1

Learning Objectives

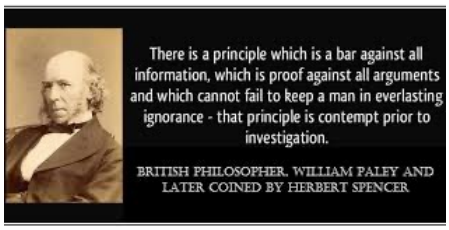
GOAL- Optimize supervision as a space for honesty, openness, growth, and safe emotion

- Understand the Traps in supervision
- Review the history of supervision
- Differentiate clinical vs. administrative supervision and their roles in development
- Learn to assess supervisor/supervisee preferences and experiences in 4 Key Domains
  - Supervision Styles and Supervisee Learning Preferences (including history of Supervision practices)
  - Theoretical/Practice Approaches (with recommendations for clinical knowledge and skills development)
  - Generational
  - Cultural
- Productively engage with feedback and suggestions
- Appreciate the power of accountability and evaluation

2

Lessons in Humility from an Educator

- You will never know it all. It's ok!
  - Embrace new learning and perspectives
  - Blind spots are a worthy pursuit! (be grateful when you find them.)
- Experience does not necessarily = proficiency
- Never assume shared meaning (i.e., CBT, Motivational Interviewing)
- Constantly seek elaboration and clarification.
  - Metaphors and analogies are especially helpful.
- Appeal and be open to diversity of teaching and learning styles



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Optimizing the Supervision Journey

- Worth the investment!
- Respect and Collaboration
- Reciprocal Relationship
- Mutual Growth
- Take Ownership
- Fear and Overcompensation
- Misunderstanding

4

Traps in Clinical Supervision

- Transference-Countertransference (over-compensation)
  - Authority/Expert and the Passive Learner
  - Boss and the Employee
  - Parent and the Child
- Blind Spots
  - Cultural and Generational
  - Educational
  - Theoretical
- Presumptuousness

5

Clinical vs Administrative Supervision

Administrators	Clinical Supervisors
Set **organizational vision, goals, and policies**.	**Clinical skill development and case conceptualization**.
Manage **budget, billing, contracts, and funding**.	Monitor **client progress and treatment outcomes** through supervisee reports.
Oversee **human resources** (hiring, firing, evaluations, compensation).	Provide **formative and summative evaluations** of clinical staff performance.
Ensure **legal and ethical compliance** at the organizational level	Ensure **ethical, culturally competent, and evidence-based clinical practice**.
Coordinate with **external stakeholders**	**Live observation, case review, feedback, and consultation** to supervisees.
Facility operations, technology, risk management, and crisis protocols.	**Supportive guidance, mentorship, and professional development**
Policies and procedures (e.g., safety, documentation, quality assurance).	Provide **remediation plans** for struggling clinicians or supervisees.
Staff workload, productivity targets, and performance benchmarks.	Address **clinical boundaries, countertransference, ethical dilemmas**.
Advocate for **organizational needs and resources**.	Advocate for **client needs within the clinical team or organization**.

6

1. Supervision Styles and Supervisee Learning Preferences

7

Case 1- Supervision Styles

Rachel, a 55-year-old clinical supervisor with a strong psychoanalytic orientation, supervises **Devon**, a 32-year-old therapist who practices from a more integrative, skills-based framework. Rachel sees supervision as a reflective space to explore the inner world of the clinician—especially how unconscious dynamics, personal history, and countertransference shape therapeutic responses. Devon, however, has begun feeling increasingly uneasy with Rachel's probing questions about his motivations, emotional reactions to clients, and parallels between his personal experiences and clinical work. While Rachel intends these inquiries to deepen insight and self-awareness, Devon experiences them as intrusive and at times judgmental, leaving him guarded and less forthcoming. Their sessions maintain a polite, professional tone, but beneath the surface, Devon is beginning to disengage—unsure how to express discomfort without seeming resistant or defensive, and uncertain whether Rachel sees him as a developing clinician or as another case to be analyzed.

8

Dialogue 1

Rachel: Let's return to your client who missed last week's session. What did that bring up for you emotionally?

Devon: Uh, I was mostly just frustrated. I'd prepared a plan, and then they didn't show.

Rachel: Frustration—yes. Do you think it connects to any deeper themes of abandonment or control for you? You know, countertransference?

Devon: *(shifts in seat)* I'm not sure. Maybe. I haven't really thought about it that way.

Rachel: It might be worth exploring what unmet needs that evokes.

Devon: Sure, I'll think about it.

Rachel: Good. This kind of self-understanding is central to analytic supervision.

Devon: Right, I get that.

Rachel: Excellent. Let's keep noticing those countertransference threads.

Devon: Okay. *(smiles politely, avoids eye contact)*

9

Dialogue 2

Rachel: Devon, I sensed some hesitation earlier when I asked about your feelings toward that client. Did I get that right?

Devon: Yeah, a little. Sometimes I feel like supervision turns toward analyzing *me* more than my work, and that makes me uncomfortable.

Rachel: Thank you for saying that. I can see how my questions might feel personal or invasive. That's not my intention.

Devon: I know—it's just that I start worrying I'm being evaluated as a person rather than guided as a clinician.

Rachel: That's really valuable feedback. My analytic lens looks for meaning in reactions, but I may need to better frame *why* I'm asking.

Devon: That would help. If I understand the purpose, I can engage without feeling exposed.

Rachel: Perfect. Maybe we can set a shared boundary—reflect on your reactions only when they clearly connect to the client's process.

Devon: I like that. It keeps things focused while still giving me space to learn.

Rachel: Good. I appreciate your honesty—it helps me supervise more attuned to your comfort level.

Devon: Thanks for hearing me out. This makes me feel more open to the deeper work you're aiming for.

10

History of Clinical Supervision

- Freudian Psychoanalytic- "training analysis"
  - Supervision mirrored therapy (inner experience of therapist)
  - Ethical boundaries were blurry (very blurry!)
- Mid-20th Century- Behavioral, Client-Centered
  - Supervisors as expert clinicians, very little formal training in supervision
- 1970s to 2000s- more systematic (licensing), ethics-focused, collaborative
- 2010s to present- outcome monitoring, use of technology
  - Supervision seen as expertise unto itself


YEAR _____

CLINICAL SUPERVISION LOG

DATE	HOURS	TOPIC	SUPERVISOR

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What do you want and need from Supervision?

Do you prefer (or want)…

- more instructional or collaborative supervision?
- structure and agenda or flexible discussion?
- equal partnership or direction and authority?
- direct and detailed correction or collaborative reflection?
- ongoing feedback (formative) or scheduled evaluation (summative)?
- case study, observation and modeling, video review and development?

Where and how does emotion and vulnerability show up in supervision?

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Brené Brown: Clarity is Kindness

- Intention: clarity over shaming (focus on growth)
- Grounded in vulnerability (honest, without defensiveness)
- Emotional tone (curiosity and compassion)
- Find clear examples
- Name discomfort (invite supervisee to own discomfort)
- Promote firm but KIND boundaries (with supervisee and clients)
- Stay GENEROUS in your assumptions

13

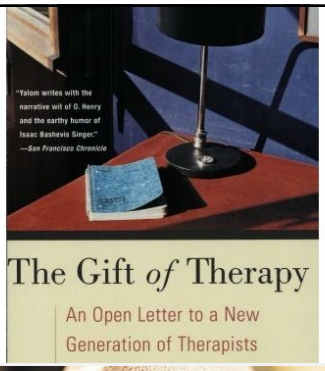
14

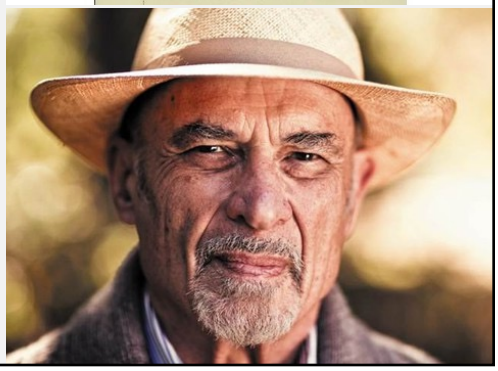
15

Yalom- The Gift of Therapy

"But offering guidance and inspiration to the next generation of psychotherapists is exceedingly problematic today, because our field is in such crisis. An economically driven health-care system mandates a radical modification in psychological treatment, and psychotherapy is now obliged to be streamlined—that is, above all, inexpensive and, perforce, brief, superficial, and insubstantial.

So I worry about psychotherapy—about how it may be deformed by economic pressures and impoverished by radically abbreviated training programs. Nonetheless, I am confident that, in the future, a cohort of therapists coming from a variety of educational disciplines (psychology, counseling, social work, pastoral counseling, clinical philosophy) will continue to pursue rigorous postgraduate training and, even in the crush of HMO reality, will find patients desiring extensive growth and change willing to make an open-ended commitment to therapy. It is for these therapists and these patients that I write The Gift of Therapy. "





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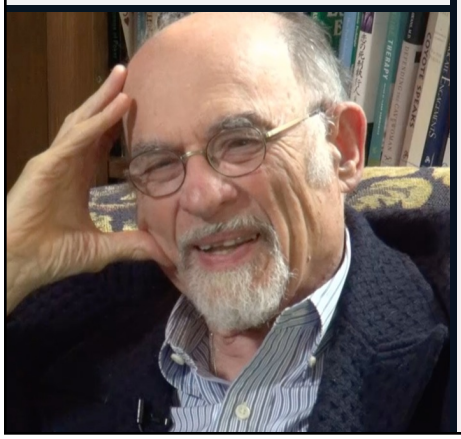
Irvin Yalom



1. Prioritize the Therapeutic/Supervisory Relationship
2. Model Authenticity and Transparency (own mistakes and struggles)
3. Focus on the (Relational) Here-and-Now
4. Normalize Therapist Anxiety and Vulnerability (uncertainty is natural)
5. Promote (Existential) Reflection (e.g., fear of failure)
6. Emphasize the Therapist's Use of Self
7. Discourage Overreliance on Technique*
8. Create a Supportive and Reflective Space (safe and non-punitive)

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What makes for excellent clinical supervision?

- Competence
- Empathy
- Communication Skills
- Flexibility
- Active Listening and Feedback
- Modeling Best Practices
- Supporting Professional Growth

> "THE ONLY WAY TO CHANGE PEOPLE'S BEHAVIOR IS TO CONNECT WITH THEM WHERE THEY ARE."
>
> – BRENÉ BROWN

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Supervision Techniques and Models

- Core Roles
  - Educational
  - Mentorship
  - Supportive Guidance
  - Gatekeeping
- Developmental Perspectives
  - Stoltenberg's Integrated Development
  - Loganbill's Stages
- Competency Based
  - Miller's Feedback Informed Treatment
- Reflective (most psychotherapeutic)
  - Irvin Yalom
  - Brene Brown

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Stoltenberg's Integrated *Developmental* Model (IDM): Toward Highly Reflective Practitioners

Level 1- Beginner	Level 2- Intermediate	Level 3- Advanced
• High motivation, high anxiety • Focused on self, worried about evaluation and mistakes • Looks for supportive, instructive supervision • (structure, positive reinforcement, skill building)	• Variable motivation, fluctuating confidence • More aware of client dynamics (but self-focused) • Struggles with autonomy and dependency • (balance support with challenge, foster reflection, encourage autonomy)	• Stable motivation, solid autonomy • Focused on client needs, self-monitors • Peer consultation over direct supervision • (consultant and collaborator; refining advanced skills)

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The Loganbill Model

(Loganbill, Hardy, & Delworth [1982])

- Stage 1: Dependence
  - Anxiety and needs approval and guidance; clear structure
- Stage 2: Conflict
  - Questioning self, clients, and supervisor
  - Frustration, ambivalence, and defensiveness
- Stage 3: Independence

Development is cyclical in nature (not a straight line)

Supervisor as teacher, challenger, and consultant

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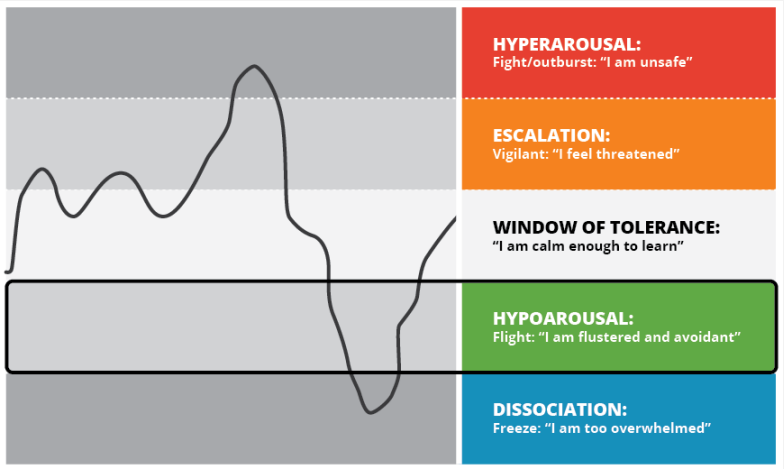
Window of Tolerance (Siegel, 1999)



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Miller's Framework on Clinical Supervision:
Feedback Informed Treatment (FIT) and Deliberate Practice

- Focused on improving measurable client outcomes and enhancing clinical performance
  - Requires feedback and practice
- Outcome Rating Scale (ORS) and Session Rating Scale (SRS): real-time feedback; progress and therapeutic alliance
- Deliberate Practice
  - Expertise based and intentional practice
  - Identify weak areas and 'learning edges'
  - Engage in focused practice (e.g., role plays and skill drills)
  - Specific and challenging tasks with immediate feedback
- Outcome Monitoring
- Therapist Growth and Resilience

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Outcome Rating Scale (ORS)

Name _____Age (Yrs.): ___ Gender: _____
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

Better Outcomes Now
https://www.betteroutcomesnow.com

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs.): ___
ID# _____ Gender: _____
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. I----------I I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I----------I We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is *not* a good fit for me. I----------I The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. I----------I Overall, today's session was right for me.

Better Outcomes Now
https://www.betteroutcomesnow.com

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2. Theoretical/Practice Approaches- Navigating the Divide

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Case 2- Theoretical Divides!

- In supervision, **Elaine**, a seasoned clinician with a strong cognitive-behavioral orientation, and **Marcus**, her supervisee, discussed a client struggling with chronic anxiety and emotional detachment. Both spoke warmly and respectfully, each affirming the other's insights, yet their underlying approaches could not have been more different. Elaine emphasized identifying maladaptive thought patterns and teaching coping skills, suggesting structured homework and measurable goals. Marcus, meanwhile, described focusing on the client's attachment history, exploring early relational wounds, and using the therapeutic relationship as a corrective emotional experience. They nodded in mutual appreciation—Marcus admiring Elaine's clarity, and Elaine praising Marcus's empathy—but neither directly named the philosophical gap between their models. The session ended with both feeling superficially aligned, though beneath the politeness lingered an unspoken tension: two clinicians committed to helping the same client, yet operating from entirely different maps of the human psyche.

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Dialogue 1

Elaine: I think your client could really benefit from tracking anxious thoughts and using reframing exercises between sessions.

Marcus: That's a great idea. I can definitely see how that could help.

Elaine: Good. It's important that she starts learning to challenge those distortions directly.

Marcus: Right. Though she tends to shut down when we talk about thoughts too quickly… I've been focusing more on how she *feels* safe with me first.

Elaine: Of course, of course. Safety's important. But you don't want to get lost in the emotions, either.

Marcus: Totally, yes. Balance is key.

Elaine: Exactly. So maybe you can guide her toward more cognitive insight next session.

Marcus: Sure, I can… try that.

Elaine: Great. I think she'll respond well once she starts using the worksheets.

Marcus: Yeah… maybe. I'll see how that fits. *(smiles politely, shoulders tense slightly)*

28

Dialogue 2

Elaine: You know, Marcus, I'm realizing I keep steering us toward cognitive techniques, and you keep bringing it back to emotional connection.

Marcus: I've noticed that too. I keep thinking, "We're saying nice things to each other, but we're not really in sync."

Elaine: *(laughs softly)* That's fair. I've been doing CBT for so long that I instinctively look for thought patterns to fix.

Marcus: And I tend to listen for attachment injuries and relational repair. I think we're using two different compasses.

Elaine: I like that metaphor. Maybe we could teach each other—next session, you show me how you conceptualize through attachment, and I'll walk you through my CBT mapping. Who know? Maybe we will find some common ground.

Marcus: I'd love that. I think understanding your structure could actually help me ground my sessions more.

Elaine: And I will keep an open mind about how your relational focus can make a major difference for the client.

Marcus: I appreciate that.

Elaine: Perfect. Let's make that our supervision goal for the month.

Marcus: Deal.

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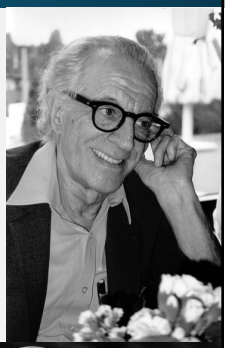
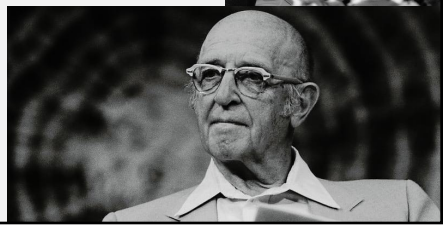
Bridging Theoretical Divides in Supervision

Carl Rogers and Albert Ellis walk into a bar.... :)

What happens if my supervisee practices from a completely different approach?

- A call for supervisor continuing education
- Look for common ground
  - Importance of relationship
  - Client well-being
- Educate each other
- Examine integration (Is it inevitable?)
- Operationalize approaches through *Documentation*





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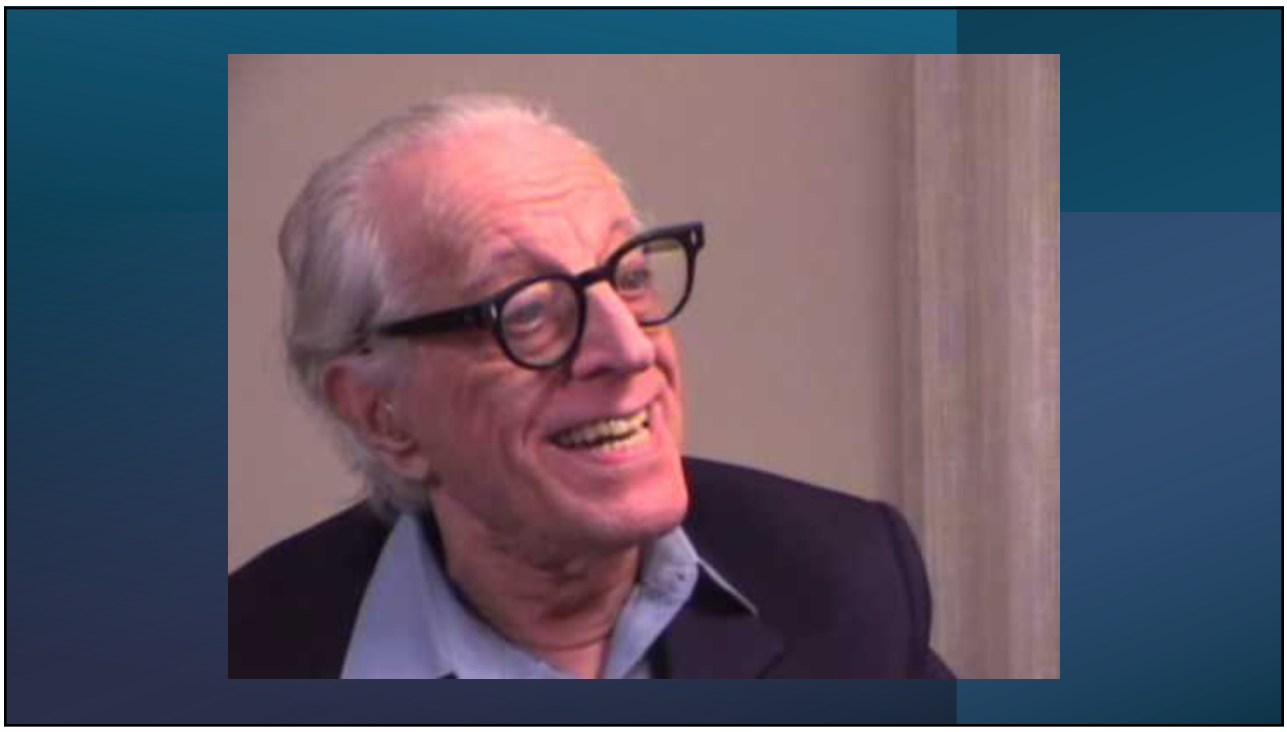

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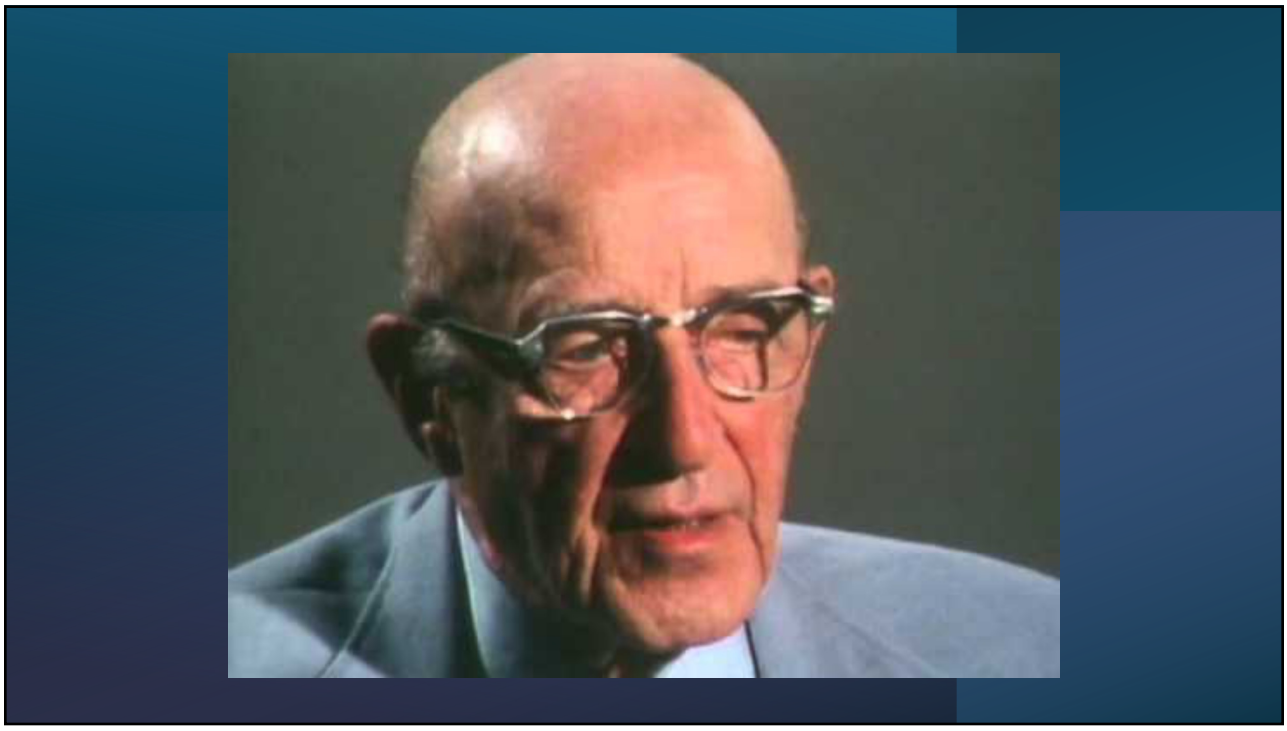

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Common Ground…
Common Denominators for Supervisors and Supervisees-

- Remove obstacles for growth
- Engaging clients, dignity and respect
- Supportive
- Empathy
- Caring is inevitable
- Mistakes
- Uncertainty
- Emotions
- Self-disclosure
- Use of self
- Self-care

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Educating Each Other on Clinical Training

- What was your clinical training like?
- What was good?
- What was not so good?
- And what do you wish it had been?
- What theoretical orientation(s) resonate most with you? What skills and techniques do you most try to apply?
- What is your Growing Edge?
- How can we use Supervision for optimal growth and development?

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Video Work

VIDEO #	DESCRIPTION (Client situation, type of approach)	TIME OF SESSION (30 Min Minimum)	TIME OF DISCUSSION (5 Min Minimum)
5	The therapist approached the session from an attachment-based perspective, guiding the client to explore aspects of her childhood, with a particular focus on her immediate family.	33:08	6:98
	Provide time markers (e.g., 3:52 to 4:40) to show me examples of each of the following. You may also provide brief explanations.		
	3 Examples of Technique	Open-Ended Questions Relating to Self and Others: 00:01-00:25; 9:57-10:12; 12:36-12:56; 13:52-14:07; 26:12-26:24 Fostering a Secure and Comfortable Therapeutic Relationship: 00:01-33:08 Motivation Interviewing: 00:01-33:08	
	3 Examples of Strengths	Simple Reflection: 5:30-5:53; 9:09-9:52; 12:37-12:48; 25:28-26:12 Nonverbal Communication: 00:01-33:08 Reflecting the Client's Affect Back to Her: 00:01-33:08	
	3 Examples of Need Development	Exploring Specific Relationships Within the Family: 25:27-26:24 Summary/Ending: 31:07-33:07 Allowing the Client to Lead to Session (aka when the client kept mentioning the lack of connection with her father): 32:07-32:35	
	1 Example of something that did not look or sound like you thought it would (good or bad)	26:12-26:24 - When I asked the client about the dichotomy of growing up very involved with family but also dreaming of leaving home as soon as she could. Firstly, I think I could have worded this question better. Secondly, I am not sure this was something that I should have	
		brought up to the client, but rather, just an observation for me.	
	1 Example of a good surprise (a strength you saw in your style that you did not expect)	00:01-33:08: My ability to stay neutral yet supportive as the client uncovered tense aspects of her childhood.	
	Lessons learned from	36:20-40:01: I learned from consultation	

David Cecil: Very good.

David Cecil: Saw all of these w

David Cecil: It's the comfort le utilizing all of the masterfully, Madi

David Cecil: What a great thin

David Cecil: Great point. We k about what this m the one hand, a p a healthy/involve that much more c

David Cecil: Beautiful.

35

3. Intergenerational Supervision

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Case 3- Intergenerational Misunderstandings

Laura, a 48-year-old clinical supervisor known for her structured and detail-oriented mentoring style, supervises **Tyler**, a 27-year-old therapist early in his career who values collaboration, flexibility, and balance. Laura takes pride in professionalism, punctuality, and precise documentation; Tyler places equal importance on authenticity, emotional transparency, and sustainable/flexible workloads. Tension surfaced when Tyler expressed frustration with "grind culture" in mental health agencies and questioned whether overtime note-writing should be expected when clinical outcomes were strong. Laura, who spent much of her early career working long hours and "earning her place," perceived this as entitlement and quietly worried about Tyler's commitment. Tyler, in turn, felt misunderstood and dismissed, interpreting Laura's tone as rigid and outdated. While they remained cordial, their unspoken assumptions began to chip away at trust—Laura viewing Tyler as overly sensitive, and Tyler viewing Laura as inflexible and disconnected from contemporary practice realities.

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Dialogue 1

Laura: You've been doing solid clinical work lately, Tyler. How are things going overall?

Tyler: Thanks. Honestly, I've been thinking about how to balance client care without burning out.

Laura: That's good. Everyone has to find their rhythm. I just tell my supervisees to push through the rough spots.

Tyler: *(hesitates)* Yeah… I guess that makes sense.

Laura: We all had to do the hard hours early on. It's just part of the job.

Tyler: Sure, I get that. I just think boundaries are important for sustainability.

Laura: Absolutely. Anyway, let's go over your treatment plans from last week.

Tyler: Okay.

Laura: You're keeping up with documentation, right?

Tyler: I'm trying. *(glances away, tension visible)*

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Dialogue 2

Laura: Tyler, I've been thinking—what I said about "earning your place" did not seem to sit well with you. I think I might have dismissed your concerns without really understanding.

Tyler: I appreciate you saying that. I've been worried about sounding lazy when I bring up balance.

Laura: You're raising an important question about how we sustain ourselves in this field.

Tyler: Thanks. I really admire your endurance—I just don't know if I can keep that same pace long term.

Laura: It is hard for me to imagine this job without those years that I did have to grind. On some level, I do feel like it was a way of paying my dues. But back then, if they had told me to take it easier and work on balance, I am sure I would have done that. It might have been better.

Tyler: And I probably assume that structure means rigidity, when it could also mean stability.

Laura: That's a good point. Maybe we can look at how structure and pacing can coexist in your practice.

Tyler: I'd like that. It would help me find balance without feeling like I'm letting standards slip.

Laura: Perfect. Let's spend the next few sessions trying to make sense of that.

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Intergenerational Supervision
Case of Samantha and Mark (Gen X and Gen Z)

BABY BOOMERS	GEN X	GEN Y MILLENNIALS	GEN Z (IGEN)
BORN BETWEEN 1944 – 1964	BORN BETWEEN 1965 – 1979	BORN BETWEEN 1980 – 1994	BORN AFTER 1995
AGE NOW 55 – 75	AGE NOW 40 – 54	AGE NOW 25 – 39	AGE NOW <24
TYPICAL TRAITS	TYPICAL TRAITS	TYPICAL TRAITS	TYPICAL TRAITS
IDEALISTIC REVOLUTIONARY COLLECTIVIST	MATERIALISTIC COMPETITIVE INDIVIUALISTIC	GLOBALIST QUESTIONING SELF ORIENTED	UNDEFINED ID DIALOGUER REALISTIC

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Insights into Generational Differences- Marketing Strategies

Feature	Baby Boomers	Gen X	Millennials (Gen Y)	Gen Z (iGen)
Core Values	Value, reliability, personal service	Independence, efficiency, skepticism	Experience, purpose, innovation	Identity, diversity, authenticity
Media Consumption	TV, print, email	Email, Facebook, websites	Social media, mobile apps, YouTube	TikTok, Instagram, YouTube Shorts, streaming
Technology Comfort	Adopters, not native users	Digital immigrants	Digital natives	Hyper-connected digital natives
Preferred Channels	TV, direct mail, email	Email, Google search, Facebook	Social media ads, influencers, mobile apps	TikTok creators, memes, social commerce
Ad Style Preference	Clear, informative, traditional	Informative with value proposition	Relatable, socially conscious, experiential	Short, bold, humorous, fast-paced
Trust Source	Experts, testimonials	Expert opinions, peer reviews	Peers, influencers, social proof	Influencers, micro-creators, TikTok trends
Brand Loyalty	High, especially with long-standing brands	Medium—based on quality and value	Low—loyal to values over brands	Very low—favor trending and agile brands
Purchase Behavior	Thoughtful, price-sensitive	Practical, comparison shoppers	Impulse-buying, subscription-friendly	Seamless mobile purchasing, short attention
Cause Marketing	Modest response unless strongly aligned	Some interest	Strongly responsive to cause-driven branding	Expect brands to be vocal and ethical
Content Type	Articles, product guides	Blogs, how-to videos	Stories, memes, interactive polls	Short-form video, memes, AR filters

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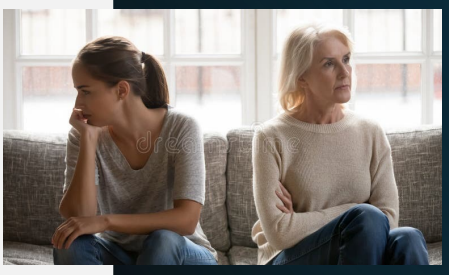
Intergenerational Connection- Matthew Kaplan and Elise Boulding

- Challenge all assumptions.
- Design supervision for mutual learning and problem solving
  - What motivates you in your work?
  - How do you like to give and receive feedback?
  - What have you learned about balancing work and life?
  - What assumptions do you think people make about your generation?
- Consider 'reverse mentoring'… 'teach me about your generation'
  - Technology, social media, trends? Are we open to these things?



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One more word…
current stressors across generations

- The world, including our country, has high conflict and confusion.
- Socio-Economics in the US are uncertain and large groups of people are diving ever deeper into debt.
- What worked for the Baby Boomer Generation did not work so well for Gen X and (arguably) Millennials.
- What worked for Gen X and Millennials will not work for Gen Z.
- What happens?
  - Previous generations wonder why the next generations aren't getting it.
  - Advice falls short and flat.
  - Mutual frustration prevails.

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4. Multi-Cultural Supervision

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Case 4- Navigating Cultural Differences

Peter, a White, U.S.-born supervisor with a background in psychodynamic and systems theory, supervises **Amira**, a second-generation Lebanese American clinician who draws heavily on collectivist and family-centered values in her therapy work. Recently, Amira discussed a case where she invited a client's extended family to participate in sessions, explaining that the client's distress was deeply tied to family honor and relational obligation. Peter grew uneasy, subtly questioning whether Amira was maintaining appropriate therapeutic boundaries. Later, Amira sensed his skepticism toward her culturally rooted interventions and began sharing less in supervision. Peter, noticing the distance, assumed she was simply becoming more confident and independent, unaware that his earlier comments had unintentionally invalidated Amira's cultural framework. What began as a small misunderstanding quietly evolved into a barrier to trust and open reflection in supervision.

45

Dialogue 1

Peter: I noticed you haven't brought that family case up again. How's it going?

Amira: It's going okay. I've been trying to integrate everyone's input without losing focus on the client.

Peter: Good, good. As long as you keep boundaries clear, I'm sure it'll be fine.

Amira: Right… though in her culture, family involvement is expected—it's how support works.

Peter: Of course, culture plays a role. Anyway, let's look at your documentation process next.

Amira: *(pauses)* Okay, sure.

Peter: We just want to make sure everything stays compliant with policy, that's all.

Amira: I understand.

Peter: Great, sounds like you've got it under control.

Amira: Yeah… I guess so. *(smiles thinly)*

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Dialogue 2

Peter: Amira, I realized I may have brushed past something important in our last supervision about your family-inclusive work.

Amira: I appreciate you saying that. I did feel a little hesitant to bring it up again.

Peter: I think I assumed my framework was universal, and I didn't stop to consider how culture shapes both therapy and supervision.

Amira: Thank you. In my community, healing is very relational—if the family isn't involved, the client often feels isolated or even shamed.

Peter: That's powerful context. I can see how my concern about "boundaries" might have come across as culturally tone-deaf.

Amira: I know it wasn't your intention.

Peter: I'd like to learn more from you about how collectivist values guide your interventions. I want to hear all about this case.

Amira: I'd like that—and I can also learn from you how to communicate my rationale clearly in clinical terms.

Peter: Perfect. Let's make this a two-way supervision goal.

Amira: That means a lot. I feel like we're actually having a conversation about culture now, not avoiding it.

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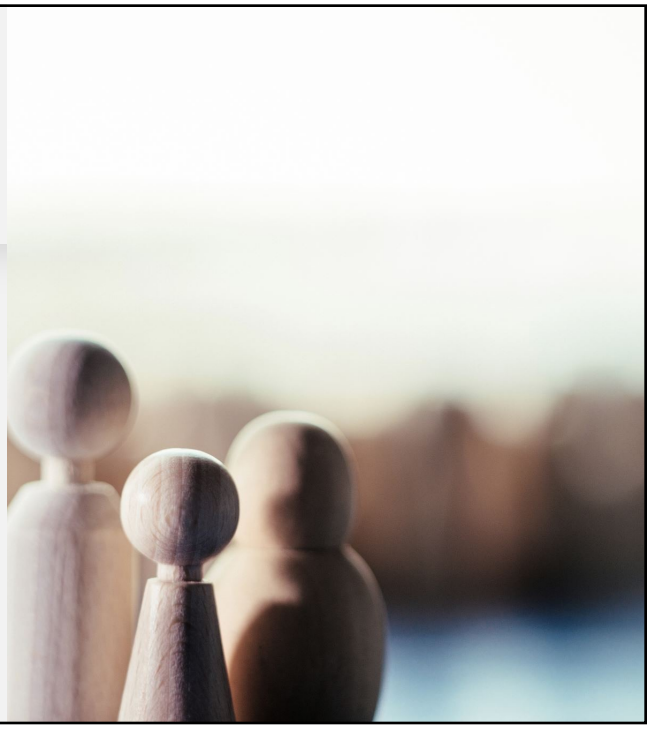
Cultural Competence in Supervision

- Cultural Curiosity
- Cultural Humility
- Inclusive Feedback
- Bias Mitigation



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Cultural Curiosity Exercise-
Supervisor/Supervisee Discussion

Can we build the kind of trust in our relationship so that we can help each other identify and overcome our blind spots?

- What is your nationality/culture of origin? Where did your ancestors come from?
- How much do you know about your culture(s) of origin?
- How meaningful is/are your culture(s) of origin to you?
- What are some stereotypes (positive or negative) about your culture(s) of origin?
  - How may I best demonstrate curiosity and how can I avoid offense?
  - Would you mind sharing with me if/how you have had negative inter-cultural experiences?
- How often does/do your culture(s) of origin play into your daily life?
- How often does/do your culture(s) of origin play into your profession and practice?

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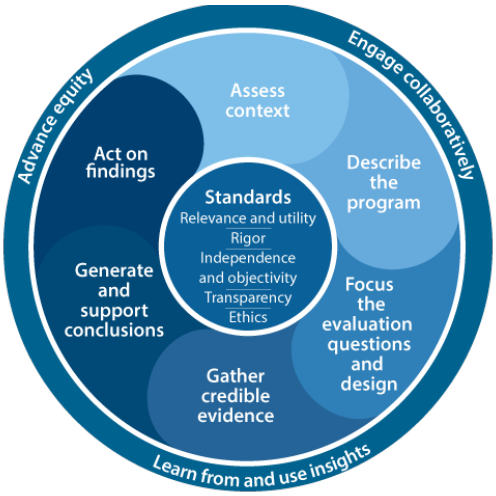
Evaluation and Feedback (Assessing Supervisee Competence)

- Formative vs. Summative Feedback
- Evaluation Tools
- Remediation Plans



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Professional Growth and Sustainability
Supervisee Self-Care and Development

- Process AND Outcomes
  - Know your process (gauge success on well executed plan)
  - Measurable Outcomes
    - Knowledge
    - Behavior
    - Supervisee and Clients optimal progress
- Continuing Education
- Peer Consultation

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Logic Models and Evaluation Frameworks

Inputs	Activities	Outputs	Outcomes		
			Initial	Intermediate	Long-term

Outcomes	Indicator(s) *(may be more than one per outcome)*	Target	Data Source

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