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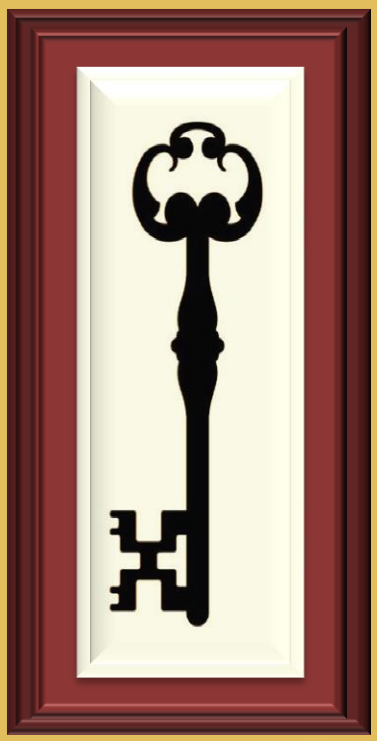
Off the Record: Insights for the Clinical Supervisor

Delve into the professional practice of clinical supervision by exploring ideas, best supervision practices, and reflections from experienced clinical supervisors



Trigger Topics: The Six "Ss" Common in Clinical Supervision (Part II)

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The previous issue explored the first three topics from "the Six Ss," which are common competencies or topics that all counselors should be prepared to discuss with clients. These "Ss" are topics that provoke or "trigger" supervisees. In Part 1 of this two-part article, the first three "Ss" discussed included: swearing, secrets, and suicide. The remaining areas will be explored here.

Spirituality

The counseling profession has experienced its own struggles with the broad topics of spirituality and faith throughout its young existence. Indeed, the ACA Code of Ethics (2014) prevents the counselor's personal imposition of a religious or spiritual belief onto the client. This ethical behavior should be discussed within every counselor development program. Conversely, it is a supervisory responsibility to prepare students and supervisees for examining the client's spiritual beliefs and values, if the client so desires. It may not be clinically appropriate or effective for the counselor to avoid this topic due to a trigger, lack of competence, training, or readiness.

It is essential to include teaching strategies for engaging the student in spiritual self-examination, such as initiating dialogue about the individual's personal beliefs or that of the family of origin traditions and practices. What is most salient is to assess the student's anxiety about the subject matter and to appropriately help to ameliorate apprehension by encouraging heightened self and other discovery, and multicultural awareness and understanding.

Recommendation: Spirituality (including faith and religiosity) is a common "trigger" topic among students. In order to address this topic with clients, new counselors often require help with gaining confidence to explore this subject with their clients, while remaining ethically and clinically considerate.

Sex and Sexuality

Sex has so many subtopics, it would be impossible to address each of them here. The overarching issues of sex and sexuality are commonplace within the therapy environment. Secrets and shame can accompany the subject of sex in many circumstances. A safe and private place to discuss it is of paramount importance for the client. For many students and supervisees, they would prefer to avoid this topic. Akin to clients, supervisees may have also experienced shame associated with a sex-related issue at some point, perhaps from within their family of origin, etc. Supervisors can engage students and supervisees in an effort to lessen the obstacles and to facilitate freedom from any stigma. There are numerous subtopics for the supervisee to gain comfort, such as pornography, sexual dysfunction, paraphilias, homosexuality, gender identity, sexual abuse, sexual intimacy, etc. Supervisors can generate a dialogue with creative or inventive strategies for skill development that communicate these topics in tactful and meaningful ways. This process starts with role-modeling by the supervisor. Students and supervisees will often emulate the supervisor's confidence, as well.

Recommendation: Who has not wished to avoid the subject of sex in some context? The topic can quickly create unease, mostly due to shame from cultural, social, or familial constructs. But, if the therapist cannot discuss sex and sexuality, then who will? Counselors must deal with this trigger topic in an effort to be available to listen and respond to any and all client sexual matters, and to know when making a referral is clinically appropriate.

Shame

The final 'S" trigger topic is shame. It is embedded in each of the first five topics (i.e. shame can be associated with sex, secrets, and suicide). Shame, not to be confused with guilt, is the deeply rooted emotion that is linked to some form of humiliation, rejection, fear, and/or hurt. Shame is included within the list of "Ss" because shame might also be a significant trigger for the beginning counselor, and, as a result, often miss the client's unspoken shame of "I'm unworthy" or "no one can love me." Again, teaching and supervision should be a safe atmosphere to prompt the supervisee's examination of shame within the therapeutic environment. It offers an opportunity for the student and supervisee to learn how to evaluate for client emotional content involving shame within the context of their theoretical orientation, and how to self-evaluate their own developmental competence for working through the shame (or if a referral for a more advanced treatment provider might be more appropriate).

Recommendation: Identifying and addressing the emotion of shame may be purposely or inadvertently avoided by the counselor due to a trigger or a lack of experience. Supervision can aid in uncovering the cloak that fosters avoidance that can be fed within the counseling relationship.

Conclusion

Being triggered is an element of this profession. Counselors attend to highly sensitive subject matter and being unprepared to address these issues can be a scary proposition. As supervisors and educators, it is important to remind supervisees that even though they will invariably encounter a topic for which they believe they are not ready, even as early as the Practicum phase, they do have support and expertise through their licensed supervision to help guide them through the process. They may need reassurance that they are not alone. Discussion of these topics allows for a wealth of teaching opportunities around self-awareness, ethical discernment, and clinical judgment. Finally, finding methods for encouraging confidence and competence on these six "Ss" may depend on the supervisor's model of supervision and personal teaching methods. Both supervisees and students will benefit greatly from the supervisor's wisdom, expertise, guidance and support.

Dusk to Dawn:
Gradually visible trends in counseling & psychology

Engage in an exploration of ideas and thoughts that illuminate future evidence-based therapies, techniques, theories and interventions in the fields of counseling and psychology

What's "App" in the Mental Health World

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Like it or not, cell phones have begun to thread themselves into the very fabric of daily functioning. For many, these hand held instant gratification gadgets have become a most constant and trusted companion. It isn't a wonder that the conservative estimate for individuals using a health care related application on their smart phone was 500 million (Morland, et. al, 2016). That is a staggering number and has caught the attention of software developers and therapists alike. In an astonishingly short amount of time, thousands of apps claiming to aid in everything from social anxiety to sexual dysfunction are literally a touch away. While the research is scrambling to catch up, mental health professionals from a variety of backgrounds are following trend and using these advances in technology to add to their intervention tool boxes.

Bridging the Gap Between Sessions

One of the most appealing aspects of a counseling related app lies in its accessibility between sessions, and mental health professionals may offer specific resources according to their client's needs (Prentice, & Dobson, 2014). Borderline personality disorder? Try DBT Diary Card and Skills Coach, an app offering distress tolerance skills, mood tracking, and narrative "diary" entries that can be sent in real time to a DBT coach. Generalized Anxiety Disorder? How about Bellybio, a free app that uses simple biofeedback to guide and chart breathing in moments of increasing stress or panic. There is even an app for the ever complex mood disorders such as recurrent depression. Optimism is easy to use and along with offering "stay well strategies", can record and track everything from water consumption, to sleep patterns, to specific triggers. These examples represent only the tiniest scratch of the iceberg, and it is easy to see why mental health professionals and clients alike are opening their minds and practices to these resources.

Picture This

Even more promising is the direction this particular field is going. With bio/neurofeedback and experiential technology improving every day, the possibilities of understanding and improving mental health through apps are endless. Particularly exciting is the development of virtual reality(VR) mental health applications. In vivo exposure therapies are effective in the treatment of many mental health disorders, but recreating some scenarios may be unrealistic or too dangerous (Gregg, & Tarrier, 2007). Imagine being able to tap into an application that can allow for exposure to almost any situation or stimulus in the controlled safety of a therapeutic setting. For example, a client suffering from PTSD after a car wreck may have such intense anxiety that he can no longer drive. Using this new technology, the client can begin the

The New Mix

Our changing world practically requires technological competency. Stay up-to-date with software, apps, programs, and other advances.

QUARTERLY SPOTLIGHT:

Positive Activity Jackpot

Based on the work of Dr. Marsha Linehan, this app assists with the selection of a positive activity in one's local community. The Department of Defense National Center for Telehealth and Technology developed this app with intended use for military service members. If there are multiple enjoyable activities nearby, the app offers the option to 'pull the lever' and it will decide for you!

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process of desensitization by virtually driving without the uncertainties and dangers of actual road time. Additionally, he would be learning how to control his stress response through real time biofeedback built into the application. For instance in one app, tones may increase and decrease in volume and pitch as the client's heart rate and breathing changes (Kuhn, et al., 2014). These VR applications are already being used and studied in the treatment of PTSD, specific phobias, anxiety disorders, and even eating disorders (Gregg, & Tarrier, 2007). As the technology evolves and continues to prove itself in efficiency and efficacy, the cost and availability of equipment and training may be closer than ever to becoming a staple intervention in most mental health offices.

Not All That Glitters is Gold

Naturally there are some inherent drawbacks to integrating mental health apps into practice. One of the most obvious is the integrity and efficacy of the app itself. Virtually anyone can put forth an app, and there is very little regulation and evaluation to support the claims of the vast majority of those available (Prentice, & Dobson, 2014). Additionally are the issues of consent and confidentiality. Many of the apps fail to outline their limitations in these areas leaving clients vulnerable to disclosure to unintended parties and ineffective, or even harmful, guidance (Shen, et al., 2015). Lastly, clients may become overly dependent on these apps impeding self awareness, reliance, and growth.

The best apps are those developed by reputable clinicians or entities in the field, provide their own consent, address confidentiality, and offer empirical support (Musiat,, Goldstone, & Tarrier, 2014). Currently the literature is sparse on the efficacy of specific apps (Olff, 2015). Two currently undergoing rigorous study are PTSD Coach and PE Coach. Both have been developed by the Department of Defense's National Center for Telehealth and Technology, the center for Deployment Psychology, and the VA's National Center for PTSD. Although initially developed for veterans, these free apps can be accessed and used by anyone. PTSD Coach can be used as a stand alone app that is based on CBT principals and interventions, while PE Coach is clear in its intention to be a "treatment companion" to prolonged exposure therapy with a trained professional. Empirical evidence for these apps is looking strong, but the same cannot be said for many others offered (Reger, et al., 2013; Kuhn, et al., 2014; Morland, et. al, 2016).

Making Apps a Reality

How do therapists go about integrating apps into daily practice? Researchers recommend the same processes and considerations as those used in implementing most any other intervention (Price., et al., 2014; Prentice, & Dobson, 2014). One wouldn't ask a client to go out and "find a place" that helps with depression, and it is equally as inappropriate to ask a client to simply search for an app that addresses the same need. Instead, do the research and ask the pertinent questions before introducing a specific app to a client. Was it created, developed, and maintained by reputable sources? What does the research say? How does it meet the specific needs of the client? Does it have any potential for harm? Is it widely used by others in the field? If it measures up to the ethical and clinical standards, the next step is providing an element of informed consent with the clients outlining the benefits and limitations of adding it to their therapeutic arsenal (Musiat, Goldstone, & Tarrier, 2014) . If the client is on board, monitor the client's commitment and the app's effectiveness in achieving agreed upon goals. In other words, use it as another means of connection, always tapping into what's "app" with both the intervention and the client.

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Behind the Curtain

Explore the experiential world with thoughts from the counselor's couch that speak to the heart of practice

Conflicting Worlds: Working with LGBTQ Clients Identifying as Christian

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Counselors working with clients identifying as Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) face unique challenges as members of these groups span across multiple cultures and religious backgrounds (Levounis, Drescher, & Barber, 2012). The LGBTQ community faces higher rates of suicide attempts, substance abuse, and mental health concerns compared to heterosexual and cisgender people (Craig, Austin, & Alessi, 2013). Strained relationships associated with the coming out process can make members of the LGBTQ community seek outside connections. These connections may be with community and religious organizations. LGBTQ clients can express their belief in spirituality or a specific religion despite facing persecution from extremist religious groups (Barnes & Meyer, 2012). The client may experience internalized phobias as their sexuality and spiritual views may clash.

WORDS OF WISDOM

Counselor meditations for daily clarity

One of the least discussed issues of individuation is that as one shines light into the dark of the psyche as strongly as one can, the shadows, where the light is not, grow even darker. So when we illuminate some part of the psyche, there is a resultant deeper dark to contend with. This dark cannot be let alone. The key, the questions, cannot be hidden or forgotten. They must be asked. They must be answered.

Clarissa Pinkola Estes

LGBTQ individuals can experience internalized homophobia and/ or internalized transphobia in addition to cultural isolation (Barnes & Meyer, 2012; Hendricks & Testa, 2012). Religious affiliations provide benefits and drawbacks such as feeling a connection to a higher power and simultaneously condemned due to sexuality or gender identity (Bowland, Foster, & Vosler, 2015). A connection to an affirming religious support can help the individual to challenge internalized phobias while also receiving love and support from community members (Barnes & Meyer, 2012).

Effective counseling lies within the respect of persons as an individual to make their own decisions and choose purposeful life direction (ACA, 2014). An LGBTQ client identifying as a member of a religious group opposing gender nonconformity or love beyond heterosexuality may be confusing to a counselor. It is not the counselor's duty to assist the client in finding another religion.

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Counselors respect the client's beliefs and use therapeutic tools to help alleviate incongruence or distortions experienced by the client (Bernard & Goodyear, 2009). Ongoing education, supervision, and consultation may be needed on the part of the counselor to understand how the client is impacted by their religious beliefs (Bowland et al., 2013).

Counselors must be aware of the LGBTQ services within the community and identifying areas of safety and affirming community resources (Pachankis & Goldfried, 2013). LGBTQ affirming spiritual supports can improve feelings of connectedness and acceptance (Bowland et al., 2013). As rural areas may be limited in resources, counselors may need to connect to national groups to find community or online services to assist their clients. Ongoing advocacy for LGBTQ clients may be needed to inform community and religious services about the experiences of the LGBTQ individuals. Trainings may be able to provide greater awareness of issues facing the LGBTQ community and provide affirming groups for parishioners that feel disconnected to their spirituality. Even for non-affirming groups, providing these trainings can allow the group to be aware of the mental health risks associated with this community.

Counselors must also be aware of their own internal reactions to their clients' experiences and belief system (Bernard & Goodyear, 2009). A client can be a member of the LGBTQ community and Christian. Counselor confusion regarding this can impact how treatment is provided (Levounis et al., 2012). Using appropriate tools and linkage with affirming community supports can assist in recovery from symptoms of internalized phobias. This may require the counselor to engage in ongoing education, supervision, and consultation. Additionally the counselor may also be expected to actively become an advocate on behalf of their clients. Despite the seemingly conflicting states experienced by Christian and other spiritual members of the LGBTQ community, a prepared and educated counselor can help the client make sense of their experiences and connect to additional supports.

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Hushed Tones

Soothe your self with discussions on caring for the counselor, self-care and related thoughts

Being Here, Now: Mindfulness in Self-Care

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The Buddhist monk Thich Nhat Hanh has shared his wisdom on mindfulness for over sixty years. His teachings are simple: breath, be present, let go, and be here-now. The philosophies are simple: the implications and results of this mindfulness are profound. Hanh (2010) noticed that younger people carry grief, anxiety, suffering and doubt. He claimed an increase in the practice of mindfulness would decrease the struggle against these factors.

The importance of the here and now contributes not only to oneself and their well-being- but to society and community. Mindfulness is being aware of oneself, surroundings, thoughts, and emotions. Davis and Hayes (2011) showed empirical evidence that mindfulness improved individual's abilities to concentrate, gain a sense of mental clarity over thoughts, and achieve levels of higher emotional intelligence. Mindfulness involves sitting with thoughts, feelings, and emotions without judgment. This in turn will allow an individual to process emotions and then react in a different way than originally intended. The act of mindfulness is a passive cognitive activity that allows an individual to exist in the present moment. Mindfulness can lead to discovering things that might otherwise be missed.

Mindfulness can be lost in a world full of technology. Hahn (2010) postulates that technological distractions steal opportunities to truly be with oneself. In fact, many experiences take away time being present with one's thoughts. He stated, "We lose ourselves in our little devices…we are running away from ourselves" (p. 62).

Application of Mindfulness

Therapists can benefit from a self-care routine that consists of mindfulness practice. If the therapist does not take time to listen to themselves with the same care as they do with clients, the risk of compassion fatigue and burnout increase (Stewart-Spencer & Brown, 2015). This is due to struggles with providing time and energy which is mandatory for self-care and attention.

Zarbock, Lynch, Ammann, and Ringer (2015) noted the impact that providing therapy has on an individual. The constant state of caring for others places the therapist in emotionally-charged situations. This may cause an emotional overload which leads to burnout. Burnout shows many characteristics including anxiety, tension, and low motivation or a cynical outlook. State of mindfulness promotes awareness and recognition of the symptoms and signs of burnout, allowing opportunities to stop and slowdown to regain emotional well-being.

Conclusion

The evidence supports the use of mindfulness practice (Zarbock, et al, 2015). Mindfulness is proven to increase overall mental health and a sense of well-being. In the words of Thich Nhat Hanh (2010), “Being truly here is very important- being here for yourself and for the ones you love. You are here, you are completely alive. That is a miracle" (p. 8).

Tip Your Hat

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