Supervision Professional Disclosure Statement

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Qualifications

- Doctor of Philosophy (Ph.D.), Counseling and Supervision, James Madison University, 2014.
- National Certified Counselor (NCC), National Board of Certified Counselors, # 284201.
- Licensed Mental Health Counselor, Washington state, # LH 60442969
- Licensed Professional Counselor, Virginia, # 0701005508

Areas I Am Qualified to Provide Supervision

I am competent and experienced in providing the following clinical supervision of counseling practice:

- Clinical mental health counseling,
- Marriage, couples and family counseling, and
- School counseling.

I have 10 years of paid counseling experience (2006 – current), in a variety of settings such as an inpatient psychiatric unit (both child & adolescent, adult, and dual-diagnosis/co-occurring disorders units), a specialized school for children with severe disabilities, and private practice. I have also volunteered for two years at a crisis hotline, providing telephone counseling to clients with suicidal ideation.

I have provided counseling services to individuals, couples, families, and groups. I have worked with children, adolescents, and adults. I have experience with addiction issues through working at a dual-diagnosis unit at an inpatient psychiatric hospital, though acknowledge that this is not my main area of competence. I have treated clinical problems that include depression, anxiety, trauma, adjustment disorders, substance use, schizophrenia, bipolar disorder, physical and sexual abuse, child neglect, autism, ADHD, selective mutism, anorexia and bulimia, conduct disorder and oppositional-defiant disorder, neurocognitive disorders including dementia and traumatic brain injury, intellectual disability, personality disorders, tic disorders, kleptomania, pyromania, trichotillomania. I also have experience with parent-child relational problems, academic failure, problematic social media use, relationship issues, and lesbian, gay, bisexual, transgender, and questioning issues. I have limited experience with sexual disorders such as premature ejaculation or inorgasmia, and also have limited experience in the treatment of sexual offenders.

I have provided a wealth of counseling interventions, including play therapy and sandtray therapy, person-centered therapy, cognitive-behavior therapy, dialectical-behavior therapy, brief psychodynamic therapy, interpersonal therapy, behavior modification, solution-focused brief therapy, existential therapy, gestalt therapy, motivational interviewing, and career counseling from a developmental (i.e., Donald Super) model. I have limited experience providing narrative therapy and longer duration psychodynamic therapy. I have used counseling techniques from these varied theoretical approaches, such as cognitive restructuring and thought logs, behavioral homework, psychoeducation, interpersonal process (i.e., "here-and-now"), empty chair, genograms, free association, systematic desensitization, visualization, guided imagery, deep breathing, progressive muscle relaxation, grounding exercises, mindfulness training, distress tolerance training, emotion regulation training, interpersonal effectiveness and social skills training, roleplaying, behavior rehearsal, scaling, exception questions, and the miracle question.

I have experience administering, scoring, and interpreting a variety of psychological assessments with clients in an inpatient psychiatric unit, including the Minnesota Multiphasic Personality Inventory (both adult and adolescent versions), Beck inventories, Millon Multiaxial Clinical Inventory, Millon Adolescent Clinical Inventory, Substance Abuse Subtle Screening Inventory (both adults and adolescents), Trauma Symptom Inventory, the Slosson Intelligence Test, the Suicide Ideation Questionnaire, the Reynolds Adolescent Depression Scale, the Child Depression Inventory, the Piers-Harris Self-Concept Scale, the Tennessee Self-Concept Scale, the Thematic Apperception Test, and the Rotter's Incomplete Sentences Bank. I have also completed beginning level training in the Rorschach Comprehensive System, and administered and scored 20 complete protocols.

Supervision Training and Experience

I have received training in clinical supervision through a doctoral course, which included a lab component of receiving "supervision of supervision" while supervising master's-level counseling students in a school counseling practicum. I also completed a 200 hour doctoral internship in supervision, whereby I received weekly "supervision of supervision" while I supervised master's-level counseling students in clinical mental health counseling internships. Subsequently, I have continued to supervise both master's-level clinical mental health counseling students and marriage, couple, and family counseling students in both practicum and internship experiences. I have been supervising graduate-level counseling students during my training and professional work experience since 2012.

Model and Approach to Supervision

My supervision style is largely based on developmental models. I believe that over time, accumulative experiences sculpt intuition. Counselors therefore become more attuned to the client's inner world and better conceptualize client cases with clinical experience. As with many new experiences, the ambiguity of the counseling process generates a significant amount of trainee anxiety for novice counselors, whereas this anxiety is mitigated by prior experience for seasoned counselors. For this reason, supervision being provided to novice counselors requires more structure and direct instruction than when provided to experienced counselors.

Along with a developmental approach, my supervision style is also based upon Bernard's (1997) discrimination model. This model includes four supervision areas and three supervisor roles (Borders & Brown, 2005). The four supervision focus areas are counseling performance skills, cognitive counseling skills, self-awareness, and professional behaviors. *Counseling performance skills* refers to competence in the effective use of verbal and nonverbal responses and techniques during counseling sessions. *Cognitive counseling skills* include case conceptualization and ability to apply theoretical constructs to client cases. *Self-awareness* is defined as the supervisee's ability to understand how their own responses, beliefs, feelings, and motivations influence their work. *Professional behaviors* include adherence to legal and ethical standards and on-site procedures. Frequent topics that I address in supervision include modeling active listening and influencing skills such as confrontation (counseling performance skills); assisting the supervisee to conceptualize the client's problems from a systems perspective and understanding how the client's problems exist in an interpersonal context (cognitive counseling skills); assisting the supervisee to recognize how to use the self in counseling practice, specifically to demonstrate I-Thou empathic attunement and resonance (self-awareness); and addressing ethical concerns that occur in the context of the counseling relationship, such as imposition of values and multiple relationships.

Each of these four focus areas in supervision is addressed by one of the three roles: teacher, counselor, or consultant. In the *teacher* role, the supervisor provides direct and education. In the *counselor* role, the supervisor uses counseling skills to understand, motivate, and model behaviors for the supervisee, or facilitate the supervisee's exploration of personal responses and feelings. In the *consultant* role, supervisors collaboratively problem-solve client problems via brainstorming.

The developmental level of the supervisor and supervisee impacts the supervisory relationship. Supervisors must be more advanced than their supervisees, yet also meet the developmental needs of the supervisee. As a

supervisor, I often alternate between roles based on the needs of the supervisee. Novice supervisees are likely to prefer more structure in supervision. At this stage of counselor development, supervision is more effective when the supervisor assumes more of a teacher role. As supervisees become more experienced, they desire less structure and direct instruction. At this stage of counselor development, supervision is more effective when the supervisor assumes more of a consultant or counselor role.

In my supervision, I require that students either videotape their work with clients, audiotape their work with clients, or are directly observed by myself while providing counseling services to clients (known as "live supervision"). My preference is to review videotape with supervisees. This has multiple benefits, including: video tape review allows the supervisee to observe their own counseling work and self-reflect on their interpersonal style with clients along with their verbal and nonverbal behaviors in session, videotape review allows the supervisor to provide feedback on what actually occurred in session rather than on supervisee self-report, and videotape review also provides more objective information from which to make evaluative decisions about the supervisee's progress and candidacy as a professional counselor.

Evaluation Procedures during Supervision

The purpose of clinical supervision is to assist counselors to obtain professional competence in providing counseling services to the public while also protecting client welfare (Borders & Brown, 2005). Data has demonstrated that unsupervised counseling experience does not help trainees to develop competence (Wiley & Ray, 1986). The supervisor functions as an evaluator of competence, assisting the supervisee to develop professionally while also ensuring the client's welfare and serving as a gatekeeper for the profession (Bernard & Goodyear, 2009).

From the outset of supervision, the supervisor must disclose and discuss their evaluative functions and performance criteria with the supervisee. As professional gatekeepers, supervisors will sometimes have the responsibility to screen out inappropriate supervisees to protect the public from harm. Supervisees must be informed of how they will be evaluated, and formative evaluations should be conducted to assure that the supervisee understands their current progress or lack thereof before summative evaluations are completed. Supervisors must create remediation plans for impaired supervisees. Since the supervisory relationship is hierarchical, there may be moments when the supervisor will direct the supervisee to take a specific course of action with the client. The supervisee must be informed of this vertical hierarchy.

As the supervisor, I will evaluate you at the end of each academic term by completing the evaluation forms that are used by the university. I will discuss with you each of my ratings, so you can understand better how I appraise your current level of counseling skill. If I notice areas of concern/deficiency, I will discuss this with you prior to completing the evaluation form so that you have the opportunity to begin remediating that concern/deficiency. As part of our supervisory relationship, I also ask that you complete a supervision rating form on my supervision of you. I will also check-in with you at the close of supervision sessions in case I need to modify my supervision approach to best match your needs as a supervisee.

Confidentiality

The issues you discuss in supervision will be confidential with the following exceptions:

1) Your performance and conduct in this clinical experience will be described in general terms when I submit evaluative reports to the university.
2) If I am asked to provide information about your clinical experience in the form of a recommendation for a job, licensure, or certification.
3) Disclosures made in triadic or group supervision cannot be absolutely guaranteed as confidential. Although I will take every measure to encourage confidentiality and act appropriately if confidentiality is not upheld.
4) If I seek consultation for my supervision of your client work.

Releasing Confidential Information for Consultation

During my work with you, I may at times want to seek consultation. Supervisors must practice within the bounds of their own competence, and seek consultation regularly to ensure that they are not unconsciously playing out parallel processes or allowing biases to direct their actions. In addition, supervisors may have undetected biases that require them to consult with colleagues. The supervisory relationship can address cross-cultural issues between supervisor, supervisee, and client. Sensitivity to cultural variables such as gender, race, ethnicity, age, sexual/affective orientation, ability/disability status, and spirituality/religious beliefs are central to supervisee development. The discussion of cultural variables has a positive outcome on the supervisory relationship and supervisee satisfaction with supervision (Gatmon, Jackson, Koshkarian, Martos-Perry, Molina, Patel, & Rodolpha, 2001). Therefore, I may also seek consultation to address any cross-cultural issues that may emerge.

Before seeking consultation, I will first ask you to give consent to release your confidential information during consultations. A space for you to sign a release is included on the last page of this document.

Session Fees and Length of Service

- Individual sessions will last for 60 minutes, and be held an average of once per week. Missed weeks will mean that we shall meet for 120 minutes during the week prior or following.
- You will not be charged a fee for receiving supervision from me, provided that you are enrolled in a graduate-level counseling course at the university.

Supervisee's Responsibilities in Supervision

1) Prepare for and attend sessions.
2) Complete homework or assignments.
3) Watch videotapes of counseling sessions and complete a tape critique.
4) Keep supervisor informed regarding all client issues and progress.
5) Maintain liability insurance at all times (minimum $1M single incident/ $3M aggregate)
6) Complete supervision record at each supervision session.

Supervisor's Responsibilities in Supervision

1) Prepare for and attend all sessions.
2) Provide feedback each session and a formal evaluation at each quarter and at the end of the supervision contract.
3) Review client case notes and other materials for quality control purposes.
4) Complete supervision record at each supervision session.
5) Maintain licensure as a Mental Health Counselor (LMHC) in Washington and status as an approved clinical supervisor.

Emergency Contact

In case of emergency, you can reach me by my cell phone, (434) 426-2732.

Complaints

I abide by the NBCC, ACA, and AMHCA Code of Ethics as well as the CCE's Standards for the Ethical Practice of Clinical Supervision. Although supervisees are encouraged to discuss any concerns with me first, you may file a complaint against me with any of these organizations should you feel I am in violation of any of these codes of ethics.

Supervision Arrangements

We will meet on the following day and time: _____

Release of Information for Consultation Purposes

☐ I consent to allow the supervisor to disclose relevant confidential information during consultation sessions.

Acceptance of Terms

We agree to these terms and will abide by these guidelines.

Supervisee: _____ Date: _____

Supervisor: _____ Date: _____

References

Bernard, J. M. (1997). The discrimination model. In C. E. Watkins, *Handbook of psychotherapy supervision* (pp. 310-327). New York: Wiley.

Borders, L. D., & Brown, L. L. (2005). *The new handbook of counseling supervision.* New York: Routledge.

Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., & Rodolpha, E. (2001). Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter? *Journal of Multicultural Counseling and Development, 29*(2), 102-113.

Tromski-Klingshirn, D. M., & Davis, T. E. (2007). Supervisees' perceptions of their clinical supervision: A study of the dual role of clinical and administrative supervisor.*Counselor Education & Supervision, 46,* 294-304.

Wiley, M., & Ray, P. (1986). Counseling supervision by developmental level. *Journal of Counseling Psychology, 33,* 439-445.