# Exercises and Activities for Clinical Supervision

## Cultivating Self-Awareness and Competence

Edited by
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Cover Design: Wiley

Cover Image: © iStockphoto/Terryfic3D

This book is printed on acid-free paper.



Published by John Wiley & Sons, Inc., Hoboken, New Jersey.

Published simultaneously in Canada.

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***Library of Congress Cataloging-in-Publication Data:***

Clinical supervision activities for increasing competence and self-awareness / edited by Roy A. Bean, Sean D. Davis, Maureen P. Davey.

pages cm

Includes bibliographical references and index.

ISBN 978-1-118-63752-4 (pbk. : alk. paper); ISBN 978-1-118-65336-4 (ebk); ISBN 978-1-118-82791-8 (ebk) 1. Psychotherapy. 2. Empathy. I. Bean, Roy A., editor of compilation.

RC480.C563 2014

616.89′14--dc23

2013042744

# Preface

Across all mental health professions, practitioners have long been focused on providing competent and effective treatment to their clients. Countless empirical studies and theoretical papers have been published in an attempt to improve the quality of clinical treatments. More recently, this collective investment in quality clinical education and treatment has been reflected in outcome-focused educational accreditation principles, more stringent measures of therapeutic success, and explicit measures of clinical competence and treatment efficacy.

In most instances, the practice of clinical training has been advanced, as exemplified by standardized educational curriculums designed to help clinicians meet outcome-based criteria for graduation and licensure. Unfortunately, a primary or unbalanced devotion to outcome-based education can be limiting in at least two ways. First, it can turn the supervisor's focus to the assessment of clinician outcomes in lieu of being actively engaged in the training process and the current experiences of the clinicians-in-training. Second, it can emphasize supervisory attention to clinician factors that are more easily observed (e.g., knowledge acquisition, skill development) rather than therapist awareness and competencies in the more subtle areas, such as overcoming personal biases or developing intuition, empathy, and perspective taking.

One of the key characteristics of a competent and emotionally stable clinician is self-awareness. In fact, regardless of the mental health specialization (e.g., professional counselor, psychologist, clinical social worker, marriage and family therapist, psychiatrist, chemical dependence counselor), all psychotherapists need to be

aware of their own biases and personal limitations. As supervisors and educators work to assess and foster competence and self-awareness, they serve an important gatekeeping function by guarding access to the profession and, more importantly, by protecting clients from inadequate and/or unethical clinical care. A greater level of self-awareness can help clinicians avoid many problems and, when needed, can facilitate the resolution of training issues. Competent clinicians who have greater self-awareness are also able to more easily keep professional boundaries and to avoid dangerous levels of countertransference and enmeshment with clients. Similarly, clinicians who have been well-trained at this level are more often able to avoid burnout and are more likely to genuinely and professionally connect to their clients.

In order to better facilitate the training process, this edited book includes a collection of tried-and-tested best practices designed to help students and new clinicians develop greater competence and self-awareness. This book is designed to help clinicians be better prepared to work with increasingly diverse client populations and challenging clinical issues. Given the self-directed nature of post-licensure professional growth and continuing education, this book is also designed to help experienced clinicians “check for blind spots” and continue their own development.

The training activities presented here are designed to create an experientially based learning opportunity for clinicians, as directed by a facilitator (typically a clinical instructor or supervisor). The activities should be used as a supplement to high-quality, attentive clinical supervision and not as a replacement. After all, the experience of supervision and education is a big part of what prepares clinicians for the experience of face-to-face work with clients.

The book chapters are divided into two sections: Core Clinical Competence and Self-Awareness and Diversity-Focused Competence and Self-Awareness. These categories are not mutually exclusive, as both types of activities are seen as necessary for optimal clinical development. The training exercises can be introduced as a supervision requirement, class assignment, implemented as part of a supervisee's remediation requirement, or self-assigned to facilitate personal growth.

## Core Clinical Competence and Self-Awareness

It has been said that in couples therapy, three sessions are going on at once—the one the therapist is experiencing and the one each partner is experiencing (Helmeke & Sprenkle, 2000). The same can be said for individual, group, and family therapy. Each person in therapy filters what is happening in the room through a complex web of life experiences, cultural influences, biases, current life stressors, and family backgrounds, just to name a few. Successfully navigating this web is part of what can make therapy challenging and exciting, because it requires clinicians to develop the ability to:

- Observe him- or herself conducting therapy
- Observe each client observing him- or herself
- Observe each client observing other family members
- Observe each client observing the clinician/self

Not surprisingly, the degree to which therapists are attuned to clients' experiences in therapy, and therapists' level of willingness and ability to change course in session

accordingly, is a well-documented common factor of effective therapy (Sprenkle, Davis, & Lebow, 2009).

This awareness involves therapists' ability to see and understand their biases, assumptions, personal well-being, and general issues. More importantly, clinicians need to be able to evaluate how these issues impact the therapeutic process (Blow, Sprenkle, & Davis, 2007). While the ability to do this is a skill, we believe it is deeper than that. A skill is something you can turn on and off, whereas we submit that truly competent clinicians incorporate this skill into who they are—it becomes an integral part of them as they gain experience.

As a whole, the first half of the book presents experiential activities designed to help therapists develop greater self-awareness and clinical competence. Presented first are two chapters by noted author and educator Harry Aponte, who with his colleagues describes activities centered on their “person-of-the-therapist” model. The first activity involves writing and then rewriting a paper designed to foster awareness. The second activity involves completing an instrument designed to complement and deepen personal insights gained in the paper. Aponte and colleagues set the stage for the book by pointing out that personal issues are unavoidable and can be a source of strength in therapy if a therapist is aware of them.

The next seven chapters focus from various angles on the foundational therapeutic attribute of empathy. Clinicians enjoy much greater influence when they understand and validate their client's reality. Being deeply and nonjudgmentally understood can be immensely healing, yet this foundational skill can be one of the most difficult for new clinicians to learn and for seasoned clinicians to retain. Unexamined assumptions and judgments often get in the way of empathy for new clinicians, whereas routine

and burnout are often the enemies of empathy for experienced clinicians.

Parker and Blackburn outline an “empathy game,” in which therapists gain empathy for clients by watching clips of recorded sessions. Schneider has developed a process through which clinicians learn to appreciate different perspectives through process recording and videotapes. Cravens and Whiting describe an activity designed to increase mindfulness and a nonjudgmental attitude. Burke and Hohman discuss a reflective listening exercise. Esmiol and Partridge outline an instrument and activity that can help clinicians seek and nondefensively accept client feedback. Banford and Tambling outline a group exercise in which therapists reflexively share themes they notice in themselves and each other. Mirick encourages therapists to gain empathy for clients by picking one of their bad habits and discussing it with a colleague.

Just as clinicians need empathy for their clients, they also need empathy for themselves. It has been said that water cannot be drawn from an empty well. If a clinician cannot identify and respond appropriately to his or her own needs, it will be difficult to do the same for his or her clients. Therefore, the next three chapters focus on self-care and developing resiliency. Bohlinger, Wahlig, and Trudeau-Hern outline a mindfulness-based meditation exercise for developing self-compassion. Gillespie and O'Reilly invite clinicians into a mindfulness and narrative-based contemplative dialogue with their colleagues, in which clinicians reconnect with their initial desires to enter the field. Akyil, Pham, and Cunningham present their “concerns of a beginning therapist” questionnaire, which is designed to help beginning therapists and their supervisors articulate growth areas and track developmental progress.

The next three chapters focus on helping clinicians understand how early life experiences with their family and peers impact their clinical work. Davis and Gonzalez-Cort outline an interview with a clinician's family of origin designed to help clinicians gain insight into their emotional triggers so they can be less reactive in therapy. Similarly, Roberts-Pittman and Viviani have therapists construct a genogram to explore their conflict styles and the effect these may have on being a therapist. Williams and Banks have therapists journal about early life experiences related to self-concept. Hall describes an activity designed to increase safety and deepen experiencing in group therapy.

Several clinical settings present unique challenges requiring specialized knowledge. The first three chapters in this section deal with trauma. Hass-Cohen, Veeman, Chandler-Ziegler, and Brimhall outline a fascinating approach to helping clinicians gain empathy for the experiences of international clients who have experienced traumas such as war and natural disasters with which the clinician may be unfamiliar. Then Hass-Cohen and Chandler-Ziegler outline an activity designed to help clinicians cope with vicarious trauma. Similarly, Schwerdtfeger discusses an approach to helping clinicians practice self-care when working with trauma. Next, Steiner and Cox describe an activity to help clinicians find alignment between their work culture and personal values.

This section closes with two chapters dealing with clinicians working in medical settings. Couden Hernandez and Kim discuss a reflecting team exercise designed to help physicians and clinicians deliver bad news compassionately in a medical setting. Mendenhall and Trudeau-Kern help clinicians prepare for the challenges of working in a medical setting by completing a “health genogram” to help clinicians understand their experiences with health-related experiences in their family.

# Diversity-Focused Competence and Self-Awareness

A culturally sensitive approach to care is essential among all clinical providers because it has been linked to provider–client engagement, treatment adherence, and the quality of mental healthcare (Langer, 1999; Núñez, 2003, 2009; U.S. Department of Health and Human Services, 2001). The client–provider relationship is built on the ability of providers to show interest in and knowledge about the client as a whole person. Yet clients' previous experiences of biased care or discrimination by others in the healthcare system, or society in general, can lead to guardedness and mistrust toward individual clinical providers and mental health institutions (U.S. Department of Health and Human Services, 2001). In addition, clinical providers may hold unconscious biases toward diverse clients. The relationship between providers and clients, therefore, is a crucial one. Trust in clinical providers is fundamental to improving clinical outcomes, especially among historically marginalized client populations in the United States.

It is important for healthcare providers to learn how to be effective with diverse patient populations where neither the culture of the provider nor the client is favored and “gain an understanding of the impact of their own culture and also a broader appreciation of interactions among cultures, rather than just memorizing characteristics of certain broad groups” (Nuñez, 2003, p. 1072).

In order to promote cultural sensitivity and self-awareness in the area of diversity competence, 21 tried-and-tested activities are presented. The authors developed these activities to help student trainees and new clinicians develop greater self-awareness and to help clinical

supervisors train supervisees to be better prepared to work with increasingly diverse client populations in the United States. Chapters were developed to challenge narrow-mindedness, to encourage self-discovery, and to identify providers' own prejudices and limitations. The topics presented in this section include the following: multicultural awareness, white privilege, gender-based privilege and oppression, culture-based privilege and oppression, class-based privilege and oppression, disability/ability awareness, deaf awareness, immigrant client and immigrant therapist awareness, sexual orientation–based privilege and oppression, co-victims of rape awareness, weight and body awareness, addiction and recovery awareness, ageism, and finally, death and grief awareness.

The first two chapters cover activities that promote general multicultural awareness. Caldwell and Galiardi describe a cultural card group activity that facilitates the discussion of oppression and privilege in relation to a range of multicultural issues (e.g., gender, age, body size, ethnic/racial background, family constellation, sexual orientation, ability/disability, educational background, religion, and socioeconomic status). Bean, Hsieh, and Clark next describe an activity where clinicians explore a change in one key aspect of their identities (e.g., gender, sexual orientation, ethnicity/race) to encourage them to develop greater perspective-taking abilities and to improve awareness of factors that can influence their own life experiences as providers.

Carter, Swanke, and Brown describe an activity to increase awareness about the power imbalances during clinical encounters. Renowned author and presenter Peggy McIntosh describes a self-awareness group exercise to help providers better understand White privilege. Newman, Pettigrew, Trujillo, and Smock Jordan, as well as Banks and

Williams, describe activities that increase awareness about social class, ethnicity, and resource disadvantages, help to uncover personal biases, and encourage more empathic approaches with vulnerable clients. Nash and Hufnell each describe experiential activities to help increase understanding and cultural effectiveness with clients who have a diverse range of abilities. Additionally, DeGraff, Sorenson, Atchley, and Smock Jordan provide readers with an opportunity for increased awareness about clients who present with substance abuse problems and co-occuring mental/physical disabilities.

In three separate chapters, Akakpo, Lasley, and Zeytinoglu and colleagues focus on immigrant clients and training foreign-born therapists in the United States. Akakpo describes a strategic game to increase self-awareness and understanding of culturally sensitive interventions for recent immigrants from Africa. Lasley describes an experiential exercise to help increase clinicians' cultural sensitivity with immigrant clients in the United States. Zeytinoglu and colleagues describe an activity for clinical supervisors to use with their foreign-born supervisees to better attend to the effect of acculturation on immigrant therapists who are seeing clients in the United States.

Walker and Hernandez and Luna, Heath, Andrews, Smock Jordan, and Higgins describe activities to help providers and student trainees develop more self-awareness and cultural sensitivity while working with lesbian, gay, bisexual, transgender/gender-nonconforming, and queer clients (LGBTQ). Merchant and Whiting describe an exercise that encourages the discovery of compassion for victims of domestic violence, and Rich describes an activity to help providers develop empathy for co-victims of rape. Pratt and Craven describe an exercise to promote greater awareness of weight and body issues experienced by clients. Piercy and Palit describe reflexive learning

activities to help providers work with clients in addiction and in recovery, and Bradford, Ketring, and Smith also describe an experiential exercise to improve empathy for clients experiencing addiction and recovery from substance abuse. Schade describes an activity designed to increase knowledge about common stereotypes about older clients, and finally Humble, Pilkinton, Brodie, and Johnson describe a learning activity using a simulated role-play of a client who receives a terminal diagnosis from a physician to help providers develop skills to practice effectively in the context of end-of-life issues.

As satisfied as we are with this book and its contents, we also have to recognize that more can and should be written on the topic of experiential-based clinical training. Awareness and competency trainings can be extended to a great many more general clinician attributes and several additional clinical populations. In particular, we note the need for additional training activities to help clinicians develop greater competence and awareness in the areas of religiosity and spirituality, working with children and adolescents, and helping families cope with severe mental illnesses. Other topics of interest (to us and to the larger training field) include working with non-English-speaking clients (and translators) and ways to partner with community leaders to reach underserved minority populations where stigmas may prevent mental health treatment.

Clinical competence and awareness are neither easily developed nor quickly mastered and an hour-long activity will not be sufficient to bring about lasting change. Regular supervision and mentoring by professional colleagues are the most direct and reliable ways to continue to grow and develop as clinicians. The reader is invited to engage students, supervisees, and/or professional associates in

conversations on these topics, using these activities as part of the experience, but not the end of it.

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# Acknowledgments

The process of developing an idea into a book is usually challenging and enjoyable, and this project is no exception. We are so very grateful for the help and support of our editor at Wiley, Rachel Livsey. We couldn't have done this without her, and all of these great ideas and wonderful training activities would have remained underutilized if not for her belief in the book. We are also very appreciative of the assistance received from Amanda Orenstein at Wiley, who helped us immensely to stay organized and on time.

We are also grateful for the wonderful editing team at the BYU Faculty Editing Service and all of their work to prepare each chapter for publication. In particular, we are indebted to Jenn McDaniel, as their valiant leader and editing supervisor, who helped us shape so much of the book and its contents. We are appreciative of the generosity of our contributors, their willingness to share great ideas with other professionals and to give up “trade secrets” for the greater good of clinical training. We look forward to seeing how far our influence extends as future generations of clinicians are prepared, professionally and personally, using these training activities.

I would also like to acknowledge the following reviewers for their thoughtful comments and feedback: Laura Simpson, PhD, LPC-S, Walden University, Germantown, TN; Linda Homeyer, PhD, Texas State University, San Marcos, TX; Jeannie Falkner, PhD, Walden University, Oxford, MS; Ann Goelitz, LCSW, Northern Westchester Hospital, Ridgefield, CT; Phil Rich, EdD, MSW, Director of Clinical Program Development at the Stetson School, Amherst, MA; Pasquale Giordano, LPC, Director of Home-Based Services at Bridges, Hamden, CT; Philip H. Brown, MSW, LCSW,

Northeast Psychotherapy Associates, LLC, Plainfield, CT; and Stephen A. Giunta, PhD, Program Coordinator, Counseling and Psychology, Troy University, Tampa, FL.

For my part, I am especially thankful for the loving support of my wife, who patiently endured the whole process from the initial pitch of the book concept to the final moments of meeting revision deadlines. You are the best, Tracey, the best! Our children (Victoria, Sydney, and Andrew) have had to share me with this book over the past year, and that hasn't always been easy or convenient—my apologies and my thanks to you. I am appreciative of my co-editors, Sean and Maureen, who started as my friends and ended up as better friends. I could not have done this without you, thank you.

*R. Bean*

Big projects like this do not come to fruition without collective sacrifice. I would like to thank those who sacrificed the most to help me complete this project, namely my wife, Elizabeth, and my children, Andrew, Hannah, Rachel, and William. I wish to thank my colleagues and graduate students at Alliant International University for encouraging me as I disappeared into another book project; I could not ask for a more supportive university culture. I also thank the authors of the chapters in this book, as well as those that were not published. Many excellent chapters were cut simply because of space limitations. Lastly, I wish to acknowledge my co-editors Roy Bean and Maureen Davey. Your kindness, support, and teamwork made this book seem like far less work that it actually was.

*S. Davis*

I would like to thank and acknowledge a great many people who helped to make this book possible. I wish to offer

sincere thanks to my spouse, Adam, and my daughter, Gabriela, for helping me carve out the time necessary for editing this book. My graduate students and colleagues provided input and plenty of constructive criticism along the way. I also want to acknowledge and thank the many graduate students and scholars who wrote chapters for our book; we could not have done this project without your hard work and dedication. Finally, I wish to acknowledge the steady support and encouragement of my co-editors Roy Bean and Sean Davis, and our publisher Wiley, who helped bring this project to fruition.

*M. Davey*

# Part 1

# Core Clinical Competence and Self-Awareness

# Chapter 1
# Facilitating Clinician Development Using Themes of Personal Issues

Karni Kissil, Alba Niño, and Harry J. Aponte

## Introduction

The quality of the therapeutic relationship has been presented in the literature as a pivotal factor linked to better therapeutic outcomes (Grencravage & Norcross, 1990; Sprenkle, Davis, & Lebow, 2009). This chapter draws from the Person-of-the-Therapist Training model (POTT; Aponte & Winter, 2000) and demonstrates the use of an instrument with the goal of increasing clinicians' awareness and acceptance of their personal issues as a way of facilitating deeper connections with their clients. The richer the relationship is with the client, the greater the clinician's capacity is to effectively assess and intervene. This chapter is the first of two and introduces the reader to the concept of the *signature theme*. In the subsequent chapter, the application of signature themes to clinical work is discussed (see “Exploring the Person-of-the-Therapist for Better Joining, Assessment, and Intervention” in this volume).

## Rationale

Most self-of-the-therapist approaches to training clinicians view *resolution* of personal issues as a necessary means of change and growth that frees clinicians to become more effective professionals (e.g., Bowen, 1972; Kerr, 1981; Satir, 2000). Although the goal of reaching resolution seems

appropriate, it can be a lifelong endeavor, and possibly even an unachievable goal, as we might never fully resolve all of our emotional and relational issues. Our clients get who we are as people and clinicians *in the present*, not who we would like to be. Because of this, the POTT approach emphasizes learning the intentional use of self *as-is*. We all carry our personal struggles into our therapeutic encounters, and they color our thinking, emotional reactions, and behavior with our clients. However, our personal issues and our struggles can be used to relate to our clients and their issues. The POTT model adopts the concept of the “wounded healer” (Nouwen, 1972), stating that we can empathize with and relate to the woundedness of others through our own woundedness. Thus, our wounds can be powerful tools allowing us to feel our clients' pain, understand their life struggles, and speak to their will to change. In order to be able to intentionally use our brokenness to connect with our clients, we must be able to consciously reach into our own wounded places and use what we find to understand and intuit where our clients may be.

POTT pivots on the concept of clinicians' *signature themes*—the lifelong, ongoing issues that run through the struggles of their personal journeys. Increased awareness and acceptance of the signature themes and continuous reflection on how they manifest themselves in therapeutic encounters translate into a clinician being able to take conscious responsibility for what he or she brings to the therapeutic engagement with a client, and result in an enhanced ability to connect purposefully and effectively with clients around therapeutic tasks.

## Activity Instructions

The exercise described as follows is intended to be the starting point of a journey of self-discovery and learning. It can be used in the context of a clinician's supervision or training, or as part of an informal mentoring/supervision group. The POTT initial exercise has three steps:

1. Writing a reflection paper addressing the topics described in the guide (see below)
2. Meeting with a mentor for personal support and to discuss the topics addressed in the reflection paper
3. Rewriting of the reflection paper, incorporating the insights gained during the discussion with the mentor

Unlike the more reflective activities in this book, it would be difficult to conduct this activity on a self-assigned basis; this journey requires the support and guidance of a seasoned clinician who serves as a mentor for the new clinician, as well as a safe and caring environment where the clinician can openly talk about his or her own family history, experiences of hurt, shortcomings, and struggles. Therefore, the instructions are written specifically for the mentors or supervisors conducting the activity.

It is important for mentors to note that the essential element in any context for this POTT exercise is that they provide the safety and support of a relationship with the student or supervisee that allows for follow-up with personal issues of the clinician that require special attention. Attending to personal issues usually brings to the surface painful memories and uncomfortable thoughts and feelings for the clinician. Thus, the environment in which the exercises are done has to be continuously supportive and stable, where the clinician knows that he or she will not be left alone to deal with the emotional aftermath of the POTT experience.

Consistent with the POTT approach, the initial reflection paper should deal with several key points. Detailed instructions for writing each part are included here:

- **Your Signature Theme.** Describe what you believe to be the personal issue that has been most dominant in your life. This is the hang-up of yours that has vexed and continues to vex you, affecting many or all areas of your life.
- **Your Genogram.** Attach a three-generational genogram of your family, with comments that may help your mentor understand who the characters are and their relationships to one another.
- **Your Family History.** Provide a history of your family as you believe it relates to your signature theme. This is your hypothesis about the contributions your family members and their relationships may have made to the origin and perpetuation of your signature theme.
- **Your Struggle With Your Signature Theme.** Speak to how you deal with your signature theme. Describe where you handle it poorly and where you deal with it most effectively. Identify who in your life is most helpful in wrestling with it and how you make good use of this person's help.
- **Your Clinical Work.** Add your thoughts regarding how you believe your signature theme has affected or may affect your relationship with clients and your work with their issues—negatively and positively.

The clinician's openness and willingness to be vulnerable are necessary when writing the refection paper. Once the paper is finished, it is shared with the mentor prior to and in preparation for the face-to-face discussion. The meeting with the mentor serves as an opportunity to explore the

thoughts addressed in the written exercise, illuminate blind spots, and carry the introspection to a deeper level. Also, the mentor is expected to assist the clinician in connecting the personal and professional realms by helping the clinician see how the signature theme might manifest itself in the clinician's work. Because the discussion of the reflection paper with the mentor can be an emotionally charged experience where the clinician might feel overwhelmed, it is important for the mentor to maintain a supportive relationship with the clinician throughout this process.

After the discussion, the clinician-in-training should write a new and updated version of the reflection paper. This updated reflection should distill the insights derived from the discussion with the mentor into a coherent narrative, allowing the clinician to give closure to this stage in the POTT journey and return to it as a point of reference as needed. It is highly recommended that the discussion with the mentor be recorded either in audio or video format, as many important issues can be discussed in a short and emotionally charged period of time, and the student may not be able to remember them completely or accurately. Students who have viewed the videotapes of this experience have frequently reported that they either missed or forgot parts of the discussion with the mentor. Students also found it very helpful when the trainer provided them with specific written feedback on their initial papers that they could refer to in the writing of the second version.

## Example

A. K. was a first-year master's-level student who attended a POTT class as part of her training as a marriage and family therapist. Each student was required to complete the initial

reflection paper, e-mail it to the POTT trainers and classmates before class, and then discuss it in class with the trainers while the other students observed and provided feedback at the end. In her paper, A. K. wrote about the process of defining her signature theme:

> *I didn't think it would be possible for me to group all the painful events in my life into just one category and call it my signature theme. However, as I began the reflection process, I started dissecting each experience one by one, and amazingly I began to see how it was all connected. I came to the realization that the experiences may have been different, but the underlying theme was always the same: the need to meet others' expectations.*

A. K. then went on to tie her signature theme to significant events in her history, such as needing to protect her mother from her father's abusiveness, getting frequent messages that she was the only source of pride and joy for her mother and grandmother, and feeling intense pressure to meet the resultant expectations. She also connected her theme to current difficulties in her relationships, stating:

> *This need to meet others' expectations has led to a number of personal challenges that I have been on a journey to overcome, including insecurity, passivity, and uncertainty. I've been so consumed with meeting others' expectations that it has been very difficult for me to live life on my own terms.*

Regarding the way her signature theme might manifest in her therapeutic work, A. K. wrote:

> *I know that there will be some clients who have expectations beyond my capabilities, and no matter how hard I try, I will not be able to meet their expectations. This will be a struggle for me because I will feel like I failed them.*

In the discussion, the trainers helped A. K. understand that her signature theme made sense considering the circumstances of her upbringing. She was also able to see the huge emotional price she was paying for working so hard to conform to others' expectations and hiding her true self (which she perceived as defective). She described feeling exhausted and drained. When discussing the way her signature theme could play out in her work with clients, A. K. was able to expand her thinking and see how her need to conform could interfere with her ability to challenge clients, but it could also be an asset by allowing her to better empathize with and understand clients with similar struggles. At the end of the exercise, A. K. had a clear idea of how she could use this particular issue—one that she has struggled with her entire life—to help her be a more effective clinician.

## Measuring Progress

To measure progress in self-awareness, it is necessary to remember that the primary purpose of this exercise in the POTT model is greater effectiveness in performance as a clinician. The proving ground to measure the effects of self-awareness in the POTT model is the actual therapeutic process, because the goal of this self-awareness is to be able to become more empathic in relating, more intuitive in assessing, and more efficacious in intervening with the client. In practical terms, this means using a variety of supervision modalities, such as live supervision and videotapes of sessions, along with the POTT's “supervision

instrument” (Aponte & Carlsen, 2009), for two purposes: (1) observing the clinician's performance in clinical sessions, and (2) assessing his or her ability to articulate the conscious and purposeful use of self in working with clients.

Also, because this type of work is emotionally demanding, it is not recommended for clinicians who are in the midst of life crises or seriously unsettling life transitions. A clinician in a turbulent process of separating from home may need to seek personal therapy before he or she is expected to be reflective about internal emotional processes when working with a conflicted parent–child relationship. A clinician who is tenuously managing his or her emotions about the sexual abuse he or she suffered at home may need to do some personal work before addressing issues of intimacy with a married couple. There needs to be recognition of when the clinician's needs exceed the limits of the support a trainer, supervisor, or group can offer. In such cases, supervisors may need to refer clinicians for focused counseling to help them deal with these issues.

# Conclusion

It is integral to the concept of the POTT model to continue to work on the person-of-the-therapist by linking the conclusions of this exercise with the clinician's clinical work. In our case, we have used this instrument at the beginning of a POTT class in a couple and family therapy program with first-year master's-level students. After following the three steps of the activity described in this chapter, students have participated in mock therapy sessions where they could receive direct clinical feedback through live supervision while focusing on their signature themes. Other options for continuity of this work are to have it as a point of reference for supervisory work, by

exploring how the signature theme is triggered by a client or how the theme can be used actively and purposefully to advance a therapeutic goal. Depending on the work context and supervisory relationship, supervisees may or may not choose to share with their supervisors their reflection papers with all of their family history. However, they should be prepared to speak about their signature themes, as these relate to the cases being supervised. It would be helpful for any trainer or supervisor mentoring within the POTT model to undergo training in working with supervisees' signature themes, which begins with learning to utilize their own signature themes in their own therapy practice.

The person-of-the-therapist reflection paper exercise attempts to bring our humanity back to the profession and to promote a way of thinking in which clinicians are not expected to be perfect and free of struggles in order to be considered effective. Rather, this exercise reminds us that this human vulnerability allows us to see more deeply into our clients and relate to them more sensitively.

## Additional Resources

Aponte, H. J. (1992). Training the person of the therapist in structural family therapy. *Journal of Marital and Family Therapy*, **18**(3), 269–281.
Aponte, H. J. (1994). How personal can training get? *Journal of Marital and Family Therapy*, **20**(1), 3–15.
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# Chapter 2
# Exploring the Person-of-the-Therapist for Better Joining, Assessment, and Intervention

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## Introduction

The central tenet of the Person-of-the-Therapist Training model (POTT; Aponte & Winter, 2000) is to help clinicians to *intentionally* use the depth of their human experience to promote deeper and more genuine connections with their clients—helping them to maximize their effectiveness in all aspects of their clinical work, including the assessment and intervention processes. In Chapter 1, we presented the first step in the POTT training: an instrument to help clinicians increase their awareness and acceptance of their personal issues and struggles (known in this model as *signature themes*). In this chapter, we present the next step in this journey: the *clinical case instrument*. This tool helps clinicians focus their attention on how signature themes and other personal factors manifest themselves in their clinical work in three areas: connection with clients, assessment, and intervention.

## Rationale

The clinical case instrument is part of the POTT model (Aponte & Winter, 2000) and is a modified version of the supervisory instrument described in Aponte and Carlsen (2009). For a brief description of the rationale of the POTT model, we direct the reader to the chapter in this volume