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# Clinical supervision of child and adolescent counselors in residential foster care: A collective case study

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Clinical Supervision of Child and Adolescent Counselors in Residential Foster Care:  
A Collective Case Study

by

Lee A. Teufel

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
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Clinical Supervision of Child and Adolescent Counselors in Residential Foster Care: A  
Collective Case Study

Lee A. Teufel

ABSTRACT

A collective case study is the study of more than one case (Stake, 1995). One therapist supervisor and three therapist supervisees from a child and adolescent residential foster care facility were observed during their individual clinical supervision and interviewed post-supervision. Currently, the literature on clinical supervision seldom addresses the supervision of working professional counselors; particularly those who are child and adolescent counselors (CACs). Using a qualitative approach, two fundamental questions guided this inquiry: (a) what is the nature of clinical supervision involving a supervisor who provides clinical supervision to counselors in a child and adolescent residential foster care center that provides mental health treatment? and (b) within the clinical supervision experience, what issues involving children and adolescents does the supervisor explore?

Participants provided detailed demographic information about their work and educational experience. During the post-supervision interviews participants recalled the content of the clinical supervision, discussed their thoughts and feelings about the supervision experience, explored how the supervision met their supervisory needs and expanded on their beliefs about the process of supervision in general. Constant

comparative analyses, both within-case and cross-case, were conducted and themes emerged from the interviews. Various themes emerged that were associated with: administrative supervision, best practices, case specific discussion, developmental understanding, ethical dilemmas, the personal issues of the supervisor and supervisees, supervision practices, treatment modalities, treatment planning, and working with various systems.

Within the clinical supervision of CACs in residential foster care the nature of supervision is related to discussing specific cases in the facility, the supervision practice as it is experienced within each supervisor supervisee relationship, and a general desire to explore the best approaches when working with the children and adolescents at the facility. Collectively the supervisor and supervisees explored issues related to children and adolescents specific to individual cases consistent with generic supervision. Implications for practice and research are also discussed.

## Chapter One

### Introduction

Supervision, as defined in counseling, is often an important mechanism for upholding the standards and practices of the profession. It provides a means for educating beginners into the profession while protecting clients and monitoring ethical practice. In counseling, increasing emphasis is placed on not only the satisfaction of the training experience for the supervisee, but also on the quality of the professional as an outcome of the developmental process of supervision. Specifically, there is a growing body of literature discussing and investigating the process of supervision and the efficacy of various models of supervision (Bernard & Goodyear, 1998, 2004; Bradley & Ladany, 2001; Goodyear & Bernard, 1998; Holloway & Carroll, 1999; Watkins, 1994).

Literature on supervision is somewhat generic and often broadly defined, rarely mentioning the population of clients that supervisees counsel. Although the supervision literature does address different models of supervision, it typically does not address special skills or qualifications that a supervisor might need in order to supervise counselors who work with a particular client population. This is particularly true for counselors who work with children and adolescents and for the professionals that supervise them. For example, child and adolescent counselors (CACs) currently do not need to have specialized training or certification to be the counselors of

children and adolescents. They simply need the same masters degree that persons who work with adults earn. Supervisors of CACs also do not currently need specialized training or certification. They only need to be “qualified” supervisors, and they only need to be a qualified supervisor if required by a state licensure board and if the supervisee is working toward licensure.

Hence, although the counseling profession does have specializations related to several areas of clinical practice, it does not have specializations related to clinical supervision, and it does not have specialization for CACs. Within the literature specific to school counselors (Crutchfield & Borders, 1997; Crutchfield, Price, McGarity, Pennington, Richardson, & Tsolis, 1997; Herlihy, 2002; Kahn, 1999; Page, Pietrzak, & Sutton, 2001; Studer, 2006) there is consensus among school counselors working with children and adolescents affirming a general lack of clinical supervision as well as a desire for clinical supervision. Similarly, with the wide range of mental health concerns and increasing prevalence of mental health issues in children and adolescents (U.S. Public Health Service, 2000) clinicians working with children and adolescents are also often asked to go beyond the scope of practice for which they were initially trained.

One reason for this may be due to lack of attention from the leadership of the profession. The Council for the Accreditation of Counseling and Related Educational Programs (CACREP) is an independent agency that reviews programs in career counseling, college counseling, community counseling, gerontological counseling, marital, couple, and family counseling/therapy, mental health counseling, school counseling, student affairs, and counselor education and supervision. According to

CACREP standards, practicum and internship students must receive a minimum amount of supervision from university instructors/faculty and supervisors at the site where the student is completing the practicum or internship (CACREP, 2001). Supervision within the CACREP standards is broadly defined as an average of one and one half hours per week of group supervision that is provided on a regular schedule over the course of the student's practicum and internship by a program faculty member or a supervisor under the supervision of a program faculty member. However, CACREP makes no distinction in the standards for the supervision of practicum or internship students based on the population of clients the student is counseling. Hence, it does not have standards or competencies for child and adolescent counselors nor child and adolescent supervisors.

The American Counseling Association's (ACA) Code of Ethics for counselors under the section of counselor supervision and client welfare broadly defines the role of supervision process. The supervisor is obligated to be trained:

“Prior to offering clinical supervision services, counselors are trained in supervision methods and techniques. Counselors who offer clinical supervision services regularly pursue continuing education activities including both counseling and supervision topics and skills” (ACA, 2005, p.14).

Specifically, the ACA ethical code discusses that supervisors and counselors practice within the boundaries of their competence and continue to educate themselves on appropriate practice. However, the competencies, skills, and techniques of CACs are not addressed by this ethical code. There is no specific mention of supervising child and/or adolescent counselors in the ACA ethical code.

### *Statement of the Problem*

Currently, the literature on clinical supervision seldom addresses the supervision of working professional counselors; particularly those who are CACs. This is particularly relevant to professional counselors such as school counselors and mental health counselors who routinely work with children and adolescents and who also express a need for more supervision in this area. This problem is compounded because the national accrediting body for professional counseling, CACREP, provides no specific competencies for CACs nor for those who supervise them. Hence, although the ACA code of ethics requires supervisors and professional counselors to practice within the boundaries of their competence, the specific competencies for CACs and for their supervisors remain largely undefined. This poses a significant problem for professional counseling, for clinical supervision and ultimately for client welfare.

### *Purpose of the Study*

This study aims to contribute to the existing research in the field of counselor supervision specifically relating to child and adolescent counselor supervision. It is the intention of this study to illustrate the process of child and adolescent supervision in order to determine how similar it is to generic supervision as well as to determine which issues and/or concerns arise in the processes that are unique to child and adolescent supervision and to determine which competencies child and adolescent supervisors should have.

### *Significance of the Study*

Little is known about the experience of clinical supervision for CACs. The significance of this study is to document the experience of clinical supervision for CACs. The naturalistic expression of the supervisees' and supervisor's experience in supervision will yield a meaningful representation of current practices in child and adolescent counselor supervision.

### *Questions Guiding the Inquiry*

The current study addresses the nature of supervision specific to CACs in a residential mental health treatment center for foster care children. Two fundamental questions will guide this inquiry: (a) what is the nature of clinical supervision involving a supervisor who provides clinical supervision to counselors in a child and adolescent residential foster care center that provides mental health treatment? and (b) within the clinical supervision experience, what issues involving children and adolescents does the supervisor explore?

### *Conceptual Assumptions*

Several assumptions frame this study. First, counseling children and adolescents is fundamentally different than counseling adults. In order to counsel children and adolescents a counselor needs to understand the developmental norms of children and adolescents. Counseling children and adolescents also requires specialized counseling skills such as play therapy.

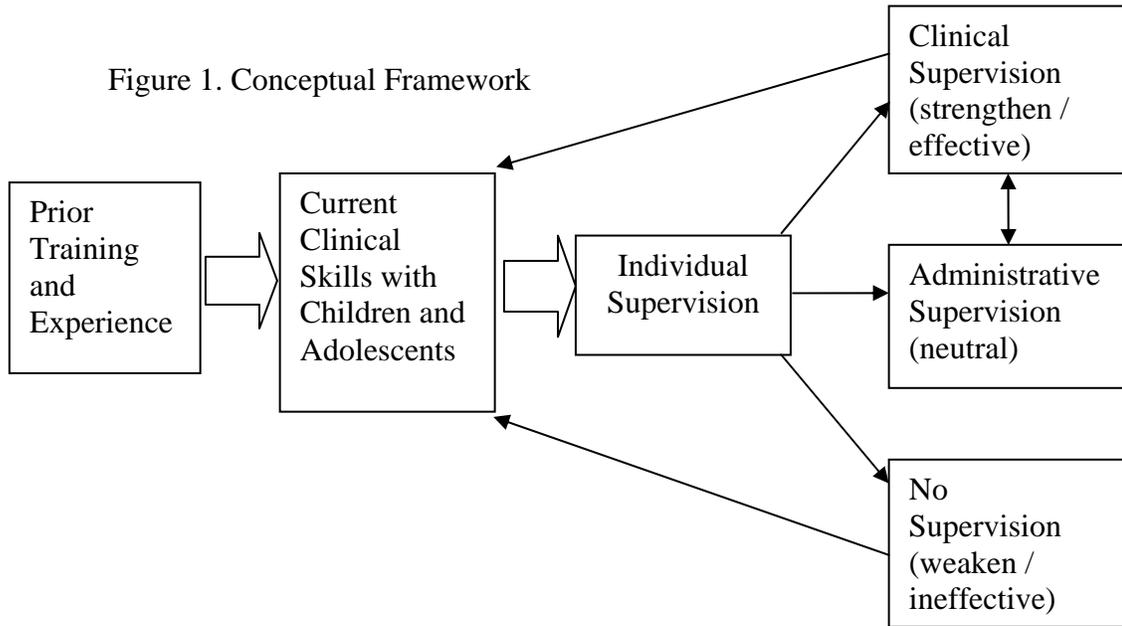
Second, clinical supervision is an important process designed to fulfill the needs of the supervisee through imparting expert knowledge and the needs of the profession by acting as a gatekeeper (Holloway, 1995).

Third, supervising persons who work with children and adolescents is different than supervising persons who work with adults and is more challenging for supervisors. The process of guiding counselors working in a children and adolescents' mental health multidisciplinary system is challenging for supervisors (Neill, 2006). For example, the following issues need to be addressed for supervisors when supervising counselors who work with children and adolescents: the heightened level of ethical responsibility assumed by CACs, the increased incidence of vicarious traumatization when working with children and adolescents whom have suffered abuse or neglect, outcome-based treatment modalities, and the stress of collaborating with possibly dysfunctional systems including but not limited to child welfare and schools (Neill, 2006).

Finally, counselors working with children and adolescents affirm a general lack of clinical supervision as well as a great desire for clinical supervision. This has been supported through research on school counselors, but the increase in mental health issues among children in general would suggest this is a concern for most counselors working with this age group. I served as a child and adolescent counselor and as a child and adolescent counselor supervisor in a mental health setting. Based on my experience in this area, I would expect the content of child and adolescent supervision to address at least the following issues: countertransference, vicarious traumatization, boundary violation, developmental understanding of client, ethical dilemmas, personal issues of the counselor, treatment modalities, working with various systems, (i.e. parents, schools, healthcare), theoretical orientation, treatment planning, best practices/research, case specific issues, utilization of supervision.

*Conceptual Framework*

Figure 1. Conceptual Framework



**Clinical Supervision Discussion Topics**

(\*may be especially important to address when working with children/adolescents)

1. Countertransference\*
2. Vicarious traumatization\*
3. Boundary violation\*
4. Developmental understanding of client\*
5. Ethical dilemmas\*
6. Personal issues of the counselor
7. Treatment modalities
8. Working with various systems, i.e. parents, schools, healthcare
9. Theoretical orientation
10. Treatment planning
11. Best practices / research
12. Case specific issues
13. Utilization of supervision

The conceptual framework of this research providing the impetus for this study is that clinical supervision strengthens the clinical skills of CACs. Counselors have prior training and experience which influences their clinical skills, yet supervision has an essential function in improving skills and maintaining professional and personal efficacy. Individual supervision can be clinical or administrative in nature. Administrative supervision has a neutral effect on clinical skills, yet within this study I believe that administrative and clinical supervision interact. Within the context of clinical supervision aspects of administrative supervision will inevitably occur. The absence of clinical supervision weakens clinical skills with children and adolescents. Clinical supervision should reflect discussion topics such as, countertransference, treatment modalities, vicarious traumatization, working with various systems, boundary violation, theoretical orientation, ethical dilemmas, treatment planning, developmental understanding of client, best practices and research, case specific issues, use of supervision, and personal issues of the counselor.

The current status of the literature on clinical supervision is limited to theoretical models of supervision, structure or content of supervision, effective supervision, skills associated with effective supervisors, supervisor training, and themes of time, race, gender and sexuality in supervision (Kilminster & Jolly, 2000). Despite the growing body of research related to working with children and adolescents and the general increase in counselor supervision literature (Bernard & Goodyear, 1998, 2004; Bradley & Ladany, 2001; Goodyear & Bernard, 1998; Holloway & Carroll, 1999; Watkins, 1994), there appears to be a lack of research

specifically related to supervising counselors working with children and adolescents. More research in the afore mentioned is needed.

### *Definition of Major Terms*

*Administrative supervisor.* An individual who oversees aspects of personnel development and the delivery of services to consumers while also focusing on issues of staff communication, budgeting, and paperwork. (Bernard & Goodyear, 2004). Similarly, an administrative supervisor helps the supervisee participate efficiently as a part of the overall system to effectively increase the continuity of the organization as a whole (Bradley, 1989).

*Clinical supervisor.* An individual who oversees services provided to clients while monitoring the professional development of the supervisee (Bernard & Goodyear, 2004). Similarly, the clinical supervisor focuses on various areas of clinical process, such areas as client welfare, counseling relationship, assessment, diagnosis, clinical intervention, prognosis, and appropriate referral techniques (Bradley, 1989).

*Countertransference.* The unresolved neurotic conflicts of the counselor or therapist (Hafkenscheid, 2005).

*Boundary violation.* An unprofessional behavior committed by a counselor or therapist that is contrary to the ethical standards of the profession regarding appropriate relationships between clients and therapists.

*Ethical dilemma.* The American Counseling Association (ACA) has a set of general guidelines for ethical practice for all its members. An ethical dilemma is considering between equally undesirable alternatives on an ethical issue.

*Functions of Supervision.* Supervision (a) assesses the learning needs of the supervisee, (b) changes, shapes, and supports the supervisee's behavior, and (c) evaluates the performance of the supervisee (Borders, Bernard, Dye, Fong, Henderson, & Nance, 1991).

*Supervision.* Supervision as defined by Bernard and Goodyear (2004, p. 8) is: “an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is: (a) evaluative, (b) extends over time, and (c) has the simultaneous purposes of enhancing the professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession.”

Supervision and clinical supervision will be used interchangeably in this document.

*Supervisor.* A supervisor is a professional providing supervision.

*Supervisee.* A supervisee is a postgraduate professional seeking supervision (Bernard & Goodyear, 2004).

*Vicarious traumatization:* A condition in which a counselor or therapist working with a traumatized client becomes traumatized as a consequence of treating the client; potentially the counselor or therapist will exhibit the same symptoms as the client. (McCann & Pearlman, 1990)

### *Scope and Delimitation of the Study*

Supervisory process plays a vital role in several professions: medicine, nursing social work, education, psychology, and counseling (Kilminster & Jolly, 2000). Each field has potential literature to add to the discussion of clinical

supervision, and as such the dialogue on clinical supervision is not exclusive to counseling. The focus of the current study is the clinical supervision of counseling, not education, medicine, or nursing. Specifically, this study focuses on the clinical supervision of counselors working with children or adolescents, not adults or the elderly. The treatment that the children or adolescents are receiving is not the focus of this study. The actual clinical treatment and counseling skills used with the children and adolescents discussed in the supervision are also not focal points in this study, except as they relate to issues in supervision. Information about the children or adolescents is not a variable of interest and will remain confidential if identifiable information is revealed during the supervision process.

#### *Overview of Dissertation Chapters*

Chapter Two will provide a historical background of the literature on supervision. A review of relevant developmental models of supervision is provided. In addition, this chapter will review and critically evaluate present literature on supervision specific to the clinical supervision of child and adolescent counselors. Chapter Three will discuss the design and methodology of the study. Within this chapter the qualitative design and logic will be explored. Similarly, the methodology for participant selection, sampling, instrumentation, procedure, analysis, and legitimation will be discussed. Chapter Four will present the results of the study by exposition of the general questions that guided the inquiry. Chapter Five presents a summary and the major conclusions of the study. The statement of the problem will be discussed in the context of the methodology used, followed by the subsequent findings. Conclusions will be discussed. Recommendations for additional research

will be made. New research questions that emerged based on this research study will be explored. In addition, recommendations from this study for use in the field of counseling and supervision will be made.

## Chapter Two

### Review of the Literature

#### *Introduction*

Supervision is an important aspect of the standard practices of the counseling profession and provides an avenue to educate beginners into the profession with valuable skills while protecting clients and monitoring ethical practice. Supervision is noted as the foremost professional training model for mental health clinicians (Alonzo, 1985). Given that mental illness is now the leading cause of disability for all persons five years of age and older (U.S. Public Health Service, 2000), clarity on the nature of child and adolescent counselor supervision is needed.

This literature review on the supervision process, will address the following: how clinical supervision is defined, the theoretical models of supervision, how supervision is delivered, and the issues that are specific to child/adolescent counselor supervision. For the purposes of this discussion counselors-in-training will be referenced as supervisees and those who provide supervision will be referenced as supervisors.

#### *Clinical Supervision Defined*

Loganbill, Hardy, and Delworth (1982) defined supervision as “an intensive, interpersonally focused one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person” (p. 4).

Another working definition, that does not encompass that concept of group supervision, is provided by Hart (1982), who defined supervision as “an ongoing educational process in which one person in the role of supervisor helps another person in the role of the supervisee acquire appropriate professional behavior through an examination of the trainee’s professional activities” (p. 12).

Clinical supervision has emerged as a specialty in counseling (Bernard & Goodyear, 2004), providing clinicians a collaborative outlet for professional development to improve patient care via reflective accountability in either group or individual settings (Cleary & Freeman, 2006). Supervision is not an extension of the therapeutic process. However, supervision is an intervention (Bernard & Goodyear). Supervision is critical in upholding professional ethics and laws, ensuring continuity of care for clients, and serving as the gatekeeper of a counselor’s overall readiness to enter the profession.

Supervision has various roles, one of which is self-regulatory. Self-regulation assists in the process and promotion of a competent and ethical professional. An important aspect of the self-regulatory process includes licensure boards and the process that supervisors and supervisee each undergo to become licensed in a state. State licensure boards assist in the self-regulation of the supervision process by requiring supervisees to participate in the process of supervision, monitor their professional behavior, and maintain continuing education for licensure (Bernard & Goodyear, 2004). Several state licensure boards require additional course instruction in supervision prior to becoming a board approved or qualified supervisor (Pearson, 2004).

### *Theoretical Models of Supervision*

There appears to be an increasing body of literature exploring the process of supervision and the various models applicable to supervision (Bernard & Goodyear, 1998, 2004; Bradley & Ladany, 2001; Goodyear & Bernard, 1998; Holloway & Carroll, 1999; Watkins, 1994). Within the broad array of clinical supervision literature and even among supervision researchers there is a working assumption “that supervision processes are guided by developmental considerations” (Falender et al., 2004, p. 776). Even with there being several distinctly different approaches to supervision having differing goals, the following are all common to models of supervision: the development of a collaborative relationship, a focus on the supervisee, and a structure that promotes growth for the supervisee (Barrett & Barber, 2005). Within counseling literature the focus of supervision models is primarily developmental (Baker, Exum, & Tyler, 2002; Maki & Delworth, 1995; Heron, 1990; Gardiner, 1989; Ronnestad & Skovholt, 2003; Stoltenberg, 1981, 1993, 2005; Stoltenberg, McNeil, Delworth, 1998; Watkins, 1993, 1994).

Most developmental models of supervision assume an incremental processes for supervisee growth, noting quantitative and qualitative changes in supervisee complexity such as seen in the Integrated Developmental Model (IDM) of supervision (Stoltenberg et al., 1998). Other developmental models of supervision have addressed counselor/therapist development over the lifespan (Ronnestad & Skovholt, 2003). The IDM is generally regarded as the primary developmental supervision model in the field of counselor supervision (Maki & Delworth, 1995). Similarly, the IDM is highly researched in terms of its theoretical validity and

reliability (Maki & Delworth, 1995; McNeil, Stoltenberg, & Romans, 1992; Leach & Stoltenberg, 1997).

*The Integrated Developmental Model.* Stoltenberg and Delworth (1987) developed the Integrated Developmental Model (IDM) of supervision based on the earlier Stoltenberg (1981) Counselor Complexity Model (CCM). The Counselor Complexity Model (CCM) is similar to Hogan's (1964) developmental model with expansions on Hogan's four-stage model of how counselor supervisees become more cognitively complex over time. The conceptual levels are similar to Hunt's (1971) Conceptual Systems Theory, which identified optimal environmental levels for advancement of development. Rooted in the belief that the field of counselor supervision needed a systematic developmental model of supervision, Stoltenberg (1981) proposed four specific stages of development that were qualitatively and quantitatively different in skill level and knowledge regarding counselor development. Stoltenberg proposed no specific time line for his levels of development, maintaining that counselor development varies from counselor to counselor, a theme he would carry forth throughout his work.

Within the CCM level 1 characteristics, the supervisee is often minimally experienced, dependent on authority figures, lacking self-awareness, anxious, and rule focused, yet highly enthusiastic about the learning process. Supervision environments of a level 1 supervisee often provide normative structure and encouragement while helping "make connections between theory and practice more evident" in the counseling experience (Stoltenberg, 1981, p. 61).

The period experienced by level 2 supervisees is a time characterized by dependency-autonomy conflict. Here the supervisee is working to become more independent and self-aware and no longer feels content to merely model the supervisor. With motivation often fluctuating at this level, the supervisory environment is less supportive while clarifying ambivalence and providing less structure to allow supervisees to assess their strengths and weaknesses. The level 3 supervisee has increased professional identity and self-awareness and shows characteristics of insight, empathy, and a differentiated interpersonal orientation. In an effort to parallel the supervisee growth at level 3, the supervisory environment is primarily peer supportive using appropriate professional confrontation. Stoltenberg (1981) discussed the final level 4 supervisee as a master counselor, able to accomplish independent practice, and they often serve as supervisors of other less advanced counselors.

Stoltenberg and Delworth (1987), and Stoltenberg, et al. (1998) expanded and refined the CCM to develop the IDM which is generally regarded as the primary developmental supervision model in the field of counselor supervision (Maki & Delworth, 1995). According to McNeil et al. (1992), the CCM failed to adequately address the possibility of supervisees “functioning at different levels of counselor development for various activities associated with counselor and psychotherapist development” (p. 504). To accomplish a well-rounded and less static model of counselor development, the IDM perspective of development is both vertical and horizontal. Hence, supervisees can exhibit behaviors consistent with more than one level at different times within the different domains.

The IDM proposes various developmental skills and tasks in counselor identity to be resolved and challenged along four different levels. Development, as discussed in the IDM of supervision, is influenced by the cognitive-developmental theorists that take both a mechanistic and organismic view of the world. The techniques and assumptions within the model tend to be mechanistic, with the levels of development tending to be organismic (Stoltenberg & Delworth, 1987). Similarly, the philosophical correlate of epistemological constructivism is reflected in the Stoltenberg et al. (1998) IDM belief of change over time and the “important role in constructing knowledge and reality” (p. 12) for counselor identity.

The primary developmental tenet upheld in the IDM of supervision is that new information is processed and made into new knowledge via Piaget’s (1970) constructs of assimilation and accommodation. Individuals will apply what they already know (assimilate) and make necessary discoveries for the environment in which they find themselves (accommodate). Through the slow and tenuous process of small steps of combined assimilation and accommodation, larger steps later emerge and cognitive development takes place (Flavell, Miller, & Miller, 2002). In combination with the work of Loevinger (1977) noting slow forward movement, Stoltenberg and Delworth (1987) provided a model of supervision with characteristically complex assimilations.

The IDM of supervision has three overriding structures and eight skill domains. The three overriding structures are: self and other awareness, motivation, and autonomy. The eight specific domains are: intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics

(Stoltenberg & Delworth). The supervisee progresses through four stages, similar to the CCM moving upward in increasing complexity with the final level of professional growth considered the “integrative” level. The level 1 supervisee is typically limited in experience and knowledge in all the specific domains, such as intervention skills or professional ethics. The supervisee here needs guidance and sufficient practice time. The overriding structure of motivation is high along with high anxiety. Autonomy is low and the supervisee is dependent on the supervisor. The supervisee also has a high need for structure and positive feedback. Awareness is highly self-focused with a general apprehension about evaluation.

Level 2 represents a transitional phase for the supervisee, with conflict of autonomy from and dependence on the supervisor often occurring. The structure of motivation fluctuates along with autonomy, thus at times creating an environment of possible resistance with the supervisor. However, level 2 supervisees also start to develop increased sensitivity to individual differences at this point as well as a greater ability to empathize with clients, both characteristic of increased awareness complexity. The level 3 supervisee is able to stabilize and focus on the idea of treatment goals and client conceptualization. Within this level, the domain of motivation is consistent, autonomy emerges as self-assurance and an indicator of professionalism, and awareness is fully developed with the intent to attend to client needs. The final level of development is the level 3 integrated or 3i counselor. This level represents a “fully functioning counselor,” with a current awareness of limitations and strengths.

*The Ronnestad and Skovholt Model.* The focus of counselor development is often the time spent in practicum and internship. However, Ronnestad and Skovholt (1993, 2003; Skovholt & Ronnestad, 1992) focused on not only these times but also on professional development past graduation throughout the lifespan. Derived from qualitative data, the model initially consisted of eight stages of therapist development and 20 themes across time. The authors interviewed 100 counselors and therapists with varied experience at a variety of stages in their careers (Skovholt & Ronnestad, 1992).

The original stages of counselor/therapist development Ronnestad and Skovholt (1993) formulated included: one pre-training stage: (Stage 1) Conventional helper; three student stages: (Stage 2) Transition to Professional Training, (Stage 3) Imitation, and (Stage 4) Conditional Autonomy; and four post-graduate stage: (Stage 5) Exploration, (Stage 6) Integration, (Stage 7) Individuation and (Stage 8) Integrity. Each stage addressed the following dimensions: Definition of Stage, Central Task, Predominant Affect, Predominant Sources of Influence, Role and Working style, Conceptual Ideas used, Learning Process, and Measures of Effectiveness and Satisfaction. In an effort to create “parsimony and clarity” Ronnestad and Skovholt (2003, p. 10) collapsed the stages into a simpler six-phase progression of development. The six phases are: the lay helper phase, the beginning student phase, the advanced student phase, the novice professional phase, the experienced professional, and the senior professional.

The lay helper phase is characterized by the inclusion of persons prior to them entering professional training. Lay helpers often offer emotional support, personal

experience, and common sense advice, yet are over-involved and too strongly identify with the other peoples experiences. Often lay helpers are friends, parents, or partners and they tend to provide sympathy rather than empathy (Ronnestad & Skovholt, 2003). As lay helpers progress into the beginning student phase, they typically start professional training feeling excited, influenced by professionals, highly anxious on multiple levels, and are generally goal driven. The primary focus, for the student at this phase is achievement. Most students appear anxious to be competent and find the training experience somewhat threatening (Ronnestad & Skovholt).

The advanced student phase is characteristically near the end of training and the students feel more cautious with a pressure to do things appropriately as they enter the professional level. Advanced students may accept or reject the various professional models with which they come into contact critically assessing and evaluating these models for the purpose of internalizing certain resources (Ronnestad & Skovholt, 2003). The first few years past graduation typically is considered to be the novice professional phase. Within this phase counselors seek to validate their training. This is often followed by a period of disillusionment with their professional training. The phase finishes with a period of exploration about oneself and one's professional environment. Novice professionals will feel as though they can integrate their own personality into therapy and their "own natural sense of humor in work with clients" (Ronnestad & Skovholt, p. 19). The experienced professional has had multiple opportunities to experience a wide range of clients in various settings leading to an authentic perception of therapeutic role. The counselor's role in this phase is consistent with his or her values, interests, and personality, and the counselor has

come to understand that his or her relationship with the client is critical to client change. Clear boundaries and the ability to calibrate levels of involvement with clients may also be characteristic in the phase for experienced professionals. In addition, many experienced professionals mentor, supervise, or teach novice counselors during this phase in their experience (Ronnestad & Skovholt). Often the supervisor is seen as a teacher within this phase and many counselors fit into this role (Ronnestad & Skovholt, 1993).

Finally, the senior professional phase is a time of high regard from others in the field. Often having had 20 to 25 years of professional experience, senior professionals are very unique and individualized in their approaches. Many senior professionals are reluctant to explore alternative or new trends in the field, yet most have a continued commitment to the field as a whole. Feelings of grief and loss are common among many senior professionals due to retirement and the deaths of those close to them (Ronnestad & Skovholt, 2003).

The Ronnestad and Skovholt Model (2003) also has identified 14 themes. Bernard and Goodyear (2004) describe these themes as a “cognitive map” for supervisors using the model. Theme 1, described as *professional development*, involves an increasing higher-order integration of the professional self and the personal self. Ronnestad and Skovholt proposed an “experienced-based generalization” or what they called “Accumulated Wisdom.” Specifically, as the counselor develops across time, his or her identity develops, professional roles become increasingly consistent, and there is a progression to matching the professional role with personal values, beliefs and life experiences. In Theme 2 the

focus of functioning shifts dramatically over time from *internal to external to internal*. Initially, the counselor or “lay helper person” is internally focused, and feelings are reflective of personal experience. During the training experience phases, the focus shifts to skill building and theories and is primarily external in nature. Then, finally, as training ends and the counselor is able to move into professional experience, the focus is again internal sometimes with feelings of disillusionment about training or potential confidence about professional practice.

Theme 3 is *continuous reflection*, a prerequisite for optimal learning and professional development at all levels of experience. Related to and influenced by the work of Vygotsky (1962, 1978) and Wood, Bruner, and Ross (1976), Ronnestad and Skovholt (2003) suggest that supervisors scaffold supervisee’s learning in their zone of proximal development. Counselors should be supported to be reflective about their work and learn how to self-supervise. Theme 4, *an intense commitment to learn*, propels the developmental processes. Most of the participants in Ronnestad and Skovholt’ (2003) study, showed no decline in professional growth. Theme 5 suggests the *cognitive map changes*: beginning practitioners rely on external expertise, and seasoned practitioners rely on internal expertise. Within this theme Ronnestad and Skovholt embrace a social-constructivist perspective, stating “both share a rejection of precisely defined realities in understanding matters of human interaction (p.31).” Further, Guiffrida (2005) states Skovholt and Ronnestad’s (1992) critical self-reflection promotes a constructivist theoretical orientation as a counselor grows and develops.

Theme 6 indicates that *professional development is a long, slow, continuous process* that can also be erratic. Development can be cyclical, and various challenges can emerge during the life course of the counselor to raise feelings of doubt, anxiety, exploration, learning, and mastery (Ronnestad & Skovholt, 2003). Theme 7 is that *professional development is a life-long process*. Ronnestad and Skovholt discuss that little is known about experienced counselors but believe through their discussions with senior professionals, that there exists a commitment to continued growth and exploration in the field throughout the lifespan. Theme 8 addresses the anxiety that many beginning practitioners experience about their professional work. Ronnestad and Skovholt believed that *over time, anxiety is mastered by most professionals*. With experience and practice many counselors are no longer afraid of their clients and feel comfortable with their skill sets as counselors (Ronnestad & Skovholt).

Theme 9 states that *clients serve as a major source of influence and serve as primary teachers* (Ronnestad & Skovholt, 2003). For overall professional growth and development, counselors need the experience of working with clients in order to build clinical skills, a theoretical orientation base, and gain positive client feedback (Orlinsky, Botermans, & Ronnestad, 2001). Theme 10 explores the fact that *professional life influences professional functioning and development throughout the professional life span*. The influence of one's personal life, past or present, can negatively or positively impact professional functioning (Ronnestad & Skovholt, 2001). Theme 11 suggests that the *interpersonal sources of influence propel professional development more than "impersonal" sources of influence*. Ronnestad and Skovholt found the relationship between the client and the counselor ranked as

the number one influence in counselor development followed by the relationship with supervisors, their own therapists, family and friends, and younger colleagues, respectively. Theme 12 is that *new counselors in the field view professional elders and graduate training with strong affective reactions*. Many times students, reacting to the power differential, either idealize senior professionals or completely devalue senior professionals (Ronnestad & Skovholt). Theme 13 discusses the *extensive experience with suffering that contributes to heightened recognition, acceptance, and appreciation of human variability*. Ronnestad and Skovholt (2001), in their work with senior professionals, report a diverse, personal, and individualized approach to assessment and the development of insight. Ronnestad and Skovholt state “there seems to be a parallel and interactive development of wisdom and aging (p.37).” Theme 14 suggests that *counselors realign from a self-as-hero conceptualization to client-as-hero conceptualization*. Over time the counselor feels more confident as a professional, yet understands the limits to what can be accomplished with therapy. Thus there is a sense of humility as a counselor (Ronnestad & Skovholt, 2001).

*Additional Developmental Models of Supervision*. Watkins (1996) discussed the existence of 25 to 30 distinct developmental models of supervision. Many of these models reflect the conceptual constructs of the CCM and IDM with some additional similarities to the Ronnestad and Skovholt (1993) model. Additional representative developmental models include the Loganbill, Hardy, and Delworth Model (Loganbill et al., 1982), Blocher’s (1983) cognitive-developmental model, and a cognitive-developmental model of supervision (Fosters & McAdams, 1998) specifically applied to persons working with children.

The Loganbill et al. (1982) Model is a cyclical model that involves three stages with eight supervisory issues. Loganbill et al. (1982) discuss the importance of assessing the developmental stage of the supervisee process and assisting supervisees with each issue. The supervisor is required to assess 24 different positions of supervisee progress within the model, representing the eight issues and three stages. The three stages are: stagnation, confusion, and integration. The eight basic supervisee issues are: competence, emotional awareness, autonomy, theoretical identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics (Loganbill et al.). Movement from the stage of stagnation through confusion to integration is accomplished via the supervisee's responding to supervision issues with increased conceptual understanding.

Blocher (1983) proposed a cognitive developmental approach based on the constructivist paradigms similar to the work Kohlberg (1968), Loevinger (1976, 1977), and Piaget (1952, 1970). Supervisees develop cognitive schemas about counseling that progress from simple to more complex. The goal of supervision is to increase the complexity of counseling cognitive schemas. Within the context of supervision, Blocher proposed that the supervisee and supervisor needed specific dynamics to increase cognitive functioning. These dynamics include: challenge, involvement, support, structure, feedback, innovation, and integration. As the supervisee and supervisor interacted with the environment, the ideal relationship would be characterized by concern, respect, trust, and communication by the supervisor (Blocher).

Foster and McAdams (1998) discuss a cognitive-developmental model for supervision, specifically for the supervision of child care counselors. This is the only developmental supervision model specifically designed and applied to supervising child counselors. Parallel to other developmental models, Foster and McAdams developed a 14-week program model and curriculum of supervision for child care counselors working with aggressive youth. The authors thought that the supervision process would increase the cognitive complexity of the counselors thus increasing the desirable counseling behaviors of the counselor. The model's curriculum was derived from Sprinthall and Thies-Sprinthall (1983) (as cited in Foster & McAdams, p. 10), which promoted the following supervisory conditions of growth: (a) a role-taking experience in helping, (b) guided reflection, (c) a balance between action and reflection, (d) continuity, and (e) a climate of that is both supportive and challenging. The skills used in this supervision were journal responses and guided reflections, with specific mention of working children during the journal responses and guided reflections. Foster and McAdams (1983) use these techniques with supervisees to assist in perspective taking when addressing the various challenging issues presented by aggressive children.

### *Supervision Delivery*

Several studies have compared the effectiveness of group versus individual supervision (Averitt 1989; Lanning 1971; Ray & Altekruze, 2000). Lanning and Averitt concluded that both supervision delivery methods were equally effective in the supervision of counselors. However, Ray and Altekruze concluded that group supervision is not only complementary to individual supervision but may also be

interchangeable with individual supervision. Yet, individual supervision is seen as the primary outlet for professional development and the “cornerstone” to traditional counselor supervision (Bernard & Goodyear, 2004).

Individual supervision for supervisees is a one-to-one relationship with the supervisor that incorporates a variety of possible supervision interventions promoting conceptual growth in the supervisee. The methods of individual supervision can be structured or unstructured. Structured supervision tends to be very didactic while unstructured supervision appears more like consultation (Bernard & Goodyear, 2004). Supervisees can benefit from structured and unstructured individual supervision at all levels of their professional counselor development. In individual supervision, a supervisor can choose to use several different methods to aid in the supervision process including self-report, discussion of process notes and case notes or, review of audiotape or videotape (Bernard & Goodyear).

Group supervision is the process of supervisors monitoring a “supervisee’s professional development in a group of peers”(Holloway & Johnston, 1985). The purpose of group supervision is to aid other group members in the achievement of their goals via interaction and peer feedback (Bernard & Goodyear, 2004). This format of supervision delivery is often provided by university training programs at some point in clinical course work (Bernard & Goodyear). The supervision of practicum and internship students in group format is one form of group supervision. Another form of group supervision is the leaderless group, in which supervisees, peer facilitate the group supervision. Group supervision often focuses on the facilitation of group therapy skills, as the supervisor aids in the practice of the group process with

supervisees in the group format (Holloway & Johnston).

### *Issues Specific to Child/Adolescent Counselor Supervision*

Often, counseling children requires that counselors modify their roles, styles, and treatment modalities. A counselor working with children needs to develop an awareness of the various influences affecting the child for which he or she serves, such as parents/guardians, school, and peers. Addressing the presenting issues of the child is only part of the counseling relationship. Counseling children presents unique issues that may elicit countertransference, vicarious traumatization, boundary violation, and questions related to various ethical dilemmas for counselors. For example, working with a foster child who is also victim of abuse presents a variety of issues. A counselor needs to understand the child's developmental level and the appropriate counseling skills to use, but also how to address childhood trauma. The counselor of this child needs to be aware of her own emotions and thoughts when also potentially communicating with various systems of care, such as child welfare, school systems, and psychiatrists. The counselor may feel overwhelmed by the intensity of therapy sessions, deficient in her understanding of child development or lacking in her clinical supervision. Thus, the child and adolescent counselor who feels issues of countertransference or vicarious traumatization, may still feel compelled to advocate for the child during discussion with child welfare or the school system potentially leading to boundary violation or ethical dilemmas.

Within the field of counselor education and supervision, the current scholarly research is limited relative to the topic of the supervision of counselors working with children. The resources are plentiful when exploring issues such as play therapy

(Albon, 1996; Kottman, 2001; Ray, Bratton, Rhine, & Jones, 2001; Schaefer, 1993), cognitive behavioral techniques for children (Barrett, Duffy, Dadds, & Rapee, 2001; Jay, Elliot, Woody, & Siegel, 1991; Kendall, 1993; Spence, Donovan, & Brechman-Toussaint, 2000), behavioral therapy (Ray, Skinner, & Watson, 1999; Romano & Roll, 2000), Attention Deficit Hyperactivity Disorder (ADHD) (Erk, 2004; Schwiebert, Sealeander, & Tollerud, 1995; Wicks-Nelson & Israel, 2003), child abuse and maltreatment (James & Burch, 1999; Miller-Perrin, 2001; Shapiro, Friedberg, & Bardenstein, 2006), and learning disorders (Brown, 2005; Reis & Colbert, 2004; Thompson & Littrell, 1998). Despite the plethora of research related to counseling children there appears to be a lack of research related to supervising persons who are counselors of children and adolescents. The current available literature related to the supervision of counselors working with children focuses on counselors providing group therapy to children (Rosenthal, 1975; Holmes, George, Stader, Swaim, Haigler, Myers, & deRosset Jr., 1998; Soo, 1998; and MacLennan, 1998), the supervision of school counselors (Crutchfield & Borders, 1997; Crutchfield, Price, McGarity, Pennington, Richardson, & Tsolis, 1997; Herlihy, 2002; Kahn, 1999; Page, Pietrzak, & Sutton, Jr., 2001; Studer, 2006), and themes within the therapeutic relationship to be addressed in supervision such as countertransference and skills such as play therapy (Metcalf, 2002; Ray, 2004).

The clear need for supervision of counselors working with children is best documented in the literature on school counselor supervision. Within the school counselor literature there is a consensus that supervision is greatly lacking for school counselors due to their isolation from other counselors, and often the responsibility

for their supervision is assumed by non-counseling professionals. Crutchfield and Borders (1997) conducted an extensive empirical study examining the job satisfaction, counseling self-efficacy, and counseling effectiveness of school counselors through pre- and posttest measures of clinical peer supervision. The study used two treatment groups and one control group to investigate the effectiveness of peer supervision over nine weeks. Due to the peer supervision format, the school counselors in the study were able to discuss aspects of job satisfaction and explore self-efficacy. However, the lack of structure without a trained supervisor present in peer supervision may have led to inconsistency in discussion about counseling interventions. The authors explained clearly the need for supervision specific to school counselors, indicating that future studies should take a forward approach in fulfilling the professional development needs of school counselors (Crutchfield & Borders). Similarly, Page et al. (2001) demonstrated through survey research the statistical lack of supervision for school counselors, finding that only 13% of school counselors were receiving individual supervision and 10% were receiving group supervision, and showing clearly that among school counselors, 57% desired to receive clinical supervision to improve primarily their school counseling practices.

Herlihy (2002), in reviewing the current status of school counselor supervision, suggests:

One reason clinical supervision has been a neglected issue in school counseling may be a perception that school counselors do not have the same level of need for supervision as do clinical mental health counselors. School administrators, in particular, may continue to perceive the school counselor's

role as being focused primarily on such activities as academic advising, scheduling, psychoeducation, and group guidance. (p. 57)

However, school counselors, like child mental health counselors, deal routinely with complicated situations, including the assessment and treatment of depression and suicidal ideation, pregnancy, substance abuse, school violence, and child abuse (Page et al., 2001). Another reason school counselors lack clinical supervision is the non-mandatory status of post-master's degree supervision in most jurisdictions, contrary to mental health counselors (Herlihy, 2002). The legal and ethical issues facing school counselors need to be addressed in supervision and focus on competence, confidentiality, boundaries, accountability and liability, and evaluation. Herlihy does identify issues that are specific to working with children, such as the challenge of maintaining confidentiality in a school system; dual relationships; and managing the difference between teacher, counselor, and consultant notes, as well as the liability of supervising a counselor who also is administratively supervised by principals or guidance administrators. Although the school counselor literature clearly documents the need for supervision, the mental health literature specific to children has yet to identify the need for child counselor supervision. Even more specifically, the school counselor literature (i.e., Herlihy) introduces ethical and legal issues that describe the complexity of being a counselor who works with children.

Crutchfield et al. (1997) discuss the isolation with which many school counselors must deal leading to feeling under supported and alone while addressing difficult situations. These authors explain that the isolation and lack of clinical supervision leads to counselors being less reflective of the counseling session and

uncertain about their counseling abilities. Counselors often become less skilled over time than when they first graduated with their degrees, thereby increasing their stress, and their need for training about current issues in counseling relative to children. Kahn (1999) is specific about the roles that school counselors assume and the implication these roles have on supervision. School counselors assume many roles that are unique to other counselors whose primary or only role might be therapy. Frequently, school counselors assume the roles of individual counselor, consultant, coordinator, small group counselor, and large group guidance counselor (Kahn). The division of responsibilities becomes an issue in supervision and suggests the need for supervisors with differential experience, knowledge, and skills. Given the diversity of roles assumed by school counselors, the need for diversity and expertise in a variety of issues parallels the wide range of issues the community mental health counselor working with children might face and need to be addressed in supervision.

Studer (2006) elaborates on the continued frustration of school counselors regarding supervision when they learn about the American School Counselor Association (ASCA) National Model. Many school counselors practicing in the field have yet to be trained on the ASCA National Model. School counselors entering the profession look to their school supervisors on site for a developmentally appropriate understanding of skills and procedures; yet, many of the practicing school counselors have not received training or supervision on the model to assist incoming students. Studer reported that 50% of 73 participants surveyed in the Southern region were still working under the traditional model. Parallel to the lack of adequate supervision noted by Studer in the Southern region, Baggerly (2002) reported that Florida school

counselors did not receive the amount of supervision they needed from their district supervisors. This result was indicated by a significant difference  $.37, t(1,171) = 6.9, p = .00$ , between the mean of needed supervision and the mean of district supervision provided. The counselors did however, receive the amount of peer supervision desired, as indicated by a lack of significant difference  $(.00, t(1170) = .03, p = .97)$  between the mean of needed supervision and the mean of peer supervision (Baggerly).

Students in training, recently graduated counselors preparing for licensure, and practicing counselors may feel isolated like the school counselor when addressing difficult therapist issues, such as of countertransference. Metcalf (2002) discusses countertransference in child therapy. The issue of countertransference makes forming and sustaining the therapeutic bond with children difficult for the therapist. Included in the challenges for the child therapist is the active nature of the child, developing appropriate boundaries, and potential regression to early developmental stages during the therapeutic process. These challenges in the countertransference processes often uncover the issues of the child (Metcalf, 2002), requiring the clinician to be aware of the process of countertransference. However the majority of the literature on countertransference pertains to adults and not children, and the countertransference reaction differs in children as compared to adults. Therapists with countertransference reactions working with children often feel limited by their professional competence (Metcalf). Often a child's countertransference reaction is frustrating to a therapist lacking skills in developmentally appropriate counseling. Children in therapy may "repeatedly play out the same scene over the course of the session" (Metcalf, p. 48).

Metcalf did not find a significant difference in the type of supervision received and the management of countertransference. However, the literature on countertransference and Metcalf support the notion increasing a counselor's self-awareness and supervision to address the issue of countertransference in child counseling, in addition to consultation, peer support, and personal therapy (Grayer & Sax, 1986; Richards, 2000, as cited in Metcalf).

Many counselors who work with children use play therapy which is based on child development theory. Similar to Piaget's (1952, 1970) theory of cognitive development, children's play is assumed to gradually increase in complexity. Different from adult talk therapy, in play therapy children are able to communicate in therapy through play. According Ray (2004, p. 29) "play is the natural language of children." Ray supports the use of a developmental model of supervision and the conception of counselors of children as a special population that needs therapists with specialized training with qualified supervisors in play therapy. Supervision of play therapy requires a supervisor who is familiar with the basic and advanced skills of play therapy. According to Ray, the basic skills of play therapy include non-verbal skills and verbal skills. The non-verbal skills are: (a) leaning forward, (b) appearing interested, (c) seeming comfortable, (d) applying a congruent tone with the child's affect, and (e) applying a congruent tone with the therapist's response. The non-verbal skills are: (a) delivery quality of response, (b) tracking of behavior, (c) reflection, (d) facilitating decision-making, (e) facilitating creativity, (f) esteem-building, and (g) relationship building. The advanced skills of play therapy are: (a) enlarging meaning, (b) identifying play themes, (c) connecting with the child, and (d)

limit-setting (Ray, 2004).

### *Summary*

As the mental health concerns of children and adolescents remain prevalent and the service demand remains high for counselors, the need for supervisor also will remain high. Kataoka, Zhang, and Wells (2002) estimated that more than 75% of children in need of mental health care were simply not served. Similarly, abused and neglected children or severely disturbed children are often most underserved (Cicchetti & Toth, 2003; Marsh, 2004). Supervisors who are familiar with the needs of this critical population who can develop the skills of supervisees working with these children are needed (Neill, 2006).

The supervisory process is a key component in addressing the training needs of supervisees and maintaining the standards of the profession. When educating supervisees with various competencies and skills, the supervisor also is protecting the client and monitoring the ethics and laws of the counseling profession. Supervision is critical to many professions including counseling (Kilminster & Jolly, 2000), but little existing literature has yet to examine the supervisory process specific to the supervision of child and adolescent counselors.

How clinical supervision is defined appears critical given the diversity of fields exploring the topic and the influx of associated theoretical models addressing supervisory process. There appears to be some consensus that counselor supervision is guided by developmental understanding (Falender et al. 2004) and thus developmental models of supervision were primarily explored with the addition of two cognitive-developmental models. As models are placed into action, supervision

delivery is often an individual process between supervisor and supervisee. Bernard and Goodyear (2004, p. 209) consider individual supervision the “cornerstone” of supervision; however, supervision also can be delivered in group format.

Finally, the issues specific to child/adolescent counselor supervision within the literature are sparse. Scant research has addressed the training needs of the child and adolescent counselor in supervision available studies have addressed the supervision of counselors providing group therapy to children (Rosenthal, 1975; Holmes, et al., 1998; Soo, 1998; and MacLennan, 1998), the supervision of school counselors (Crutchfield & Borders, 1997; Crutchfield, et al., 1997; Herlihy, 2002; Kahn, 1999; Page, et al., 2001; Studer, 2006), and themes within the therapeutic relationship to be addressed in supervision such as countertransference and skills for example play therapy (Metcalf, 2002; Ray, 2004). Supervision of child and adolescent counselors still remains largely unexplored.

Chapter Three will discuss the qualitative design of the study. Within this next chapter the specifics of a collective case study will be outlined and the design logic will be explored.

## Chapter Three

### Method

#### *Design*

This study employed a qualitative design, specifically a collective case study method. A collective case study is a case study of more than one case (Stake, 1995). I used a demographic questionnaire, post-supervision interviews, and direct observation of the supervision to explore the various thoughts, feelings, and experiences of the supervisor and supervisees during supervision. As Stake (2005, p. 454) states “the qualitative researcher is interested in diversity of perception, even in the multiple realities within which people live.”

#### *Participants*

*Study Site.* Participants for this particular study are masters-educated therapist supervisees and a masters-educated licensed therapist supervisor from a residential children’s treatment facility. The facility is familiar to me due to prior practicum students completing training at the facility and ongoing contact between the facility administrative staff and myself regarding the progress of these students. Due to this connection and prior association, the facility was willing to participate in the study and grant access. Prior to choosing this facility, I had identified another facility with a supervisor and supervisees counseling children. The initial facility supervisor was a known licensed mental health counselor that I knew. However, during the month that

I planned to request approval from the original facility to conduct research, the supervisor resigned and accepted another position supervising counselors and counseling adults. As an alternative choice, I explored the current residential foster care facility in early January 2007 due to my prior association with practicum students and the facility's exclusive counseling of children and adolescents.

The residential foster care facility and more specifically, the intensive counseling and therapy program are portions of a very large not-for-profit organization serving the Central Florida region that was originally established in 1892. The residential facility houses female and male children ages 5 to 17 years who are victims of abuse neglect and abandonment. The facility is accredited to house between 50 and 70 children at any one time. The residential foster care facility is for children and adolescents who have had previous multiple foster care placements. These children have remained in the child welfare system for an extended period of time. The children receive counseling, meals, and clothing, in a supportive environment until a permanent adoption or foster care family is located. Examples of services provided may be on-going behavior modification, use of medication to control behavioral issues, and/or therapeutic support for post traumatic stress disorder, etc. In addition to medication and therapeutic support services, various other services are provided at the facility and include: intensive counseling, family therapy, foster care and adoptive kinship care to assist in the search for placements for the children, community-based care to assist with case management, family support centers for parenting and prevention, and opportunities to volunteer throughout the various programs. The participants of this particular study are from the residential life

staff, specifically the intensive counseling and therapy program assisting the resolution of abuse and trauma. Participants often call their program the “clinic.”

*The Sample.* The sample size is four participants: three supervisees and a supervisor. Three supervisees with one supervisor were selected for this particular case study based on the Creswell (1998) suggested upper limits of no more than four cases. The sampling design for this study was a pairwise sampling design (Onwuegbuzie & Leech, 2005). The pairwise sample design treats all cases as a set and compares them to all other cases in order to understand the nature of clinical supervision for CACs. All are cases “compared to all other cases one time in order to understand better the underlying phenomenon, assuming that the collective voices generated by the set of cases lead to data saturation” (Onwuegbuzie & Leech, p. 11). The nature of the supervision experience was compared and contrasted to understand process and content, thus a constant comparative analysis with both cross-case and with-case analyses were used.

The purposive sampling scheme is a convenience scheme (Onwuegbuzie & Collins, in press; Onwuegbuzie & Leech, in press-a), one in which participants from a local south Florida residential children’s mental health treatment center who were conveniently available and who were willing to participate in the study were selected. I chose a setting that was known to me and participants that were conveniently available. For the purposes of this study one supervisor and three supervisees were interviewed at a south Florida residential children’s mental health treatment center. In part, snowballing also enhanced the sampling, as the supervisor was familiar with the staff at the facility and helped in recruitment of supervisees and supervisee

participation in the study.

There were three licensed supervisors at the residential foster care mental health treatment facility where the study took place. The supervisor chosen for this sample is responsible for the supervision of the masters-prepared therapists preparing for licensure, and conducts individual supervision with the therapists on staff in accordance with their facility accreditation. The supervisor is a licensed clinical social worker under the rules and statues set forth by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling in the State of Florida. Similarly, the supervisees are masters- prepared, licensed eligible therapists, with either a masters in social work, counseling, or psychology. Educational background and license information of the supervisor and supervisees was gathered in the demographic questionnaire and reviewed during the rapport-building stage of the interviews.

### *Instruments*

I used an open-ended question format to interview the research participants. The demographic questionnaire (see, Appendix B) was completed via email by the research participants prior to the observation of supervision. The post-supervision interviews (see, Appendix C) were face-to-face and semi-structured. I reviewed demographic information, including educational background and license information, prior to the start of the post-supervision interview, as part of rapport building with both the supervisees and supervisor.

The demographic questionnaire and the post-supervision interview were the same for both the supervisee and the supervisor. The demographic questionnaire

covered demographic information, educational information, and license information. The post-supervision interview consisted of basic descriptive questions about the most recent individual clinical supervision experience. In addition, each supervisee and the supervisor participated in a follow-up interview. The unstructured follow-up interview was an open-ended interview format. The unstructured follow-up interview was for the purpose of member checking, and was conducted face-to-face.

### *Pilot Study*

The questions for the demographic questionnaire and the post-supervision interview were pilot tested in late May 2007. The participants were asked to provide feedback about the content and quality of the demographic questions and the interview questions.

One supervisor and one supervisee were recruited for the pilot study through the doctoral program in Counselor Education and Supervision at the University of South Florida. The supervisor was a licensed mental health counselor, 31 years old with a masters degree in Counselor Education and currently working on her doctoral degree in Counselor Education and Supervision. Her undergraduate degree was in psychology. The supervisee was a 27 year old registered mental health counselor intern, seeking supervision for licensure with a masters degree in Rehabilitation and Mental Health counseling. She was also working on her doctoral degree in Counselor Education and Supervision. Each pilot study participant reviewed and signed the informed consent to participate in the research study.

The intention of the pilot study was to validate the instrumentation. Miles and Huberman (1994) argue for a lot of prior instrumentation when using multiple cases

to form a collective case study. It is important to focus the interview and observation schedules in an effort to decrease extraneous information for the various cases.

Without prior tested instrumentation partial or unclear questions may enter the interview, yet with prior tested instruments and proper use, meaningful findings will emerge (Miles & Huberman, 1994).

Pilot study participants answered the following demographic questionnaire:

1. Please tell me your first name and last initial for identifying purposes only.
2. Having re-read the consent form, do you still agree and consent to participate in this research study?
3. What is your age?
4. What was your undergraduate major?
5. What is your masters degree specialization?
6. How long have you worked at this facility?
7. What has been your work experience with children and/ or adolescents?
8. What specialized training in counseling children and/or adolescents do you have?

The feedback about the content of the demographic questionnaire yielded results that impacted the final demographic questionnaire. Each pilot participant agreed that gender and ethnicity needed to be included. In addition, both pilot participants felt question number 7 could be clearer and potentially divided into two separate questions. As a result the question was divided and became: a) How long have you worked with children and/ or adolescents? b) What has been your work experience with children and/ or adolescents?

Pilot study participants answered the following post-supervision interview questions:

1. Would you describe your most recent individual supervision session?
2. What were your thoughts during the supervision session?
3. What were your feelings during the supervision session?
4. Would you describe the issues or topics discussed in the supervision session?
5. Please discuss how your needs were met in the most recent supervision session?
6. Please, add any additional information about the supervision experience you believe to be important?

Pilot study participants also provided feedback about the content and quality of the post-supervision interview questions and their influenced the final post-supervision interview questions. Both pilot participants thought that question number 5 was difficult to answer. They believed that the word “needs” seemed personal, and when the question was asked, they were unsure of how to answer it. The pilot participant supervisee suggested placing an adjective in front of “needs” to clarify the intention of the question. There was some discussion about the possibility of using a different word other than “needs.” Words, like “gained” and “satisfied” were discussed, but it was agreed that “supervisory needs” related to the content of question and felt most comfortable to both the supervisee and supervisor. The result of the participant feedback was that the question was changed to: Please discuss how your supervisory needs were met in the most recent supervision session.

Both pilot participants thought it was important to use non-verbal gestures and to probe when appropriate during the post-supervision interviews. They were unsure about how much to say when answering the interview questions. As a result, question number 6 was slightly modified. The pilot participant supervisor thought it was important to separate the question into two distinct questions. The result was the following: What else about the supervisory experience do you believe is important? And is there anything else you would like to add to this interview?

### *Procedure*

I served as the interviewer. The research design is a collective case study involving more than one case (Stake, 1995). The use of a collective case study design is appropriate in the study of supervision content given the use of interviews, the importance of sharing personal experience, and the setting. I used audio tapes, field notes, and transcripts as data sources. Confidentiality was maintained for all participants. Data were stored in secure location, and any participant-identifiable references will be destroyed within one year of the completion of the study (Christians, 2005). An Institutional Review Board (IRB) form was completed and approved in mid-May 2007. Consent forms were reviewed and signed by all participants, prior to the start of the study (See Appendix A).

I contacted two of the three licensed supervisors at the facility initially to assess the feasibility of the study at the site. These were the supervisor of practicum and internship students and the supervisor of masters-prepared therapists. I contacted only two of the three licensed supervisors at the facility due to my prior knowledge that the third supervisor was a psychologist who worked primarily with psychology

students. The supervisor of the post-masters therapists works full-time at the facility, where as the other supervisor does not. In addition, the population of working counselors was the population I was seeking, not practicum and internship students. Thus, the supervisor of the post-masters therapists was my choice. I sought permission for the study from the facility management team. I had an individual meeting with the supervisor to confirm the research protocol and to review expectations. I coordinated future arrangements for the interviews and observation of supervision times with the supervisor via email. I began data collection the first week of June 2007, and the follow-up interviews for the purpose of member checks were complete the first week of July 2007.

I interviewed the supervisor and supervisees individually post-supervision using a digital hand-held audio recorder to record the interviews. I also took field notes (see, Appendix E) during the observation of supervision. All interviews were conducted at the residential facility within the various individual offices of the supervisees and supervisor.

The post-supervision interviews (see, Appendix C) took place after the observation of the individual supervision session and were anticipated to take approximately 30 minutes. However, they were much shorter: approximately 10 to 15 minutes. The interview was semi-structured with open-ended questions and opportunities for participant feedback. Prior to the interview, participants completed a demographic questionnaire (see, Appendix B) with questions regarding demographic information, educational background, and licensure. I reviewed the demographic questionnaire with the participants prior to the start of the post-supervision interview

as part of rapport building. Each participant had an initial interview and a follow-up interview. The initial interview consisted of basic descriptive questions about the supervision process and questions about the professional experience of the supervisees and supervisor.

The follow-up interview lasted approximately 15 to 20 minutes. The purpose of the follow-up interview was to review information gathered at the initial interview and to review the themes that emerged from the constant comparative analysis. These interviews were also semi-structured and employed open-ended questions, which I developed.

### *Data Analysis*

I used a cross-case analysis and a within-case analysis of the post-supervision interviews from the supervisees and supervisor. I also used constant comparison analysis to aid in coding and chunking of themes from the post-supervision interviews prior to the within-case and cross-case analyses being performed. The cross-case analysis was intended to provide a clearer picture of the experience of the participants in comparison with each other. The within-case analysis provided a way of analyzing and interpreting the participants' experience in supervision as individuals and not in comparison to each other.

Data from both the supervisee and supervisor post-supervision interviews was transcribed. I labeled subsets of data into smaller parts with a descriptive title or code. Themes emerged based on these groupings. As suggested by Leech and Onwuegbuzie (in press), a way to increase the accuracy of codes is to engage in member checking with participants. Accordingly I asked participants to read the

themes generated from the constant comparison analysis during the process of member checking in the follow-up interview. At this time they had the opportunity to add anything they had forgotten to say as well as to correct or clarify anything I had written.

The transcribed material was then entered into, ATLAS.ti 5.0 (Muhr, 2004). The computer data analysis software was also used to assist in the coding of themes and analysis of data (Muhr). ATLAS.ti.5.0 was used in addition to the constant comparative analysis.

### *Legitimation*

The establishment of credibility in collective case studies needs to be rigorous. Stake (1995) recommends triangulation and member checking specifically for collective case studies. I used several strategies to establish the internal credibility of the study and to promote the accuracy of the information shared by the participants interviewed. These included: peer debriefing, member checks, external audits, and clarification of researcher bias.

*Clarification of researcher bias.* One of the threats to the credibility of the current study is researcher bias. I did have certain personal assumptions when interviewing participants or analyzing data due to my prior experience as a counselor and supervision experience in children's mental health services. As the researcher of this particular study, I have previous experience as both a child therapist and as a supervisor of child therapists. I am a licensed mental health counselor with seven years of clinical experience working with children and adolescents and four years of experience supervising counselors who provide therapy to children and adolescent.

My experience was clarified from the outset, via disclosure of assumptions, to increase the credibility of the results (Merriam, 1988). My assumptions and prejudices have shaped the research questions and the interpretation and approach to the study. My researcher bias was addressed via peer debriefing process, member checks, and external audits.

*Peer debriefing.* Peer debriefing was used in this collective case study during the analysis phase. I met weekly with a doctoral student in counselor education familiar with the collection of qualitative data. This particular student has had a research methodology course in qualitative design. These meetings were approximately a half hour in length, every week, with the most significant proportion of discussion comprised during the analysis phase. These meetings were productive in a several ways including: (a) reducing my stress and anxiety, (b) identifying efficient coding procedures, (c) exploring issues I may have missed. For example, during the analysis phase, the peer debriefer and I reviewed my procedures with ATLAS.ti.5.0. During a lengthy discussion about coding, we reviewed how I used not only ATLAS.ti.5.0, but also manually did a constant comparative analysis of themes. She helped confirm my coding conceptualizations.

*Member checks.* Credibility increases based on the representation of data of the participants and their subsequent member checks. Participants were given the opportunity during the member checking process to verify the accuracy of the transcribed interview contents. This process helped to increase the descriptive validity of the study (Maxwell, 1992). Descriptive validity is the factual account of the event that transpired in the interview. In addition, participants were given the opportunity to

review the themes which emerged from the constant comparison analysis. As part of the interpretive process, the participants helped to verify the themes and increased the interpretive validity of the study (Maxwell). Interpretive validity is the accuracy of participant experiences as reported and understood by the researcher of the study (Maxwell). I asked participants for feedback on the accuracy of the themes and for input based on the details and categorization of the data into specific themes. When there were any discrepancies between the themes I categorized and the themes the participants believed emerged from the interviews, the discrepancies were then reviewed with the external auditor.

*External audits.* I collaborated with an external auditor to establish further credibility of the findings. This external auditor is also the person responsible for peer debriefing and was quite willing to review qualitative information for the experience because she is in the process of completing her course work for her doctorate in counselor education and supervision. Her primary motivation was professional and scholarly reciprocity. The intended meeting schedule for auditing was two initial meetings and four meetings during auditing, with each meeting to last approximately one hour. The focus of the auditing process was to uncover my consistencies and inconsistencies in the constant comparison analysis of themes of the supervision process with child counselors. Our discussions focused on comparing the codes and themes that emerged from the analysis. The auditor noted a “1” for consistent findings and a “2” for inconsistent findings. Consistencies and inconsistencies in the coding of emergent themes were not discussed in an effort to maintain neutrality as a standard of “confirmability” in the auditing process as recommended by Roman and

Apple (1990, p. 64). However, because the auditor is also the peer debriefer issues were streamlined relative to coding procedure.

*Transferability.* Transferability of findings, often seen as an alternative to “generalizability” or “external validity” in quantitative research, means the degree to which the intended research is applicable in one or more settings or contexts due to the similarity of the settings (Lincoln & Guba, 1985). Given that this study is intended to increase the current understanding of supervision experience for CACs, it is possible to propose that the findings of this study may be extended to CACs, counselors in supervision, or counselors working with abused children and adolescents. I described in detail the setting and context of the supervision experience of participants of the case study to enable the readers to have a clear understanding. I also used field notes from the interviews in addition to observations about the interview process to gather descriptive information. I used verbatim quotes when possible to provide the best examples of a participant’s experience and/or response.

*Dependability.* The establishment and accomplishment of dependability in this study was made possible through the constant collaboration with a peer debriefer, external auditor, and the participants. The detailed documentation of methodology and the research process is equivalent to establishing the qualitative version of “reliability” but far more flexible and termed “dependability” (Guba & Lincoln, 1989).

### *Summary*

This study was a collective case study. The participants were three supervisees and a supervisor from a residential foster care facility who agreed to provide

demographic information, have their individual clinical supervision observed, and then be interviewed post-supervision. A within-case analysis and a cross-case analysis of themes were completed. Legitimation included: clarification of researcher bias, external audits, member checks, and peer debriefing.

Chapter Four will present the results of the study by exploring the general questions that guided the inquiry.

## Chapter Four

### Results

The following chapter will present the results of the study. Each case of the collective case study is presented in detail. The cases involve one supervisor and three supervisees. These cases are illuminated through demographic information and through observation information. Both within-case and cross-case thematic findings are presented.

#### *The Supervisor*

*Sandnes.* Sandnes is one of several supervisors at the residential foster care facility. She is one of two supervisors for the intensive counseling and therapy program, and she supervises the counselors who have completed their masters degree. The other supervisor in the intensive counseling and therapy program supervises the counselors who are currently in practicum or internship at local universities in counseling, psychology, or social work programs. Sandnes was chosen to participate in the study because of her work schedule and because she supervises the clinicians who participated in this study.

Sandnes was helpful in the facilitation and the scheduling of the supervision observation and post-supervision interviews. Similarly, she coordinated and scheduled via email with her supervisees to ensure on-time attendance to supervision and interviews. She provided several email communications to me confirming

scheduled supervision, and when there were minimal time changes, she was quick to email me an update. In person, she was noticeably busy. It appeared that she coordinates with additional employees other than the counseling or therapy staff. This function of her job appeared to take extra time and required the ability to perform other tasks while still working with the counseling staff.

Sandnes is a 36-year-old Caucasian female. I observed her to be wearing a wedding ring. I also observed her to be dressed in a casual but professional manner. Her disposition is one of warmth and frequent smiling. She reported that her undergraduate degree was in psychology with a minor in child development and family relations. Sandnes expanded on her decision to pursue psychology, noting that psychology was familiar to her and that her father is a clinical psychologist. It took Sandnes four and half years to complete her undergraduate degree, and she described herself then as not focused, really immature and unclear of what she really wanted to do. She completed her undergraduate degree at Western Carolina University.

Sandnes has a masters degree in social work from the University of South Florida and is a licensed clinical social worker. She went to school full-time for two years in order to complete her degree. Prior to entering graduate school, Sandnes was working at the facility she currently works at now. When she was working in the residential part of the facility, it became clear to Sandnes that she wanted to be a therapist and work with children and families. When she returned to school to complete her masters degree, her exposure to clinicians had been primarily the social workers at the facility. Sandnes reported admiring and respecting the social workers she worked with at the time, and due to this admiration, Sandnes chose to pursue social

work in graduate school. Sandnes said she felt lucky to be accepted into her masters program.

Sandnes has worked at the residential foster care facility for 13 years. Prior to working at this facility, she developed her expertise with children through babysitting in high school and in college for three years working in two different child development centers. She reported loving the experience of completing a minor in child development as an undergraduate.

For the first three years of her residential experience, Sandnes worked in the residential program, spending three nights a week in the cottage. She felt it was an intense experience but described the experience as helpful in her developmental understanding of working with traumatized children. She also described feeling stressed, physically bruised, and tired. However, she believes it was also the best experiences she could have ever had.

After her experience in residential portion of the facility, Sandnes was a Primary Caregiver for three children for two years. Two of those children still keep in contact with her and are both now adults. As a result of this experience, she feels she is a better person and certainly a better mother from having had that time with those children. During this time she felt very lucky in that her direct supervisor was an MSW and provided excellent feedback and guidance.

Sandnes then became a Primary Trainer to teach the new staff how to work with the children at the residential foster care center. After three years in this position, she believed it was time to go back to school, and that is when she decided to apply to the School of Social Work. She was accepted and completed her field placement in

one and one half years under the guidance of a child analyst. She carried a full case load, and because, at the time, the center was not billing Medicaid, the paperwork was minimal. Therefore, she remembers much thought, planning, and training was done in regard to each client's treatment. Sandnes said she felt like a sponge and took every opportunity to learn from anyone who was willing to help her.

When she graduated, she became a full-time therapist, then the assistant clinical director and now the clinical director. During her work as a therapist, Sandnes worked in the Family and School Support Teams program (FASST). The FASST program is an early intervention program for families and their children. FASST is also a multi-disciplinary intervention team comprised of schools, community members, and family representatives. Utilizing a strength-based approach, the FASST program supports children to be successful and independent at home, in school, and in the community. She recalled this in-home work experience with children and families as uniquely different than in-office work, and as an experience that greatly increased her skill base with at-risk populations.

Sandnes was trained under a child analyst for three and half years during her internship and some time after completing her internship. She described her supervision during her internship and the initial year and half after as psychodynamic. The residential foster care facility also primarily operated under this orientation at the time as well. She reported feeling very comfortable with this theoretical orientation. Sandnes has since branched out to attend several trainings on cognitive behavioral therapy and play therapy. She is also working to log the 100 clinical hours required to become a registered play therapist.

Not only does Sandnes provide clinical supervision and administrative supervision, she also receives administrative supervision on a weekly basis. She reported that she meets her clinical needs of supervision through her co-workers, the psychiatrist on staff, and by attending trainings. During the member check process, Sandnes described that she would like to have clinical supervision that was not just based on work groups, continuing education, or co-workers. The discussion was rather lengthy and Sandnes explored a feeling of loss of not having clinical supervision and also a fear of losing “something” by not being challenged at a clinically conceptual level. She described peers in the field that also feel a similar loss and she sees them addressing their needs through seeking additional education and certifications as a means for clinical growth and cognitive stimulation. Sandnes has peers in the field who have years of experience, similar to herself, who wish they had clinical supervision and have left agency or residential work for private practice hoping that it would provide greater challenge. Sandnes described this solution to the lack of clinical supervision for experienced therapists as a false hope with its own set of issues. Thus, Sandnes continues to address her clinical supervision needs through the outlets she described and reported that she really looks forward to the training opportunities she attends as a way of networking with other highly trained professionals in the field who can challenge her.

When asked to clarify her role as a clinical director at the residential foster care center, Sandnes noted the following as her job responsibilities related to the clinicians that were interviewed:

1. Directs Counseling Services. Responsible for all aspects of clinical treatment on the therapeutic residential campus.
2. Selects, supervises and trains clinical and department support staff.  
Responsible for completing employee evaluations on those directly supervised and for ensuring that an effective employee development, discipline and recognition programs are implemented for clinical employees within the framework of residential foster care center policies and procedures.
3. Provides input to the Residential Services Director on residential staff performance as it pertains to treatment plan implementation, and coordination of efforts between clinical and residential staff, etc.
4. Ensures the implementation of the Primary Caregiver Model and that the model drives all program decisions with respect to structure, operation and systems.
5. Ensures staff completes appropriate documentation in accordance with federal, state and Council on Accreditation requirements.
6. Ensures confidentiality of client information and records.
7. May represent the residential foster care center on various committees, i.e. Steering Committee, Utilization Management with Hillsborough Kids, Inc. (HKI), Out-of-Home Care Committee, etc.
8. Reviews data for a quarterly report for clinical services and approves report before it is submitted.
9. Collaborates with Residential Director and Residential Manager to develop plans to address crisis situations.

10. Develops and conducts agency training in areas of expertise.
11. Develops and refines policies and procedures, including infrastructure issues in assigned areas. Makes recommendations to the Management Team on policy revisions.
12. Supervises students and clinical employees when necessary.
13. May carry therapy cases on an as needed basis.
14. Directs the coordination and training of the interns as needed.
15. Works within the philosophy, function, and personnel practices of the residential foster care center.
16. Perform other duties as assigned.

*Sandnes in supervision.* Sandnes typically conducts individual clinical supervision in her office. However, during the two weeks when I observed individual supervision and interviewed her and the supervisees, the air-conditioning was broken in the majority of the building including her office. With the exception of her post-supervision interviews and one of the supervision observations (Erica), all other supervision occurred in the supervisees' offices. This was not a normal occurrence. It was simply due to the fact that the supervisees' offices, (Jenifer and Paulina's offices respectively), did have air-conditioning and Sandnes's office did not. Sandnes was initially humorous about the warm temperature, but by the last interview, she was reporting frustration and irritation at the lack of progress in getting the air-conditioning fixed.

When conducting supervision, Sandnes sits at a table in the corner of her office with the supervisee. She takes notes on what the supervisee is saying the entire

supervision. During the member check process, Sandnes clarified that the documentation was about what the supervisees address in therapy with the children and adolescents. Sandnes reported that she is required to document that each supervisee has supervision each week and that each child and adolescent is reviewed for Medicaid and the facility's accreditation through the Council on Accreditation (COA). The supervision session is intended to last one hour; two of the three that were observed lasted one hour, and one supervision session lasted 35 minutes. Sandnes reported herself to be someone that is always at the facility early and also punctual to appointments, unless there is a facility crisis she needs to address. She was 15 minutes late for one supervision session due to attending to a crisis in one of the facility's cottages where the children and adolescents live.

Sandnes allowed for the supervisees to direct the discussion in supervision. The supervisees primarily discuss cases, and Sandnes reflects on their experience when conducting therapy, asks for clarification, and occasionally provides ideas or feedback. At the end of the supervision session Sandnes shifts the clinical supervision discussion to administrative supervision. She did this in each of the three individual clinical supervision sessions. The clinical supervision session ends with administrative supervision issues being discussed. These issues, such as having one of the supervisees cover an orientation training, audit review, or paperwork within their computer system, were all initiated discussions by Sandnes and not the supervisees.

Sandnes's supervision style appears to be a strength-based approach and non-confrontational. In supervision she uses non-directive and supportive techniques. In general Sandnes's supports their professional competence via praise, feedback,

clarification, and a positive supervisory relationship. Sandnes operates from a person-centered model of supervision. The person-centered model of supervision goals include, promoting supervisee self-confidence and helping the supervisee grow in his or her understanding of himself or herself. Supervision in a person-centered model is often a modified therapeutic interview that involves genuineness, warmth, and empathy (Bernard & Goodyear, 2004). Sandnes, a person-centered supervisor, relied on the facilitative process and the context of the relationship.

Sandnes made statements in supervision such as, “I’m proud of you” to Erica at the start of supervision. During Jenifer’s supervision session involving a lengthy discussion about trauma, Sandnes confirmed Jenifer’s ideas and provided additional feedback while clarifying her ideas. At the end of Paulina’s session she stated, “awesome, you have some great stuff going on with your kids!” When asked during the post-supervision interview what else she believed was important about the supervisory experience, Sandnes gave a different response each time she was interviewed, but each response related to developing a positive, strength-based relationship with the supervisee in which they feel supported. She stated the following in Erica’s post-supervision interview:

I think in [Indiscernible] are important to develop a relationship with people you’re supervising and that they are not fearful in coming to you for a question or throwing out ideas. They’re able to kind of connect with you on some level.

In Jenifer’s post-supervision interview Sandnes notes:

I think being very open and willing to hear whatever people come for with and not be self-conscious or worried about what to come forward with. I think it’s important to have [Indiscernible] support [Indiscernible] sense of humor about what we’re dealing with.

And I just think having a safe place to be able to talk about what you guys do here. Very supported.

In Paulina's post-supervision interview, Sandnes summarized her general approach to supervision:

I think it's hard—I think a lot of these therapists, they get caught up in listening at the cases that many aren't so well are struggling with the overall stress or non air conditioning or whatever it is. That really being, you know, pointing out those things that are going really well and are really helping these kids, making a difference.

When I asked Sandnes during the member checking process to clarify how she would like clinical supervision to be ideally she described, "like it was before Medicaid and Council on Accreditation (COA)." Sandnes believes that the supervision she provided prior to advent of Medicaid and the introduction of accreditation policies and procedures was distinctly different. Prior to Medicaid and COA, Sandnes described feeling less restricted and able to spend more time with her supervisees. With further discussion, Sandnes made it clear that she is aware that in supervision she has to move quickly through things, such as the cases and is unable to delve deeper into what the therapist is doing in therapy. Sandnes described wanting to be able to do process recording with her supervisees. She believes that the lack of in-depth discussion and process on cases is accounted for via clinic meetings and case reviews in a group setting. Sandnes also reported that she has an open door policy for all of her staff when it comes to personal issues and needs.

I would expect the supervision session in a residential facility to be focused on case discussion with the general goal being supervisee development. Within the case discussion I would expect the topics of discussion to be highly specific to

counseling children and adolescents. For example, the supervisor might discuss techniques, such as play therapy, the developmental level of the child, or how to review the case with child welfare. Within the promotion of supervisee development I would expect additional discussion specific to counseling children and adolescents. For example, the supervisor could explore issues of countertransference the counselor might have while in session with a child who was physically abused or discuss ideas for self-care for the counselor who may be experiencing vicarious traumatization. Theoretically, many supervision models are developmental and support the development of supervisees. However, Sandnes did not follow a developmental supervision model. In addition, her technique of case review appeared to be a generic form of supervision and common to many supervision experiences. The lack of developmental quality within the supervision could be due to several factors, such as lack of time for supervision within the facility, external controls according to Medicaid and accreditation, or potential lack of prior supervisory training for Sandnes.

### *The Supervisees*

*Erica.* Erica is a 25-year-old Caucasian female. I observed her to be wearing a wedding ring. She is dressed in a stylish, contemporary, yet professional manner. She was carrying a very large bag, full of a variety of things that seemed to spill over as she sat down prior to the start of supervision. She was the first supervisee I observed during individual supervision and interviewed post-supervision. Erica was a willing and enthusiastic participant. She expressed concern about the confidentiality of the clinical cases she discussed in supervision after my supervision observation to

her supervisor. Her supervisor clarified the informed consent, as did I with the supervisor, that none of the children's identifiable information from the clinical case discussion was being used for the study. Erica reported that she was satisfied with the answer.

Erica started working at this residential foster care facility two and half years ago. She first started at this facility as an intern while completing her masters degree in social work. Erica completed her masters degree at the University of South Florida. She also currently works as a motivational caretaker in homes for persons with Asperger's Syndrome using positive reinforcement, modeling, and social skills techniques. In addition, she is currently an in-home Applied Behavior Analysis (ABA) therapist, providing care for a child with Autism disorder using ABA therapy techniques and social skills training two days per week. During this time, she serves as an aid and therapist during inclusionary time in a typical kindergarten classroom. She has also worked as an ABA therapist at a school for Autism and other related spectrum disorders during a summer program while completing her masters degree.

In the summers, while completing her undergraduate degree, Erica worked as a youth camp counselor at a Jewish Community Center. She has also worked as a nanny, and as a Sunday school teacher assistant at a Synagogue. During this time Erica also volunteered with the Boys and Girls Club and at another residential foster care facility. Erica completed an internship at Sands Hospital for Children with Diabetes during her undergraduate degree. Her undergraduate degree is in psychology from the University of Florida. While an undergraduate, Erica worked as a research assistant and collaborated on several publications.

Since completing her masters degree, Erica has continued to further her training. She has worked on completing a certificate in marriage and family therapy at the University of South Florida. In addition, she has participated in the following trainings through her current job or at the University of South Florida: Behavior Modification training, Applied Behavior Analysis Training for Children diagnosed with Autism & other related spectrum disorders training, Crisis Management and Intervention training, Directive and Non-Directive Play Therapy training for Traumatized Children, Diversity training, AIDS/HIV training, Introduction to Trauma training, and How to Treat Client's with Post Traumatic Stress Disorder (PTSD) training. She also reported recently attending the Sexual Abuse Intervention Network (SAIN) Conference in the Tampa Bay area of Florida. Erica described always reading new research from *Psychology Today* and other journals and books about children, trauma, behavior analysis and/or PTSD.

Erica is currently a registered clinical social work intern in the state of Florida. She is working on the required clinical hours and the required supervision hours in order to be eligible to take the licensure exam to be a licensed clinical social worker. She is currently receiving her supervision for licensure at this residential foster care facility from the same supervisor that participated in the study. Erica anticipates completing all of her required clinical hours and supervision hours by August of 2008 and plans to take the social work licensure exam in August 2008.

*Erica in supervision.* When I observed Erica in supervision, she appeared “rushed” to start the process. The rushed behavior was not warranted because the supervision started on-time. The sense of urgency may have been compounded by the

supervision starting right when she walked in the door. As noted by the supervisor, Erica is known for being late for work. This behavior is reportedly improving. On the day I observed the supervision, Erica was supposed to be at the residential facility a half hour earlier than when she actually arrived.

During supervision, Erica reviews her day planner and the notes in her day planner as she goes through her individual and family cases. Initially during the observation, Erica seemed nervous. Her body posture during the first half hour was tense, forward leaning and restricted, with arms and legs crossed. However, the second half hour, she was relaxed with her body posture leaned back in the chair and arms unfolded. Erica talked very fast during the entire supervision session.

Erica covered a great deal of information during the supervision session. She currently has seven individual cases and seven family cases. Within the discussion of her cases she addressed medication compliance, children regressing in their behavior, and case collaboration. She tended to provide mostly factual information and often used jargon, such as he or she's "a mess," when describing cases. Erica and the supervisor discussed other cases in more detail, such as, an emotional phone call during family therapy, a case that is moving to terminate parental rights (TPR), and a case that is getting ready to be discharged. In addition, Erica discussed an issue with the supervisor about aggressive children and planning consistent group activities. As supervision ended, Erica started to talk about issues related to a child with sexual acting out issues. They briefly discussed the differences between acting out sexual trauma and being a sexual perpetrator. Erica also agreed to do a portion of orientation training for the supervisor as supervision finished.

Erica is energetic and fast paced during supervision. She generally covered the majority of her cases. However, she did not go in detail into any of her cases, but remained on the surface of each of her cases. Both Erica and her supervisor described her in supervision similarly. Erica stated:

I usually feel pretty rushed to talk about, you know, everybody and get everything in on what's going on. I try to just get the highlights. There's so much. There's so much that you have to leave out in order to cover everybody.

Similarly, the supervisor described a feeling of wanting to slow Erica down, yet appreciating her enthusiasm:

Sometimes as in yesterday's, sometimes you have to reel Erica in a little bit because she's very -- She's very enthusiastic. She has tons of ideas and kind of jumps ten feet forward before thinking through.

*Jenifer.* Jenifer is a 52-year-old Caucasian female. I observed her to be wearing a wedding ring. Jenifer was dressed in a casual, but professional manner. She wore glasses and at times took them off and on. She was the second supervisee I observed during individual supervision and the second I interviewed post-supervision. During the process of obtaining consent, Jenifer showed great interest in what I hoped to find in my research. She questioned the assumptions of the research, and following the completion of data collection, she showed a keen interest in relevance of supervision at the facility. However, Jenifer was reluctant to expand on her answers to questions and was relatively guarded in her responses.

Jenifer started working at this residential foster care facility three years ago. Prior to working at this facility, she counseled children and adolescents at an outpatient mental health facility. At that outpatient mental facility she also completed

her practicum and internship. In addition to having experience in outpatient mental health, Jenifer prior to completing her masters degree, worked in residential care, as a child care worker. It was during her work as a child care worker, that Jenifer made the decision to return to graduate school and complete her masters degree. Jenifer also reported a history of working in the school system.

Jenifer completed her masters degree in family psychology and completed the degree in two years from Capella University in Minneapolis, MN. Her undergraduate degree is in history and Spanish. She described choosing that major because she “liked it” and reported that it was “a long time ago.”

Jenifer recently took the Florida State Board exam for Marriage and Family therapists. She received supervision outside the facility from a licensed Marriage and Family therapist in order to fulfill the supervision requirement to take the licensure exam. She has not yet received her exam results. During the last few months she has been studying for the licensure exam. She also discussed having had training in child trauma counseling.

*Jenifer in supervision.* Prior to the supervision observation Jenifer was with a child who was being seen for medication review. She ended the session early to start supervision. The supervisor was running late, and this delayed the start of supervision by 15 minutes due to her a handling a crisis in one of the cottages where the children and adolescents live. The supervision occurred in Jenifer’s office, which was not the normal practice, but was preferable due to the lack of air-conditioning in the supervisor’s office. Jenifer suggested the change in location.

In Jenifer's office, there was classical music playing softly in the background, an area for play therapy, with a toys and a chalk board. Jenifer and the supervisor sat at a table on the left side of the room. There are children's drawings on the wall and a feelings chart posted behind me as I sit at Jenifer's desk.

In the supervision session, Jenifer immediately began talking about training ideas, sharing workbooks, skills, games, and therapy tools for counseling children and adolescents. For the majority of the supervision session, Jenifer focused on issues related to techniques or the best practice when working with a child or adolescents. She discussed trauma, cognitive behavioral therapy (CBT), attending play therapy conferences, and addressing a cottage issue as it relates to the children and adolescents she counsels. As the supervision continued, Jenifer discussed a few individual cases. One case in particular has an issue related to the residential staff and potential abuse reporting. With other cases, Jenifer expanded on some of the counseling techniques she is using with the children, such as, narrative therapy and reflection. The supervisor gave some suggestions for a case where a child is unwilling to explore her feelings. Jenifer appeared defensive about the suggestions the supervisor provided, such as "creating the optimal level of anxiety" and "striking while the iron is cold." Jenifer did not appear very open to the supervisor's suggestions.

Jenifer and the supervisor discussed child trauma. Jenifer seemed reluctant to the idea of delving deeper into trauma resolution with certain children. The supervisor and Jenifer discussed research on trauma resolution and counseling skills with children who have a history of trauma. As the supervision ended, Jenifer

discussed treatment plans and was encouraged by the supervisor to use the new “kid friendly” version. The discussion moved to administrative implementation of the treatment plans, and Jenifer joked about not wanting to do “more work.” Jenifer ended the supervision session early, noting that she had a medication review to attend with a child. The supervision session lasted approximately 35 minutes; substantially shorter than the other supervision sessions.

*Paulina.* Paulina is a 42-year-old Hispanic female. I observed her to be wearing a wedding ring. She wore casual, yet professional clothing. She had short brown hair. Her tone was most noticeable with a warm, soft spoken voice. She was the third and final supervisee I observed during individual supervision and interviewed post-supervision. During the week of initial observation and interviews, she was at a training. Similar to the other participants, she presented herself as willing to participate in the study, yet busy with the day to day demands of the job of a residential counselor. She was also interested in the topic of the study and asked several questions once the interview was over. Paulina’s questions and comments were related to the importance of supervision for counselors who work with abused or traumatized children. She made comments related the counseling at this current residential facility as being intense, and very important.

Paulina started working at this residential foster care facility seven and half years ago. Prior to working at this facility she worked for the FASST program for five years. Prior to her experience at FASST, she completed her practicum and internship at this residential foster care facility but in a different program other than intensive residential counseling. She completed her practicum and internship with the Family

Preservation Project doing play therapy and psychotherapy with teenagers. The Family Preservation Project works to keep families together and to keep children out of the child welfare system. The counseling in this program is extensive and targets children who are truant, runaway, and exhibit other child management problems.

Paulina completed her undergraduate degree in Ecuador. Her major was clinical psychology and she reported that the orientation used during her undergraduate studies was psychodynamic. She also described going to college right after graduation. Paulina thinks that her degree from Ecuador is equivalent to a bachelor degree but described it as much more demanding. She believes her degree was more demanding as a result of having to complete a thesis that took an additional six to eight months after the traditional four years to complete.

Paulina completed her masters degree in social work (MSW) at the University of South Florida. She went part-time and was able to complete her MSW in three years. When asked to describe any specialized training she may have received, she reported that she regularly attends a lot of conferences and seminars related to sand play, play therapy, working with teenagers, working with children with PTSD, and anger issues.

Paulina has completed the supervision and clinical work hour requirements in order to take the LCSW licensure exam. Sandnes, the supervisor participant of this study and Paulina's current supervisor, has supervised her for the majority of her supervision requirement. She is currently preparing to take the clinical social work licensure exam this year.

*Paulina in supervision.* Paulina's supervision also occurred in her office because the air-conditioning continued to be broken in the supervisor's office and the majority of the building. Paulina's office, however, did have air-conditioning and she suggested that the supervision take place in her office. Paulina and the supervisor sat at a table to the right in the office while I sat at Paulina's desk chair during the supervision observation. The office had a space for play therapy with toys and a sand tray. Paulina also had toys on her desk and pictures created by children hanging on the walls.

Initially, Paulina appeared reserved and cautious, she had her arms crossed and her voice tone was very soft. Paulina started her discussion with a difficult case in which a child is not making much progress therapeutically or behaviorally in the facility. She went on to discuss, also in detail, several other cases. In her post-supervision interview, Paulina expressed a desire to go into more detail about the cases, stating:

You know, what happened in the sessions. Sometimes, you know, more detail of, you know, if there was something that, you know, made a lot of sense or brought back some history or trauma or something that I didn't understand and I needed for Sandnes to help me understand where it is coming from.

As the supervision continued, Paulina relaxed, and her body posture was more energetic and her voice was stronger. She described some of the various techniques and counseling skills she uses with the children and adolescents in therapy such as, play therapy, sand tray therapy, art therapy, and genograms.

As she presented the cases to the supervisor and they discussed the cases, Paulina's attitude was positive toward the children, and adolescents, therapeutic

progress. However, she did conceptualize the entire case, in every detail, even if the therapy was not currently effective. Paulina's affect would match the case she was describing. When she described a difficult case, she appeared somber and low, and when she described a case that was progressing in a positive direction her energy was up and her voice was louder. As supervision ended, Paulina was asked to provide a receipt for a clinical training she was at last week in order to receive reimbursement, and she was also reminded of other administrative issues.

#### *Within-case findings*

*Erica and Sandnes.* Within the post-supervision interviews of Erica and Sandnes following their individual supervision session, several common themes emerged. It was evident from each of their post-supervision interviews that several topics are covered in the one hour supervision session. Both the supervisor, Sandnes, and the supervisee, Erica, make an effort to take full advantage of the time they have. Various topics were covered in the supervision and both reported an urgency to get through all the information. Each of them felt a desire to discuss individual cases.

Sandnes stated, "so I mean there's a lot of catching up and getting up to speed on certain cases. We have so many cases that change so rapidly, and we kind of needed to be on the same page there." Similarly, Erica reported, "I was feeling rushed, and I was feeling pressured to just try to make sure I ran through everybody and hit all the highlights and all the important things." Erica goes through a list of her cases during supervision and Sandnes looks for updates related to Erica's cases. Erica speaking about her process of discussing cases, offers these statements: "Basically what we do is we start off with just a brief description of what's going on with each

of my kids.” “I usually start with individuals at first and then I go to my family cases.” “I always think that I need to get to each one of my kinds.” “I usually have like a mental list of what I go through.”

Sandnes reviews the process Erica goes through, noting “she gave some updates on some kids that had been discharged and how they’re doing. And then it’s just overall summary on the clients.”

Erica and the other counselors work with various other systems. These other systems include, but are not limited to HKI (Hillsborough Kids, Inc.), the court system, child welfare, doctors including psychiatrists, and schools. Erica, in supervision with Sandnes discusses her collaboration with these various systems as part of her treatment with children and adolescents, “We talked about following up with a couple of e-mails to HKI regarding a 30-day letter that we just put in for some kids.”

Furthermore, Erica states:

[I] talk about how they’re doing in therapy and then any case management stuff. Like if there’s anything going on with them with HKI or the court system, family application stuff, any letters that need to be written to the court or anything like that and then any problem behavior.

Sandnes also discussed working with various systems and highlighted an inclusion of discussion about appropriate therapeutic practices within the supervision session.

Sandnes reported:

Going into the other ones looking at a lot of court situations where the parents are either going to be reunified or they're looking to get a TPR and the kid is kind of in limbo and talking about what affect that has on the child here. Talk about medications. Wanted to speak with our psychiatrist on medications for certain kids, some that maybe need an adjustment or something. They just need to be looked at in general.

Working with various systems, in addition to working with programs within the same facility were challenging for Erica. Working with other programs and also dealing with families in the most therapeutically appropriate and boundary clear way, provided much discussion during the supervision session. The ethical issue of boundaries resulted in both Erica and Sandnes discussing it in the post-supervision interview.

Erica reported:

It's helpful for her to reinforce that I need to make sure everybody knows that they're being on the speaker phone, because sometimes I like to be sneaky and not let everybody know that they're on speaker, even though you have to.

Sandnes was clearer than Erica that the speaker phone and family therapy discussion in supervision; was a discussion about boundaries.

Sandnes stated:

Like I was thinking the boundary issues like when she was talking about one of the children work with one of the people from Search, it's our aftercare adoptions department. There's some boundary issues with that. And I clarified with her last week, but she didn't seem to get the whole – One is that she stopped that one and [Indiscernible] she's created another incident with them.

I think also talking to her about general reminders about boundaries and whatnot where I had reminded her that you need to tell people their on speaker phone [Indiscernible] calls, because that's not really a good idea not to tell people.

In an effort to address individual case specific issues and boundaries, Erica and Sandnes both reported key personal elements in the process of supervision. Each of them describe what they think is important in the supervisory process.

Erica stated:

Other therapists here know about them, but Sandnes knows more in detail about what's going on with them and what they came in with and their diagnosis and what they're dealing with on a regular basis.

Erica goes on to discuss the supervisory relationship in the following context, "so it's always comforting to be able to talk, just to kind of talk and be able to vent about what's going on with them." Similarly she describes thinking the following, "I think it's important to have supervision because I think you need that reassurance that somebody else knows what's going on in your sessions." Sandnes would agree with Erica, when she stated, "she's making decisions all by herself. Not that you can't, but some things we just need to run by [Indiscernible]."

Sandnes goes on to explore her rationale for decision making and the supervisory relationship:

I think in [Indiscernible] are important to develop a relationship with the people you're supervising and that they are not fearful in coming to you for question or throwing out ideas. They're able to kind of connect with you on some level.

Not that you're their friend, but you're a friend employee and able to be approached and go over situations where you don't have people just making decisions on their own or making them [Indiscernible] or hiding things from you and not reporting everything to you. And available for feedback.

In addition, Sandnes states:

You go either talk things out. I mean, that's real important also. And the ability to let people know they can come and [Indiscernible] vent to you. You may not be a therapist, but you can let off some [Indiscernible]. [Indiscernible] stressful field, and you see such terrible things every single day. You could really need that time to go let it off.

As Erica and Sandnes ended their supervision, Sandnes shifted the clinical supervision into administrative supervision. Erica commented only minimally on the administrative supervision in the post-supervision interview, noting that they

reviewed her schedule. However, Sandnes focused more discussion in the post-supervision interview on the aspect of administrative supervision, noting how it met her supervisory needs, “I needed someone to cover a training topic for an orientation. And I definitely needed to get somebody to do that, so that was covered.” Similarly, Sandnes discussed what she believed to be important administrative information: “clarifying some things, and I needed to go over what we were doing in training today and that we had the audit coming up. We were looking at that kind of stuff, so be aware of that stuff.”

Within the post-supervision interviews of Erica and Sandnes the themes of individual case discussion, working with various systems, ethical dilemmas, the best practices when working with children and adolescents, the personal aspects of supervision, and administrative supervision emerged. These themes were consistent in Erica’s and Sandnes’s interviews. I believe that because the themes are consistent between Erica and Sandnes, their perceptions of what happened in the supervision experience are also similar. In addition, Erica and Sandnes both perceived similar meaning from the supervision experience. Erica and Sandnes cover a great deal of information within the supervision session. The relationship between Erica and Sandnes demonstrates Erica’s need for approval and guidance from Sandnes. This supervisee dependent relationship at times is challenged as Erica searches for her own independence when she challenges boundaries and makes clinical decisions on her own. I attribute the quality of this relationship to Erica’s developmental level as a therapist, having only graduated with her masters degree in social work one year ago.

Further discussion of their relationship to the collective case will emerge in the cross-case findings and in the collective case discussion.

The supervision experience between Sandnes and Erica was somewhat unique because it serves three purposes: clinical supervision, licensure supervision and administrative supervision. The primary purpose observed and noted during the post-supervision interviews was supposed to be clinical supervision. However, aspects of licensure supervision may have been present since the process of clinical supervision is also preparing Erica for licensure as a licensed clinical social worker. In addition, at the end of every clinical supervision session, Sandnes includes aspects of administrative supervision. However, since Sandnes does not operate from a developmental supervision model and currently is providing a form of generic supervision within a person-centered supervision model, it is unlikely that Erica's counseling competencies will be challenged within clinical supervision.

Erica in supervision with Sandnes, as described from a developmental perspective, is dependent on her supervisor for structure, positive feedback and clarification. Erica, however, does show motivation, a general sense of confidence, and enthusiasm about her therapeutic work. In addition, she is aware of client progress but needs to be challenged on appropriate boundaries with the client's family. Of all the supervision sessions observed and discussed post-supervision, Sandnes and Erica covered the most conceptually in the supervision session. Erica reportedly continues to struggle with boundary issues, yet she is defensive when Sandnes addresses the issue. This behavior is characteristic of the supervisee developmental level 2 in the Integrated Developmental Model (IDM), when a

supervisee shows “dependency-autonomy conflict” (Stoltenberg, et al., 1998). Erica is no longer content to simply model Sandnes, but still is dependent on her for support and feedback.

*Jenifer and Sandnes.* Within the post-supervision interviews of Jenifer and Sandnes common themes emerged consistent with their experience in individual supervision with some individual differences. Jenifer was quick to start the process of supervision and immediately started talking about training and the facility’s push to develop additional resources for best practices when working with children and adolescents. Sandnes was eager to hear about her ideas but also wanted to explore other clinical aspects with Jenifer. Jenifer reported how they discussed trainings, “we discussed some of the educational aspects of clinic training, and that’s something that we reviewed recently in clinic meetings.” Sandnes explored in more detail Jenifer’s discussion about training, “...a bunch of training and brought in material to show me so we can get enough stuff as we’re gathering up resources for this summer.” In addition Sandnes mentioned the facility’s eagerness for, “getting more training on CBT.”

Because Jenifer wanted to explore her individual cases, Sandnes seemed glad to see a shift in the focus from idea development to individual case exploration. Jenifer expressed a desire to discuss individual cases:

I didn’t get to a lot of individual kids. A lot of times I’ll just go through the kids and kind of keep her up to date on what’s going on wit my kids, but I didn’t really get a chance to do that. I usually have a list, and I didn’t get to all my list today either.

Similarly, she stated, [I was] “wondering if I was going to get through the list, because I do have some other stuff other stuff I need to talk to Sandnes about.”

Sandnes enjoys Jenifer’s ideas in supervision, but expresses relief about hearing about the cases. Similar to Jenifer, she wanted to explore the individual case issues.

I get excited. I love working [Indiscernible] people have some ideas, and Jenifer always has new and different ideas almost every single time we meet. I was a little excited. I was relieved and sometimes when Jenifer and I meet, she likes to focus on all her ideas and stuff as opposed to talking more about what she’s doing with the kids.

Jenifer and Sandnes did not appear to report similar beliefs about the supervisory experience. Jenifer reported supervision as feeling, “just kind of impatient. Trying to get through it all kind of like it’s a chore.” Similarly Jenifer stated:

Kind of like you’re a student again. You’re kind of like listening, but at the same time, you’re almost like you feel like you’re a student but also you’re a colleague. So it’s kind of a little bit of an odd feeling when you’ve got both positions.

Sandnes also reported feeling conflicted related to two positions, but her feelings about the supervisory process are rooted in a relationship not a behavioral chore.

Sandnes described the following conflict between clinical and administrative implementation:

And I love hearing it and then I start thinking about what could go wrong with it, which is pretty bad. Because I think if she’s come up with some really cool things for the treatment plan, it’s going to be a nightmare switching anything on our computers and stuff and other incomplete and nightmare in battle and possibly could cost money, which we don’t have to do right now. And I know it would be better for the kids, it’s just the whole other administrative part of it.

Sandnes, described efforts to make supervision an open and supported environment.

There is minimal indication that Jenifer connects with Sandnes’ efforts. Sandnes

describes, “I think being very open and willing to hear whatever people come for with and not to be self-conscious or worried about what to come forward with.”

Additionally Sandnes stated that, “I think it’s important to have [Indiscernible] support [Indiscernible] sense of humor about what we’re dealing with.” Jenifer responded and appeared to minimize her response, “I pretty well usually feel like I’m listened to. Whether something happens that I suggest of not, that’s – I just generally feel like it’s productive in a way.”

Sandnes did mention certain things about the individual supervision session that Jenifer did not. Sandnes expanded on the attempts both she and her clinical staff are making in treatment planning to make it more developmentally appropriate. She noted that Jenifer is implementing the new treatment plan, “so that helped me in my goal of showing that we’re attempting to be kid friendly. So I can show the auditor that we are attempted to be kid friendly.” Jenifer and Sandnes talked at great length about children’s trauma, and Jenifer mentioned that they talked about trauma, “we talked a lot about the trauma issues the kids face.” However, Sandnes went into greater detail about the specificity of the discussion and the impact she was trying to get across in the supervision, i.e. “kid’s trauma, different – started talking about [Indiscernible] re traumatizing to [Indiscernible] experience reexperience their trauma.”

Within the post-supervision interviews of Jenifer and Sandnes the themes of individual case discussion, the best practices when working with children and adolescents, and the personal aspects of supervision emerged. These themes were consistent in Jenifer’s and Sandnes’ interview. Sandnes’s post-supervision interview

yielded the additional theme of developmental appropriate understanding of children and adolescents when treatment planning. I believe Jenifer and Sandnes would have a similar perception about what happened in supervision, given their similar description of the supervision content. However, it seems that Jenifer and Sandnes would have a different perception as to why the supervision transpired the way that it did. Sandnes with-in supervision is clearly focused on the relationship she has with her supervisees and promoting her agenda of case review. Jenifer, on the other hand, sees supervision as an opportunity to develop ideas and explore possibilities. Jenifer and Sandnes have alternative agendas and differing perceptions that contribute to the quality of their supervisory relationship. Their supervisory relationship appears to be a working relationship that leaves Jenifer wanting more developmental stimulation and Sandnes primarily frustrated in her redirection to discussion about generic case review. Further discussion of their relationship to the collective case will emerge in the cross-case finding and in the collective case discussion.

The supervision experience with Jenifer and Sandnes serves two purposes: clinical supervision and administrative supervision. The observed supervision session and the post-supervision interviews revealed that clinical supervision is primarily occurring, however at the end of the supervision session, Sandnes does shift to administrative supervision. Jenifer did note that she has outside supervision for licensure, in her efforts to become a licensed marriage and family therapist. It appears that the outside influence of additional supervision and potentially divergent professional identities may have contributed to a perfunctory supervisory relationship between Jenifer and Sandnes. Jenifer's developmental supervision needs to stimulate

her professional competence appear to be fulfilled outside of supervisory relationship with Sandnes. Jenifer appears aware of the generic nature of the clinical supervision between her and Sandnes.

Jenifer, described from a developmental supervision perspective is autonomous, with consistent motivation. As I observed her in supervision, she showed some doubts about the effectiveness of her therapeutic approach but was focused on what was best for the client. Within the supervision session and as described by Sandnes, Jenifer is often very focused on ideas and developing different skills. This is a common practice for a supervisee that is at the developmental level 3 of the IDM, in which the supervisee is focusing on developing a more personalized approach to practice and trying to understand the “self” in therapy (Bernard & Goodyear, 2004). Jenifer appears to have her developmental supervisory needs satisfied via outside supervision and thus frequently explores conceptual ideas instead of processing therapeutic issues. Sandnes, at times, is frustrated by the lack of case discussion, yet operating from a person-centered supervision style, she does not confront Jenifer’s tendency to focus on ideas versus cases.

*Paulina and Sandnes.* Within the post-supervision interviews of Paulina and Sandnes common themes emerged that were consistent between each other. Each reported a similar experience in individual supervision with minor differences in personal reflection. Both Paulina and Sandnes described reviewing cases specific issues and focusing on long-term planning. Paulina reported that she talked about, “what is happening and what is their long-term plan, and how each what is happening with them, indication, and just the whole of each child and what [Indiscernible]

sessions.” Sandnes paralleled what Paulina stated, noting that “she went over the majority of her cases and what’s going on with them but focusing on long-term plans as well as what they’re current doing in therapy.”

Paulina displays a level of reflection about the individual case discussion and Sandnes is complementary of her work in therapy with the children and adolescents.

Paulina describes:

...the other thing that was interesting is I kind of caught myself, like with the ones that are doing work, just getting more into [Indiscernible]. And then whenever I talk about the ones that are [Indiscernible], okay, [Indiscernible] calming. You know, even with me, my reactions.

Similarly Paulina reflects about her skills in the therapy session and uses this as personal time in supervision:

I’m getting someplace. Competent and doing some work and getting excited about the future for some of the children. Or in other cases, just being more concerned and trying to look and see what would work or, you know, how could I help. And with the ones that, you know, that specifically would one that never came to see me say okay. You know. What else could I have done? You know. Or maybe just realize even if I would do anything, she would never even come. She was not, you know, a client for therapy.

Sandnes makes an effort to complement this in her post-supervision interview. She comments, “that she’s a really good therapist.” “A lot of her (Indiscernible), little things that she’s come up with are researched.” Sandnes believes that Paulina is humble and not boastful in her abilities, describing Paulina as:

She’s just modest. She’s not real forceful in our meetings constantly telling people this is how it should be done and this is how I work with kids or whatever, but she’s just a really good, solid, therapist with these kids. She uses a variety of different things, and they really connect with her. And she just does really well with them.

Within their individual supervision Paulina and Sandnes primarily focused on the discussion of specific cases and specifically some of Paulina's more challenging cases. Sandnes noted feelings of frustration and administrative concern, while Paulina looked for feedback and assistance in developing additional approaches. Sandnes described the following with regards to her and Paulina's discussion about Paulina's difficult cases, "at the beginning, we started with such a downer case, which is such a hopeless thing that's spun off the kid that sure makes you feel like what are we doing here." She added, "I get very frustrated." Paulina felt the following based on her supervisory experience, "for me knowing that maybe I'm on the right track. I'm getting that feedback from Sandnes saying yeah. This is where it's coming from, or this is what the child's working with."

Sandnes and Paulina differed on their expressed needs in supervision. Sandnes had concerns related to administration and individual case specific issues, whereas Paulina wanted additional individual personal feedback within the supervisory process which related to individual case specific issues. Sandnes expressed administrative issues in the individual supervision with Paulina when she stated:

I have to look at utilization management as well as how long these kids have been here, where our plan is, what we're doing, and really from the very first day of them getting here, when do we discharge them and how are we getting them to the next level. And being able to hear her plan on cases.

Paulina expressed a desire for additional personal feedback and more assistance in the development of best approaches when working with the children and adolescents. She described:

I think sometimes I would like to get more – maybe other ideas of like okay, how to do it better. I haven't been that direct of like okay. Tell me maybe what I could do or how could I just help or, you know, be not stuck or things like that. Or be more specific like okay, you know, what was happening. Like for something during the sessions, maybe -- You see, that's something that I used to do before. Like the process recording.

Similarly, Paulina referenced wanting to process issues related to countertransference, stating, “whenever you bring things from your own stuff that many times, I don’t know.” In addition she discussed wanting to talk about “my health. Me. Saying okay, you know. When you are doing those things, okay, you brought back things from you maybe you should check,” in the supervision experience.

Within the post-supervision interviews of Paulina and Sandnes the themes of individual case discussion, the personal aspects of supervision, and the best practices when working with children and adolescents emerged. These themes were consistent in Paulina’s and Sandnes’s interviews. Sandnes’s post-supervision interview yielded the additional theme of administrative supervision. While within Paulina’s post-supervision interview the theme of countertransference emerged. I believe that Paulina and Sandnes would perceive what happened in the supervision experience very similarly. Due to their extensive history as supervisor and supervisee, and given their positive affirmations of each other, I also believe they would report similar perceptions as to why the supervision occurred the way that it did. The quality of their relationship is very fluid, and there is a clear routine to their supervision process. This supervisory relationship has lasted almost two years and can be attributed to a similar belief system about supervision and counseling. Further discussion of their relationship to the collective case will emerge in the cross-case finding and in the collective case discussion.

The supervision experience between Paulina and Sandnes serves three purposes: clinical supervision, licensure supervision, and administrative supervision. During the process of observing the supervision and reviewing the process of supervision during the post-supervision interviews it emerged that primarily Paulina and Sandnes engage in clinical supervision. Their clinical supervision is also part of Paulina's licensure requirement to become a licensed clinical social worker. Paulina's professional competencies have been promoted through her supervisory relationship with Sandnes and also through additional outlets such as clinic meetings and trainings. Since Sandnes does not operate from a developmental supervision model, it is not clear how Paulina's development was directly promoted in clinical supervision. Potentially, Paulina's desire to fill the gaps of a generic supervision format, given her desire to delve deeper into cases and issues such as countertransference, propelled her own development. However, Paulina did appear to be very satisfied by the supervisory relationship which was promoted by the person-centered supervision model Sandnes does appear to use. It was also evident during the observation of supervision and as reported by both Paulina and Sandnes, that at the end of the clinical supervision, Sandnes shifts the discussion to administrative supervision.

Paulina described from a developmental supervision perspective is not only confident in her skill set and autonomous, but also displays a wide array of competencies with a personalized approach. She described herself as competent, reflected affect when describing cases, and conceptualized cases both positive and negative. This awareness of strengths and weaknesses, combined with an integrated personalized approach is characteristic of the developmental level 3i (Integrated) of

the IDM. Sandnes is highly supportive and complementary of Paulina, believing that she is a “really good therapist.” With Paulina functioning at an integrated level and Sandnes supervising her with a person-centered approach, the supervision session was observed to have aspects of peer supervision and peer collaboration.

#### *Across-case findings*

The experience of the participants in supervision as reported in the post-supervision interviews in comparison to each other yielded similar and different themes. These themes included: administrative supervision during clinical supervision, best therapeutic practice when working with children and adolescents, discussion of case specific issues, understanding of child or adolescent development, ethical dilemmas, personal needs of the counselor or supervisor as they relate to supervision, supervision practices, treatment modalities, treatment planning, and working with various systems.

In addition, to recurrent themes there were recurrent topics. These recurrent topics are often part of a theme. However, topics were actually stated by the participants, whereas themes were the categories I chose to represent recurrent topics. The recurrent topics of the study were: boundary issues, cases, clarification, court, decisions, discharge, education, feedback, feelings, ideas, kids, long-term planning, research, supervision, schedule, training, trauma, and venting. With the addition of less common topics to the recurrent topics, the themes emerged. There were similarities and differences across the cases in the topics discussed and the themes that emerged.

Consistently across the cases, both supervisees and the supervisor reported the practice of listing or trying to go through each specific child case, adolescent case or the family case of a child or adolescent and the issues associated with the cases. It was this practice that resulted in comments such as: Erica stated, “Basically what we do is we start off with just a brief description of what’s going on with each of my kids. I usually start with individuals at first and then I go to my family cases.” Sandnes, similarly when discussing Erica, supervision stated, “So I mean there’s a lot of catching up and getting up to speed on certain cases. We have so many case that change so rapidly, and we kind of needed to be on the same page there.” Jenifer described her normal routine in supervision as, “a lot of times I’ll just go through the kids and kind of keep her up to date on what’s going on with my kids.” Sandnes paralleled her comments with “and then also kid’s specific situations and ways of working with them and their trauma and what our goals are here...” Finally Paulina similarly stated, “The children, of each one of the session and what is happening...” Sandnes agreed and stated that, Paulina “went over the majority of her cases and what’s going on with them but focusing on long-term plans as well as what they’re current doing in therapy.” The practice of listing cases or reviewing cases appears common to any supervision session.

The supervisor and supervisees were similar in their discussion of the themes of the practice of supervision and the personal needs of the counselor in supervision. They all described the practice of supervision as an opportunity for feedback and ideas, and the supervisory experience as personally supportive. Erica described looking to Sandnes to provide extra thoughts when she stated, “you know,

for any extra ideas or support that she might want to provide.” She went on to state that Sandnes, “also will provide me with books and things like that that I get to borrow and look through.” Jenifer similarly described the following as important about supervisory practice, “just the education I guess, the education part of it. Um, I don’t get a lot of feedback without direct supervision or observation of therapy.” Paulina was similar in her response, “And if there’s anything specifically very, you know, that I’m concerned then I stand or talk more about it and then get feedback of what would be best.” I observed Sandnes showing an effort to provide feedback and ideas to her supervisees.

Parallel to the theme of the practice of supervision is the theme of the personal needs of the counselor in supervision. Sandnes, as a supervisor, creates a supervisory environment of support, where supervisees can relate to her and share their emotions. Erica consistently noted the ability to “vent” and shared feelings of “reassurance” and “support” when in supervision with Sandnes. In supervision with Sandnes, Jenifer described feeling “listened to.” Similarly, Paulina noted, “for me knowing that maybe I’m in the right track. I’m getting that feedback from Sandnes saying yeah.”

Across the cases, the supervisees and the supervisor were also similar in their discussion of the best therapeutic practices for children and adolescents. The specific counseling skills and techniques the supervisees use in therapy were discussed in supervision and I observed the supervisee and supervisor reviewing these skills as they pertained to the cases. However, during the post-supervision interviews, only one participant highlighted the best therapeutic practices that were discussed in

detail. Jenifer and Sandnes discussed in detail, “trauma training,” and “talked a lot about the trauma issues the kids face.” In addition, Sandnes noted that Paulina’s therapeutic approaches with the children are “researched.” The focus of the supervision session is case review and divergence from case review potentially makes the next supervision rushed. Thus, exploration of child specific competencies in supervision discussion appears to not be promoted, given only one supervisee’s exploration. Additional, in-depth discussion on child trauma and therapy would align the supervision session with a non-generic supervision format.

During each clinical supervision session, Sandnes would introduce administrative supervision issues at the end of the clinical supervision session. Each time that she discussed administrative issues the administrative issues were different, but consistently, across cases, Sandnes discussed administrative topics at the end of clinical supervision. Sandnes expressed having an administrative mindset during clinical supervision, noting:

I have to look at utilization management as well as how long these kids have been here, where our plan is, what we’re doing, and really from the very first day of them getting her, when do we discharge them and how are we getting them to the next level.

At the end of clinical supervision she discussed a variety the administrative issues including: grant reimbursement for a training Paulina attended, schedule changes, reviewing the audit results, hurricane emergency plans, having Erica cover a topic in the orientation training, and converting the new “kid friendly” treatment plan paperwork to their facility’s computer system.

Differences also emerged in the themes across the cases. The most noticeable difference was the mention of outside supervision by Jenifer and its relevance to the theme the practice of supervision. Jenifer discussed feeling different in supervision:

If it's one of my kids in a family session or something that, you know, I have supervision outside the residential facility because I'm a marriage and family therapist and they're social workers. So I receive that.

Another difference was the theme of ethical dilemmas and issues, specifically boundaries, countertransference and transference. Erica discussed the importance of talking about transference, when in fact I think she meant countertransference, stating "And, you know, if somebody—if a client is really bothering you for some reason, to be able to discuss that transference, you know, those personal feelings that come up in therapy all the time. I think that's incredibly important." Paulina discussed wanting to possibly explore her countertransference issues, however did not explicitly discuss countertransference during supervision. Sandnes discussed the importance of addressing boundary issues within Erica's supervision session, but did not in any of the other supervision sessions, stating "like I was thinking the boundary issues like when she was talking about one of the children work with on of the people...And I was thinking, oh, we need to go back to that again. I didn't really totally address it with her yesterday."

Sandnes was observed consistently discussing the implementation of a developmentally appropriate treatment plans for the children at the residential treatment facility. Sandnes also reported and discussed the "kid friendly" treatment

plan in a post-supervision interview. The use of this specific treatment plan was important to Sandnes as noted by the following:

Well, I told—I didn't ask. I told people they are to use this class (Indiscernible) I was really glad that she asked and clarified and didn't just blow it off or not utilize it, because we have (Indiscernible) every single week, and I really wanted it to be incorporated right now on everybody's plan. So that helped me in my goal of showing that we're attempting to be kid friendly.

I observed each supervisee discussing the “kid friendly” treatment plans during supervision with Sandnes, but none of the supervisees mentioned the developmentally appropriate treatment plans during the post-supervision interviews. This discussion in supervision, across all supervisions was an opportunity for the process of supervision to be specific to child and adolescent therapy. Sandnes made an effort to shift the generic case review discussion to specific treatment planning techniques for children and adolescents in each supervision session. Despite this effort to be non-generic in supervision, the supervisees did not relay the same level of support for the developmentally appropriate technique across the cases.

The supervisees, Erica, Jenifer, and Paulina, consistently review cases in supervision. In addition, the supervisees also make an effort to discuss the most appropriate practice when working with a child or adolescent in therapy. The dominant themes across the interviews with the supervisees were the review of cases and the best therapeutic practices when working with children and adolescents. The lack of specificity or ability to delve deeper into the cases promoted the generic nature of the supervision. Each supervisee consistently felt a pressure to review each case, thus limiting her ability to explore in more detail the best practices when

working with children and adolescents in therapy or other issues they personally may have believed relevant to counseling children and adolescents.

The supervision that Sandnes provided to Erica, Jenifer, and Paulina was consistently geared to review the child and adolescent cases. The dominant themes across all of Sandnes's interviews were her review of cases, her desire to address the personal needs of the supervisee, and her discussion of administrative supervision at the end of clinical supervision. As noted by Sandnes, this practice of case review during weekly clinical supervision is required by their facility accreditation and by Medicaid. Sandnes described during the follow-up interview, member check process, wishing that the supervision experience could be like it was before accreditation and Medicaid. She was cognizant that as a supervisor she was only reviewing cases and not going into detail. The lack of detail during the review of the cases maintained the generic or surface quality of the supervision. Sandnes operates from a person-centered model of supervision during supervision, to address the primary supervision goal of case review, and the potential other issues of best therapeutic practice when working with children and adolescents, a developmental understanding of the child or adolescent, ethical dilemmas, personal needs of the counselor, treatment modalities, treatment planning, and working with various systems. Despite reporting that her personal theoretical orientation is psychodynamic and that she would do process recording with her supervisees, Sandnes appears handicapped by time and external controls. Her supervision style is limited to facilitating self-confidence in the supervisee via support, understanding, and process.

### *Summary*

The results of the clinical supervision observation and the demographic questionnaires were presented in detailed descriptions of each case. Similarly, the results of the post-supervision interviews were presented via with-in case and cross-case analyses. Several themes emerged from these analyses and included: administrative supervision during clinical supervision, best therapeutic practice when working with children and adolescents, case specific issues, understanding of child or adolescent development, ethical dilemmas, personal needs of the counselor or supervisor as they relate to supervision, supervision practices, treatment modalities, treatment planning, and working with various systems.

Chapter Five will discuss the main conclusions of the study. The statement of the problem will be explored in relation to the methodology used, followed by the subsequent findings. Conclusions will be discussed. Implications will be described. Recommendations for additional research will be made based on this study.

## Chapter Five

### Summary and Conclusions

The following chapter will present a summary of the collective case and the major conclusions of the study. The statement of the problem will be discussed in the context of the methodology used, followed by the subsequent findings.

Recommendations for additional research will be made. Implications for new research questions that emerged based on this research study will be explored. In addition, recommendations from this study for use in the field of counseling and supervision will be made.

To summarize, how clinical supervision is defined appears critical given the diversity of fields exploring the topic but there appears to be some consensus that counselor supervision is guided by developmental principles (Falender et al. 2004). As models are placed into action, supervision delivery is often an individual process between supervisor and supervisee. As seen in the collective case study, the interaction between the supervisee and supervisor took place during individual supervision. Bernard and Goodyear (2004, p. 209) consider individual supervision the “cornerstone” of supervision, however, supervision also can be in the format of group.

The issues specific to child and adolescent counselor supervision within the literature are minimal. Rarely does research address the needs of the child and

adolescent counselor in supervision. The current study sought to contribute to the existing research in the field of counselor supervision specifically relating to child and adolescent counselor supervision. It was the aim of this study to illustrate the process of child and adolescent supervision in order to determine how similar it is to generic supervision as well as to determine which issues and or concerns arise in the processes that are unique to child and adolescent supervision and to determine which competencies child and adolescent supervisors should have.

### *Collective Case*

Collectively, the clinical supervision experience for child and adolescent counselors in residential foster care as reported through the experiences of the represented cases was both similar and different. As a group their similarities are greater than their differences, especially in their experience in supervision. They each participate in weekly individual clinical supervision for one hour, and each participant has the same clinical supervisor, who is also a participant. As they work together, counsel children and adolescents in the same facility, and participate within the same supervision paradigm, these cases have a collective identity.

Singularly, each participant is identifiably her own individual. The supervisor, Sandnes is a 36-year-old Caucasian female with 17 years experience working with children and adolescents, with the majority of her experience having been at this residential facility. She is also a licensed clinical social worker. The supervisees, Erica, Jenifer, and Paulina each have considerable experience, represent more than one cultural group, and are at different stages in their careers developmentally. Erica is a 25-year-old Caucasian female with four years experience working with children

and adolescents and is a registered clinical social work intern. Jenifer is a 52-year-old Caucasian female with seven years experience working with children and adolescents and she is a registered marriage and family intern. She recently took the marriage and family licensure exam. Paulina is a 42-year-old Hispanic female with seven and half years experience working with children and adolescents and is a registered clinical social work intern. She has completed all the requirements to take the licensure exam for clinical social work, and she plans to take the exam this year. Seen from a developmental supervision perspective, Sandnes is supervising three very different supervisees. Each is at a different level developmentally as defined by the IDM of supervision (Stoltenberg, et al., 1998).

The three supervisees are each at different development stages, as supervisees, according to the IDM. Erica would be considered a level 2 supervisee, in which she remains highly dependent on Sandnes, but is working to make the transition from being dependent to being autonomous. Sandnes demonstrated a delicate balance on the most appropriate way to approach Erica so as to not offend her. At times, Erica would appear confident in her skills and other times unclear regarding the appropriate direction to take the therapy. However, she was generally very client-aware and focused on her cases. Jenifer would be considered a level 3 supervisee. She was primarily focused on developing additional skills and competencies during the supervision session, as a means of developing her own personal style in therapy. Jenifer was clearly autonomous, and she was also aware of both clients and self. Paulina would be considered a level 3i (integrated) supervisee. She was flexible during the supervision session and discussed her strengths and weaknesses. Paulina,

while exploring case conceptualization, demonstrated a personalized approach; that addressed multiple therapeutic competencies. The difference between Jenifer and Paulina is that Paulina is fully integrated in her identity as a counselor, whereas Jenifer is continuing to search for her personal style as a counselor.

These different developmental levels could be challenging for a supervisor. However, Sandnes approached her supervisees primarily from a person-centered model of supervision. She may have been interested in supporting the development of her supervisees, but due to accreditation and Medicaid requirements to review each case each week in supervision, Sandnes felt the need to move quickly in supervision and remain supportive. The lack of direct confrontation and delving deeper into the professional functioning of her supervisees, such as in the domains suggested in Stoltenberg, et al. (1998) (e.g. intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment plans and goals, and professional ethics) appeared too time consuming in the clinical supervision hour for Sandnes.

In supervision, collectively the cases appeared to represent the typical residential child and adolescent counselor and supervisor. The counselors and supervisor in clinical supervision discuss the child and adolescent cases and the specific details of the cases, the best therapeutic practices when working with children and adolescents in counseling, the developmental understanding of the child or adolescent, ethical dilemmas, the personal needs of the counselor or supervisor as they relate to supervision, supervision practices, treatment modalities, treatment planning, working with various systems, and administrative supervision issues during

clinical supervision. Consistently the participants reviewed cases during clinical supervision. This practice is consistent with generic supervision, as is the discussion of best therapeutic practices when working with clients, ethical dilemmas, the personal needs of the counselor, supervision practices, treatment modalities, treatment planning, and administrative supervision. During the member checking process I discovered that it was an accreditation requirement that the clinicians not only have individual supervision one hour per week, but they also must document the review of each child and adolescent case during the supervision.

Individual supervision is typically seen as the primary outlet of supervisory process (Bernard & Goodyear, 2004). The supervisees and supervisor all reported in various degrees that during the individual clinical supervision reviewing cases was a consistent practice which lead to additional discussion of the best therapeutic practices, understanding of the child or adolescent development, ethical dilemmas, treatment modalities, treatment planning, and working with various systems. As part of their supervisory experience the supervisees and supervisor also explored how their personal needs were met in supervision. It was through the supervisor's strength-based, non-confrontational, and positive style of supervision, generally considered a person-centered model of supervision, that the supervisees reported feeling listened to, reassured about their work, and a general sense of competence. In addition, despite the individual supervision being designated as clinical supervision, each supervision experience did have elements of administrative supervision. Consistently administrative supervision occurred at the end of the clinical supervision experience.

## *Conclusions*

The current study set out to address the clinical supervision of working professional counselors; in particular the clinical supervision of CACs. At this time, CACREP, the national accrediting body for professional counseling, provides no exact clarification on the competencies for CACs nor for those who supervise them. Hence, although the ACA code of ethics requires supervisors and professional counselors to practice within the boundaries of their competence, the specific competencies for CACs and for their supervisors remain largely undefined. This poses a significant problem for professional counseling, for clinical supervision and ultimately for client welfare.

Although, the majority of participants in this study were clinical social workers, the results of the study could still be useful to child and adolescent counselor supervision since CACREP also defines social work as a related field and allows for practicum and internship students to be supervised by such professionals. This study may be as relevant to a related field as it is to counseling.

The subsequent findings of this research concluded thematic findings representative of not only a clinical supervision experience but also a clinical supervision experience that was specific to CACs. The nature of the supervision experience as reported by the supervisees and supervisor involved primarily discussion of the child and adolescent cases and a general review of the issues related to the cases. In addition, the nature of the supervision experience was described as primarily supportive environment for feedback, reassurance and clarity. Given this supervisory experience the supervisee and supervisor reported discussing a variety of

issues while exploring the child and adolescent cases. The supervisees and supervisor did discuss additional issues relative to the children and adolescents which related to the best therapeutic practices when working with children and adolescents in counseling, the developmental understanding of the child or adolescent, ethical dilemmas, treatment modalities, treatment planning, and working with various systems. However, collectively the supervision format was surface case review, lacking in-depth discussion of therapeutic issues and supervisee developmental concerns. I concluded that this practice of case review with minimal exploratory discussion and supervisee development was prescribed by facility accreditation and by Medicaid. As a means of coping with prescriptive supervision, the supervisor, Sandnes, appears to choose to provide person-centered supervision which is empathetic and supports the confidence of the therapist in a system that is not conducive to in-depth client conceptualization or supervisee development.

It is important to note that these supervisees and supervisor did address the issues that were covered in the counseling sessions with the child and adolescents. Studies have shown that children and adolescents in residential foster care settings have substantially more issues related to family dynamics, multiple placements, and service history, and depict the children and adolescents as having emotional disabilities and disruptive behaviors far greater than traditional foster care children and adolescents (Breland-Noble, Farmer, Dubs, Potter, & Burns, 2005; Handwerk, Friman, Mott, & Stairs, 1998; Wulczyn, Kogan, & Harden, 2003). The mental health concerns of children and adolescents remain prevalent and the service demand remains high for counselors, the need for supervision also will remain high. It is

estimated that more than 75% of children in need of mental health care were simply not served (Kataoka, Zhang, & Wells 2002). In addition, abused and neglected children or severely disturbed children are often most underserved (Cicchetti & Toth, 2003; Marsh, 2004). Supervisors of child and adolescent counselors who are familiar with the needs of this critical population are in high demand (Neill, 2006). As such, addressing the case specific issues, the best therapeutic practices, the developmental understanding, potential ethical dilemmas, treatment modalities, treatment planning, and working with various systems are all critical topics to address in supervision when working with children or adolescents in residential foster care. However, these topics were reviewed as they pertained to certain cases, not discussed in detail, due to the sense of urgency to cover each case.

*Child and Adolescent Counselor Competencies.* CACs need specific competencies. Children and adolescents have specific developmental, educational, personal, social, and behavioral needs. The competencies of a child and adolescent counselor should reflect a knowledge and skill base specific to the needs of children and adolescents. Their knowledge and skills should be based in counseling interventions and theory. Specifically, CACs should develop competencies specific to children and adolescents in the professional domains of: intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment plans and goals, and professional ethics. In order to accomplish professional competence CACs need to not only fulfill their masters educational requirements, but also take graduate courses in child development, counseling children, family counseling, play therapy,

and consultation and collaboration.

Child and adolescent counselors have a specific skill set different from generic counselors. Counseling children requires an in-depth understanding of child and adolescent development, child and adolescent cognition, child and adolescent social development, and counseling skills and interventions specific to children, adolescents, families, parents, and caregivers. In addition, child and adolescent counselors often require skills beyond the skills of a generic counselor regarding case collaboration with the school system, the legal system, and child welfare. Child and adolescent counselors are able to conceptualize child and adolescent clients according to the client's therapeutic needs in a way that is developmentally and cognitively appropriate. A child and adolescent counselor uses child and adolescent therapeutic specific skills and techniques in therapy, such as play therapy, to address the needs of the client.

The participants of this study demonstrated potential in numerous competencies related to interventions skills specific to children such as play therapy, family therapy, consultation and collaboration, client conceptualization, theoretical orientation, treatment plans, and professional ethics. However, the participants in the study primarily focused on the competency of client conceptualization. The majority of discussion within the supervision session was focused on case discussion with a lack of in-depth discussion about intervention skills, treatment plans and goals, professional ethics, individual differences, and interpersonal assessment. There was minimal discussion about theoretical orientation.

*Supervisor Competencies.* The supervisors of CACs also need specific competencies. In addition, to being a competent child and adolescent counselor, a supervisor CACs needs to understand supervision theory and how to implement supervision theory in her professional environment. A child and adolescent supervisor needs to understand the variety of issues such as, the increased incidence of vicarious traumatization when working with traumatized youth, evidenced based treatment modalities, the stress of collaborating with possibly dysfunctional systems including but not limited to child welfare, and intricate knowledge about how to work with interdisciplinary treatment teams of school psychologists to psychiatrists the CACs will face. A supervisor of CACs must not only have the knowledge base that supervising CACs is different than supervising adult counselors, but also have supervision skills specific for CACs. To ensure the supervisor's clinical and professional competence, their developmental needs should be promoted through continued clinical supervision and training on issues specific to children and adolescents.

The supervisor in this study is very knowledgeable. She has extensive experience within the facility and understands the details of residential foster care. The supervisor's ability to educate, collaborate and consult with her supervisees about the system in which they work is an excellent asset to her supervision practice. In addition, to her knowledge about the facility and system of residential foster care, the supervisor's competence in understanding child and adolescent development is also an asset to her supervision practice. Despite the depth of knowledge and experience competence it is unclear how much supervision theory the supervisor actually applies. Her competence in supervision appears stunted by outside controls and additional

education and support could help to propel her supervision process forward. Given the opportunity, I would recommend that Sandnes not only fulfill the competencies I have proposed for supervisors of CACs, but also given her observed and reported circumstance also find more time for providing supervision to her supervisees, have her own clinical supervision, and encourage her not to be fearful of confronting her supervisees.

### *Limitations*

As future research seeks to develop additional competencies for CACs and additional competencies for the supervisors of CACs, it would be important to consider the variables that might have influenced the outcomes of the current study. There are a number of factors that may have influenced the results of the study. First, the facility is a residential foster care facility. Residential settings are held to accrediting standards and third party payers which greatly influence the quality of service and the type of service. As a result, the type of supervision was impacted by an external body rather than the decision of the clinical supervisor. Potentially other settings would not have similar limitations. Second, the supervisor and two of the three supervisees are clinical social workers and not counselors. Clinical social work is a related field to counseling. However, most social workers have a different theoretical orientation or educational background than counselors and they also have a different traditions related to supervision. Third, only one supervisor was observed and interviewed post-supervision for this case study. Although, this provided a clear and in-depth picture of how she provides supervision, using only one supervisor participant can illuminate only one supervisory process perspective. The factor of the

limited discovery time and environmental factors was a limitation. For this particular study, supervision was observed only one time per participant and then the participants were interviewed after that supervision session. Potentially additional supervision observations, then a post-supervision interview would have provided a clearer picture of the nature of supervision for a collective case of CACs. Thus, another limitation related to only interviewing each supervisee and supervisor once post-supervision is that the results may have been a reflection of an atypical day.

Forth, the scope of practice under which supervisees counsel was broad. Specifically, the supervisees of this study are asked to counsel children with various, if not vague, presenting problems and labels leading to invariably unclear description of case conceptualizations and feeding into the child counselor role of multi-task professional. Fifth, it became clear during the initial interview and rapport building stage of the study that additional demographic information could have been gathered. Only minimal information about each participant was asked, such as, age, gender, and ethnicity. Additional information about marital status, children, and family history could have added, potentially critical information about their ability to relate to and counsel children and adolescents. Finally, the two weeks during the observation of supervision and during the post-supervision interviews, the air-conditioning was broken in the majority of the residential foster care facility. I believe that the uncomfortable conditions at the facility truly limited the participants' willingness to expand on open-ended questions.

### *Implications*

This study is an exploratory study of the clinical supervision for CACs. My

study focused on what is the nature of clinical supervision in residential foster care, particularly what issues involving children and adolescents are explored in the supervision session. However, other studies are needed about supervision theory as it applies to professional practice. It is apparent from this study that theory to practice is not always a workable reality. Supervisors and supervisees working with children and adolescents need a specialized supervision model. As seen in this study, the supervisor was resigned to being a person-centered supervisor, when potentially in an ideal setting she would have been a developmental supervisor.

*Alternative Model.* One potential model for the supervision of CACs in residential foster care is a developmental strength-based model of supervision (Coll, Simmons, & Teufel, 2006). A strength-based perspective as defined by Baker (1999) is “an orientation...that emphasize the client’s resources, capabilities, support systems, and motivation to meet challenges and overcome adversity...It emphasizes the client’s assets that are used to achieve and maintain individual and social well-being” (p. 468). In a developmental strength-based model of supervision, the supervisor would use strengths to address deficits to in turn promote development of the supervisee.

In the current residential foster care facility with CACs, one could apply a developmental strength-based supervision model based on the supervisor’s desire to be supportive, but also delve deeper into supervisory issues. It has been noted that supervisors can create an atmosphere that is supportive and one that uses a strengths perspective. Cohen (1999) states that the supervisor can create a central strength-based orientation in supervision, by promoting supervisee success, rather than

exerting resources to seek questions, problems, and dissatisfaction.

The first step in developing a supervision model that focuses on strengths is to change the supervisor's focus to supervisee successes rather than supervisee skill deficits. A supervision session that focuses on the strengths, success, and initiatives can provide a motivating, learning environment that supports supervisees and the supervisor (Cohen, 1999). The supervisor should emphasize supervisees' successes in a given case, in order to use its implications in other situations. For example, when a supervisee effectively uses a technique on a particular case, the supervisor uses that example to strengthen a supervisee's ability in other cases. This process of supervision should also include a focus on appropriate self-awareness and self-criticism, to enhance self-growth (Cohen, 1999). Glasser and Suroviak (1989) demonstrate that even with the most distressed population, using a strength perspective can change the individual's view of resignation to resilience. That is, the individual eventually develops a systematic plan that encourages self-improvement.

The model is based on an integrative model that assesses supervisee competencies on three different stages of development from Stoltenberg and Delworth (1998). A strengths-based model promotes self-efficacy through both the development of autonomy and the development of competency. A strengths model allows supervisees to progress "faster" in the dimension of autonomy and self-efficacy, than they would in a traditional developmental model. Hence, supervisees quickly develop both self- and other- awareness, consistent motivation, and a positive self-concept (Coll, et al., 2006).

In addition, to exploring a developmental strength-based supervision model as

it applies to supervisors who work with CACs, it is also important to address the lack of specific skills for CACs and for CACs supervisors. Counselor Education programs need to address skills and competencies for CACs and CACs supervisors. It is important for Counselor Education programs to identify the needs of their students and continue to offer electives and certificate programs that address specialty areas, such as play therapy and counseling children. Courses in child development, counseling children, family counseling, consultation, and play therapy should be required of students who are obtaining school counseling masters degrees or students obtaining a mental health masters degrees that are planning on working with children, adolescents or families. Supervision courses within Counselor Education programs should be clear to highlight the importance of supervising within competence area and the skills to be an effective CACs supervisor. Thus, if you are going to supervise CACs it is important to develop competencies in counseling children and adolescents, in addition to being an effective supervisor.

*Implications for School Counseling.* Specifically, the literature on school counselor supervision pointed to a clear need for increased supervision. The consensus that supervision is lacking for school counselor implies a need for not only more supervision for school counselors, but also specificity is needed in the competencies and standards of supervision provided to school counselors. School counselors routinely feel isolated from other counselors and often the responsibility for their supervision is assumed by non-counseling professionals. School counselors often deal with serious mental health issues, aggression, abuse, and behavioral issues. When supervision is assumed by a non-counseling professional the implication is that

the supervision is administrative supervision. A school counselor, like a mental health counselor of children and adolescents needs clinical supervision to increase their skills and competencies when working with children and adolescents. In addition, clinical supervision when provided by a competent supervisor ensures the standards and practices of the school counseling profession, such as the American School Counselor Association (ASCA) National Model.

*Recommendations for additional research*

Adding to the literature on the clinical supervision of CACs is an important component in the development of competencies for supervisors of child and adolescent counselors. Studies are needed that expand on theoretical assumptions and move into professional practice. Future research needs to address the theoretical components of supervision competencies for specialty areas and for professional areas that apply outside of the educational settings of practicum and internship. Such studies would focus on the supervision experience and the application of supervision theory in settings.

Another suggestion for research is to study more closely the experienced supervisor. An experienced supervisor, similar to an experienced counselor, has had many opportunities to experience a wide range of clients in numerous settings leading to an authentic perception of therapeutic role. The experienced supervisor, mentors, teaches and supervises novice supervisees. Experienced supervisors may or may not be receiving clinical supervision. Examining the various practices of an experienced supervisor and how they satisfy their supervisory needs would add to the literature on master therapists. The various roles of experienced supervisors is also a topic of

interest. Almost half of supervisees report that their clinical supervisor was also their administrative supervisor (Evans, 1993; Kenfield, 1993; Tromski-Klingshirn & Davis, 2007). Most supervisees found that having a clinical supervisor as an administrative supervisor was a benefit not only to the supervisee but also to the supervision experience and the client (Tromski-Klingshirn & Davis). Additional research needs to address the impact of the administrative role on the quality of the clinical supervision experience when in clinical supervision. Similarly, when there is a blended role of administrative and clinical supervision, whatever the factors that contribute to administrative supervision being a benefit to clinical supervision need to be explored.

The current study addressed CACs in residential foster care, but future research could address specifically just supervisors in residential foster care or just CACs in residential foster care. A study of only supervisors or only CACs would further the detail of demographic, social, gender, cultural, and/or perception information about their supervisory experience. It is possible that the results may have reflected a hesitation to say something negative about the supervisor or the supervision process. Future studies and interview questions should make an effort to explore individual differences and supervision satisfaction. Similarly, the current study was a case study. Additional research could have a participant pool to compare the experiences of CACs in supervision in residential care to CACs in supervision in outpatient care. Given the high influence of managed care, such as Medicaid, future research needs to investigate the impact of managed care standards on supervision quality and supervisee satisfaction in residential and outpatient settings. Related to the

impact of managed care and quality assurance standards, the development of a tool or a form for child and adolescent supervisors to help them better manage their time during the supervision session for the purposes of quality assurance appears greatly needed given the current study.

Greater in-depth exploration of the issues specific to children and adolescents discussed in the supervision session needs to be addressed in the literature. Given the need for developmentally appropriate practice when working with children in therapy (Myers, Shoffner, & Briggs Kielty, 2002; Ivey & Ivey, 1990, 1998); future studies need to investigate whether the treatment provided is congruent with the treatment discussed in supervision among CACs. As supervision literature expands and improves its empirical basis, greater attention needs to be paid to the process of supervisee development specific to CACs. Models of supervision need to address competencies that explore supervisee development in specialty areas, such as counseling children. Accrediting bodies and national associations need to support research on the supervision of CACs, and thus increase the likelihood of specific competencies for supervisors of child and adolescent counselors. In order to achieve such goals, counselor supervision, as the “gatekeeper of those who are to enter the particular profession” (Bernard & Goodyear, 2004, p. 8) should address the development of child and adolescent counselors.

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## Appendices



## **Informed Consent to Participate in Research**

### **Information to Consider Before Taking Part in this Research Study**

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Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study.

We are asking you to take part in a research study that is called: Clinical Supervision of Child and Adolescent Counselors in Residential Foster Care: A Collective Case Study.

The person who is in charge of this research study is: Lee A. Teufel.

The research will be done at your facility.

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### ***Purpose of the study***

The purpose of this study is to document the experience of clinical supervision for child and adolescent counselors and a supervisor working in a residential treatment facility. Your participation in this study will help increase the knowledge about the supervision of child and adolescent counselors.

### ***Study Procedures***

If you take part in this study, you will be asked participate in: 1) a 30 minute interview about your professional background and your most recent experience in individual supervision; and 2) a 15 to 20 minute interview to review the content of the initial interview and review the themes of the interview analysis by the researcher.

### ***Alternatives***

You have the alternative to choose not to participate in this research study.

### ***Benefits***

I don't know if you will get any benefits by taking part in this study.

### ***Risks or Discomfort***

There are no known risks to those who take part in this study.

### ***Compensation***

I will not pay you for the time you volunteer while being in this study.

### ***Confidentiality***

I must keep your study records confidential. I will maintain any and all field notes for one year after the completion of the study. They will be kept confidential and kept secure. Transcribed interviews will be reviewed by an external auditor and peer debriefer who will also maintain confidentiality.

However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator, external auditor, and peer debriefer.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.) These include:
  - the University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
  - the Florida Department of Health, people from the Food and Drug Administration (FDA), and people from the Department of Health and Human Services (DHHS).

I may publish what we learn from this study. If I do, I will not let anyone know your name. I will not publish anything else that would let people know who you are.

### ***Voluntary Participation / Withdrawal***

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study, to please the investigator or the research staff. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study. Decision to participate or not to participate will not affect your job status.

### ***Questions, concerns, or complaints***

If you have any questions, concerns or complaints about this study, call Lee A. Teufel at (813) XXX-XXX.

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

If you experience an adverse event or unanticipated problem call Lee A. Teufel at (813) XXX-XXX.

If you have questions about your rights as a person taking part in this research study you may contact the Florida Department of Health Institutional Review Board (DOH IRB) at (866) 433-2775 (toll free in Florida) or 850-245-4585.

### ***Consent to Take Part in this Research Study***

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

**I freely give my consent to take part in this study.** I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

\_\_\_\_\_  
Signature of Person Taking Part in Study

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Person Taking Part in Study

### ***Statement of Person Obtaining Informed Consent***

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
- What procedures/interventions/investigational drugs or devices will be used.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research. This person speaks the language that was used to explain this research.

This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

This person does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give informed consent.

This person is not taking drugs that may cloud their judgment or make it hard to understand what is being explained and can, therefore, give informed consent.

\_\_\_\_\_  
Signature of Person Obtaining Informed Consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Person Obtaining Informed Consent

## Appendix B: Demographic Questionnaire

### Clinical Supervision of Child and Adolescent Counselors in Residential Foster Care: A Collective Case Study

#### *Demographic Questionnaire:*

1. Please tell me your first name and last initial for identifying purposes only.
2. Having re-read the consent form, do you still agree and consent to participate in this research study?
3. What is your age?
4. What is your gender?
5. What is your ethnicity?
6. What was your undergraduate major?
7. What is your masters degree specialization?
8. How long have you worked at this facility?
9. a. How long have you worked with children and/ or adolescents?  
b. What has been your work experience with children and/ or adolescents?
10. What specialized training in counseling children and/or adolescents do you have?

## Appendix C: Post-Supervision Interview

### Clinical Supervision of Child and Adolescent Counselors in Residential Foster Care:

#### A Collective Case Study

##### *Interview Protocol*

##### *Descriptive Questions:*

1. Please describe your most recent individual supervision session?
2. What were you thinking during the supervision session?
3. What were the feelings you experienced during the supervision session?
4. What issues or topics do you recall being discussed in the supervision session?
5. Please discuss how your supervisory needs were met in the most recent supervision session?
6. What else about the supervisory experience do you believe is important?
7. Is there anything else you would like to add to this interview?

## Appendix D: Field notes

June 4, 2007

Lee A. Teufel

10:00AM

Supervision Observation No. 1

### Field notes

oc: room is warm, air conditioning not working. The supervisor and supervisee sit in right corner of the office at a table. I sat in the supervisor's chair, close to her office desk.

they started supervision very quickly, the supervisee was running late, she had initially planned on being there early, but ended up being there at exactly 10AM. They jumped right into talking about things at a very quick pace. Both seemed nervous.

1. discussion about caseload, discharge
2. assigning random, versus issue based
3. family dynamics of cases
4. students leaving
5. specific cases
6. issues related to medication compliance, counselor comments "a mess," regression,

oc: seems to be telling factual information, supervisee talks very fast.

Supervisor is taking notes the entire time. Supervisee is reviewing notes and cross referencing datebook.

7. discussion about case collaboration with HKI
8. turning point in family therapy
9. emotional phone call with child and mom
10. TPR case
11. within TPR case – unique therapeutic issues, some diagnostic issues
12. kid is ok in therapy if general discussion of abuse, no specifics in therapy
13. possible PTSD
14. discharge case, follow-up services, family therapy

oc: both supervisor and supervisee seem relaxed now, leaned back body position. Time is ½ hour into supervision session.

15. aggressive children
16. regression
17. explosive/impulsive behaviors

18. wanting, planning consistent group activities
19. boundaries
20. sexual behavior
21. supervisor provided supervisee a book about sexual behaviors
22. both supervisor and supervisee commented on how hot it was in the room
23. paused to get an additional fan
24. issues related to sexual acting out, these issues may be acting out trauma versus perpetrator
25. placement issues for children
26. supervisor noted that she was running out of room to write about everything supervisee was talking about
27. asked supervisee to over a training on daily notes, it is an administrative training, administrative issues

oc: I was thinking that this discussion is clearly not related to clinical supervision. It does not relate to cases. It is clearly administrative supervision.

28. the training is related to BEHAS, and daily notes on the computer, computer issues
29. audit people, audit reviews, monthly/weekly paperwork
30. billing, psychiatric and summaries need to be completed

oc: again I was thinking as the supervisor finished, she finished with administrative issues and not clinical issues, I was wondering if this was a common practice of hers.

June 6, 2007  
Lee A. Teufel  
2:15PM  
Supervision Observation No. 2

Field notes

oc: supervisor was rushed and running late. She appeared to be multi-tasking with other staff. Supervisee once supervision started jumped immediately into topics.

oc: observation occurred in the supervisee's office. The air conditioning continues to be broken. However there is air conditioning in the supervisee's office, but not the supervisor's office. Supervisor and supervisee sit at a small table in the left of the room, I sat in the counselor's chair close to her office desk, in the right of the room. There was classical music playing in the background, very faint.

1. sharing workbooks, skills, games, therapy tools
2. they want to get their list together by the end of summer to order what they want
3. training/tool technique for treatment planning
4. goals in clouds (then rate on a scale), more visual
5. supervisee had been using it
6. trauma screening inventory, manualized form
7. web training on how to deal with certain issues
8. need to find training on CBT, play therapy conferences
9. Lopez (dorms in residential), there are facility issues
10. cleaning and clothing
11. corrective experiences
12. move to discussing child issues and specifically abuse report issue
13. Child name, family issues, case plans
14. "I" statements difficult, some feelings
15. Child name, narrative story, reflection
16. Supervisor gave some suggestions for safety reflections
17. defuse the power of it

oc: the supervisee didn't seem very open to the suggestion, seems resistant to the suggestion, supervisee questioned how much to push the issue of trauma and abuse resolution.

18. the supervisor expanded on the idea of creating optimal level of anxiety and striking while the iron is cold.
19. supervisor and supervisee debated the idea of going deeper with trauma resolution
20. discussion explored supervisors experience with population and prior training in area
21. idea of experiencing things currently
22. coping, planting seeds for future positive coping

23. research that has been done, developmentally
24. discussion around case examples
25. long term cases versus short term cases
26. short term cases
27. with short term cases treatment planning may need to look for trend for future, may be more effective
28. treatment plan are not currently kid friendly, needs to change, way to complex
29. need to configure a way with computer to use new forms, but we don't want more work
30. possibly talk to bill

oc: again I was thinking to myself the supervisor ended with some discussion of an administrative focused discussion, i.e. configuring treatment plans to their computer systems. This discussion was not related to the various clinical issues discussed.

June 12, 2007  
Lee A. Teufel  
9:20PM  
Supervision Observation No. 3

Field notes

1. supervisee asked if she should start with kids

oc: supervisor is taking notes, supervisee has hands and arms crossed over chest  
supervisee is soft spoken.

oc: observation occurred in supervisee's office. Air conditioning continues to be broken in the entire building. Supervisee does have air conditioning in her office. Supervisor and supervisee sat to the right of the room a table; I sat in the counselors chair, more in the middle of the room.

2. Child name
3. one child having significant difficulty
4. talks about hurting self
5. other systems involved
6. child attachment to residential foster care
7. aggressive behaviors
8. ask for med review and then will likely refuse meds
9. supervisor is open to idea of med review
10. supervisee is worried about the follow-up of medication
11. should talk to him about refusal and resistance
12. probably going to therapeutic foster care
13. all siblings are in disruptive placements
14. for the first time he cursed at the supervisee, yesterday
15. supervisee plans on continuing to be supportive
16. Child name
17. doing good
18. talked to caseworker
19. potential sibling placement for adoption or foster
20. incredible in therapy/play
21. in sand tray she displays sibling interaction
22. comparison between siblings and parents
23. also did feeling identification with light bright with colors
24. case is probably going to go TPR
25. Erica the other counselor didn't start family therapy
26. more sibling visitation
27. Child name
28. didn't want to come to therapy
29. didn't want to do treatment plan

30. meds were adjusted
31. issues with other staff and coming to therapy
32. there needs to be consistency with staff on no hitting
33. raised the issue of mixed messages
34. how does the child relate to people he cares about
35. gave pictures
36. together in session with Child name
37. working through loss and anger
38. idea of can't be wrong with these kid "to Child name"
39. they had everything and now they don't have anything
40. cloud sheet for treatment plan with Child name
41. helps with kids, they like it, kids understand, rate self
42. Child name
43. Erica has the family for family therapy
44. they may be doing a relative placement
45. supervisee had done a genogram
46. supervisee wanted to explore the family dynamics, grandfather is a possible alcoholic
47. talk about feeling
48. she said she liked grandmother and grandfather
49. role play and feelings
50. proud of self, no bad behaviors
51. family dynamic issues
52. special education needs, possible IEP
53. Child name
54. doing great with transition
55. whole month of transition, once a week with family
56. anxious in session
57. session and in general preparing to say goodbye
58. Child name
59. better behavior in the cottage
60. looks more organized
61. wants to call Caretaker name, she will ask why aren't you calling me
62. possible placement
63. doesn't want to come to family, phone call issue with family
64. phone call and primary therapist

oc: it appears that the primary therapist can't also be the family therapist, to avoid dual role. However in this case the primary therapist has been making the phone calls; at least temporally until another therapist is assigned

½ through session, supervisee relaxes body posture, voice is clear and strong

65. hard to place, back and forth in therapy
66. Caretaker name has never seen one of her tantrums
67. Child name and Child name

68. work together
69. play therapy together
70. finishing therapy, creates great anxiety
71. they need a closing ritual
72. need to match with a family
73. minimal behavior issues
74. Child name, gone
75. Child name
76. supervisee notes that he is so ready to me, knows the plan
77. going to Boston
78. play, behavior, assertive
79. educational needs are questionable
80. supervisee, pauses, "let me think?"
81. "want me to go through all of them"
82. "want to control everything" laughter...

oc: I am thinking that the supervisee really tends to focus on the positive

83. Child name
84. didn't want therapy

oc: supervisee seems low, somber

85. supervisee reports that this is a difficult case
86. both supervisor and supervisee discuss how the child can be distorted in behavioral presentation
87. Child name
88. talked with worker
89. treatment plan review

oc: supervisor now moves into more administrative based issues

90. asks the supervisee, if she brought her receipt from the training she went to last week
91. reminds supervisee of clinic today
92. in clinic today, they are going to discuss new policy on suicide, audit, and sign hurricane evacuation policy, due Friday in senior management meeting

### About the Author

Lee A. Teufel received a Bachelor's Degree in Psychology with a concentration in Biological Sciences from Ohio University in 1998 and a Masters degree in Education with a concentration in Community Counseling also from Ohio University in 2000. She worked in an outpatient mental health center counseling children and adolescents affected by abuse and neglect. In addition, she has worked in inpatient treatment centers, including private contractors for the Department of Juvenile Justice. While in the Ph.D. program at the University of South Florida, Ms. Teufel was an active graduate student, working as the graduate assistant in the department of Counselor Education. Ms. Teufel has presented at national, state, and local conventions on issues related to family reunification, foster care placement, counseling children, counseling critical needs populations, and counseling in higher education. She is passionate about counselor supervision and counseling children and adolescents.