

Finding Your Strength

Supervision Suite · Supervision tools

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Part 1 · Overview

The Recovery Files — Clinical Series

Finding Your Strength

Through Supervision

"The best supervisory relationship is not one that evaluates you — it is one that grows you. The clinician who learns to use supervision intentionally becomes exponentially more effective than the one who merely survives it."

Supervision Score

—

Not Yet Assessed

Assessment

Complete

About This Intensive

This intensive is designed for substance use disorder treatment clinicians at every stage of their career — from new counselors finding their footing to seasoned practitioners looking to extract maximum value from supervision. Clinical supervision is one of the most powerful professional development tools available to you. Most clinicians use only a fraction of what it offers. This intensive will help you understand supervision more deeply, identify the barriers that limit your engagement, develop the skills to use it strategically, and build the courage to bring your full clinical self into the supervisory room.

- ☐ Understanding Supervision 6 core concepts
- ☐ The Supervisory Relationship 6 relational dimensions
- ☐ Barriers to Engagement 5 barriers explored
- ☐ Countertransference & Self-Care 5 critical dimensions
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Overall Progress

Part A: Recognizing My Patterns 20 questions

—

Part B: Developing My Strengths 20 questions

—

Overall Supervision Engagement Score

—

0 sections marked complete · Progress auto-saves to this browser

Part 2 • Understanding Supervision • 6 core concepts

Understanding Clinical Supervision

6 Foundational Concepts Every SUD Clinician Should Know

What Clinical Supervision Really Is — and Isn't

Clinical supervision is one of the most misunderstood relationships in the behavioral health field. Many clinicians experience it primarily as evaluation — a periodic check-in where their work is reviewed, their deficiencies noted, and their competence measured. This understanding is not wrong, but it is profoundly incomplete. Supervision, at its best, is a structured professional relationship designed to serve three simultaneous functions: administrative oversight, clinical education, and personal and professional support.

When all three functions are operating, supervision becomes one of the most powerful forces for clinician development available. When only the administrative function is active — which is unfortunately common in high-caseload, under-resourced treatment settings — supervision becomes a bureaucratic exercise that gives everyone an alibi but grows no one.

What matters is understanding what genuine supervision can be — and then doing your part to help make it that, regardless of what system you are in or what supervisor you have been assigned.

1. How would you describe your primary understanding of supervision before beginning this intensive — what did you believe supervision was for, and where did that understanding come from?

Take your time — honesty and depth matter here...

2. Have you ever experienced supervision that felt genuinely growth-oriented rather than primarily evaluative? What made that experience different, and what did it give you?

Take your time — honesty and depth matter here...

The Three Functions: Administrative, Educational, and Supportive

Bernard and Goodyear's foundational model of clinical supervision identifies three distinct functions that effective supervision must address. The administrative function ensures clinical competence and ethical practice. The educational function promotes skill acquisition, theoretical integration, case conceptualization, and clinical development.

The supportive function — often called the restorative function — is perhaps the most critical and the most neglected. Without a deliberate restorative function in supervision, clinicians absorb the weight of the work without a structured place to process it, and the cumulative effect is vicarious trauma, compassion fatigue, and eventually burnout. The supportive function of supervision is not optional or soft — it is clinically protective.

1. Which of the three functions — administrative, educational, or supportive — is most consistently present in your current supervision experience? Which is most consistently absent?

Take your time — honesty and depth matter here...

2. How much space does the supportive function have in your supervision? When did you last bring emotional weight directly into supervision rather than carrying it alone?

Take your time — honesty and depth matter here...

The Supervisory Alliance: The Relationship at the Center

Research on supervision outcomes consistently identifies the supervisory alliance as the primary driver of trainee development and client outcomes. The supervisee who comes to supervision prepared, who discloses genuinely, who articulates their learning needs, who brings their actual clinical struggles rather than their successes, and who invests in the relational dimension of the work is going to have a fundamentally different supervision experience than the one who shows up minimally.

You have more agency over the quality of your supervision than you may realize — and the primary vehicle for that agency is the quality of the alliance you help build.

1. How would you rate the quality of your current supervisory alliance on a 1-10 scale — and what specifically drives that rating?

Take your time — honesty and depth matter here...

2. What is your contribution to the supervisory alliance — what do you bring, and what do you withhold?

Take your time — honesty and depth matter here...

Parallel Process: The Therapy Room in Supervision

Parallel process describes the way that the dynamics of the therapeutic relationship — what is happening between the clinician and their client — unconsciously reproduce themselves in the supervisory relationship. A clinician who is struggling with a resistant, defensive client may become resistant and defensive in supervision.

Parallel process is not a problem to be eliminated — it is data. When a skilled supervisor notices it and names it explicitly, the clinician gains insight not just into their supervision dynamic but into the clinical dynamic they are managing. Learning to recognize parallel process is one of the more advanced and rewarding capacities in clinical supervision.

1. Have you ever noticed parallel process in your supervision — a dynamic in the room that mirrored something happening in your clinical work? Describe what you noticed.

Take your time — honesty and depth matter here...

2. Does your supervision currently create enough safety and depth for parallel process to emerge and be explored?

Take your time — honesty and depth matter here...

The Clinician as Whole Person: Bringing Yourself to Supervision

One of the most damaging myths in the helping professions is that clinicians are — or should be — emotionally neutral instruments of therapeutic technique. The research does not support this myth. The clinician's own psychological health, self-awareness, and degree of emotional integration are among the most consistent predictors of therapeutic effectiveness.

Bringing yourself to supervision means being willing to surface how the work is affecting you, what it is activating in your own history, where you are struggling and where you are thriving. For clinicians in the SUD field, many of whom have their own personal recovery history, this dimension of supervision is particularly important.

1. How much of yourself — your emotional life, your personal history, your responses to the work — do you bring into supervision? What do you typically leave at the door, and why?

Take your time — honesty and depth matter here...

2. In what ways does your personal history with addiction, family systems, or trauma intersect with your clinical work in SUD treatment?

Take your time — honesty and depth matter here...

From Passive Recipient to Active Participant

The most powerful shift a clinician can make in their relationship with supervision is from passive recipient to active participant. The active supervisee arrives with a prepared agenda, has specific questions, brings the cases that most challenge them, surfaces their emotional responses, names what they need, and tracks their own development across supervision sessions.

The skills required for active supervision participation — self-awareness, vulnerability, agenda-setting, feedback reception, self-advocacy — are also the skills that make clinicians effective with their clients. Developing them in supervision develops them everywhere.

1. On a scale of 1 to 10, how actively do you participate in shaping your supervision experience? Where do you tend to retreat into passivity?

Take your time — honesty and depth matter here...

2. What would it mean to fully claim supervision as a resource that exists for your growth? What would you do differently in your next session?

Take your time — honesty and depth matter here...

Part 3 · The Supervisory Relationship · 6 relational dimensions

The Supervisory Relationship

6 Dimensions of the Relationship at the Center of Your Growth

The Power Differential: Understanding and Working With It

Every supervisory relationship contains an inherent power differential — the supervisor evaluates the supervisee, holds professional authority, and participates in gatekeeping decisions. The key is learning to hold both realities simultaneously: the supervisor has authority over me AND this relationship is fundamentally a growth partnership — and then acting from the growth partnership frame whenever possible.

Effective supervision requires what developmental researchers call "good-enough safety" — not perfect safety, but enough safety to take the risks that growth requires. As the supervisee, your agency lives in recognizing how much of the felt danger is structural and real, versus how much is driven by your own internal dynamics.

1. How does the power differential in supervision affect your engagement? Where do you find yourself managing your perception rather than engaging authentically?

Take your time — honesty and depth matter here...

2. What is the actual risk profile of full disclosure in your current supervision? How does your emotional response compare to that actual risk level?

Take your time — honesty and depth matter here...

Trust and Disclosure: The Engine of Supervisory Growth

The relationship between trust and disclosure in supervision is reciprocal and developmental. Disclosure of genuine clinical struggle generates the trust that makes further disclosure possible. Withholding creates a supervision experience that becomes progressively shallower.

Trust is built through small, tested acts of disclosure. The clinician who has never risked genuine disclosure in supervision does not need to begin with their deepest professional wound — they can begin with one honest case presentation that includes not just what they did but what they felt and what they are still unsure about.

1. What is the most honest thing you have ever disclosed in supervision — and what was the response? How did that exchange shape what you bring to supervision going forward?

Take your time — honesty and depth matter here...

2. What are you currently withholding from supervision — a case, a feeling, a clinical mistake — that would genuinely benefit from being explored?

Take your time — honesty and depth matter here...

Evaluation Anxiety: Working Through the Fear of Judgment

Evaluation anxiety — the fear that supervision will reveal incompetence, trigger corrective action, or damage professional standing — is the single most common barrier to supervisee disclosure and the most significant inhibitor of supervisory growth. Evaluation anxiety typically operates at a level of intensity disproportionate to the actual threat.

Naming this pattern in supervision — "I notice I tend to present my most polished work here, and I want to understand why" — is often the most effective single intervention for reducing evaluation anxiety while simultaneously deepening the supervisory alliance.

1. How prominent is evaluation anxiety in your supervision experience — and where do you think it comes from?

Take your time — honesty and depth matter here...

2. What would it look like to begin gradually testing new behavior in supervision — to take a small, specific risk of disclosure you have been avoiding?

Take your time — honesty and depth matter here...

Receiving Feedback: The Art of Growing Without Defending

The ability to receive clinical feedback without becoming defensive is one of the most important professional capacities a clinician can develop. Clinical feedback frequently touches identity — when a supervisor questions your case conceptualization, it can feel like they are questioning

your competence as a person.

The key cognitive shift is separating the information from its impact on identity. Feedback about your work is information about the work — not a verdict on you as a person or as a clinician.

1. How do you typically respond when receiving critical feedback in supervision — internally and externally? Where does defensiveness show up?

Take your time — honesty and depth matter here...

2. Describe a piece of supervisory feedback that genuinely changed how you practice. What made you able to receive it?

Take your time — honesty and depth matter here...

When the Supervisory Alliance Breaks Down

Ruptures in the supervisory alliance are a normal part of any significant professional relationship. They are not proof that the supervision has failed; they are clinical data and an opportunity for repair.

The two most common supervisory ruptures are: the supervisor providing feedback in a way the supervisee experiences as shaming, and the supervisee's defensiveness creating a distance the supervisor cannot bridge. Both forms of repair require vulnerability. Both are worth doing.

1. Has there ever been a rupture in a supervisory relationship that went unaddressed — and what was the impact? What would repair have required?

Take your time — honesty and depth matter here...

2. Is there currently an unaddressed strain in your supervisory relationship? What would you say to address it?

Take your time — honesty and depth matter here...

Working Productively with Different Supervision Styles

Supervisors vary enormously in their theoretical orientation, supervisory style, and interpersonal approach. The capacity to extract developmental value from supervisors whose style does not match your preferences is a professional skill — and an important one, because you will rarely be able to choose your supervisor.

The clinician who resents a supervisor for not spontaneously providing what they need but never asks for it is choosing to be a victim of their supervision rather than an agent of it.

1. What supervision style do you learn most effectively from — and what has happened when supervised in ways that did not match your learning needs?

Take your time — honesty and depth matter here...

2. Is there a specific aspect of your current supervisor's style that creates friction for your development? Have you ever named this directly?

Take your time — honesty and depth matter here...

Part 4 · Barriers to Engagement · 5 barriers explored

Barriers to Supervisory Engagement

5 Barriers That Limit What Supervision Can Give You

Fear of Evaluation and Being "Found Out"

The fear of being found out — the imposter's terror that supervision will reveal the gap between how competent you appear and how competent you actually feel — is one of the most pervasive and underexamined barriers to supervisory engagement in the SUD treatment field.

The fear of being found out is maintained by two faulty assumptions: first, that competent clinicians do not struggle or make errors; and second, that disclosure of struggle will lead to evaluation and consequence rather than to learning and support. Both assumptions are wrong.

1. Where does the fear of being "found out" live in your supervision experience — what specifically do you most fear your supervisor discovering?

Take your time — honesty and depth matter here...

2. What would change in your supervision if you were to fully let go of managing your supervisor's perception for one session?

Take your time — honesty and depth matter here...

The Helper Identity and the Difficulty of Asking for Help

The helper identity — the deep self-understanding that "I am someone who helps" — is a profound professional asset. It also creates a specific barrier to using supervision fully. If you are the helper, you are not the one who needs help.

The ability to identify what you need and ask for it — in supervision and in life — is a mark of recovery strength, not weakness. The clinician who cannot ask for help in supervision cannot fully model for their clients the courage that recovery requires.

1. How does your helper identity affect your ability to be a genuine help-receiver in supervision?

Take your time — honesty and depth matter here...

2. If you are in personal recovery: how does your recovery experience affect your ability to be vulnerable in supervision?

Take your time — honesty and depth matter here...

Imposter Syndrome in the Clinical Setting

Imposter syndrome — the chronic, persistent belief that you are less competent than others perceive you to be — is extraordinarily common in the helping professions and particularly prevalent in SUD treatment. Research suggests it is most prevalent among high-achieving individuals who have navigated significant adversity.

Supervision is one of the most powerful available interventions for imposter syndrome — specifically, supervision in which the clinician risks full disclosure and discovers that their actual clinical judgment is consistently met with something other than confirmation of their feared inadequacy.

1. How active is imposter syndrome in your professional life — and how does it specifically affect what you bring to supervision?

Take your time — honesty and depth matter here...

2. Have you ever disclosed directly: "I often feel like I do not know what I am doing as much as I appear to"? What happened — or what stops you?

Take your time — honesty and depth matter here...

Systemic and Organizational Barriers to Good Supervision

Not all barriers to effective supervision are internal. Many SUD treatment settings create systemic conditions that make quality supervision difficult: caseloads that leave no time for genuine

preparation, administrative tasks that dominate supervision time, supervisors who are themselves burned out.

The appropriate response is strategic advocacy for what you need and creative problem-solving about where else you can find it. If your primary supervision is dominated by administrative functions, you may need to advocate explicitly for developmental time.

1. What systemic or organizational barriers most significantly limit the quality of supervision you receive?

Take your time — honesty and depth matter here...

2. What supplementary sources of clinical consultation and support do you currently draw on, and what additional resources could you cultivate?

Take your time — honesty and depth matter here...

When the Supervisor Is the Problem

It would be dishonest to address barriers to supervision without acknowledging that sometimes the primary barrier is the supervisor. Supervisors who are shaming, dismissive of the emotional dimensions of clinical work, unavailable, or incompetent in their supervisory role are real phenomena in the SUD treatment field.

The challenge is to distinguish between two different sources of felt danger: the internal dynamics (evaluation anxiety, imposter syndrome) and the external reality (a supervisor whose behavior is genuinely limiting or harmful). A bad supervisor is not a reason to give up on supervision; it is a reason to be strategic about where else you find it.

1. Have you had supervisory experiences that were genuinely harmful or significantly limiting? What was the impact and how did you navigate it?

Take your time — honesty and depth matter here...

2. How do you currently distinguish between your internal barriers and external problems with the supervision you are receiving?

Take your time — honesty and depth matter here...

Part 5 • Countertransference & Self-Care • 5 critical dimensions

Countertransference & Self-Care

5 Dimensions of Clinical Self-Protection Through Supervision

Recognizing Your Countertransference Signals

Countertransference — the clinician's emotional, cognitive, and behavioral responses to clients that originate in the clinician's own history, needs, and unresolved material — is an unavoidable feature of clinical work, not a failure of clinical technique. The goal is awareness: the ability to recognize when your own internal world is influencing the clinical interaction.

Common signals include: overidentification with clients, rescue fantasies, excessive frustration with non-progressing clients, avoidance of sessions with particular clients, and over-accommodation to client preferences. Every one of these signals belongs in supervision.

1. What are your most consistent countertransference patterns — the specific client presentations, behaviors, or themes that most reliably activate your own emotional material?

Take your time — honesty and depth matter here...

2. How quickly do you typically recognize countertransference when it is occurring — and how regularly does it make its way into supervision?

Take your time — honesty and depth matter here...

Vicarious Trauma: The Occupational Wound of the SUD Clinician

Vicarious trauma — the cumulative transformation of the clinician's inner world through empathic engagement with clients' traumatic material — is not a sign of clinical weakness. It is an occupational reality. The critical point is that vicarious trauma is not a crisis event — it is a cumulative process, often invisible to the clinician until it has progressed significantly.

The most effective intervention is not crisis response but prevention: the systematic use of supervision, peer support, and restorative self-care practices as ongoing protective factors rather than emergency measures.

1. What current symptoms of vicarious trauma — if any — do you recognize in yourself? Be honest about where you actually are on the vicarious trauma continuum.

Take your time — honesty and depth matter here...

2. How systematically are you using supervision and peer support as vicarious trauma prevention — versus treating them as resources you access only after you are already struggling?

Take your time — honesty and depth matter here...

Using Supervision to Process Difficult Cases

The cases that are most difficult are the cases that most need to be in supervision. They are also the cases that clinicians are least likely to bring, because the emotional vulnerability required to present them honestly is precisely the vulnerability that the supervisory environment most struggles to hold.

Learning to bring difficult cases to supervision requires naming both the clinical dimension and the personal dimension simultaneously: "I want to talk about a case that I am struggling with clinically, and I also want to tell you that it is affecting me personally."

1. What is the hardest case you are currently carrying? Have you brought it fully into supervision — both the clinical complexity and the personal impact?

Take your time — honesty and depth matter here...

2. What would you need to say at the beginning of a supervision session to create space for genuine processing of a difficult case?

Take your time — honesty and depth matter here...

Compassion Fatigue and the Long Road of Prevention

Compassion fatigue — the gradual depletion of the clinician's empathic capacity through sustained exposure to client suffering — is not identical to burnout, though they often co-occur.

Burnout is primarily organizational; compassion fatigue is primarily relational.

Compassion satisfaction — the meaning, fulfillment, and genuine pleasure derived from doing effective clinical work — is the protective factor against compassion fatigue. Supervision is one of the primary venues where compassion satisfaction can be cultivated: where successes are named, where growth is tracked, and where the meaning of the work is periodically reclaimed.

1. How would you rate your current compassion satisfaction on a 1 to 10 scale? What is driving that number, and what has changed over time?

Take your time — honesty and depth matter here...

2. How often does supervision include explicit celebration of clinical successes versus focusing exclusively on problems? What would you need to do to change that ratio?

Take your time — honesty and depth matter here...

Building Your Restorative Practice: Self-Care Through the Supervisory Lens

Genuine restorative practice for SUD treatment clinicians is specific, personal, and regularly evaluated: it is what actually restores you, not what is supposed to restore you. Supervision is one of the most powerful restorative practices available precisely because it addresses the specific weight of clinical work in a structured, relational context.

The starting question is not "what self-care practices do I know I should be doing?" — it is "what actually restores me after a hard clinical week, and how consistently am I doing it?"

1. What genuinely restores you after difficult clinical work — not what should restore you, but what actually does?

Take your time — honesty and depth matter here...

2. How explicitly does supervision function as part of your restorative practice?

Take your time — honesty and depth matter here...

Part 6 • Advocating for What You Need • 5 advocacy strategies

Advocating for What You Need

5 Strategies for Claiming Supervision as a Growth Resource

Knowing What You Actually Need from Supervision

Self-advocacy in supervision begins with self-knowledge: a clear, specific understanding of what you need from supervision to grow, to be protected, and to sustain effective clinical practice. Most clinicians have never been explicitly asked to identify their supervisory needs and are therefore unable to advocate for them.

The three supervisory need dimensions — learning needs, support needs, and administrative needs — require different types of supervision time and different types of supervisory response.

1. What are your three most significant unmet supervisory needs right now — one learning need, one support need, and one administrative need? Be as specific as possible.

Take your time — honesty and depth matter here...

2. Have you ever explicitly communicated your supervisory needs to your supervisor? What happened when you did, or what has prevented you from doing so?

Take your time — honesty and depth matter here...

Preparing for Your Sessions: The Foundation of Active Participation

The single most consistent predictor of supervision quality from the supervisee's side is preparation. The clinician who arrives with a prepared agenda consistently reports higher satisfaction with supervision, higher rates of clinical growth, and better use of supervision time.

Session preparation does not need to be elaborate. A brief pre-supervision ritual — ten to fifteen minutes of reflection — asking: What has been most challenging clinically this week? What case is still in my head? Where do I feel uncertain? Is there anything I have been avoiding bringing?

1. Describe your typical preparation for supervision: what do you do in the hours before to make it as productive as possible?

Take your time — honesty and depth matter here...

2. Draft the agenda for your next supervision session as if you had taken fifteen minutes of genuine preparation beforehand. What would be on it?

Take your time — honesty and depth matter here...

Raising Difficult Topics: A Framework for Courageous Disclosure

A three-part framework for raising difficult topics: First, name the difficulty — "There is something I have been reluctant to bring to supervision, and I want to try to talk about it today." Second, describe the clinical dimension. Third, name the personal dimension — "And the reason I have been avoiding it is..."

This framework does the essential work of signaling both the content and the emotional context simultaneously, which gives the supervisor the information they need to respond to the whole disclosure.

1. What is one topic you have been consistently avoiding in supervision? Using the three-part framework, write out what you would say if you were to raise it in your next session.

Take your time — honesty and depth matter here...

2. What typically stops you from raising difficult topics in supervision — and how has that avoidance affected the quality of your supervision?

Take your time — honesty and depth matter here...

When Supervision Isn't Working: Options and Actions

The clinician who recognizes that their supervision is not serving their developmental needs has more options than most realize. The first and most important option is direct conversation:

naming explicitly in supervision what is and is not working. This conversation is almost always the most effective first intervention — and the one most consistently skipped.

If direct conversation does not produce change, the options expand: consultation with a trusted senior colleague, supplementary consultation through peer groups or professional organizations, and in cases of genuine ethical violation, formal reporting processes.

1. If your supervision is not currently meeting your developmental needs: have you named this directly to your supervisor? What would you say, and what specifically are you hoping would change?

Take your time — honesty and depth matter here...

2. What is the full range of options available to you if direct conversation does not produce the change you need?

Take your time — honesty and depth matter here...

Building a Broader Supervisory Ecosystem

Formal supervision is not the only source of supervisory support available to SUD treatment clinicians. Peer consultation groups — structured groups of clinicians at similar career stages who meet regularly to discuss cases — are among the most consistently valuable supplementary resources. They provide multiple perspectives, reduce isolation, and create a collegial community that organizational supervision often cannot replicate.

Building this broader ecosystem is not a supplement to organizational supervision — it is a complement that makes organizational supervision more effective.

1. Beyond your organizational supervision, what elements of a broader supervisory ecosystem do you currently draw on? Where are the gaps?

Take your time — honesty and depth matter here...

2. What is the most significant developmental support resource currently absent from your professional ecosystem — and what one action could you take this month to begin building it?

Take your time — honesty and depth matter here...

Part 7 · Self-Assessment · 40 questions · 2 parts

Supervision Engagement Self-Assessment

40 Questions Across 10 Clinical Development Domains · 1 = Rarely · 5 = Always

Your Scores

Part A — Recognizing My Patterns Questions 1-20

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Part B — Developing My Strengths Questions 21-40

—

Overall Supervision Engagement

—

Assessment Instructions

Rate each statement from 1 (Rarely true for me) to 5 (Always true for me). Respond based on your actual experience, not how you would like to respond. There are no correct answers — only honest ones.

Part A: Recognizing My Supervision Patterns

How honestly and actively do I currently engage with supervision? (20 questions)

Domain 1: Presence & Engagement

I arrive at supervision with a clear sense of what I want to work on.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I am fully present and engaged during supervision sessions rather than distracted.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I follow through on insights and commitments from supervision in my clinical practice.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I track my clinical development over time and notice growth.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 2: Vulnerability & Disclosure

I bring my most difficult cases to supervision rather than only the ones I feel confident about.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I disclose my emotional responses to clients and to clinical work honestly in supervision.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I name it when I am confused or uncertain about a clinical decision.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I bring clinical mistakes and errors to supervision rather than managing them privately.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 3: Using Supervision for Growth

I actively use supervision to develop new clinical skills, not just to review existing practice.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I ask my supervisor specific questions about theory, technique, and case conceptualization.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I request feedback on my clinical work, including feedback I anticipate might be difficult to hear.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I apply supervisory feedback to my practice and report back on what I noticed when I did.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 4: Barriers & Defenses

I notice when I am managing my supervisor's perception rather than engaging authentically.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can name specifically what I find most difficult to bring to supervision.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I distinguish between internal barriers (my own dynamics) and external barriers (the supervision itself).

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I have raised the topic of my supervision barriers or avoidance directly in supervision.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 5: Countertransference Awareness

I recognize countertransference when it is occurring — during or shortly after the session.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I bring countertransference material into supervision rather than managing it privately.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I am aware of which client presentations or themes are most likely to activate my own material.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I monitor myself for vicarious trauma symptoms and address them proactively.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Part B: Developing My Supervision Strengths

Am I building the capacities that make supervision genuinely effective? (20 questions)

Domain 6: Advocacy & Agency

I communicate my learning needs and supervisory preferences clearly to my supervisor.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I prepare specifically for supervision sessions — identifying agenda items before the session.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

When supervision is not meeting my needs, I address it directly rather than enduring it passively.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I seek supplementary consultation and peer support beyond my primary organizational supervision.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 7: Application to Practice

Insights from supervision produce visible, specific changes in how I conduct clinical sessions.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I integrate feedback from supervision into my treatment planning and case conceptualization.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I note when supervisory input doesn't match my clinical experience and raise the discrepancy directly.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can articulate specifically how my clinical practice has changed as a result of supervision over the past year.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 8: Self-Care Integration

I use supervision explicitly as a restorative resource — for emotional processing, not just case review.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I have a consistent set of restorative practices that actually restore me after difficult clinical work.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I monitor my compassion satisfaction and compassion fatigue levels and adjust my self-care accordingly.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

My organization's supervision structures actively support my wellbeing, not just my compliance.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 9: Relational Intelligence in Supervision

I can receive critical supervisory feedback without becoming significantly defensive or withdrawing.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I notice and can name relational dynamics in supervision — including parallel process and ruptures.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I have repaired ruptures in supervisory relationships by naming them directly and engaging in dialogue.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I adapt my engagement style to work productively with supervisors whose style differs from my preferences.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Domain 10: Long-Term Professional Growth

I have a clear sense of my professional development goals for the next one to three years.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Supervision is an explicit part of how I am pursuing those professional development goals.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I am actively building a professional community — mentors, peers, consultants — beyond my organizational supervision.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I experience genuine meaning and professional satisfaction in my clinical work.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Part 8 · Deep-Work Worksheets · 10 exercises

Deep-Work Worksheets

Exercises for Transforming Your Relationship with Supervision

How to Use These Worksheets

These worksheets are designed for slow, honest engagement. Work them with a trusted colleague, in personal therapy, or in supervision itself if the alliance supports it.

Worksheet 1 — My Supervision History and Patterns

1. Describe your most significant supervision experience — the one that most shaped how you approach supervision today. What happened in that relationship, what did it give you, and what did it cost you?

Take your time — depth and honesty matter more than polish...

2. What patterns do you notice across your supervisory relationships? What do you consistently bring? What do you consistently withhold?

Take your time — depth and honesty matter more than polish...

Worksheet 2 — The Supervisory Alliance Inventory

1. Rate your current supervisory alliance on a 1–10 scale across three dimensions: Goal Agreement, Task Agreement, and Bond Quality.

Take your time — depth and honesty matter more than polish...

2. What is the most significant gap in your current supervisory alliance — and what is your contribution to that gap?

Take your time — depth and honesty matter more than polish...

Worksheet 3 — My Countertransference Trigger Map

1. List the five client presentations that most reliably activate your own emotional material. For each, describe specifically what gets activated.

Take your time — depth and honesty matter more than polish...

2. For your most significant countertransference trigger: what is the personal history that underlies it?

Take your time — depth and honesty matter more than polish...

Worksheet 4 — My Clinical Growing Edges

1. Name your three most significant clinical growing edges — the specific skills or capacities that represent the frontier of your current development.

Take your time — depth and honesty matter more than polish...

2. Who is the most clinically sophisticated version of yourself — the clinician you are working toward being? Describe that clinician specifically.

Take your time — depth and honesty matter more than polish...

Worksheet 5 — Barriers to Full Disclosure in Supervision

1. Inventory everything you are currently not bringing to supervision — the cases, the feelings, the mistakes. Write it here, in this private space, without the editing that supervision receives.

Take your time — depth and honesty matter more than polish...

2. Write a first sentence — the opening of a supervision disclosure you have been avoiding. What would you say if you were to bring it up at the start of your next session?

Take your time — depth and honesty matter more than polish...

Worksheet 10 — Letter to My Supervisor

1. Write a letter to your current (or most recent significant) supervisor — the full, honest version of what you have never said. What has this supervisory relationship given you that you have never adequately acknowledged?

Take your time — depth and honesty matter more than polish...

2. Close the letter with a commitment about who you are going to be in supervision from this point forward — what you are going to bring, how you are going to show up.

Take your time — depth and honesty matter more than polish...

Part 9 · My Action Plan · 5 commitment sections

My Supervision Action Plan

Assess · Commit · Prepare · Advocate · Grow

From Insight to Action

Everything in this intensive has been preparation for this: developing a specific, committed plan for transforming your relationship with supervision. Insight without action is incomplete.

My Honest Supervision Baseline

1. Rate your current supervision on a 1–10 scale across three dimensions: Depth, Growth, and Protection. What does the profile tell you?

Be specific — action plans require specificity and commitment...

2. If your most difficult professional crisis happened tomorrow, is your current supervision relationship strong enough to hold you in it?

Be specific — action plans require specificity and commitment...

My Priority Growth Area in Supervision

1. What is the single highest-priority supervisory growth area — the specific barrier or avoidance whose address would most change the quality of supervision you are receiving?

Be specific — action plans require specificity and commitment...

2. What specifically will you do to address this area? Who will hold you accountable?

Be specific — action plans require specificity and commitment...

My Professional Growth Commitment Statement

1. What is the most important insight from this intensive? What has genuinely shifted in how you understand your relationship with supervision?

Be specific — action plans require specificity and commitment...

2. Write your Personal Supervision Commitment Statement: what you are committing to bringing, what you are committing to no longer withholding, and why.

Be specific — action plans require specificity and commitment...
