BAHAN KULIAH DIUNDUH DARI INTERNET

The Making Of A Therapist : Developmental Considerations and a Therapeutic Model for Supervision (2002 revision)

The most visible creators I know of are those artists whose medium is life itself. The ones who express the inexpressible--without brush, hammer, clay, or guitar. They neither paint nor sculpt--their medium is being. Whatever their presence touches has increased life. They see and don't have to draw. They are artists of being alive (anonymous)

Many sculptors describe their work as a process of uncovering and discovering what lies beneath their magnificent materials; to discover the hidden swirl and patterns within the marble and to let them emerge with all their unique brilliance and beauty. As both supervisors and therapists we are engaged in a parallel process with life. By knowing our inner selves we are better able to guide the hands of clients, interns and supervisees so that their own brilliance may emerge. In this course we will first consider the developmental phases of a therapist and how they parallel human development. It will give the supervisor pause to consider this information gleaned over years of self work and supervision. Sometimes we may be expecting our supervisees to grasp or practice something that is out of reach of their experience. We must help them find the tools to carve the new path of understanding for themselves. We will survey various models and styles of therapy and supervision and their tools/techniques. An integrated model of therapy is presented which I have found to be a valuable and flexible tool for supervisees to grasp the complexity of seeing clients. Finally, issues of supervising interns in various medial, school and play therapy sessions are considered.

Over the years I have noticed that the developmental stages of a therapist often parallel human development. Students enter the field wide eyed, a little frightened, and in awe of their new journey. There is an excitement and self-centeredness evident, as the desire to serve and help motivates them toward this new adventure. The supervisor is well advised to recognize and welcome this phase with the understanding that the initial vision is not always very self aware. It is important that we welcome this new enthusiasm into the field, the way we welcome a new baby with joy. It is important not to be too jaded but still a bit overprotective of the clients. We don't want a supervisee's personal values to permeate work and alienate a person in distress.

Therapeutic boundaries are a need for structure similar to a toddler learning to walk, having *theories and diagnoses to give stability, predictability and a safety net for the client and therapist*. Although an advanced therapist or an older student may have a great deal of experience to draw from when making a decision, a new therapist is often a little wobbly, not having seen a case to completion and just trying out some of the theories on themselves. This is a crucial step in development: that we are all able to look at ourselves through the frameworks we are putting upon clients. This can be done in the classroom or therapy and preferably both. *Therapist know thyself.* It saves a lot of work and time in transference/ countertransference issues.
Just as we all need to develop balance to walk the supervisee must develop a balance in their inner and outer life to hold appropriate **therapeutic boundaries** with a client. The desire to serve and help has to be tempered within the walls of the therapy room and hour. If you start helping your clients in different ways outside of therapy, you must be mature enough to know the consequences of opening that boundary. A young therapist cannot know those consequences. They will quickly learn if they give their client a ride home. They will watch as the client initiates the beginnings of a friendship and becomes hurt of offended if it does not develop.

Sam entered the field of therapy after spending a year with an active environmental group. He had chosen to become a therapist to "give voice to others who had no voice" like the trees he had staunchly defended. He was a very ethical and powerful young man and chose to do his graduate internship in a very impoverished neighborhood where people truly had little voice. He was having a hard time understanding why his clients did not perceive his dedication. It came to light that in therapy sessions he was using parallels from his environmental activist activities. He said clients seemed to shut down and look away. It was suggested by the supervisor that perhaps he needed to listen more closely to the voice of the new neighborhood in which he was working. Naturally, he embraced the suggestion with enthusiasm reading popular magazines, seeing music and listening to the music he heard around him. He was soon able to feel a greater sense of success in his work.
Additionally, the supervisor must model these appropriate boundaries with the supervisee. There is no place for dual relationships in the supervision relationship. ***Under no circumstances should the sexual boundary ever be crossed.*** **S**upervision is a relationship of power: one person is the leader, one the follower. This does not lend itself to an equitable intimate relationship. Along the same line it does not lend itself to a healthy therapy relationship. **Supervisors *should not be their interns' therapist***. The boundaries and expectations get blurred and the end result is confusion rather than clear lines of communication.

Transference and counter transference issues must be examined in the supervisory relationship not only with regard to personal psychological development but also in regard to cultural/age/gender and race awareness. ***A naive attitude of stating that these things don't matter negates the reality that all of these factors do influence a person's life experience.*** If you supervisee comes from a background with which you have had no contact be

open to being the student of their experience. Do not feign a knowledge that is not genuine. **Both as supervisors and therapists we want to stay open to learning.**

In additional to the theories and self understanding it is essential that the therapist is clear on his/her issues of scope of practice and accountability. Issues around reporting child abuse, Tarasoff issues, and competence must be thoroughly discussed to protect the client, intern and supervisor. Please visit the Findlaw site and read about Tarasoff. We are responsible for keeping our clients safe within certain parameters and have a special duty for following the ethical and legal guidelines established for our practice. It may be necessary to review these considerations with supervisees. If you feel a particular client is out of the level of competence for your supervisee we have the responsibility to make appropriate referrals. This is especially critical when the issues concern physical complaints. We must not jump to the conclusion that it is psychosomatic in origin without having it checked by a medical doctor. If you have a legal question consult a lawyer. Quite simply know your scope of practice and stay within it. Please visit the American Foundation for Suicide Prevention.

Please visit the National Clearinghouse for Child Abuse and Neglect.

As with any learning process becoming a competent therapist requires lots of practice and work towards a mastery of the field. Often recent graduate school graduates experience an adolescent feeling like *you kind of know it all* and at the same time being a bit overwhelmed by being out in the big world without the safety support of school. Most graduates are still required to accumulate supervised hours at this time. The supervisor is in a similar position to that of a parent of an adolescent: encouraging yet still monitoring the choices of the beginning therapist and sometimes pulling in the reins a little bit. This can be tricky given the participants own issues around adolescence and transference and countertransference issues must be addressed.

Patricia had recently graduated from an expressive arts therapy program with honors. She was thrilled at being able to start out on her own and buy a new professional wardrobe. Her supervisor cautioned her against buying what her mother would have chosen. Patricia looked at her supervisor askance. At which point the supervisor was able to laugh and admit that when she had first bought her "new wardrobe" ten years previously she had bought very conservative clothes of which her mother would have approved. She was certain Patricia, who was a very expressive dresser, would not fall victim to this same dynamic.

The next three stages are often past the time a therapist is engaged in regular supervision. With maturation and following a sense of mastery, *life continues to humble you.* New developments and client issues may walk through your door that totally undo a previous way of looking at things. When clients started telling me about their initial drug experimentation at age eight, when a friend from Ethiopia questioned the practice of only telling your problems to

strangers, these incidents made me look deeper into the practice of psychotherapy. These are the kind of issues that propel a therapist into **consultation groups and professional support groups** with other mental health practitioners. To investigate and question precepts that have carried you this far. To continue to explore the "edges" that will be discussed in the following model ; to continue the path of discovery in our own masterpiece of life.

Burn Out. All the energy is gone. There is little joy in your work. All the stories seem to sound the same. No one seems to be getting better. The human race is destined to live in repeated patterns. You find yourself looking forward to the hour being over. It is time to take a break. I have always thought we should start some type of therapist rest fund; so, that a rest does not mean financial stress but just a break to regroup and renew. Ideally, we have always figured rest and renewal into our lives. However, after many years of practice we can all hit a bottom. We need to recognize and honor the need for a retreat or rest. Please visit the Ogden Medical Center site on burnout.

The current literature is now looking at **compassion fatigue and secondary poast traumatic stress** or what happens to people in the helping profession when they feel they just can't help anymore. Please visit

"What is Compassion Fatigue?" for more information please visit *Gift from Within*

You may also be interested in the video by Dr. Frank Ochenberg on "When Helping Hurts".

Rest is the choice that allows **assimilation** of all you have learned so far. It gives you a chance to stand back and observe where you have come from and where you are going: a chance to look at your work and appreciate the **beauty and wisdom** you have gained in the process. We must encourage our interns not too push to hard to get through to licensing without observing their progress thus far. The learning plan and evaluation tools are invaluable for this exercise. It is only by standing back that you can truly appraise your work and your place in it.

Models of Supervision

Creating structure and goals always give definition to any developmental process. It is always a wise idea to devise an Learning Plan with your intern to identify their strengths and weaknesses. This is discussed at length in the Making of a Therapist II. Essentially, you want to identify strengths and gaps in learning or experience and design goals for their professional development. With these goals in mind the types of supervision you used should be varied for the most comprehensive service to the intern.

There are many models and techniques that are valuable supervision tools: direct observation via two- way mirror or a cotherapy situation, video and or audio taped sessions, process notes, clinical case presentations, role playing and group supervision. Special attention will also be given to supervising the presentation of interns in IEP and medical case situations, and play therapy and sandplay sessions.

Individual vs. Group Supervision

Individual supervision is essential for all beginning therapists/ counselors. There is no way to contain the number of questions and issues that arise during the process of becoming a therapist without a strong, mentoring supervisory relationship. There needs to be a mutual respect of the supervisor and supervisee and recognition of the boundaries contained within this relationship. In individual supervision many of the issues of transference and countertransference regarding teachers, parents and authority figures may emerge. There are many ways the supervisor may mirror the "parent", "judge", or "teacher".

- Be understanding but clear on boundaries
- Be supportive yet expect the highest degree of professionalism to insure quality and safety of all.
- We are responsible for the welfare of our interns clients.

The supervisor, while not the therapist, must be aware of the emergence of these issues and, perhaps, suggest outside therapy when appropriate. As empathy is the cornerstone of healing in the human arena, it is very hard, if not impossible, to be a good therapist without the experience of being a client.

"Playing With Others"

I have noticed that sibling rivalry dynamics often arise when the group supervisor is also the individual supervisor. This may also happen even when the supervisor is not the same in both sessions. We, as supervisors, must keep on top of these dynamics and not to let them dominate the experience of the group or supervisory relationship. If you find yourself being pulled to strong and uncomfortable emotions in these settings, you may want to access your own peer or outside consultation. The line between supervision and therapy can get blurry in these learning situations.

Janeen was in an advanced group supervision setting wherein each intern was presenting his or her own interest in technique to the group. She volunteered to be the subject in a psychodrama. The intern leading the group had had several workshops in the technique and was close to certification. During the psychodrama a memory of a fatal accident emerged and one of the other group participants was

evoked to start verbally attacking Janeen due to her own memories emerging. After the words and tears were flying the supervisor stepped in and apologized for letting it go so long. the psychodramatist was insulted but had clearly lost control of the group. The intern 'on the attack" continued privately with the supervisor about how much the other intern reminded her of a sister. Janeen was given some extra individual time to recuperate from the strange and emotional experience.

Knowing when to draw the line around allowing the introduction of powerful, psychotherapeutic techniques is a crucial part of setting safe boundaries in supervision.

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OVERVIEW

Clinical supervision is the construction of individualized learning plans for supervisees working with clients. The systematic manner in which supervision is applied is
called a "model." Both the Standards for Supervision (1990) and the Curriculum Guide for Counseling Supervision (Borders et al., 1991) identify knowledge of
models as fundamental to ethical practice.

Supervision routines, beliefs, and practices began emerging as soon as therapists wished to train others (Leddick & Bernard, 1980). The focus of early training,
however, was on the efficacy of the particular theory (e.g. behavioral, psychodynamic, or client-centered therapy). Supervision norms were typically conveyed
indirectly during the rituals of an apprenticeship. As supervision became more purposeful, three types of models emerged. These were: (1) developmental models,
(2) integrated models, and (3) orientation-specific models.

DEVELOPMENTAL MODELS

Underlying developmental models of supervision is the notion that we each are continuously growing, in fits and starts, in growth spurts and patterns. In combining

our experience and hereditary predispositions we develop strengths and growth areas. The object is to maximize and identify growth needed for the future. Thus, it is
typical to be continuously identifying new areas of growth in a life-long learning process. Worthington (1987) reviewed developmental supervision models and noted
patterns. Studies revealed the behavior of supervisors changed as supervisees gained experience, and the supervisory relationship also changed. There appeared to
be a scientific basis for developmental trends and patterns in supervision.

Stoltenberg and Delworth (1987) described a developmental model with three levels of supervisees: beginning, intermediate, and advanced. Within each level the
authors noted a trend to begin in a rigid, shallow, imitative way and move toward more competence, self-assurance, and self-reliance for each level. Particular
attention is paid to (1) self-and-other awareness, (2) motivation, and (3) autonomy. For example, typical development in beginning supervisees would find them
relatively dependent on the supervisor to diagnose clients and establish plans for therapy. Intermediate supervisees would depend on supervisors for an understanding of difficult clients, but would chafe at suggestions about others. Resistance, avoidance, or conflict is typical of this stage, because supervisee self-concept is easily threatened. Advanced supervisees function independently, seek consultation when appropriate, and feel responsible for their correct and
incorrect decisions.

Once you understand that these levels each include three processes (awareness, motivation, autonomy), Stoltenberg and Delworth (1987) then highlight content of
eight growth areas for each supervisee. The eight areas are: intervention, skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics. Helping supervisees identify their own strengths
and growth areas enables them to be responsible for their life-long development as both therapists and supervisors.

INTEGRATED MODELS

Because many therapists view themselves as "eclectic," integrating several theories into a consistent practice, some models of supervision were designed to be
employed with multiple therapeutic orientations. Bernard's (Bernard & Goodyear,1992) Discrimination Model purports to be "a-theoretical." It combines an
attention to three supervisory roles with three areas of focus. Supervisors might take on a role of "teacher" when they directly lecture, instruct, and

inform the
supervisee. Supervisors may act as counselors when they assist supervisees in noticing their own "blind spots" or the manner in which they are unconsciously
"hooked" by a client's issue. When supervisors relate as colleagues during co-therapy they might act in a "consultant" role. Each of the three roles is task-specific for
the purpose of identifying issues in supervision. Supervisors must be sensitive toward an unethical reliance on dual relationships. For example, the purpose of
adopting a "counselor" role in supervision is the identification of unresolved issues clouding a therapeutic relationship. If these issues require ongoing counseling,
supervisees should pursue that work with their own therapists.

The Discrimination Model also highlights three areas of focus for skill building: process, conceptualization, and personalization. "Process" issues examine how
communication is conveyed. For example, is the supervisee reflecting the client's emotion, did the supervisee reframe the situation, could the use of paradox help the
client be less resistant? Conceptualization issues include how well supervisees can explain their application of a specific theory to a particular case--how well they see
the big picture--as well as what reasons supervisees may have for what to do next. Personalization issues pertain to counselors' use of their persons in therapy, in
order that all involved are nondefensively present in the relationship. For example, my usual body language might be intimidating to some clients, or you might not
notice your client is physically attracted to you.

The Discrimination Model is primarily a training model. It assumes each of us now have habits of attending to some roles and issues mentioned above. When you
identify your customary practice, you can then remind yourself of the other two categories. In this way, you choose interventions geared to the needs of the supervisee instead of your own preferences and learning style.

ORIENTATION-SPECIFIC MODELS

Counselors who adopt a particular brand of therapy (e.g. Adlerian, solution-focused, behavioral, etc.) oftentimes believe that the best "supervision" is analysis of
practice for true adherence to the therapy. The situation is analogous to the sports enthusiast who believes the best future coach would be a person who excelled in
the same sport at the high school, college, and professional levels. Ekstein and Wallerstein (cited in Leddick & Bernard, 1980) described psychoanalytic supervision

as occurring in stages. During the opening stages the supervisee and supervisor eye each other for signs of expertise and weakness. This leads to each person attributing a degree of influence or authority to the other. The mid-stage is characterized by conflict, defensiveness, avoiding, or attacking. Resolution leads to a "working" stage for supervision. The last stage is characterized by a more silent supervisor encouraging supervisees in their tendency toward independence.

Behavioral supervision views client problems as learning problems; therefore it requires two skills: 1) identification of the problem, and (2) selection of the appropriate learning technique (Leddick & Bernard, 1980). Supervisees can participate as co-therapists to maximize modeling and increase the proximity of reinforcement. Supervisees also can engage in behavioral rehearsal prior to working with clients.

Carl Rogers (cited in Leddick & Bernard, 1980) outlined a program of graduated experiences for supervision in client-centered therapy. Group therapy and a practicum were the core of these experiences. The most important aspect of supervision was modeling of the necessary and sufficient conditions of empathy, genuineness, and unconditional positive regard.

Systemic therapists (McDaniel, Weber, & McKeever, 1983) argue that supervision should be therapy-based and theoretically consistent. Therefore, if counseling is structural, supervision should provide clear boundaries between supervisor and therapist. Strategic supervisors could first manipulate supervisees to change their behavior, then once behavior is altered, initiate discussions aimed at supervisee insight.

Bernard and Goodyear (1992) summarized advantages and disadvantages of psychotherapy-based supervision models. When the supervisee and supervisor share the same orientation, modeling is maximized as the supervisor teaches--and theory is more integrated into training. When orientations clash, conflict or parallel process issues may predominate.

SUMMARY

Are the major models of supervision mutually exclusive, or do they share common ground? Models attend systematically to: a safe supervisory relationship, task-directed structure, methods addressing a variety of learning styles, multiple supervisory roles, and communication skills enhancing listening,

analyzing, and
elaboration. As with any model, your own personal model of supervision will continue to grow, change, and transform as you gain experience and insight.

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Direct Observation

" Parental Supervision Advised"

Taping Sessions

Although it can be time intensive, listening and viewing tapes together is invaluable. **Encourage your intern with the proper permissions signed for release to tape by the client to make use of these learning tools.** One of the advantages of direct

observation is to provide direct feedback to the intern about their intonation, body posture and confidence in presenting an intervention. Many interns may be harshly self critical and, therefore, they must be encouraged not to focus on that type of feedback, rather what they did right and how they can build on these interventions. This is inherent to all strength based learning systems. We must consider developmental levels of the intern in develponig appropriate goals. Newer counselors may need more supportive and basic lessons in interventions; whereas, a more advanced intern may be challenged on their methods and encouraged to further refine their techniques. It is good to decide how much time you will spend on a particular supervision technique and recognize and use the method most useful for the intern's development.

Cotherapy

Some supervision situations allow for a therapist and intern to have cotherapy sessions. This can be particularly helpful in family or group therapy sessions. In these sessions both the therapist, intern and client benefit. The extra eyes and ears can provide an objectivity and space for everyone to be heard. You can more easily develop strategies to recognize alliances and communication patterns as they establish themselves within the session. Sometimes a therapist has the luxury of a two way mirror where they may observe the intern. It is often arranged that the supervising therapist can send in interventions.

Process notes

Process notes are when an intern is encouraged to sit down after a session and write verbatim everything they can remember of what was said making note of their own reaction and responses and everything they remember about the client. Obviously, a great deal of time should be given following a session for this process, but it is a valuable exercise to increase observation skills and memory.

Role playing

Role playing is an effective tool both in individual and group supervision settings. Being able to reenact situations from previous counseling sessions or anticipate your most difficult situation with a group of colleagues, creates a protected space to explore your options for interventions. It can also provide a kind of brainstorming session; wherein, peer feedback can increase your understanding and give inspiration.

Clinical case presentations

In class, clinical case presentations should follow a structured design,

- including a description of the presenting problem,
- its history, a full DSM diagnosis,
- interventions and
- progress report.

Here, I present an integrated model of therapy which I have found can be utilized to address many of these issues from a variety of theoretical backgrounds. Being comfortable with presenting in class will provide practice for presenting in outside professional situations.

An Integrated Therapeutic Model

The following is and integrated model of therapy that was developed over many years of sessions and discussions with colleagues. It has been a very helpful and inclusive model for training students and supervisees.

Our multi-cultural society and gaps in the traditional family and individual developmental stages have left therapists struggling to find new and comprehensive guidelines for therapy. Using signposts from many therapists who have blazed the intrapsychic and systemic trails before us, we have developed a model, a map, to guide us and allow plenty of space for individual and cultural differences.
The first thing we know about a client is the presenting complaint. We are greatly indebted to the work of Milton Erikson and his brilliant understanding of life's metaphors. Working with the idea that initial symptom points the way into a multi- leveled understanding of the individual or family, we have begun our trek. Our map is derived from the evolving Medicine Wheel of Native America. With constant learning through the four directions, we discover the vision of the ancestors in the East (history), the lessons of daily living in the South (current milieu), the internal struggles of the West (in session dynamics), and the wisdom that comes from the integration and higher perspective of the North (transpersonal) It is with deep reverence and gratitude that we see our model fitting this ancient path. I welcome any further feedback on our conceptualization of this model. To relate this model to the developmental process we would look at the early childhood issues in the east, the current issues in the south, the transference issues in the west and spiritual issues in the north.

When the client says "I'm just depressed all the time", we begin to look at this statement through four particular viewpoints: family of origin, including both personal and cultural experiences; current environment and ways that mirror

or are disparate from early beginnings; in session dynamics transference/counter transference issues as well as meaning attributed to being in therapy, and transpersonal factors regarding the person's spiritual view of life, not merely a religious affiliation. Starting with the individual we need to get as accurate a picture of their early childhood and family or origin as possible.

THE EAST: EARLY CHILDHOOD AND GENERATIONAL PATTERNS

1. Who comprised the family system?

2. Who provided most of the early childhood attention and care? Was it in home or outside their home? For what period of time were they in the client's life? How was the good-bye honored?

3. Were there daycare providers involved and what was their relationship to the family? Were they included in family rituals? How many hours were spent with them per week?

4. Were there any major illnesses or losses within the family? (Changing of caregivers, schools, deaths, divorces, moving of significant friends or family) How were these handled?

5. What was the nature of their sibling relationships? For adults, are they ongoing?

6. What were the rules and roles regarding elders? Are they facilitating or limiting in the life of the client today?

7. What were the rules and role models around gender? Is this currently a source of strength or friction?

8. How does the client's cultural background influence his/her experience? The experience of an urban Black youth living in "the hood" is going to be quite different from a recent immigrant from an impoverished or warring country or a Western European exchange student or a White fourth generation "native" or a Native American youth being taught that he belongs to the earth and yet feels little support in the environment.

9. Is there a generational component that the client is aware of in regard to his/her behavior? (abuse, substance abuse, antisocial behavior, depression, etc.)

10. From all of the above factors what values did the client learn or incorporate around his/her body, image vs. reality, mind, emotions, and spirit?

THE SOUTH : CURRENT ENVIRONMENT

The current milieu is a paradox. First, it is an easy area to assess because people are generally able to talk about the details of their present situation. On the other hand, it is generally a stressor in the current situation that has pushed the client to the edge to seek therapy. In general we are interested in four main areas: family, work, school, and love. The things folks are not willing to initiate talking about are often the issues that are most crucial: violence and addiction. These issues need to be confronted before any other therapy can take place. To be effective, therapy needs to be a place of consistency and safety. If there is violent and addictive behavior not being addressed, the therapy is not safe, predictable, or helpful. Therapy raises anxiety. If you raise the anxiety of a person they often respond with their dysfunctional patterns, i.e., violence and addiction. Thus, not addressing these issues is counterproductive to what we are trying to do.

The next area that is important to explore is his/her current living situation and how his/her symptom manifests therein. If a person is living in the middle of an impoverished violent neighborhood it would be expected that he/she would be feeling some degree of numbness or depression. On the contrary, if the client has all the external trappings of success and still feels despair your direction may be slightly different.

HOME/CULTURE

If you have no experience as a therapist with the environment or culture the client is describing, it is imperative that you gain knowledge. Do not feign knowledge. Ask you client about his/her experience. Read books, see movies, get a sense of what their current experience is. You cannot hope to guide if you know nothing about the territory. Many minority clients have complained about this lack of knowledge or assumptions based upon the dominant culture values which differ from their own. This experience will negate or minimize the reality of their experience: an experience they have often felt far too often.

For example, an intern came to me regarding help working with his predominantly minority population. He could not understand the clients' reticence to talk. There were many current, excellent movies available concerning similar social environments. I asked if he had seen any of them. He responded he meant to get around to it. This became his assignment for the next week: view at least two of the current movies and read two short stories reflecting the possible circumstances his clients faced. His awareness changed dramatically following this assignment.

WORK OR SCHOOL

1. Are the client's symptoms being worked out in a work or school environment?
2. What commonalties exist between the people involved in current situations and those in the client's previous history?

3. What level of stress is the client under in his/her occupation?
4. Is the client unemployed or underemployed?

LOVE

1. Does your client have working, healthy relationships?
2. Does he/she have strong friendships and support systems?

There are parts of therapy that may be quite despairing. It is important to have strong, significant relationships other than just the therapist.

3. IN SESSION DYNAMICS

The third vista we need to examine closely is the one directly in front of us. How is the symptom going to manifest in our office?

THE WEST : IN SESSION DYNAMICS

COUNTERTRANSFERENCE

The Symptom

1. What are our feelings and/or judgments about the symptom, client in front of us?
2. How do we think they heal?
3. Are we willing to allow for variations in our thinking?
4. Are there times when we have manifested the symptom?
5. What self interventions have helped?
6. Do we think these should help others? Why?

Therapy

1. What has been our personal experience of therapy?
2. Have we dealt with personal issues closely related to those of the client?
3. Are we finished with those issues?
4. Can we get enough from consultation, or do we need another turn at therapy to bring greater resolution?
5. Are we willing to do the work?

Culture, Age, Gender and Social Class

We all have early familial and social programming around these issues. Acknowledgment is the first key.

1.What do we think or feel about this client's circumstances and culture? Is it intriguing and exciting to explore these new lands?
2.Do we feel that the client should just get with the program and assimilate in order to succeed?
3.Do we have any personal history of the client's lifestyle and culture? Was it positive or negative and how is it going to shade our experience with the client in front of us? We are human; past experience does matter.
4.Is there an age difference between us? Do we share similar life

experiences in regard to marriage, parenthood, etc.?
5.What are our gender differences? Is there sexual transference?
6. Social class makes a huge difference in many aspects of one's life experience. It is something often minimized in our country with euphemisms of how it should be. Again, be open and willing to hear and feel these issues.

TRANSFERENCE

The Symptom
1. What was the precipitating event to bring the client into therapy once again?
2. Does the client feel like a failure?

Therapy
1. For the client's part, what is the meaning he/she assigns to being in therapy?
2. Is it voluntary? Is there a stigma attached to therapy?
3. Does the client have a history of therapy?
4. What were the positive or negative outcomes of the client's previous work?
5. Is it acceptable to bring his/her problems to someone outside the family?
6. What are the repercussions, real or imagined, for this transgression?
7. Who is the appropriate mediator for difficulties?
8. What are the coping mechanisms the client has used to deal with this problem to date?
9. How and when did these things stop working?
10. How can the client's coping mechanisms be reframed as strengths?

Culture, Age, Gender and Social Class

1. Are there cultural, age, gender and class differences between therapist and client?
2. Are there imprinted rules of conduct regarding these differences?
3. Is there a history of animosity between the cultures?
4. Are there expectations with regard to professionals or authority figures?
5. How will the therapy you provide duplicate, or provide, a different experience?

Many of the issues in this category are embedded on an unconscious level. As they
surface and are discussed, it is often both uncomfortable and exhilarating. Most of our "isms" are based upon ignorance and restricted thinking. As we are able to look at them and let them go, we experience a new level of freedom.

Many of the considerations heretofore mentioned may be very familiar to the seasoned therapist. The fourth viewpoint, transpersonal factors, and its inclusion with traditional therapeutic thinking is where we discovered our most unique and exciting points of transformation: the EDGES.

THE NORTH : TRANSPERSONAL EDGES

There are four questions we consider crucial to diagnosis, prognosis and treatment:

1. To what degree does the client feel he/she has power or control in his/her environment? How is this manifest through family or origin, culture and environment and in session dynamics?
2. Does the client have a sense of a higher power to which they reach for guidance, forgiveness, and strength?
3. Does the client believe that each individual is capable of making a personal connection to this higher power?
4. How does the client view his/her responsibility for making the values associated with a higher power manifest in his/her life?

In the more chaotic, violent environments, these are the characteristics that help the individual cope and survive. They define resiliency. These characteristics also allow the individuals in less stressful surroundings to embrace the challenge of becoming something greater than outer achievement. Individuals from both backgrounds will often feel moved to heal and contribute to society in a more compassionate and meaningful way. We, as therapists, must acknowledge, understand, follow, nurture, and guide these strivings for the health of our clients. Then, perhaps, our small scale work will increase its influence from individual to family to help heal in ever larger dimensions.

If your client feels no sense of power or purpose within his/her life at this time, or at any other time in his/her life, he/she will be extremely difficult to work with as it is beyond the scope of therapy to give life meaning where there is no preset value in this regard. If, however, there is a sense of purpose, however minimal, you, as the therapist, have a lot to work with regarding resiliency. Access to this greater sense of purpose and divine connection overcomes what we might normally view as incomprehensibly debilitating loss and trauma.

Elizabeth Kubler-Ross has noted that when a child has experienced early trauma, there is likely to be an early development of spiritual sense of Self. These are our child clients who often seem "wise beyond their years". In indigenous cultures the Shaman or medicine man is often someone who has gone through extreme trauma early in life in addition to a grueling and humiliating initiatory experience. If we in some way can hold for the client a sense of purpose in his/her most difficult life experiences, it is my contention that the client, too, may come through these initiations with a greater wisdom deserving of deep respect. Through the use of this model we have been able to guide many developing therapists on their journey to becoming professionals.

I include supplementary articles on substance abuse clinics and schools, as I have found these are often the sites of internships. I also include information on supervising in play and sandplay therapy situations.

Medical settings

Medical settings can be intimidating as the hierarchy of physician/psychologist and adjunctive therapists may exist. The intern may not feel totally comfortable with their own expertise and may need guidance with their presentation in an inpatient facility. Hopefully, it will be a interdisciplinary team effort approach with each professional respected for their expertise. Not all medical personnel have mental health expertise. While we must rely on them for psychopharmocology and physiology issues, scope of practice must be mutually respected. This is most often the case with each professional welcoming the input of others. The intern must be well versed in the DSM IV classifications as this is the language of the medical community. Their treatment plan and interventions should be correlated to the diagnosis with clear goals and objectives.

The following article is presented for clinicians supervising interns in

substance abuse settings.

ERIC_NO: ED372355
TITLE: **Clinical Supervision in Addictions Counseling: Special Challenges and Solutions**. ERIC Digest.
AUTHOR: Juhnke, Gerald A.; Culbreth, John R.
PUBLICATION_DATE: 1994
FULL_TEXT:
OVERVIEW

Since the early 1970's addictions counseling has experienced significant growth and change. Addictions treatment has become "big business" and as a result, there is
a new consciousness for cost management and containment. Top priorities now include reducing staff turnover, preventing employee burnout, and maintaining
credentialing to meet insurance reimbursement requirements (Powell, 1993).
As the field matures, continued professional training becomes increasingly important.
Declining budgets within many agencies, however, often prohibit participation in costly seminars designed to promote advanced clinical skills. A solution to this
dilemma is ongoing, in-house clinical supervision (Powell, 1991).

In the addictions profession's infancy, supervision was often little more than a more senior level helper telling another what to do. In addition, directions to

the junior
level treatment provider were primarily based upon the supervisor's personal recovery experience. Today, a more professional and systematic approach to clinical
supervision is warranted. A good counselor won't necessarily be a good supervisor (Machell, 1987). Therefore, addictions supervisors need to be well versed in
both advanced supervision techniques and addictions counseling.

Despite increased numbers of addictions treatment programs over the past twenty years, addictions supervision has been virtually neglected. Evidence of this is
demonstrated through the limited number of journal articles written on the topic of addictions supervision. For example, a recent search for articles written on the
topic resulted in only ten citations; of these, only four specifically addressed the topic of providing clinical addictions supervision.

One conspicuous exception has been the work of David Powell, who has written consistently about addictions supervision since the mid 1970s. His seminal writings
have resulted in descriptive and databased articles, culminating in the recent publication of his second book on supervision in addictions counseling. Powell (1993)
has developed a model of clinical supervision which blends aspects of several supervision theories. His model is developmental in nature and addresses nine
descriptive dimensions of clinical supervision issues (e.g., influence, therapeutic strategy, counselor in treatment, etc.). Powell also outlines issues specific to
addictions counseling and supervision. It is because of these unique aspects of addictions counseling that attention is greatly needed in the area of supervision.

WHAT MAKES ADDICTIONS SUPERVISION DIFFERENT?

Although a great number of issues related to the supervision process are similar across different types of counseling (e.g., school, mental health, family, career, etc.),
at least three supervision issues are idiosyncratic to substance abuse counseling and deserve special attention (Powell, 1993). First, a significant number of addictions
treatment providers are paraprofessionals. Unlike professional counselors, paraprofessionals have not fulfilled the educational requirements for a master's degree in
counseling or an allied human service field. Paraprofessionals in some states are required to have little more than a high school diploma or equivalent and pass a state
certification examination. They, therefore, lack formal graduate school instruction pertinent to the eight common core areas considered rudimentary

to the counseling profession (i.e., human growth and development, social and cultural foundations, helping relationships, group, lifestyle and career development, appraisal, research and evaluation, and professional orientation). Paraprofessionals also may lack the fundamental counseling skills typically developed through participation in an organized sequence of practica and field-practica experiences (e.g., counseling internships) common to counselor education program graduates. The implication for supervision is clear. Supervisors must be continually aware that paraprofessionals lack fundamental counselor training. Therefore, the supervision milieu must contain a strong educational component to ensure a minimal level of skill and knowledge-based competencies. Supervisors may find that informal lectures related to counseling theories and practice of counseling techniques enhance clinical sophistication and promote greater treatment effectiveness. Undoubtedly, clinical supervisors working with paraprofessionals who lack adequate training may need to assume a greater proportion of the responsibility for treatment planning and can help paraprofessionals learn how to apply their existing skills with diverse clients.

A second complicating factor related to addictions supervision is that many professional counselors and paraprofessionals facilitating addictions treatment strongly believe that one must be in recovery to provide effective treatment (Powell, 1993). Treatment providers espousing such a "recovery-only" position may be highly resistant to supervision from non-recovering persons. Direct inquiry by the supervisor can be helpful in understanding the counselor's position on this matter. For example, the supervisor may find it helpful to ask the supervisee, "How will my not being in recovery effect our supervision relationship?" Whatever the response indicated by the supervisee, the supervisor will need to follow-up by asking, "How can we effectively work together so our clients receive the best possible treatment?" Such directness is typically prized within the substance abuse community and encourages supervisee honesty. Failure to address this important topic can result in pseudo-supervision, which wastes valuable time and inevitably impedes client progress. Even the most adamant helper who believes one needs to be in recovery to facilitate effective addictions treatment, will typically recognize the benefits of supervision when the emphasis is placed upon working together for the sake of the client.

Finally, it should be noted that to some degree all treatment providers are influenced by personal issues. In an attempt to be helpful, however, recovering helpers may
be particularly vulnerable to imposing their personal experiences and unconscious beliefs on a client (e.g., what worked for me will work for you). A client's relapse
also may provoke unconscious responses in the recovering helper (i.e., loss of empathy, reduction in patience, etc.) which may negatively effect the counseling
relationship. Therefore, the supervisor's attentiveness to these possible issues is critical. Encouraging recovering helpers to embark on a "recovery expedition" can be
helpful. Here, helpers ask others how they initiated their recovery experience and what things they find helpful to maintain chemical abstinence. Participation in the
recovery expedition teaches helpers that there exists no single method in which people initiate or maintain the recovery process. Helper behaviors, cognitions and
feelings resulting from a client's relapse or a client's unwillingness to commit to the abstinence process can be discussed within small group experiences. Such small
group experiences can promote effective ways of dealing with anger, frustration, and fear related to the helper's own recovery.

OTHER INGREDIENTS VITAL TO THE SUPERVISION PROCESS

Because supervision has been neglected within many addictions agencies, basic supervision practices are often foreign to addictions helpers. Therefore, it is critically
important for addictions supervisors, as it is for all supervisors, to establish supervision practices in a nondemeaning manner which emphasizes client benefits. To
secure such practices, it is imperative that addictions supervisors: 1) establish a solid working relationship with the supervisee, 2) assess the supervisee's counseling
skills, 3) agree to contract for the conduct of supervisory sessions, and 4) establish learning goals with the supervisee (Borders & Leddick, 1987). Mutually agreed
upon goals for supervision need to be concrete, attainable, and specific. Together, both the supervisor and the supervisee need to determine methods for attaining
these goals and ways to evaluate progress in each area (Bradley & Boyd, 1989).

Effective supervision principles include consistent meeting times and a collegial atmosphere, both of which contribute to a working relationship vis-a-vis a structured
hierarchy in which the supervisor dictates counseling interventions. This promotes the supervisee's "ownership" of the case. As both supervisor and supervisee

become more familiar with the working relationship, professionalism grows and clients benefit. This typically leads to increased supervisee effectiveness and
satisfaction.

CONCLUSION

A number of factors endemic to the addictions field make supervision within this community both challenging and rewarding. Effective supervision requires developing the skills of front-line staff at all levels and addressing possible supervisee concerns related to non-recovering treatment providers. When these issues are
adequately addressed within the supervision process, the promotion of professionalism and professional identity will occur.

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SCHOOL SETTINGS

IEP

AN IEP is and Individualized Education Plan and will be involved with any child with special needs who you might see in counseling. As a supervisors we should be familiar with the process in helping to create social/ emotional goals with the parents, child and school that support the client and does not compromise their confidentiality. Most parents will welcome your presence and support. Establishing a good rapport with the school personnel when working with children, is remarkably effective in helping them see the child in a new light. Many of my referrals from schools were considered "beyond help". I include the following information for both supervisor and intern.

When working with schools:
1) with permission and proper release have contact with the school
2) do not share confidential information rather act as evidence that more help and support is being sought out and utilized by the client
3) give proper respect and support to the school for their efforts
4) help bridge and communication difficulties between the family and schools

ERIC_NO: ED449636

TITLE: Creating Useful Individualized Education Programs (IEPs). ERIC Digest #E600.
AUTHOR: Smith, Stephen W.
PUBLICATION_DATE: 2000
AVAILABILITY: ERIC Clearinghouse on Disabilities and Gifted Education, Council for Exceptional Children, 1110 North Glebe Rd., Arlington, VA 22201-5709; Tel: 800-328-0272 (Toll-free); e-mail: ericec@cec.sped.org; Web site: http://www.ericec.org.
FULL_TEXT:
The Individualized Education Program (IEP) is the cornerstone of the Individuals with Disabilities Education Act (IDEA), which ensures educational opportunity for
students with disabilities. The IEP is a quasi-contractual agreement to guide, orchestrate, and document specially designed instruction for each student with a
disability based on his or her unique academic, social, and behavioral needs.

By law, the IEP must include certain information about the child and the educational program designed to meet his or her unique needs (U.S. Department of
Education, 2000). This information includes:
* Current levels of educational performance
* Measurable goals and measurable objectives or benchmarks
* Special education and related services
* The extent of participation with non-disabled children

* A statement of how the child's progress will be measured and how parents will be informed of that progress
* The extent of modification of participation in state and district-wide tests
* The dates and location of services to be provided
* Beginning at age 14 (or younger), a statement of transition services the student will need to reach post-school goals
* Beginning at age 16 (or younger), a statement of transition services to help the child prepare for leaving school
* Beginning at least one year before the child reaches the age of maturity, a statement that the student has been told of any rights that will transfer to him or her.

In defining the IEP and making these requirements, the intent of Congress was to bring together teachers, parents, and students to develop an educational program
that is tailored to the student's needs and provides documentation of a quality education based on those individual needs (Smith, 1990). Over the years, however,
complying with the explicit tenets of the law (i.e., procedures related to developing and documenting an IEP) took precedence over developing a high quality
program that educators can implement for each student who has special needs (Smith & Brownell, 1995). Planning and implementing a procedurally sound IEP will
always be a challenge: The developers of IEPs must deliver a high-quality framework to help teachers perform at their best in providing specially designed instruction
for each of their students with disabilities.

CONNECTING THE IEP AND CLASSROOM INSTRUCTION

The law clearly states that a relationship should exist between the IEP and classroom activities. Each student's present level of performance should serve as the basis
for IEP annual goals and objectives. This basic link between the student's needs and his or her program represents the very essence of special education and
specially designed instruction.

Every effort should be made to ensure that each annual goal and short-term objective is directly related to the statement of the student's present level of performance.
In this way, annual goals and objectives are based on assessment data and not on unfounded beliefs about programs thought to be beneficial to the student,
irrespective of diagnostic findings.

The IEP should contain goals and objectives for all areas in which the student cannot substantially benefit from the regular education program, including

related
services. One suggestion is that an average of 4 short-term objectives for each of 4 to 10 annual goals could be a recommended standard.

In planning interventions, the IEP team needs to take into account the student's current skill level, the teacher's skill, the resources, and the likelihood that the
intervention will be implemented. This last factor often depends upon the (a) effectiveness of the intervention, (b) the length of time and skill required for the
intervention, and (c) the significance of the student's needs.

The IEP must be reviewed at least annually, and goals and objectives are modified as the student continues to demonstrate mastery. The attainment of the stated
objectives is measured by daily performance as determined by the teacher and frequent objective measures of the student's ability to perform the skills needed to
attain the goal. The criterion for mastery should be of a type and level appropriate to the behavior being learned. If the objectives subordinate to a goal are
sequenced by a task analysis, the standard for mastery should be the level of the skill needed to address the next objective.

PARTICIPANTS IN DEVELOPING IEPS

The IEP can be a dynamic process wherein professionals, parents, and sometimes students, can plan for an instructional future that is truly responsive to the student's
unique individual needs. When professionals understand the necessity for the IEP and the opportunity it provides for collaboration, dynamic planning, and successful
implementation, the lawful intent of specially designed instruction will be fulfilled. The IEP can be viewed as the product of the referral process and it can be viewed
as an educational outline delineating the major part of the service and delivery process. When professionals do not understand the IEP process, problems with
developing and implementing IEPs may stem from their differing roles and perspectives:
* Content teachers may feel untrained to handle the academic and behavioral needs for special education students. They may feel that the input from specialists is too
unrealistic for implementation in the regular classroom, or they may feel that IEP goals and objectives are only for the special education teacher and not relevant in
their day-to-day instruction. Because of these attitudes, special educators may feel that they lack cooperation from regular education teachers, particularly in facilitating the mainstreaming of students with special needs.
* Parents may be concerned about including their children in regular classes

and whether they will be provided with the support services required for success.
* The IEP may be perceived as a document that is prepared by individuals who are not involved in the daily learning activities of the child. Similarly, the IEP may be
viewed as unnecessary paperwork that must be completed, with the special education teacher mostly responsible for its development. Another problem is that
developing an IEP is often seen as cumbersome and time consuming. Finally, the IEP may be perceived as involving persons whose specific job is the evaluation of
children, rather than seeing the gathering of information from a more ecological viewpoint (i.e., from many different settings).

In an effort to address some of these problems, the IDEA requires that the following participants be involved in the IEP meeting:
* The student, if appropriate
* A parent (and, if desired, the family)
* At least one of the student's special education teachers or, if appropriate, related services providers
* At least one of the student's regular education teachers
* A local educational agency representative
* Other agency personnel who have knowledge or expertise required to best serve the student's needs.

The goal of the IEP is to deliver a comprehensive, free and appropriate education, with the involvement of many participants. With these participants present, the
IEP meeting can focus on developing an accurate and relevant description of the child's strengths and weaknesses in many different settings, including the current
educational setting. This more open perspective allows for the shared responsibility of educating children with disabilities among all involved professionals. With this
shared responsibility, it is more likely that both the regular and special education daily programming will concentrate on the identified goals of the IEP.

Involving a variety of participants in developing the IEP also increases the number of professionals available to deliver the needed support and guidance. Their
participation as a decision-making team will provide essential and relevant information, allow for evaluating data provided by other professionals, and enhance
cooperation as team members. It is hoped that the expanded knowledge and awareness of the involved professionals and a more complete view of their services and
expertise will result. When professionals understand the necessity for the IEP and the opportunity it provides for collaboration, dynamic planning, and successful

implementation, the lawful intent of specially designed instruction will be fulfilled.

RESOURCES

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expressed in this publication do not necessarily reflect the positions or policies of OERI or ED.

As a parent and child advocate in some regard, we as counselor should be familiar with the following information to support parents in their efforts to get services for their child.

ERIC_NO: ED437766

TITLE: **Rights and Responsibilities of Parents of Children with Disabilities:**

Update 1999. ERIC Digest #E575.

AUTHOR: Knoblauch, Bernadette; McLane, Kathleen
PUBLICATION_DATE: 1999
AVAILABILITY: ERIC Clearinghouse on Disabilities and Gifted Education, The Council for Exceptional Children, 1920 Association Dr., Reston, VA

20191-1589. Tel: 800-328-0272 (Toll Free); e-mail: ericec@cec.sped.org;
Web site: http://www.ericec.org.
FULL_TEXT:
WHAT ARE YOUR RIGHTS, AS A PARENT, IN THE SPECIAL EDUCATION PROCESS?

Public Law 105-17, the Individuals with Disabilities Education Act (IDEA) Amendments of 1997, enhances the rights of children with disabilities and their parents. It
builds on the rights provided under Public Law 94-142, the Education for All Handicapped Children Act, of 1975. A fundamental provision of these laws is the right
of parents to participate in the educational decision-making process. Currently this includes the right to:

--A free appropriate public education for your child. "Free" means at no cost to you as parents or to your child, except for incidental fees normally charged to parents of students without disabilities as part of the regular education programs. "Appropriate" means that your child's program must be individually designed to
meet his or her unique educational needs.

--Request an evaluation if you think your child has an impairment that may require special education or related services. You also have the right to get an independent evaluation if you disagree with the evaluation obtained by the school.

--Be notified in writing ("written prior notices") whenever the school proposes any of the following: an evaluation to determine whether your child has a disability; a
reevaluation; or a change in your child's educational placement. You are also entitled to be notified in writing if the school refuses your request for an evaluation or
change in educational placement for your child.

--Informed consent. This means you understand and agree in writing to the evaluation and educational placement decisions for you child. Your consent is voluntary
and may be withdrawn at any time.

--Request a reevaluation of your child at any time. The school must reevaluate your child if conditions warrant, or if you or your child's teacher requests a reevaluation; but in any case, the school must reevaluate the child at least once every three years.

--Have your child tested in the language he or she knows best. For example, if your child's primary language is Spanish, this is the language in which he or she must
be tested. Students who are deaf have the right to an interpreter during the testing. Students who are blind or visually impaired have the right to have the

tests
provided in Braille or large print, or to have the test read aloud.

--Have access to your child's education records. A school must comply with a parent's request to inspect and review his or her child's education records within 45
days of the receipt of the request. Generally, schools must have written consent from the parent before releasing any information from the student's records.
However, records can be released to certain education officials without the parent's consent. If you feel that some information in your child's records is inaccurate or
misleading or violates your child's rights, you may request that the record be changed. If the school refuses, you have the right to request a hearing, or you may file a
complaint with your state education agency.

--Be fully informed by the school of all rights that are provided to you under the law and all procedural safeguards that the school must follow to ensure that the rights
of all are protected.

--Participate in the development of your child's individualized education program (IEP) or, if your child is under age 3, individualized family service plan (IFSP). You
have the right to participate in all IEP or IFSP team decisions, or any other decisions regarding your child. The school must make every possible effort to notify you
of the IEP or IFSP meeting and then arrange it at a time and place that is convenient for both you and the school. The school is responsible for reviewing this plan at
least once each year, but you have the right to request an IEP or IFSP meeting at any time during the school year.

--Be kept informed about your child's progress, by means such as periodic report cards, at least as often as parents of children who do not have disabilities.

--Have your child educated in the least restrictive environment. This means that, to the maximum extent possible, your child should be educated in regular classes
with his or her non-disabled peers, and your child should receive supplementary aids and services in his or her neighborhood school. If education outside the regular
classroom is determined to be most appropriate, your child should be educated in the most integrated setting possible.

--Voluntary mediation or a due process hearing to resolve differences with the school that can not be resolved informally. Be sure you make your request in

writing,
date your request, and keep a copy.

WHAT ARE YOUR RESPONSIBILITIES, AS A PARENT, IN THE

SPECIAL EDUCATION PROCESS?

Parents have a key role in the special education process. The following suggestions may offer some guidance:

--Develop a partnership with the school. Share relevant information about your child's education and development. Your observation can be a valuable resource.

--Ask for an explanation of any aspect of the program that you don't understand. Educational terms can be confusing, so do not hesitate to ask.

--Make sure the IEP or IFSP goals and objectives are specific and measurable. This will ensure that everyone teaching your child is working toward the same goals.
Take the IEP or IFSP home to think about it before you sign it. You have 10 school days in which to make a decision.

--Make sure your child is included in the regular school activities program as much as is appropriate, including, at least, lunch, recess, and non-academic areas such
as art, music, and physical education.

--Monitor your child's progress and periodically ask for a report. If your child is not progressing, discuss it with the teacher and determine whether the program
should be modified. As a parent, you can initiate changes in your child's educational program.

--Try to resolve directly with the school any problems that may occur with your child's evaluation, placement, or educational program. Most states have protection
and advocacy agencies that can provide you with the guidance you need to resolve a problem.

--Keep records. There may be questions about your child that you will want to discuss, as well as meetings and phone conversations you will want to remember. It
is easy to forget important information that is not written down.

--Join a parent organization. Besides sharing knowledge, experiences, and support, a parent group often can be an effective force on behalf of your child. Parents
often find that, as a group, they have the power to bring about needed changes to strengthen special services.

AS THE PARENT OF A CHILD WITH A DISABILITY, WHAT CAN

YOU OFFER THE IEP OR IFSP PROCESS?

Parents of children with disabilities can and should be involved in a number of ways, including the following:

--Before attending an IEP or IFSP meeting, make a list of things you want your child to learn. Take notes about aspects of your child's behavior that could interfere
with the learning process. Describe the methods you have found to be successful in dealing with these behaviors.

--Bring any information the school may not already have to the IEP or IFSP meeting. Examples include copies of medical records, past school records, or test or
evaluation results. Remember, reports do not say all there is to say about a child. You can add real-life examples to demonstrate your child's ability in certain areas.

--Find out what related services are being provided, and ask each professional to describe the kind of service he or she will be providing and what improvement you
might expect to see as a result of these services.

--Ask what you can do at home to support the program. Many skills your child learns at school can also be used at home. Ask to meet with the teacher when your
child is learning a new skill that could be practiced at home.

--Discuss methods for handling discipline problems that you know are effective with your child.

--When you feel teachers and school personnel are doing a good job, tell them.

WHAT RESOURCES ARE AVAILABLE TO HELP YOU?

Your local and state education agencies have information to help guide you through the special education process. Since the specific criteria and procedures used by
school districts may vary, your local director of special education can help you access such information. Additional resources are available from national organizations. Some of them will also be able to direct you to local and state chapters that can provide more local support.

RESOURCES

The ARC, 500 East Border Street, Suite 300, Arlington TX 76010; Tel: 209.832.4300.

Children with Attention Deficit Disorders (CHADD), 8181 Professional Place, Suite 201, Landover, MD 20785; Tel: 301.306.7070.

The Council for Exceptional Children, 1920 Association Drive, Reston, VA 20191-1589; Tel: 888.cec.sped (Toll Free); Tel: 703.620.3660.

Learning Disability Association (LDA), 4156 Library Road, Pittsburgh, PA 15234; Tel: 412.341.1515.

National Information Center for Children and Youth with Disabilities (NICHCY), PO Box 1492, Washington, DC 20013; Tel: 800.695.0285 (Toll Free); Tel:
202.884.8200.

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Research and Improvement, U.S. Department of Education, under Contract No. ED-99-CO-0026. The opinions expressed in this report do not necessarily reflect
the positions or policies of OERI or the Department of Education.

The following is an article with special reference to school counselors but is also valuable for supervisors working with interns in school mental health programs.

ERIC_NO: ED372353

TITLE: **Supervision of School Counselors.**
ERIC Digest.

AUTHOR: Henderson, Patricia
PUBLICATION_DATE: 1994
FULL_TEXT:

THE NEED

Professionally appropriate supervision is emerging as a highly effective means of nurturing school counselors' professional development. New challenges in schools
and increased understanding of the complexity of professional development dictate the need for increased attention to and use of effective supervision practices.
Today's children and youth need highly skilled help in managing the complicated situations in which they live. School counselors see an increasing number of suicidal
children as well as adolescents. The upsurge in substance abuse, gang involvement, and violence are well publicized. Increasingly, parents turn to the schools to help

them solve problems that face them, including those posed by their children.
In order to effectively help children in their classrooms, teachers seek consultative help
from counselors. The comprehensive guidance programs (Gysbers & Henderson, 1994) being implemented in today's schools call for school counselors to use all of
their professional skills.

Focused and constructive supervision is of benefit to all practitioners whether they are novices or experienced, highly competent or insufficiently trained. Due to
reductions in caseloads, renewed commitment to elementary counseling, and retirement of counselors who entered the field in the 1960's, the number of new school
counselors is increasing. As noted by Matthes (1992), "we expect novice counselors to assume the same responsibilities as experienced counselors" (p. 245). They
encounter the same complex problems posed by today's students and they face similar ethical dilemmas. Such problems require the consultative and educative
assistance of a competent counselor supervisor.

Wiggins' (1993) longitudinal study adds urgency to the need for supervision by experienced counselors. He found that "more than 28% of the total group...were
independently rated as low in effectiveness...10 years previously [and] were still rated in that manner--and still employed as counselors" (p. 382). Clearly, in the ten
year period, supervisory interventions would have helped some of these counselors improve the quality of their performance!

THE PROCESS

Although it is a relatively new discipline, supervision is compatibly defined in both education and in counseling. The purpose of supervision is the growth and
enhanced effectiveness of the practitioner (Borders, 1991; Sergiovanni, 1984). "It is characterized by a cycle of feedback, practice, and additional feedback" (Borders, 1991, p. 253), based on interpretation of gathered data in light of established standards.

Because of the emphasis on skill-based performance evaluations generated by educational reform, many states (e.g., Mississippi, North Carolina, Texas) have
defined school counselors' roles and needed competencies: program management, counseling, guidance, consulting, coordinating, student appraisal, and referral.
With these behavioral standards as a basis, supervisors and counselors operate with the same definitions for effective performance. The value of timely feedback has

been reinforced in the career-ladder-related-teacher-appraisal systems, setting the climate for the same practice for all categories of educators.

CLINICAL, DEVELOPMENTAL AND ADMINISTRATIVE SUPERVISION

When competently done, supervision not only enhances the quality of counselors' skills, but also helps hone professional judgment, "encourages greater self-awareness, and fosters an integrated professional and personal identity as a counselor" (Borders, 1991, p.253). Barret and Schmidt (1986) outlined a useful schema for distinguishing between the kinds of supervision needed for/by school counselors: clinical, developmental, and administrative. In this distinction, the purpose of each supervision type accounts for the different procedures used by the various supervisors available in schools.

The purpose of clinical supervision is enhancement of counselors' professional skills and ethical functioning. The data sources which support clinical supervision include observations of counselors applying their professional skills and values. In the school setting, the typical opportunities for gathering data to support clinical supervision are available (e.g., live and/or recorded observations, case presentations, and consultations). Clinical supervisors must be counselors who are competent in the school counselor functions and in supervision practices.

The purpose of developmental supervision is improvement of the guidance and counseling program and counselors' pursuit of professional development. Data sources which support developmental supervision are recordings of goals and activities undertaken to attain goals and measures of goal attainment, program plans and implementation calendars, self-reports, and consumer satisfaction surveys. Developmental supervision is best provided by competent school counselors from the same system as the supervisee.

The purpose of administrative supervision is assurance that counselors have worthy work habits, comply with laws and policies, relate well with other school staff and parents, and otherwise work effectively within the school system. Data sources supporting administrative supervision are such things as work schedules, recordkeeping and documentation systems, and evidence of team efforts. Either school counselor supervisors or building administrators may be providers of administrative supervision.

PERFORMANCE IMPROVEMENT SYSTEMS

Particularly relevant in the school setting is clarifying the place of supervision in the overall system for helping counselors' improve their performance. Whether or how
data used in supervision will apply to summative evaluation needs to be spelled out. Supervision provides opportunities for personalizing the professional
development processes. The combination of feedback from supervision and from performance appraisal is data which counselors and their supervisors use as the
basis for professional development goals.

SUPERVISORS

The cyclical nature of the supervisory process is enhanced by the lengthy supervisor-supervisee relationships typical of elementary and secondary school settings.
The multiple opportunities for supervision over significant lengths of time allow supervisory relationships to be rich ones.

The primary obstacles to fully effective school counselor supervision are caused by the insufficient number of school counselor-competent supervisors. Where there
are such supervisors, there is little or no relevant counselor-supervisor training available and/or no specialized certification required. Although the building principals
can provide useful administrative supervision, it is unlikely that they are current in the clinical functions of counseling. Competent school counselors are usually
available to fulfill the developmental and clinical supervision roles, but they often lack training and certification in supervision.

Although development of the appropriate job descriptions and provision of the relevant training at this time are the responsibility of local school districts (Henderson
& Lampe, 1992), the Standards for Counseling Supervisors (Dye & Borders, 1990) and the Curriculum Guide (Borders et al., 1991) provide the guidelines needed.
A pool of potential clinical and/or developmental supervisors are available in many communities. Current school counselors can fulfill roles as peer supervisors. An
increasing number of mid-sized school systems employ central office-based guidance supervisors. Some intermediate education agencies and some state departments of education provide such expertise. Schools are also contracting with community-based, Licensed Professional Counselors, or counselor educators.

THE STATUS

Supervision of professional practice is an effective, but perhaps underutilized means of nurturing the professional development of new and experienced school
counselors. It is a personalized vehicle for assuring that children, their families, and teachers benefit from quality services. For counselor supervision to be practiced
more universally in the nation's schools, states need to require appropriate certification, counselor education programs need to offer appropriate counseling
supervisor training, and schools and district counseling supervisors need to report their counselor supervision practices and findings.

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Supervision in Play therapy/Art therapy/ Sandplay modalities

To be an effective supervisor of these techniques one must have experience and knowledge of them. The following article outlines the usefulness of play therapy and art therapy with child clients. I can also attest that these techniques including art and sandplay are deeply therapeutic when working with adults around trauma that is difficult to express in words. This type of trauma can occur at any time of life, but the propensity of these techniques to allow early childhood material to emerge is remarkable. Please take the time to understand the techniques, but be mindful of your scope of practice. If you do not feel well educated in these techniques you might suggest the intern get additional training or refer the intern to an expert in these areas for outside consultation.. Essentially the supervision process in these techniques is the same with others requiring a specialized knowledge.

1. The intern should be encouraged to research the materials available on the technique and perhaps come to a deeper understanding of symbols and the symbolic process of the psyche.
2. Teaching the intern to follow process and keep their objectivity will be a major part of this work.
3. Transference and countertransference issues particularly in regard to parent/teacher issues will need to be examined as issues of self expression vs messiness and control vs free self expression are likely to arise for the intern.
4. Respecting the need of the intern to find their way parallels respecting the needs of the client to discover their healing through these techniques.
5. Process notes can be essential in developing observation skills in these modalities.
6. Most sandplay supervision includes studying photos of the trays and outside symbol research.

Since the advent of the Internet the access to symbol research is far more available. Please visit www.sandplay.org for links to symbol studies and research papers.

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4116; E-mail: ericcass@uncg.edu; Web site: http://www.uncg.edu/~ericcas2
FULL_TEXT:
In the process of growing up, children's problems are often compounded by the inability of adults in their lives to understand or to respond effectively to what children are feeling and attempting to communicate. This "communication gap" is widened as a result of adults' insistence that children adopt that means of expression commonly used by adults. Efforts to communicate with children on an exclusive verbal level assume the presence of a well-developed facility for expression through
speech and thus confine children to a medium that is often awkward and unnecessarily restrictive. Play is to the child what verbalization is to the adult. It is a medium for expressing feelings, exploring relationships, describing experiences, disclosing wishes, and self-fulfillment. The problems children experience do not exist apart from the persons they are. Therefore, play therapy matches the dynamic inner structure of the child with an equally dynamic approach.

RATIONALE FOR PLAY THERAPY

Because children's language development lags behind their cognitive development, they communicate their awareness of what is happening in their world through their play. In play therapy toys are viewed as the child's words and play as the child's language--a language of activity. Play therapy, then, is to children what counseling or psychotherapy is to adults. In play therapy the symbolic function of play is what is so important, providing children with a means of expressing their inner world. Emotionally significant experiences can be expressed more comfortably and safely through the symbolic representation the toys provide. The use of toys enables children to transfer anxieties, fears, fantasies, and guilt to objects rather than people. In the process, children are safe from their own feelings and reactions because play enables children to distance themselves from traumatic events and experiences. Therefore, children are not overwhelmed by their own actions because
the act takes place in fantasy. By acting out through play a frightening or traumatic experience or situation symbolically, and perhaps changing or reversing the outcome in the play activity, children move toward an inner resolution, and then they are better able to cope with or adjust to problems.

In a relationship characterized by understanding and acceptance, the play process also allows children to consider new possibilities not possible in reality, thus greatly expanding the expression of self. In the safety of the play therapy experience, children explore the unfamiliar and develop a knowing that is both experiential-feeling and cognitive. It can then be said that through the process of play therapy, the unfamiliar becomes familiar, and children express outwardly through play what has

taken place inwardly. A major function of play in play therapy is the changing of what may be unmanageable in reality to manageable situations through symbolic representation, which provides children opportunities for learning to cope.

THE PROCESS OF PLAY THERAPY

Given the opportunity, children will play out their feelings and needs in a manner or process of expression that is similar to that for adults. Although the dynamics of expression and the vehicle for communication are different for children, the expressions (fear, satisfaction, anger, happiness, frustration, contentment) are similar to those of adults. Children may have considerable difficulty trying to tell what they feel or how their experiences have affected them. If permitted, however, in the presence of a caring, sensitive, and empathetic adult, they will reveal inner feelings through the toys and materials they choose, what they do with and to the materials,and the stories they act out. The play therapy process can be viewed as a relationship between the therapist and the child in which the child utilizes play to explore his or her personal world and also to make contact with the therapist in a way that is safe for the child. Play therapy provides an opportunity for children to live out, during play, experiences and associated feelings. This process allows the therapist to experience, in a personal and interactive way, the inner dimensions of the child's world. This therapeutic relationship is what provides dynamic growth and healing for the child.

Because the child's world is a world of action and activity, play therapy provides the therapist with an opportunity to enter the child's world. The child is not restricted to discussing what happened; rather, the child lives out at the moment of play the past experience and associated feelings. If the reason the child was
referred to the therapist is aggressive behavior, the medium of play gives the therapist an opportunity to experience the aggression firsthand as the child bangs on the Bobo or attempts to shoot the therapist with a gun and also to help the child learn self-control by responding with appropriate therapeutic limit-setting procedures.

Without the presence of play materials, the therapist could only talk with the child about the aggressive behavior the child exhibited yesterday or last week. In play therapy, whatever the reason for referral, the therapist has the opportunity to experience and actively deal with that problem in the immediacy of the child's
experiencing. Axline (1947) viewed this process as one in which the child plays out feelings, bringing them to the surface, getting them out in the open, facing them, and either learning to control them or abandon them.

TOYS AND MATERIALS

Although desirable, a fully equipped playroom is not essential for children to express themselves. What is important is that children have ready access to playmaterials selected for the purpose of encouraging expression. All toys and materials do not automatically encourage children's expression or exploration of their needs, feelings, and experiences. Therefore, toys should be selected, not collected. Play therapy is not used as a way to pass the time or to get ready to do something else. The purpose is not to engage the child's hands while trying to elicit some verbal expression from the child's mouth. Consequently, careful attention
should be given to selecting play materials that aid in the following:
Exploration of real life experiences
Expression of a wide range of feelings
Testing of limits
Expressive and exploratory play
Exploration and expression without verbalization
Success without prescribed structure

Mechanical or complex toys would not fit these objectives and so are avoided. Play materials that require the counselor's assistance to manipulate are inappropriate. Many children in need of play therapy have poor self-concepts and are overly dependent. Play materials should not reinforce such problems. Landreth (1991) has provided a list of specific toys and materials.

SETTING LIMITS IN PLAY THERAPY

Limit setting is a necessary and vital part of the play therapy therapeutic process. Although the procedures for setting limits may vary, the setting of therapeutic limits is part of all theoretical approaches to play therapy. The structure of therapeutic limits is what helps to make the experience a real-life relationship. Limits in play therapy have both therapeutic and practical benefits in that they preserve the therapeutic relationship, facilitate the child's opportunities to learn self-responsibility and self-control, among many other dimensions, and provide the child and the therapist with a feeling of emotional security and physical safety. This feeling of emotional security enables a child to explore and express inner emotional dimensions that perhaps have remained hidden in other relationships.

Play therapy is not a completely permissive relationship because children do no feel safe, valued, or accepted in a relationship without boundaries. Boundaries provide predictability. Therefore, children are not allowed to do anything they want to do. A prescribed structure provides boundaries for the relationship that the play therapist has already determined are necessary. The play therapy relationship has minimal limits. Messiness is accepted,

exploration is encouraged, neatness or doing something in a prescribed way is not required, and persistent patience is the guiding principle. The child's desire to break the limit is always of greater importance than actually breaking a limit.

Because play therapy is a learning experience for children, limits are not set until they are needed. The child cannot learn self-control until an opportunity to exercise self-control arises. Therefore, placing a limitation on a child pouring paint on the floor is unnecessary unless the child attempts such an activity. Limits are worded in a way that allows the child to bring himself or herself under control. The objective is to respond in such a way that the child is allowed to say "No" to self. "You would like to pour paint on the floor, but the floor is not for pouring paint on; the pan on the table is for pouring paint into" recognizes the child's feeling, communicates what the floor is not for, and provides an acceptable alternative. The child thereby is allowed to stop himself or herself.

PLAY THERAPY RESEARCH AND RESULTS

Play therapy is not an approach based on guess, trial and error, or whims of the play therapist at the moment. Play therapy is a well-thought-out, philosophically conceived, developmentally based, and research-supported approach to helping children cope with and overcome the problems they experience in the process of living their lives. Play therapy has been demonstrated to be an effective therapeutic approach for a variety of children's problems including, but not limited to, the
following areas:
abuse and neglect
aggression and acting out
attachment difficulties
autism
burn victims
chronic illness
deaf and physically challenged children
dissociation and schizophrenia
emotionally disturbed children
enuresis and encopresis problems
fear and anxiety
grief
hospitalization
learning disabilities
mentally challenged children
reading difficulties
selective mutism
self-concept and self-esteem

social adjustment problems
speech difficulties
traumatization
withdrawn children

The popular myth that play therapy requires a long-term commitment for many months is unfounded as is shown in case studies and research reports reported by Landreth, Homeyer, Glover, and Sweeney (1996) in their book, Play Therapy Interventions with Children's Problems.

PROFESSIONAL TRAINING

Prospective play therapists have to be adequately trained. Most play therapists have a master's degree in counseling, psychology, or social work, although other disciplines also are represented in the field. A master's degree representing some area of the helping profession with emphasis on the clinical or counseling aspects of therapeutic relationships is a general prerequisite. Within or in addition to such a program, training should incorporate the areas of child development and basic counseling skills including acquisition of a theoretical approach incorporating a rationale for behavior change consistent with the play therapy approach utilized. The program of study should include extensive training in the area of play therapy and a supervised practicum experience with children in play therapy.

FUTURE TRENDS IN PLAY THERAPY

The field of play therapy is growing and is now represented by the Association for Play Therapy, an international professional organization. A national Center for Play Therapy has been established at the University of North Texas. Increasing numbers of elementary school counselors and therapists in private practice and agencies are incorporating play therapy into their work with children. There is a trend in family therapy to address social and emotional values of developmental as
well as family group session issues. In filial therapy, parents are trained to use play therapy procedures with their children. This method is well researched and has proven to be effective in ameliorating children's problems through enhancing the parent-child relationship.

CONCLUSION

Play therapy is based on developmental principles and, thus, provides, through play, developmentally appropriate means of expression and communication for
children. Therefore, skill in using play therapy is an essential tool for mental

health professionals who work with children. Therapeutic play allows children the opportunity to express themselves fully and at their own pace with the assurance that they will be understood and accepted.

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OVERVIEW

Art has played a part in the helping professions since ancient times (Fleshman & Fryrear, 1981). As early as 500 BC, the Egyptians utilized concerts and dance in
the treatment of the mentally ill. Likewise, the Greeks used drama as a way of assisting the disturbed in purging their repressed emotions. The Hebrews relied on
music, and other arts, in restoring and promoting mental health too, the most famous example being David who played his harp to soothe a distraught King Saul.
Literature was seen by the Romans as a specific way of helping too. Lucretius thought poetry could disperse the "terrors of the soul" (Coughlin, 1990, p. A6).

In recent times, there has been renewed interest in the use of the arts in counseling, especially art forms that are considered "expressive." Informed counselors can
assist their clients in developing their potential through concrete and abstract verbal and nonverbal art forms that inspire, direct, and heal. Therefore, it is important
that counselors know how the arts are used in helping. This type of background enables them to make informed decisions based on the type of treatment available. It
can also give them more versatility in the services they provide.

WHAT ARE THE EXPRESSIVE ARTS?

The expressive arts consist of verbal and nonverbal ways of representing feelings. They allow individuals options in conveying their emotions. Expressive arts usually
take the form of a unique creation, such as a song or painting. However, they may appear rather mundane as well. The common denominator they share is the
utilization of silent insight and natural abilities. The most well known verbal arts are drama and literature, while the best known nonverbal arts are music, dance/movement, imagery, and visual expression (i.e., drawing, painting, or sculpting).

Generally, verbal and nonverbal arts complement each other and there is considerable integration of them in many artistic expressions. For example, the production
of a play usually requires verbalization, directed movement, music, and visual effects such as scenery and costumes. Thus, the expressive arts may be utilized by
themselves or combined (Gladding, 1992).

HOW THE EXPRESSIVE ARTS ARE USED IN COUNSELING

Numerous ways exist to utilize the expressive arts in counseling. The needs of clients, the skills of counselors, and the nature of the problem(s) are the main considerations in employing them. Expressive arts are used on primary, secondary, and tertiary levels of prevention in all forms of counseling (Caplan, 1964).

THE ARTS IN COUNSELING: PRIMARY PREVENTION

Primary prevention focuses on modifying environments and teaching life skills so that individuals maintain or enhance their mental health. A major emphasis is on
instruction. The expressive arts are excellent tools to use in teaching. They are usually innately interesting to participants. Also, their attractiveness helps individuals
remember lessons.

On an individual level the school is a natural setting for primary prevention to occur through the use of guidance. For young children, toys, puppets, and drama are
effective in modeling and reinforcing appropriate prosocial behaviors (Irwin, 1987; James & Myer, 1987). Music is also a powerful medium for helping children
remember guidance lessons. This is especially true if children have fun in the process (Bowman, 1987).

Drama and music may be helpful for adolescents and adults, too, but often individuals in these age groups are more attuned to the language arts (e.g.,

literature). For
this population, specific stories that illustrate how choices are made in different life stages are appropriate (Lerner & Mahlendorf, 1992).

THE ARTS IN COUNSELING: SECONDARY PREVENTION

Secondary prevention is the process of working with specific high risk individuals or groups to forestall or reduce problems due to psychological crises. The focus is
on minimizing dysfunctionality. The expressive arts can be utilized for children, adolescents, and adults. For example, these individuals can soften their pain and make
their feelings more concrete and understandable through painting/drawing, writing, playing music, or displaying body movements. Often persons who are worked
with on this level express themselves best through engaging in semi-structured, open-ended artistic exercises, e.g., drawing, or decorating (Adelman, 1988).

THE ARTS IN COUNSELING: TERTIARY PREVENTION

Tertiary prevention is aimed at reducing the impairment that occurs as a result of psychological disorders. This type of intervention is what most people consider
"counseling." On this level the concentration is on healing and wholeness.

The expressive arts come into play at this time through the relief and concreteness they provide clients. For example, persons on almost all levels can keep a journal
of their feelings or find and discuss with their counselor photographs of life experiences. Thus, emotions are released in a way that leaves a reminder. An inspirational
example of the use of art on a self-help basis for the treatment of depression is the story of Elizabeth "Grandma" Layton, an 82-year old grandmother from Kansas
who used the contour method of drawing portraits of herself to overcome depression and start enjoying life at age 68 (DeAngelis, 1992).

USING THE EXPRESSIVE ARTS IN COUNSELING--STRENGTHS AND LIMITATIONS

There are many reasons to employ the expressive arts in counseling and some cautions to take. Among the major strengths of the expressive arts in counseling are:

1. The arts help clients create and improve their self-concepts.
2. The arts enrich the lives of clients and counselors and help them see new facets of the world they may have previously missed. This new or renewed view of life is
often energizing.
3. The arts help clients focus on what is troubling them and to gain direction.

Through verbal and nonverbal means the dynamics underlying old problems become
clearer and insight grows.
4. The arts are a natural way of conveying feelings and are socially acceptable. Emotions that are released through artistic expression are often therapeutic on many
levels.
5. The arts promote flexibility and change. Clients who use the arts learn to stay open to new possibilities in their lives. The limitations of using the arts in counseling
are tied to the persons and processes involved.
*One drawback to using the arts is that some individuals resist doing anything that is creative because they fear that artistic expression is only for the very disturbed.
*A second limitation of using the arts is the ineffectiveness of them for persons who work as artists, who are concrete thinkers, or who are mentally disturbed. In
such cases there is resistance and little insight is gained.
*A third limitation of using the arts is they may be misused by unskilled counselors.

CONCLUSION

The ancient wisdom of the past about the use of the arts and healing is being rediscovered. The expressive arts in counseling are becoming better known and more
utilized. They are an effective way of helping many clients prevent and resolve problems. They are also a means of enriching the lives of all involved and making the
change process in counseling more noticeable. Whether in the form of music, drawing, movement, writing, or acting, the arts play a vital role in counseling.

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In conclusion, we have looked at different models and techniques of therapy and supervision and the issues associated in working with the different populations. We have recognized and honored the knowledge and level of our supervisees helping t nurture and refine their abilities as mental health professionals. To do this we must use the tools and techniques with which we feel most comfortable and skilled. We must stay open to learning while protecting the safety and well being of those in our professional care . We must function as the mentor to the developing apprentice in the healing arts and guide them to the best of our abilities honoring the time when there skills stand alone.

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