

## Article 36

### **Effective Clinical Supervision for Adolescent Residential Treatment Centers: An Exploratory Outcome Study**

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#### **Abstract**

Adolescent residential treatment centers (RTCs) serve high-risk, high-need adolescent populations. A sound clinical supervision approach helps improve counseling skills and can increase the overall effectiveness of clinical assistance to youth. This study evaluated the use of a unique clinical supervision approach in an adolescent RTC setting. The approach was constructed based on Walborn's process variables, Ivey's skills and stages of the counseling process, and Bernard's Discrimination Model. These concepts were used as the tools for supervision planning and outcome evaluation. The participants were 16 clinicians working in a residential treatment site for adolescents. The participants were assessed over at least a 1-year period and were supervised by one of two clinical supervisors at least bi-weekly. The results of the outcome study indicated that there were significant outcome improvements in six of seven areas among clinical staff.

*Keywords:* clinical supervision, adolescents, residential treatment center

Foundational to any competent clinical experience is equally competent supervision. According to Bernard and Goodyear (2014), supervision “has two central purposes: 1) To foster the supervisee’s professional development—a supportive and educational function and 2) To ensure client welfare—the supervisor’s gatekeeping function is a variant of the monitoring of client welfare” (p. 13). Monitoring of client welfare (e.g., via clinical supervision) takes on a critical level of responsibility in adolescent residential treatment centers (RTCs) where clients do not have familial, and other informal supports readily available (Coll et al., 2015). RTC clinicians provide services to clients with the greatest need and address the clinical concerns of children at pivotal points in development; therefore, they need high quality clinical supervision (Coll et al., 2015). Connor, Doerfler, Toscano, Volungis, and Steingard (2004), for example, examined the behaviors and backgrounds of adolescents admitted into residential treatment. Their study found that due to the severity of the symptoms of this population, individualized treatments under clinical supervision were necessary for effective interventions.

Unfortunately, systematic supervision is sorely lacking in many or perhaps most adolescent RTCs (Connor et al., 2004). Indeed, Coll and Haas (2013) noted that within RTC settings, “consultation and clinical supervision are essential to prevent isolation and redundancy of ineffective techniques” (p. 104), yet are too often absent. The consequences are dire because when clinical supervision is missing, clinicians are typically less effective (Bernard & Goodyear, 2014).

Schulman and Safyer (2006) declared that increasing research attention in clinical outcomes generally has borne much fruit over the last generation. And that attention is yielding important new insights into the workings of therapy and providing a more solid empirical foundation for its practice. That same sort of attention must now be brought to bear on clinical supervision outcome research, specifically by establishing strong, direct links between supervision and therapy outcome, and establishing what specifically in supervision enhances effective therapy (Schulman & Safyer, 2006).

There are some promising developments. An RTC-related field, substance abuse treatment, encouraging case studies have published supporting clinical supervision (Coll, 2008; Tyson, Culbreth, & Harrington, 2008) and suggesting specific processes (Center for Substance Abuse Treatment, 2007). But, to date, few significant, empirically tested outcome studies have been delivered. In one of the few RTC research examples, Decker, Bailey, and Westergaard (2002) reported that a lack of clinical supervision among staff contributes to anxiety and stress responses, which often result in high turnover rates. On the other hand, Coll et al. (2015) recently discovered that when a clinical director of an adolescent RTC utilized assessment tracking and feedback via clinical supervision for substance abuse treatment quality assurance, higher levels of positive youth behaviors occurred. Beyond these albeit promising studies, no other significant research referencing the use of clinical supervision within adolescent RTCs was found in the professional literature.

Curry, McCarragher, and Dellmann-Jenkins, (2005), summarized major empirically based barriers to the delivery of effective clinical supervision—training, time, and scarcity of qualified supervisors (which certainly apply to the RTC setting). Foster and McAdams (1998) indicated that promoting the benefits of clinical supervision for agencies could drive both delivery of clinical supervision and further study (e.g., proving

that clinical supervision is the major force for clinical improvement and the key in reduction of clinician turnover).

Byrne and Sias (2010) strongly recommended the use of Bernard's Discrimination Model (DM) for clinical supervision of professional service providers and especially for working with adolescents in RTCs. Because the DM has high degrees of "intentionality, flexibility, and focus on professionalism" (Byrne & Sias, 2010, p. 207), it is ideal for RTCs. They also added that this model is structured so as to particularly meet the needs of newer supervisees, who are often employed in high turnover environments like adolescent RTCs. Of note, the DM is considered one of the most accessible models of clinical supervision (Bernard & Goodyear, 2014). The DM attends to four separate foci and three supervision roles. The four foci are professional behavior (ethical actions, professionalism), process skills (helping skills demonstrated), conceptualization (identifying patterns and processes), and personalization (attempts to keep counseling uncontaminated by personal and/or transference issues). The three roles are teacher (supervisor delivers direct, didactic feedback), counselor (supervisor works in a facilitative manner to enhance the supervisee's internal reality), and consultant (supervisor challenges the supervisee to think and act on their own). As Bernard and Goodyear noticed (2014), "the supervisor might be responding at any given moment in one of nine different ways" (p. 52).

This study, therefore, explored outcome-based evidence related to effectiveness of clinical supervision in adolescent RTCs. The purpose of this study was to examine the processes and outcomes of clinical supervision at a RTC utilizing the DM and a pair-wise summative assessment pretest-posttest design. The intent was to test the efficacy of a comprehensive, repeatable clinical supervision approach and to contribute to the knowledge base in this field.

## **Method**

### **Research Site**

The adolescent residential treatment site used in this study was a 70-bed facility accredited by The Joint Commission with an on-site accredited school located in the Rocky Mountain region of the United States. The residents, ages 12 to 18 years, were court mandated for a variety of reasons. Treatment at the facility typically consists of a full school day; recreational, outdoor, and equine therapies; and individual, group, and family counseling. Residents average one hour of individual counseling, four hours of group counseling, and 30 minutes of family counseling per week (Coll, Stewart, Juhnke, Thobro, & Haas, 2009).

### **Participants**

This study included 16 clinicians working at the described RTC. The study also included two clinical supervisors. Of the 16 clinicians, 12 were female, and four were male. The clinicians ranged in age from 25 to 47 years at the beginning data collection point (mean = 33.4, median = 30.5 years of age). All 16 participants were assessed at least two times over a 1-year period. Participants had 5.2 years of experience (mean=5.2, median = 4.0) ranging from one to 14 years. All the participants held master degrees in either counseling or social work. Of the 16 participants, 11 were licensed professional

counselors (LPC) and five were licensed clinical social workers (LCSW). Four of the LPCs and one of the LCSWs held provisional licenses.

The average age for the two clinical supervisors was 60 years old. Both had been licensed professional counselors for over 25 years, were affiliated with the agency for over 30 years, and were state certified clinical supervisors.

### **Instrumentation for Data Collection**

Two assessments were adopted and adapted. The first assessment was based on Walborn's (1996) seminal work. Walborn developed evidence of four process variables common across all therapeutic approaches: the therapeutic relationship, positive client expectations, cognitive insight, and emotional expression during counseling.

He further defined the four process variables as such: (a) the therapeutic relationship, as assessed via expert vs. non-expert, early alliance, supportive relationship, and collaborative relationship; (b) positive client expectations, as evaluated by expectations for helping and the ability to socialize the client to counseling; (c) encouraging cognitive insight, thorough offering new understanding to the client by paraphrasing and then interpreting; and 4) promoting emotional expression during counseling by allowing catharsis and by emotionally engaging in the process (Walborn, 1996). The clinical supervisors developed a form using Walborn's process variables and assessed each clinician using a 1–3 scale, with 1 being low and 3 being high (see Appendix A).

The second assessment utilized was based on Ivey, Ivey, and Zalaquett, (2013) skills and stages of the counseling process. Ivey et al.'s (2013) four distinct stages (and accompanying skills) of the counseling process are defined as rapport building, defining the goal, encouraging change (action and decision making), and terminating. They also explained parallel client work through four stages: initial disclosure, in-depth exploration, action, and termination. The two clinical supervisors at the agency adopted and adapted a form using these stages and skills as well (see Appendix B).

These two instruments were selected because they met the desired criteria set forth for selection by the agency based on accreditation and internal goals. The goals included comprehensiveness of evaluation regardless of theoretical approach, inclusion of assessment for both stages and skills (Ivey et al., 2013), inclusion of a summary process highlighting key variables (Walborn, 1996), and repeatability.

These instruments were used to capture pretest to posttest evaluative data from the 16 participants during the data collection period. The clinicians each provided an audio recording and at least 20 minutes of a written transcript of their work with a client (resident) initially and then again about 12 months later. These recordings were systematically reviewed, and the clinicians were assessed with Walborn's process variables and Ivey et al.'s (2013) skills and stages of the counseling process to determine their individual therapeutic strengths and challenges and the most appropriate supervision interventions to be employed. Goals were then set for individual clinical supervision using the DM (see Appendix C). As previously discussed, the DM was chosen to target, implement, and track clinical supervision goals as it is widely considered the most comprehensive, utilized, and effective of current clinical supervision models and is particularly recommended for RTC settings (Bernard & Goodyear, 2014; Byrne & Sias, 2010; Tyson et al., 2008).

## **Procedure**

Over at least a 1-year period, 16 participants were assessed twice using the instruments described by the two supervisors (one assessment each year), utilizing an audiotaped session and tape transcript of counseling with a selected resident. The clinical supervisors separately critiqued specific counselor therapeutic interactions with residents and compared assessments to increase inter-rater reliability. The clinical supervisor working with the clinician then shared completed assessment and evaluation material with them and set individual goals for improvement. Depending on the baseline assessment results, each clinician was given individual supervision on a bi-weekly to monthly basis. At about the 9–12 month mark, a follow-up assessment was conducted and the same procedure was undertaken.

## **Results**

Pair-wise t-test analysis demonstrated statistically significant pretest-posttest changes for the following variables: Pair 1 (Therapeutic Relationship), Pair 2 (Demonstrating clinical expertise), Pair 3 (Promoting Cognitive Insight), Pair 4 (Emotional Expression), Pair 5 (Demonstrating Effective Stage I Process Skills), and Pair 6 (Demonstrating Effective Stage II Process Skills [In-Depth Exploration and Goal Setting]). Mean differences pretest to posttest ranged from .125 to .875 on a 3-point Likert scale; significant p values ranged from .000 to .004; and pretest to posttest effect sizes ranged from .36 to 2.57 (see Table 1).

Specifically, Pair 1 (Therapeutic Relationship,  $p < .000$ , effect size 2.57) and Pair 5 (Demonstrating Effective Stage I Process Skills,  $p < .000$ , effect size 2.56) demonstrated the most significant changes (see Table 1). There was no statistically significant pretest-posttest difference for Pair 7 (Demonstrating Effective Stage III Process Skills, mean difference = .125,  $p = .164$ , effect size = .36; see Table 1).

## **Effect Size (ES)**

Cohen (1988) suggested that effect sizes of .20, .50, .80, 1.20, and +2.0 should be considered small, medium, large, very large, and huge, respectively. Statistically significant gains from baseline to one year later fell in the large, very large, and huge ranges, as specified by Cohen. The conclusion can thus be made that test results have not only statistical significance, but also practical significance (Cohen, 1988).

## **Discussion and Recommendations**

The results here indicate that there were statistically significant pretest and posttest differences in all areas except Demonstrating Effective Stage III Process Skills (Action and Decision Making). These overwhelmingly positive results align with the assertions and limited empirical finding that systematic clinical supervision helps promote therapeutic improvements and is considered essential if a therapist hopes to consistently implement effective interventions with clients. In addition, the significant changes in these areas presumably reinforce outcomes previously found about clinical supervision benefits (e.g., clinical improvement and reduction of burnout, (Culbreth,

1999). The approach presented in this study helps to meet the need for supervision that can also presumably mitigate clinician issues like anxiety and stress responses (Decker et al., 2002).

*Table 1*  
*Comparison of the Means Pretest and Posttest*

| Therapeutic Process Variables   | Pre  | Post | Sig  | Differences | Effect Size |
|---|------|------|------|-------------|-------------|
| Pair 1<br>Therapeutic Relationship  | 2.00 | 2.87 | .000 | +.875       | 2.57        |
| Pair 2<br>Promoting Positive Client Expectations  | 2.12 | 2.87 | .000 | +.750       | 2.21        |
| Pair 3<br>Promoting Cognitive Insight   | 2.00 | 2.67 | .000 | +.687       | 1.44        |
| Pair 4<br>Encouraging Emotional Expression  | 1.87 | 2.31 | .004 | +.437       | .913        |
| Pair 5<br>Demonstrating Effective Stage I Process Skills (Rapport Building)                       | 2.00 | 2.87 | .000 | +.875       | 2.56        |
| Pair 6<br>Demonstrating Effective Stage II Process Skills (In-Depth Exploration and Goal Setting) | 1.94 | 2.56 | .001 | +.625       | 1.22        |
| Pair 7<br>Demonstrating Effective Stage III Process Skills (Action and Decision Making)           | 2.00 | 2.12 | .164 | +.125       | .36         |

Byrne and Sias (2010) encouraged the use of the DM for the setting in this study, as they believed it would be an ideal format for RTCs and hypothesized that the structure of the model could be particularly appropriate for the needs of newer supervisees. Their hypotheses were supported, with the average years of experience for participants being only four years, and with four provisional counselors included (in their first year). Also, with the statistically significant changes reported, Byrne and Sias appear to be correct that a more, rather than less, structured clinical supervision model like the DM is an ideal format for RTCs with the adolescent population.

The therapeutic process variable that did not move significantly was Demonstrating Effective Stage III Process Skills (Action and Decision Making). With the lack of literature on clinical supervision in adolescent RTCs in general, it is difficult to analyze and understand why. It could be that residents were not at the facility long enough to successfully move through this stage; therefore, clinicians did not have many chances to practice these stage skills. It may also be that the supervisors did not focus

enough in this area. More research is needed to better evaluate and understand what may be happening with this particular important supervision area.

Although more research generally is needed in the area of clinical supervision in adolescent RTCs in general, this study contributes to greater clarity about practical models, applications, and benefits to applying solid clinical supervision constructs in adolescent RTCs.

### **Recommendations**

One compelling necessity is the need for the development of supervision manuals (Schulman & Safyer, 2006). Clinical treatment manuals have increasingly emerged as viable means to research outcomes and have trained therapists in particular theory-specific skills. Indeed, over a decade ago, professionals referred to the treatment manual as a “small revolution” in clinical practice (Schulman & Safyer, 2006). Since then, treatment manuals have only become more plentiful.

Although treatment manuals are not without drawbacks, they have served a useful purpose in advancing the field of counseling. Unfortunately, comparable manuals for training clinical supervisors have been slow to develop. Only one prominent manual exists—*Competencies for Substance Abuse Treatment Clinical Supervisors*, by the Center for Substance Abuse Treatment (2007). That is a beginning, but 10 times as many clinical treatment manuals existed 15 years ago. Because such attention in supervision is lacking, the field's advancement has been delayed. Schulman and Safyer (2006) suggested that a good supervision manual could be useful in at least three ways: in defining and concretizing the (particular) supervision experience, thereby rendering it more researchable; in facilitating the training of supervisors in particular supervision processes and skills; and in facilitating the training of supervisors in model-specific supervision approaches (e.g., the DM). Thus, such manuals can have ready benefit for field-based supervision training and practice as well as research.

### **Limitations**

There are several limitations to this study. The first is that all participants were Caucasian. For future research, a more diverse participant population is needed in order to understand if this model is applicable on a multicultural level.

The second limitation is that highly consistent supervision could possibly have been undermined by crises and other urgent circumstances and that may have affected the efficacy of supervision to a certain degree. Working with inpatient populations can often be very crisis-oriented and stressful. Making a clinical supervision appointment a priority is not always realistic when more urgent matters are at hand. Not maintaining consistency with the clinical supervision process and model could have affected the outcomes and progress for some of the clinicians. This can also present a challenge because, with urgent matters at hand, the content of a clinical supervision session can drift to immediate problem solving, perhaps sacrificing long-term supervision goals.

Other limitations include: participants were limited to one agency, in one part of the country; the lack of a control group; and the number of participants was small. With a larger number of participants and a control group, data would be more accurate and representative of a larger population. Future research should be conducted to address

these limitations and to further explore the usefulness and effectiveness of clinical supervision approaches and models in adolescent RTCs.

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Appendix A

Common Therapeutic Process Variables

Session #: \_\_\_\_\_ Name of Clinician: \_\_\_\_\_  
CL Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Client Age: \_\_\_\_\_

**FOUR process variables common across approaches** (Walborn, 1996)

1 = needs improvement, 2 = adequate/proficient, 3 = above proficient (circle one)

- |   |   |   |   |
|---|---|---|---|
| 1. The Therapeutic Relationship                                 | 1 | 2 | 3 |
| a. Expert vs. Non expert  | 1 | 2 | 3 |
| b. Early alliance   | 1 | 2 | 3 |
| c. Supportive relationship                                      | 1 | 2 | 3 |
| d. Collaborative relationship                                   | 1 | 2 | 3 |
| 2. Positive Client Expectations                                 | 1 | 2 | 3 |
| a. Expectations of help   | 1 | 2 | 3 |
| b. Socializing the client to counseling                         | 1 | 2 | 3 |
| 3. Cognitive Insight  |   |   |   |
| a. Offering new understanding<br>(paraphrasing, interpretation) | 1 | 2 | 3 |
| 4. Emotional Expression During Counseling                       | 1 | 2 | 3 |
| a. Catharsis (ID emotion)                                       | 1 | 2 | 3 |
| b. Emotionally engaged in the process                           | 1 | 2 | 3 |

Adapted from: Walborn, F. S. (1996). *Process variables: Four common elements of counseling and psychotherapy*. Pacific Grove, CA: Brook/ Cole Publishing.

Summary

Strengths?

Specific goals?

Appendix B

Therapeutic Stages and Skills

| Client Stages   | I: Initial Disclosure   | II: In-Depth Exploration   | III: Action   | IV: Termination   |
|---|---|--|---|---|
| Client Work (Ivey, Ivey, & Zalaquett, 2013)                 | Communicating the nature of concerns, including content, affect, and context. Clarifying spontaneous meanings of the concerns throughout disclosure<br>-Anxiety related to disclosure<br>-Testing the counselor | Building deeper understanding of the meanings of personal concern and formulation of tentative goals.<br>-Fear of looking within<br>-Cognitive limitation<br>-Resistance to disclosure<br>-Trust issue | Testing alternative and building plans to fulfill desired goals. Building a belief in those plans that is strong enough to support action.<br>Taking action with support from counselor<br>-Client resistance/fear of change<br>-Environmental resistance to change | End the counseling, solidify change<br>-Resistance to separation  |
| <b>Clinician proficiency Scale</b><br><b>Low 1 → High 3</b> | <b>1 2 3 NA (circle one)</b>  | <b>1 2 3 NA (circle one)</b>   | <b>1 2 3 NA (circle one)</b>  | <b>1 2 3 NA (circle one)</b>  |
| Counselor Stages  | Rapport Building  | Defining the Goal  | Encouraging Change (decision making & behavior )  | Terminating   |
| Counselor Skills  | Attending behavior, pacing, paraphrasing, clarifying, summarizing , perception check, providing therapeutic conditions, questioning, expanding skills, reflection of feeling.                                   | Immediacy, self-disclosure, confrontation, focusing, interpretation, goal setting, structuring, assessment, hypothesis testing, other influencing skills.  | Intervention (such as role playing, cognitive restricting, reframing, systematic desensitization, etc.,) designed specifically for client in relation to goal. Educating.   | All prior skills, summarizing, self-disclosure, and immediacy related to counselor and client feeling about termination. Structuring for future directions. Referral skills, modeling, termination. |

NA = Not Applicable

*Appendix B (continued)*

| <b>Skill/Concept (adapted from Ivey, Ivey, &amp; Zalaquett, 2013)</b>  | <b>Mastery</b> | <b>Focus</b> | <b>Comment</b> |
|--|----------------|--------------|----------------|
| Attending behavior (eye contact, body language, vocal quality, verbal tracking)  |                |              |                |
| Questioning(open/closed)   |                |              |                |
| Encouraging (minimal, keyword, restatement)  |                |              |                |
| Paraphrasing (using important word and check out)  |                |              |                |
| Summarizing (attending-summarizing client's point of view; influencing-summarizing counselor's point of view)  |                |              |                |
| Reflection of content (I hear you saying...)   |                |              |                |
| Reflection of feeling (You are feeling...)   |                |              |                |
| Reflection of meaning (You mean..., you are about, you value, your intention is...)  |                |              |                |
| Interview structure/theoretical approach/interview style-making a choice with client/problem in mind. (Intentional model: 1. Establish rapport; 2. Define problem; 3. Define goal; 4. Explore alternative/confront incongruity; 5. Generalize to daily life)   |                |              |                |
| Confrontation -incongruence, contradiction, mixed messages-check impact (CIS)<br>1=Denial 2=Partial examination 3=Full examination but no change 4= Decision to live with incongruence 5= Development of new behaviors   |                |              |                |
| Development Assessment (D1-D4)<br>D1= Preoperational (Client lacks skills, needs to be told what to do.)<br>D2= Concrete operational (Has skills, but not using them)<br>D3= Formal operation (Can separate problem from self and examine thoughts and actions)<br>D4+ Mutual (Client is intentional, can generate solutions and choose from them) |                |              |                |
| Focusing (adding more specific information about client problem)   |                |              |                |
| Immediacy ("I-you" talk; here and now observations of feelings, body language, etc.)   |                |              |                |
| Hypothesis testing (Could it be...)  |                |              |                |
| Influencing Skills<br>1. Directives<br>2. Logical consequences (Probable outcome)<br>3. Interpretation (New frame of reference )<br>4. Self- disclosure<br>5. Feedback (concrete, specific, nonjudgemental)<br>6. Instruction  |                |              |                |
| Assessment   |                |              |                |
| Interventions (role play, etc.)  |                |              |                |
| Skill integration adapting skill usage to different theories, clients, & situations  |                |              |                |

Appendix C

Discrimination Model (Bernard)

|                       | Teaching       | Facilitating (CNSL) | Consulting     | AIM                      |
|-----------------------|----------------|---------------------|----------------|--------------------------|
| Personalization       | Interventions: | Interventions:      | Interventions: | -CO<br>-CO-CL<br>-CO-SUP |
| Conceptualization     | Interventions: | Interventions:      | Interventions: | -CO-CL<br>-CL<br>-CO     |
| Process, Skills       | Interventions: | Interventions:      | Interventions: | -CO-CL<br>-CO            |
| Professional Behavior | Interventions: | Interventions:      | Interventions: | -CO-SUP<br>-CO<br>-CO-CL |

CO= counselor

CL = client

SUP = clinical supervisor