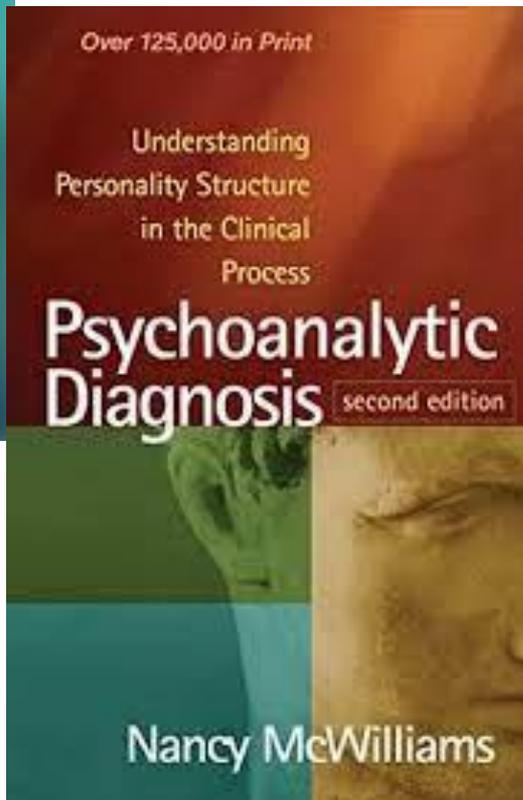
# Psychodynamic Diagnostic Manual

second edition  
**PDM-2**

edited by  
**Vittorio Lingiardi**  
**Nancy McWilliams**

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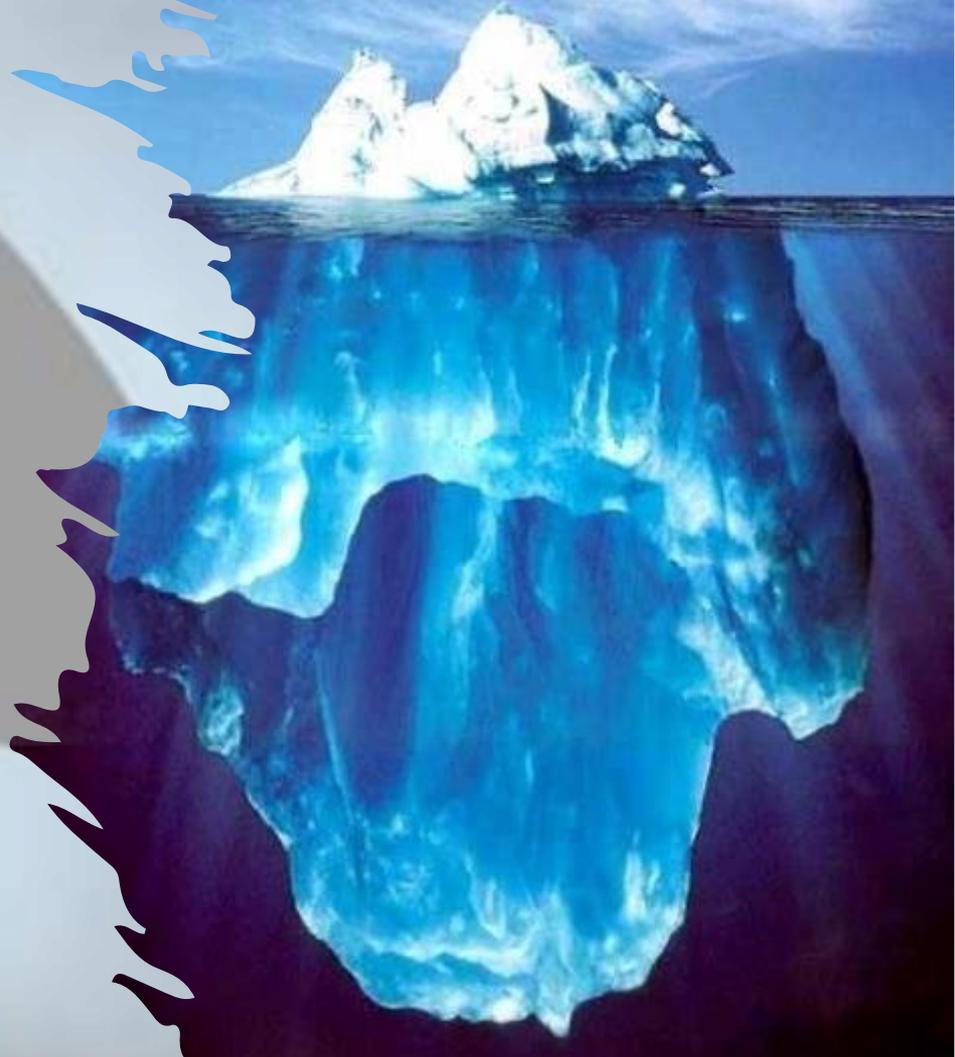
## Specific Resistances to Feedback – Psychoanalytic Dynamics



- **Depressive**
- **Paranoid**
- **Schizoid**
- **Histrionic**
- **Obsessive/Compulsive**
- **Borderline**
- **Narcissistic**
- **Anti-Social**

## Depressive/Masochistic

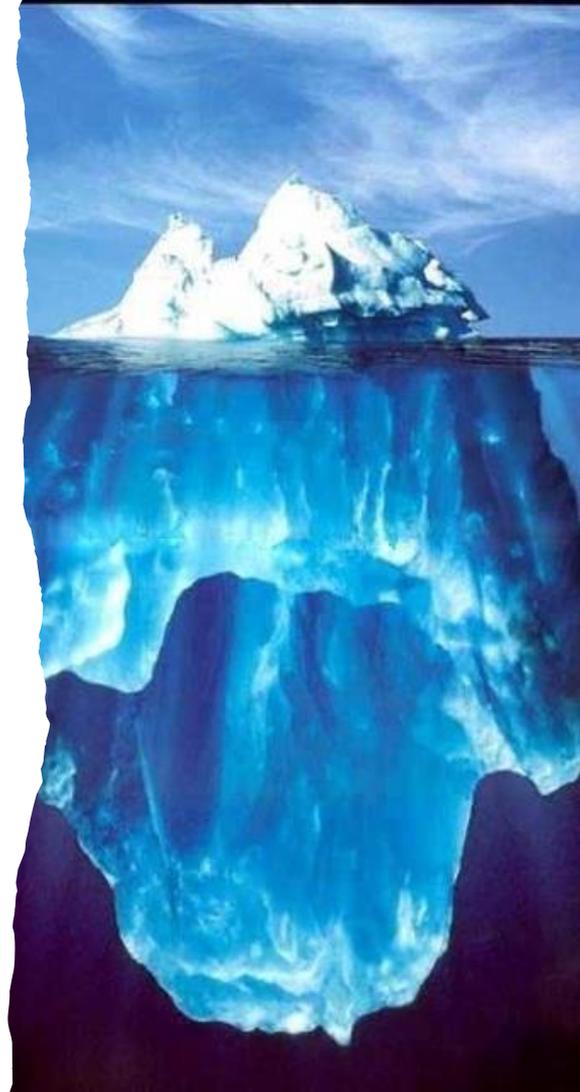
- Chronically self-critical. Beating the supervisor to the "punch".
- Ingratiating to the supervisor.
- **Countertransference: Tendency for Supervisors to cheerlead & withhold criticism.**





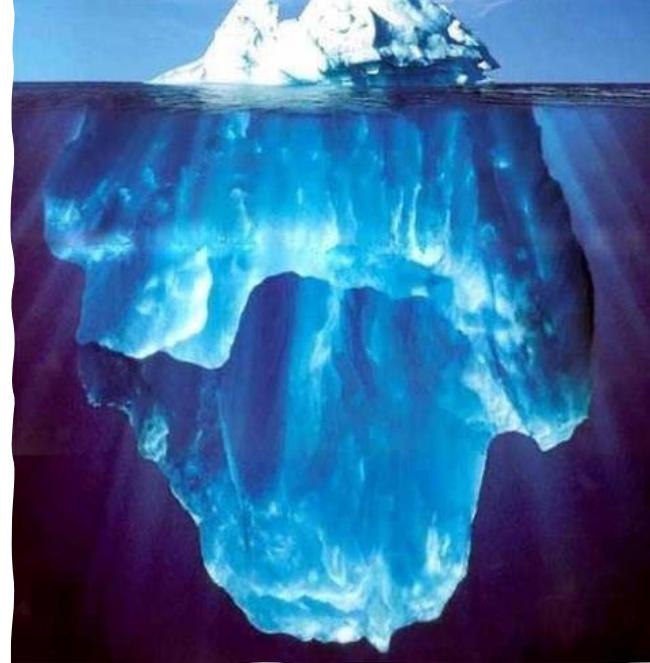
## Deeper Dynamics in Supervision: Paranoid

- Ascribe hidden motives to clients.
- Ascribe conspiracies to agencies, the Board, authority figures.
- The whole candidate process feels unsafe.
- **Countertransference:** Supervisors tend to try to set the candidate straight through reality testing.

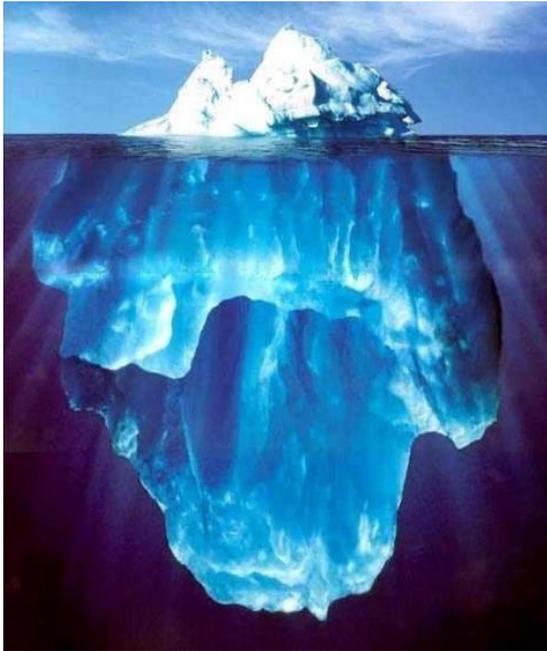


# Deeper Dynamics in Supervision: **Schizoid**

- The Mental Health Industry iconoclast.
- Everything that has come before them is bunk.
- Challenges traditions, customs, "best practice".
- Aloof: They act as if they know something that everyone else doesn't.
- **Countertransference: Supervisors tend to emotionally distance themselves, or keep justifying therapeutic points of view. "If you're so smart, you tell me".**



## Deeper Dynamics in Supervision: Histrionic



- Dramatic reactions to things that many just roll with.
- Couples/Family therapies become battle fields of social justice.
- **Countertransference:** Supervisors can feel like infants in comparison to the candidate's vast & advanced specialty knowledge

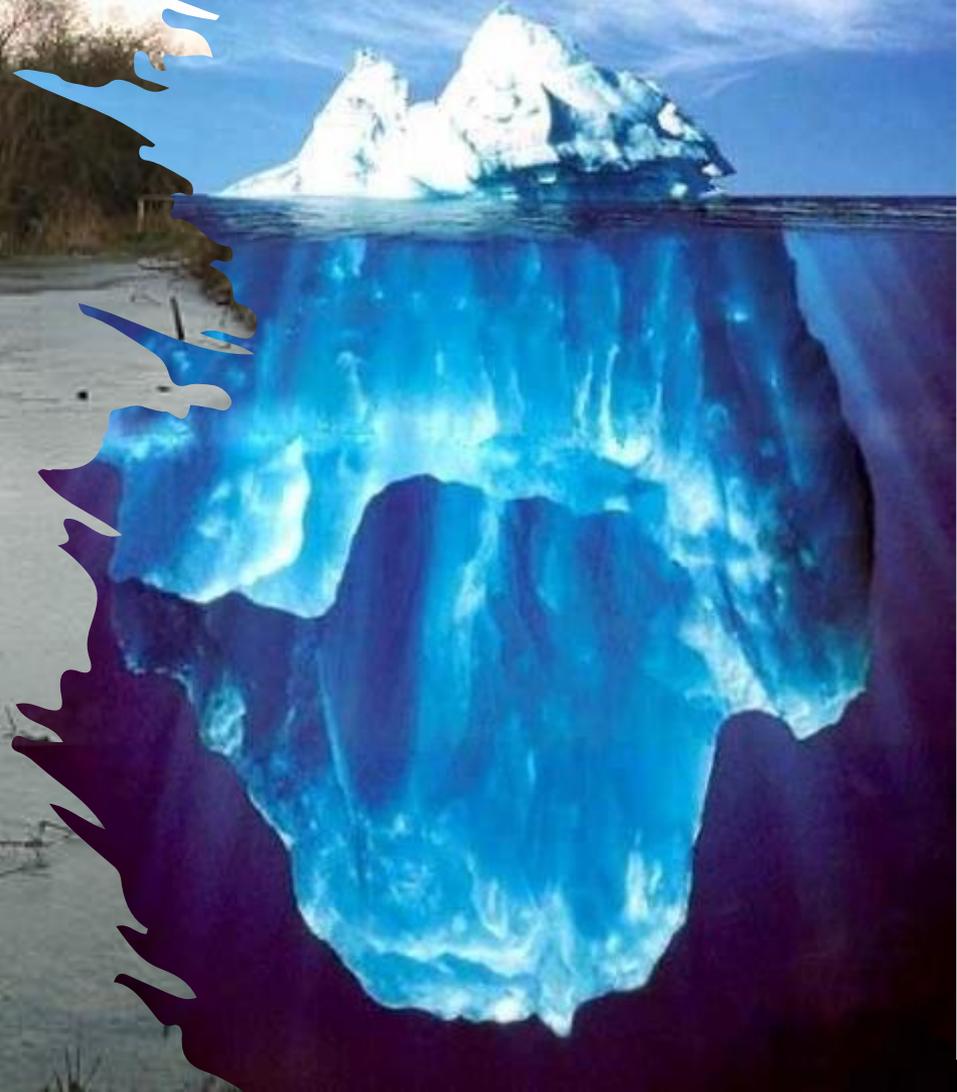
## Deeper Dynamics in Supervision: Obsessive Compulsive

- Need protocols and manuals.
- They want precise words to say.
- Present cases with punctilious detail, but no intuitive understanding.
- Cannot access imagination and flexibility.
- **Countertransference: Impatience. Boredom. Fantasies of “pushing them into the deep end of the pool”.**



## Borderline

- Low affect tolerance.
- Calls supervisor in “crisis” for things that could wait.
- Angel/Demon as Supervisor
- Countertransference: Dread, exhaustion, walking on icy pond.



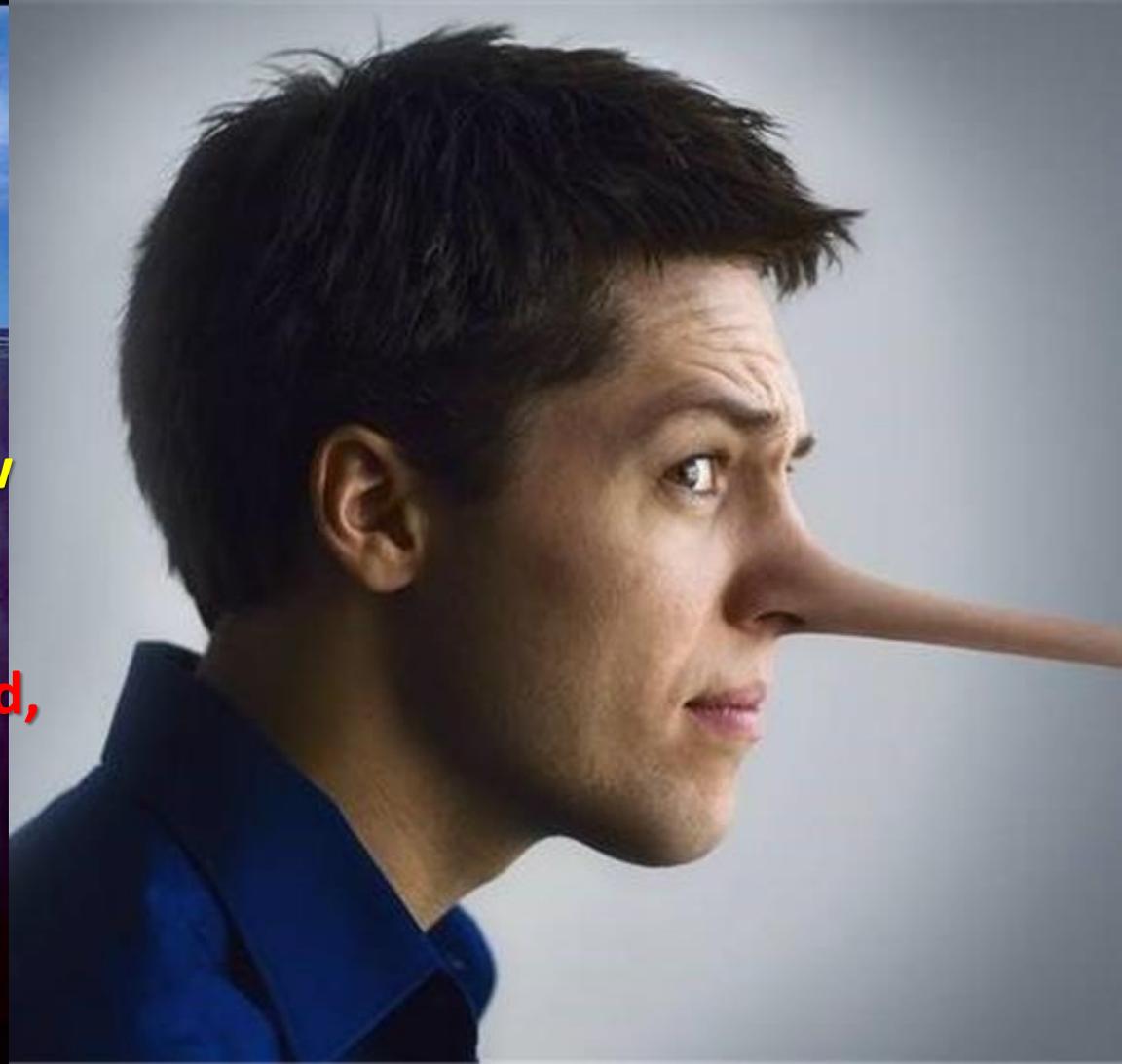
# Deeper Dynamics in Supervision: Narcissism

- Advisors, but never advised.
- Performative—sharing only brilliance.
- Supervisor is boring, uninspiring.
- Countertransference: Hits to self-esteem, trying to impress candidate. Self-doubt.



Anti-Social  
Dishonest Psychopathology

- Dishonesty, cheating, viewing those who follow the rules as "sheep".
- **Countertransference:** Shock, feeling outsmarted, deep loathing and punishment fantasies.



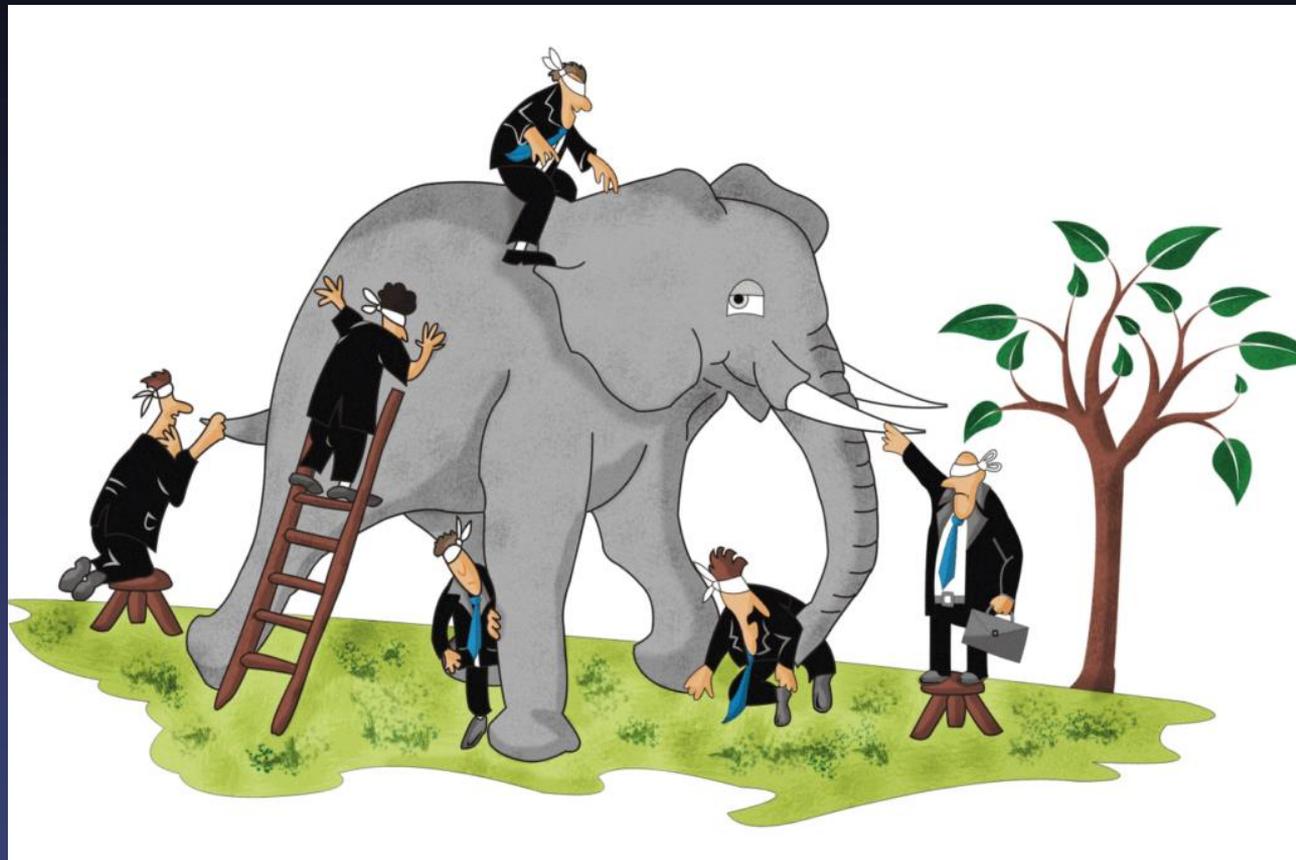


Behavioral

Cognitive

Emotional

Psychodynamic



# Thank You!

Evals & CEU's