Maryland Counseling Association

A BRANCH OF ACA

COMPASS POINTS

ISSUE 12 | VOLUME 3 | WINTER 2020

Inside this Edition

Articles	3
MCA Membership	6
MCA Board	7
Organization Chart	8

Mission

"Serving the Counseling, Guidance, and Human Development Professions"

MCA Officers

President:
Ajita Robinson

President Elect:
Carol ZA McGinnis

Secretary:
Cynthia Taylor

Treasurer:
LaNail Plummer

Immediate Past President:
Catherine Eaton

Member-at-Large:
Glenda Laurent Dickonson

Executive Director:
Open

SAVE THE DATE

2nd Annual Maryland Counselors for Social Justice (MCSJ) CONFERENCE

April 18, 2020

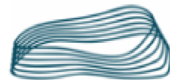
*Keynote Speaker *Education Sessions *Poster Sessions *Vendors *Panel Discussions *Networking *Breakfast *Lunch *CE's

"Be a bush if you can't be a tree. If you can't be a highway, just be a trail. If you can't be a sun, be a star. For it isn't by size that you win or fail. Be the best of whatever you are."

Martin Luther King Jr.

Pula Counseling and Consulting, LLC now offering supervision

Pula Counseling and Consulting, LLC has openings to provide clinical supervision for 2-3 LGPCs, either clinical mental health or school counselors, working toward their full license. Dr. Sara Pula offers both individual and group supervision at an affordable rate, online, and in person. For more information, please contact Dr. Pula at sarapula@aol.com.



Psychoanalytic Studies Program

OPEN HOUSE

The PSP is a combined course of studies for psychoanalytically-oriented scholars, psychotherapists and those seeking full analytic training. Enjoy a casual afternoon with Faculty and Students.

Discover what makes the PSP a unique and individualized course of studies.

Sunday, March 1, 2020
3:00 - 5:00 pm

3204 Klingle Road, NW
Washington, DC 20008

The information session will begin at 3:30 p.m.
Wine and cheese will be served

Classical meets modern in a
community of Psychotherapists,
Psychoanalysts & Scholars

RSVP Lynn Friedman, Ph.D. at 301-656-9650 or drlynnfriedman@gmail.com

Articles

The Role of Theory in Clinical Supervision *Written by Dr. Courtney Gasser, PhD, LP and Dr. Katy Shaffer, PhD*

We believe that one of the most rewarding experiences in being a clinician is helping future generations of counselors-in-training develop into agents of change in people's lives. This can feel like "giving back" to our profession as we do what others did for us by mentoring and guiding counselors who are at an earlier stage of counselor development. In order to do this well, though, it is essential that clinical supervisors operate from a theoretical orientation for supervision. In this article, we will discuss elements involved in being a supervisor as well as the importance of using theory in clinical supervision, with a focus on utilizing Bernard's Discrimination Model. We will pose questions for reflection for clinical supervisors in order to help foster their supervisory practice when training others as well as some supervision resources.

It is usually the case that the clinical supervisor has completed their clinical training and has more experience as a clinician than the supervisee (Bernard & Goodyear, 2019). Yet, being the more senior clinician does not mean that the senior clinician is equipped to provide supervision. Clinicians must develop as supervisors by engaging in supervision-focused educational experiences, developing a supervision theoretical orientation, and being aware of and sensitive to the ethical, legal, and multicultural issues that are present in supervision. Similar to developing as a clinician, supervisors should engage in supervised practice of their supervision skills, so that they can build their competency in skills such as giving growth-oriented feedback. Beyond giving evaluative feedback, supervisors also have the responsibility to assist in gatekeeping regarding who enters the counseling profession (Bernard & Goodyear, 2019).

Suffice to say, there are many responsibilities involved in being a good clinical supervisor. Focusing on the role of theory, it is important to remember that practicing from a theoretical orientation guides our interventions not only with clients but also with supervisees. Theory improves the practice of supervisors by helping us be more intentional about how we interact with supervisees (Bernard & Goodyear, 2019). There are many models of supervision available to supervisors to choose from, including models that were derived from traditional psychotherapy theories, those that are considered developmental models, and so forth. Here, we will focus on Bernard's Discrimination Model (Bernard, 1997), since this model offers an especially parsimonious perspective on the provision of clinical supervision that offers flexibility when working with counselors-in-training that have a range of developmental levels.

Bernard's Discrimination Model offers a fairly simple and accessible framework that also captures the complexity of supervision. The model is comprised of three supervisory roles with three areas of focus (Bernard, 1997). The three roles that supervisors may operate from are the teacher role, the counselor role, and the consultant role. The teacher role involves the supervisor interacting with the supervisee in ways that instruct the supervisee on being a clinician. For example, if a supervisor is informing the supervisee on how to correctly document their work or on how to perform a Gestalt two-chair with a client, the supervisor is operating from the teacher role. The counselor role involves supervisors helping the supervisee examine their own countertransference and developing awareness of dynamics occurring in the therapy relationship. For example, if the supervisee is hesitant to challenge a client with whom the supervisee feels especially close, the supervisor may help the supervisee examine what is standing in the way of appropriately challenging the client as part of the counselor role. Finally, supervisors can intervene from the consultant role by providing support as a sounding board for the supervisee as the supervisee finds their own answers in performing clinical work. For example, the supervisee may be well aware of several appropriate interventions for a particular client issue, thus needing to talk through their ideas regarding choice of intervention with the supervisor. In this manner, the supervisor is acting more as a consultant.

Finally, the three foci for supervision are a focus on intervention skills, conceptualization skills, or personalization (relationship) skills (Bernard, 1997). So, a supervisor can blend the roles with the foci; for example, a supervisor may focus on personalization skills when taking on the role of consultant. For instance, this might involve working with an advanced supervisee (beyond their first practicum) who recognizes and brings up in supervision that she is unable to connect in a deep way with a particularly challenging client. The supervisor would help the trainee generate hypotheses and think through what might be happening in the session between the therapist and client. For instance, is the trainee nervous about the client's trauma history and opening that up for deeper exploration? Or, is the trainee experiencing countertransference because the client's flat affect reminds the supervisee of her adoptive mother?

...continued

When using Bernard's model, supervisors should use all three roles within any given supervision session and can focus on the three foci depending on what the supervisor deems to be most important for the supervisee's learning. Taking into account the supervisee's developmental level, the supervisor should adjust the use of their role accordingly. When working with beginning counselors-in-training who are in their first practicum, supervisors may work from the teacher role more than the other two roles. This can provide beginners with more structure and support, helping lessen their anxiety as they learn what it is to be a counselor. Likewise, supervisees who are more advanced will likely need less teaching and more of the consultant role from their supervisors. Advanced supervisees will have more experience and will be better equipped to sort things out by talking through their ideas with a more experienced colleague (the supervisor). Furthermore, clinical supervisors should not be afraid to ask their supervisees, regardless of developmental level, about what might be going on for them emotionally as supervisors draw their attention to issues such as countertransference. In this way, the supervisor can move from the counselor role (asking about emotions because it is relevant to the clinical work) to the consultant role (applying one's reactions to what is occurring in one's clinical work). As part of ethical supervision, supervisors are not the supervisees' counselors, and do not treat the supervisees. However, it is important and necessary to talk with the supervisee about their emotional reactions and experiences pertinent to their work as a counselor.

Finally, in applying Bernard's Discrimination Model to your own supervisory work, we recommend considering not only the developmental level of your supervisee (e.g., beginner, advanced trainee, LGPC) but also the clinical population that your trainee is serving. Even advanced supervisees may benefit from a teacher role in supervision if they are encountering a new population they have never worked with before (e.g., a supervisee who is moving from college counseling to substance abuse work). Conversely, some new supervisees may have worked in paraprofessional capacities before beginning counselor training (e.g., PRP or case management) and may bring more skills or awareness to the work than their current academic progress may suggest. Last but not least, culture should be explored within every role and foci for all members of the supervisory triad: supervisor, supervisee, and client.

In order to help support the work we do as supervisors, we offer the following questions for reflection:

- What supervisory role do you operate from most of the time? Where might this come from for you?
- What might help in utilizing another, less-utilized role more in your work?
- What do you think your supervisee needs most from you from moment to moment? How might that change which foci you utilize?
- How might the supervisee's culture impact your use of role and foci?

As supervisors do their work, there are many resources available. For example, the Maryland Board of Professional Counselors and Therapists provides resources for clinical supervisors, including a sample Professional Counselors Contract for Supervision and sample Professional Disclosure Statement for non-licensed practitioners like LGPC's (http://dhmh.maryland.gov/bopc/SitePages/ApprovedSupervisor.aspx). Supervisors also need to gain familiarity with COMAR 10.58.12 Supervision Requirements (http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.58.12.*). Also, documents such as the American Counseling Association's Code of Ethics (https://www.counseling.org/publications/overview/knowledge-center/ethics#2014code) and the American Counselor Educators and Supervision Best Practices for Supervision (http://www.acesonline.net/resources/) provide excellent guidance regarding practicing supervision.

In this article we have focused on the use of theory in supervision, presenting one model as a resource for supervisory work. Also, we have provided some questions for reflection and resources in order to help stimulate supervisor's thoughts on this work. Lifelong growth and development as supervisors as well as clinicians is a part of our ethical and professional prerogative as we attempt to impact the lives of others in the most positive and beneficial manner possible. It is our hope that supervisors continue to examine themselves and the work they do with their supervisees, ever reaching for greater competence and mastery as clinical supervisors.

References

American Counseling Association (2014). Code of ethics and standards of practice. Alexandria, VA: Author.

Bernard, J. M. (1997). The discrimination model. In C. J. Watkins (Ed.), Handbook of Psychotherapy Supervision (pp. 310-327). Hoboken, NJ, US: John Wiley & Sons Inc.

Bernard, J. M., & Goodyear, R. K. (2019). Fundamentals of clinical supervision (6th ed.). Upper Saddle River, NJ: Pearson.

Proactive Hospital-based Intervention to Provide Psychiatric Services (PHIPPS) *Written by Marybeth Anne Heather, LCPC, NCC, Oscar Joesph Bienvenu, MD, PhD and Elizabeth Alice Noyes, PMHNP*

Mental illnesses often co-occur with general medical illnesses (Jones et al., 2004; Triplett, Carroll, Gerstenblith, & Bienvenu, 2019; Ward, Lally, & Druss, 2017), including in general hospital (non-psychiatric) settings (Bourgeois, Kremen, Servis, Wegelin, & Hales, 2005; Saravay, 1996; Silverstone, 1996). Since mental illnesses also tend to prolong non-psychiatric hospitalizations, hospital administrators increasingly show an interest in ready access to clinicians with mental health expertise (Triplett et al., 2019). Unfortunately, in many areas of the country, psychiatric care is segregated from other medical care, though there is an important movement afoot to remedy this (so-called "integrated care").

Colleagues at Yale-New Haven Hospital pioneered a new proactive psychiatric model to address co-occurring mental and general medical illnesses in a general hospital setting (Sledge & Lee, 2015), and other academic institutions scattered across the country have started to adopt similar programs. Though models differ across institutions, proactive psychiatric consultations tend to take a team approach, with psychiatrists, advanced practice psychiatric nurses, and psychiatric social workers (Triplett et al., 2019). Proactive psychiatric consultation differs from the traditional consult model in that team members screen admissions to specific medical floors for mental illness symptomatology, diagnoses, medications, and intervention needs, rather than simply responding to medical staff requests (Triplett et al., 2019). Thus, unexpected crises emerge less often, and clinicians with less psychiatric expertise are able to increase their knowledge base about psychiatric morbidity with expert help (Triplett et al., 2019).

Johns Hopkins Hospital, Baltimore Maryland, started piloting what we call a PHIPPS team in 2016 (Proactive Hospital-based Intervention to Provide Psychiatric Services). Proactive psychiatric consultation programs reduce the amount of time patients with mental illnesses spend on medical wards, compared to the traditional reactive consultation model (Desan, Zimbrean, Weinstein, Bozzo, & Sledge, 2011; Sledge et al., 2015; Sockalingam et al., 2016; Triplett et al., 2019). We now have two PHIPPS teams, covering most inpatient medical units at Johns Hopkins Hospital. Not surprisingly, clinicians in other departments are quite interested in expansion to other areas of the hospital. The teams have been well received by medical staff, who felt under-supported previously. We are happy to be able to connect our patients to community and inpatient mental health resources as needed and are happy to be part of a movement that could sweep the country.

References

Bourgeois, J. A., Kremen, W. S., Servis, M. E., Wegelin, J. A., & Hales, R. E. (2005). The impact of psychiatric diagnosis on length of stay in a university medical center in the managed care era. Psychosomatics, 46(5), 431–439.

Desan, P. H., Zimbrean, P. C., Weinstein, A. J., Bozzo, J. E., & Sledge, W. H. (2011). Proactive psychiatric consultation services reduce length of stay for admissions to an inpatient medical team. Psychosomatics, 52(6), 513–520.

Jones, D. R., Macias, C., Barreira, P. J., Fisher, W. H., Hargreaves, W. A., & Harding, C. M. (2004). Prevalence, severity, and co-occurrence of chronic physical health problems of persons with serious mental illness. Psychiatric Services, 55(11), 1250–1257.

Proactive Psychiatric Consultation For Hospitalized Patients, A Plan for the Future | Health Affairs. (n.d.). Retrieved September 21, 2019, from https://www.healthaffairs.org/do/10.1377/hblog20150528.048026/full/

Saravay, S. M. (1996). Psychiatric interventions in the medically ill. Outcome and effectiveness research. The Psychiatric Clinics of North America, 19(3), 467–480.

Silverstone, P. H.(1996). Prevalence of psychiatric disorders in medical inpatients. J Nerv Ment Dis; 184:43–51.

Sledge, W. H., Gueorguieva, R., Desan, P., Bozzo, J. E., Dorset, J., & Lee, H. B. (2015). Multidisciplinary Proactive Psychiatric Consultation Service: Impact on Length of Stay for Medical Inpatients. Psychotherapy and Psychosomatics, 84(4), 208–216.

Sockalingam, S., Alzahrani, A., Meaney, C., Styra, R., Tan, A., Hawa, R., & Abbey, S. E. (2016). Time to Consultation-Liaison Psychiatry Service Referral as a Predictor of Length of Stay. Psychosomatics, 57(3), 264–272.

Triplett, P., Carroll, C. P., Gerstenblith, T. A., & Bienvenu, O. J. (2019). An evaluation of proactive psychiatric consults on general medical units. General Hospital Psychiatry, 60, 57–64.

Ward, M. C., Lally, C., & Druss, B. G. (2017). Medicaid Expenditures for Fee-for-Service Enrollees with Behavioral Diagnoses: Findings from a 50 State Claims Analysis. Community Mental Health Journal, 53(1), 1–7.

Why Should You Join MCA?

Membership is important to your professional growth and career development. It provides:

- Continuing education units at discount prices
- Early notification of MCA and all division events
- Current public policy issues and new laws of interest to professional counselors
- Grant opportunities
- Four newsletters with opportunities to publish and advertise
- Leadership training and greatly reduced registration costs to annual, regional or national conferences for board members
- Support and advocacy for professional counseling in the state of Maryland
- Electronic reminders to renew your membership
- A list of events that you have participated in

Click here to join MCA today!

Not ready to join? Choose the non-Member Contact option for a no-cost way to add your name to our email list.

To register for MCA or any of our events, please go to www.mdcounseling.org

Find us on Facebook (@mdcounseling) and Twitter (@md_counseling)

Contact the MCA President for more information about committees and open board positions.

DIVISION PRESIDENTS

MACES President
Sara Pula
MACES@MDCounseling.org

MALGBTIC President
Sergio Washington
MALGBTIC@MDCounseling.org

MAMCD President
Leslie Holley
MAMCD@MDCounseling.org

MAMFC President
Miranda Mixon
MAMCFC@MDCounseling.org

MASERVIC President
Maya Georgieva
MASERVIC@MDCounseling.org

MCDA President
Lucinda Nobles
MCDA@MDCounseling.org

MCSJ President
Don Trahan
MCSJ@MDCounseling.org

LCPCM Liaison
Dr. Danielle LaSure-Bryant
LCPCM@MDCounseling.org

MSCA Liaison
Nikki Ham

COMMITTEE CHAIRS

Advocacy Chair
Open
advocacy@MDCounseling.org

Archives Chair
Open
archives@MDCounseling.org

Awards Chair
Open
awards@MDCounseling.org

Bylaws Chair
Latonia Laffittee
bylaws@MDCounseling.org

Credentialing Chair
Perri Hooper
credentialing@MDCounseling.org

Emerging Leaders Chair
Felicia Pressley

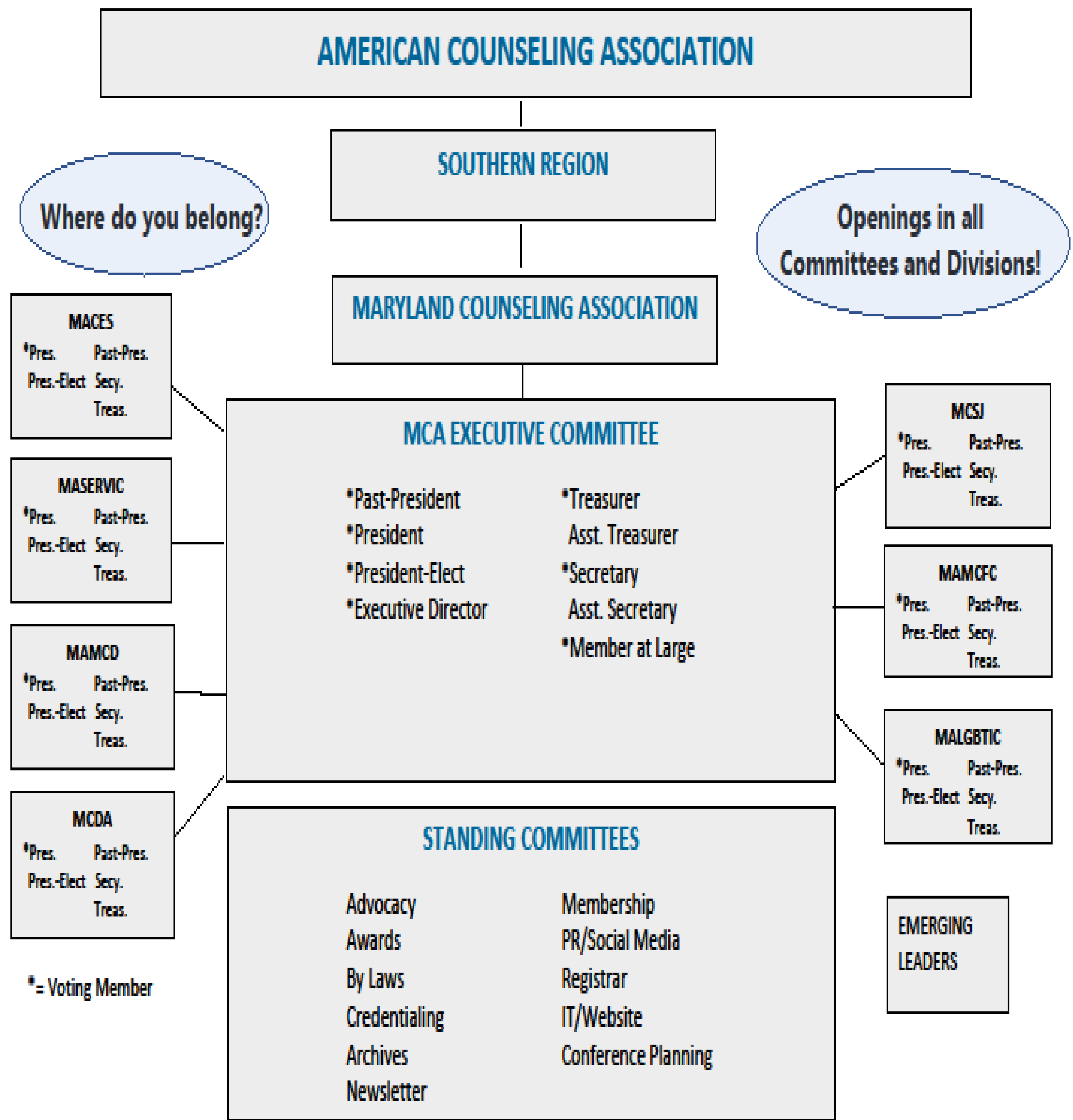
Membership Chair
Kerri Legette McCullough
membership@MDCounseling.org

Newsletter Chair
Michelle Schoonmaker
newsletter@MDCounseling.org

Public Relations Chair
Annyck Hamez
public.relations@MDCounseling.org

Program Planning Chairs
Eunice Humphrey
&
Lenese Stephens
program@MDCounseling.org

Registrar Chair
Open
events@MDCounseling.org



MACES-Maryland Association of Counselor Education and Supervision
MASERVIC-Maryland Association for the Spiritual, Ethical and Religious Values in Counseling
MAMCD-Maryland Association for Multicultural Counselor and Development
MCDA-Maryland Career Development Association
MCSJ-Maryland Counselors for Social Justice
MAMCFC-Maryland Association for Marriage, Couples and Family Counseling
MALGBTIC-Maryland Association of Lesbian, Gay, Bisexual and Transgender Issues in Counseling

****MSCA**-Maryland School Counselor Association
****LCPC-M**-Licensed Clinical Professional Counselors of Maryland
****MAMHC**-Maryland Association of Mental Health Counselors
**These organizations are not active divisions, but we have liaisons with each.