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Developing Competent Counselors[1]

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Integrating Wellness, Personal Growth, and Core Skills within Clinical Supervision

Throughout a counselor's developmental process, transference and countertransference issues are likely to arise (Gelso & Hayes, 2007). There is considerable importance placed on addressing those issues with counselors as soon as possible once they, or their supervisors, becomes aware of transference issues – the reasons for which are numerous. Unaddressed transference and countertransference issues are one contributing factor to burnout, which leads to staff turnover. The time and cost needed to recruit and train new staff can be better utilized to retain current staff which leads to greater continuity of care for the clients and more consistency within the program as a whole. Within the therapeutic environment, there is an isomorphic process which occurs between staff, clients, the program as a whole, and outside connections (Todd & Storm, 2002). For example, when staff feel burned out, they may feel unmotivated to meet contractual obligations (such as documentation deadlines), client care may suffer, and the way the community views the program may be impacted. However, the opposite is also true; when healthy communication exists between all levels of staff and concerns are addressed appropriately as they arise, counselors are likely to use those experiences in their therapeutic work with the clients. Community resources and referral sources also tend to become aware of how both staff and clients view their program; a functional program operation creates a positive reputation in the community.

The first part of this article will discuss transference and countertransference issues. Following the discussion on the variety of methods available to address transference and countertransference issues, the second part of the article will discuss creating a wellness plan. In order to be successful in working with transference and countertransference issues, as well as creating a workable wellness plan, an openness policy must exist for counselors at all levels of development to feel comfortable discussing transference, countertransference, compassion fatigue, and burnout. If this openness is not present, counselors may feel pressure to ignore signs of compassion fatigue; transference and countertransference issues may go unresolved.

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A lack of openness can possibly lead to long term repercussions for the counselor, clients, and program. Therefore, it is important to normalize the experience of countertransference within the therapeutic relationship (Gelso & Hayes, 2007). In order to create the type of supervision environment where counselors feel comfortable speaking up about their concerns as they arise, counselors must feel safe in the supervision group and within the supervisory relationship (Campbell, 2000). This means the counselors are certain they will not be ridiculed or judged when discussing their countertransference issues. Instead, the supervisor and/or supervision group will provide a safe place for counselors to explore their countertransference issues and have resources for additional assistance if the issues are beyond the scope of the supervision environment. Finally, it is important to note that although for the context of this article countertransference will be discussed as it relates to the counselor-client relationship, when countertransference occurs in the supervisory relationship it must be readily addressed as well.

Transference and Countertransference

The first question that must be addressed in this article is what does the terms transference and countertransference mean? Transference refers to clients' placement of feelings originally directed towards significant others in their life onto the counselor (Wallin, 2007). For example, clients might project feelings related to their mother or father figure onto the counselor. In some cases this may lead to a belief that the counselor is nurturing and loving; in other situations feelings of anger and mistrust may arise. In the clients' mind the counselor may also come to represent their ideal partner or friend; this may lead to platonic, romantic, or sexual attraction. Depending upon the life history of the client, the counselor may also represent oppressive systems or an opposing cultural group (i.e. higher social class, an ethnic group the client may have had conflict with previously, etc). Due to the clients' complicated thoughts, beliefs, and emotions entangled with the issue of transference developing ways to guide a counselor to work with these issues will be discussed so that clients may gain deeper insight and to preserve the therapeutic relationship.

Countertransference occurs when counselors' emotions, beliefs, and biases are projected onto their client; as with transference this is typically related to the counselor's life history. Countertransference involves an emotional connection with the client beyond what other counselors would deem as appropriate within the therapeutic relationship. The counselor's acceptance of the client's transference is another example of countertransference (Gelso & Hayes, 2007). For example, when clients project feelings related to their parental figure onto their counselors, the counselors may find themselves wanting to protect the clients and reach beyond their boundaries to assist the clients. In such cases it is important to explore issues of both transference and countertransference in order to rebalance the therapeutic relationship, reestablish boundaries, and promote client growth. Again, there are many ways to recognize and respond to countertransference during individual and group supervision which will be explored throughout the first half of this article. When not addressed, countertransference can lead to violations of boundaries and potential harm to clients.

Although these are issues which are present in every form of counseling and therapy, some areas are more influential regarding the level of transference and countertransference experienced in particular by developing Alcohol and Drug Counselors. Two of these areas

include a higher potentiality for the client to have similar life experiences as the counselor (i.e., history of alcohol and other drug (AOD) use, treatment history, legal issues, etc) and the degree of confidence the counselor feels working with co-occurring issues (depending on education, training, and experience). As with all other developing counselors, it is imperative to acknowledge what stage the individual counselors are in regarding their professional development and base the intensity of supervision and oversight on their level of development.

Looking at Language

One of the simplest methods to explore whether countertransference issues are present is through listening to the ways in which clients' cases are presented and discussed by the counselors whom are being supervised, as well as other staff. Some indicators of countertransference issues may include nicknames given to the client by counselors or staff (typically the client is unaware of this nickname), negative labels placed on the client, difficulty with being empathetic about any aspect of the client's circumstances, and speaking about the client case in such a way that the counselor appears hopeless about the client's ability to change behaviors or progress in treatment. Signs of the counselor becoming over involved with the client may include talk of overstepping boundaries, having strong emotional reactions when discussing the client's case, and providing supplementary assistance to the client at the expense of the rest of the counselor's caseload. A general rule that can be followed when presenting client cases is to ask the counselors to speak about the client as they would if that client was in the supervision room. This format will provide the counselors with the opportunity to pay attention to the actual words they are using to describe the clients, their situations, and their recovery process. At times, the counselors may be able to pick up on their own countertransference issues just by paying attention to the words they use when speaking about the client. Besides verbal cues, nonverbal indicators are also especially important to tune into. The counselor's body language, facial expressions, and tone of voice are all clues into potential countertransference issues. Ways to address nonverbal indicators will be explored further in the section on live supervision.

Case Presentations

During case presentations, the counselors are asked to present a certain percentage of their caseload each week and discuss the treatment being offered as well as the clients' response to treatment. When providing the counselors with a format for case presentation (i.e., demographic information, history of AOD use, mental health concerns, culture and gender-specific dynamics, legal issues, client strengths) an emphasis should also be placed on presenting any transference or countertransference issues the counselor is aware of. There are some obvious limitations of this approach including that transference and countertransference issues presented would be restricted to those within the counselors' awareness that they feel comfortable bringing up during supervision. In order for this type of supervision to be successful in addressing such issues the safety within the supervisory environment, as previously discussed, must be considered a top priority for the supervisor.

Live Supervision

The purpose of live supervision is to observe the developing counselor in a comprehensive way which is impossible to do with case presentations alone (Campbell, 2000). Live supervision

techniques allow the supervisor to gain new information about the therapeutic treatment being offered by the counselor instead of solely relying on the perceptions of the counselor alone. Additionally, as someone outside of the therapeutic relationship and with more practical experience, the supervisor may recognize issues of transference and countertransference the developing counselor may not yet be aware of. Finally, live supervision methods are utilized as a learning tool for others in the supervision group.

Remember to ensure the following precautions are met: no contractual obligations are being breached by the form of live supervision being utilized; the management or other staff who need to approve the use of live supervision techniques have done so; and proper signed agreements and/or releases are obtained by the client prior to participation in any of the live supervision methods. Additionally, to preserve the client's confidentiality, make certain used tapes are kept in a locked cabinet. At times, the supervisor may want to retain the audio or videotapes to monitor a counselor's progression with issues discussed during supervision or to compare a client's progression through treatment goals with a future tape. If the supervisor does not deem it is necessary to retain the audio or videotape, these may be destroyed or recorded over. Finally, it would be prudent for supervisors to check with their particular state's laws and the codes of ethics of the certification and/or licensing boards the supervisor and counselors belong to regarding confidentiality so all legal and ethical mandates are upheld.

A variety of supervisory methods are presented in order to accommodate a range of funding resources and possible contractual restrictions (i.e. some settings may not allow the videotaping of clients). The following are forms of live supervision which can be relatively easily utilized in an alcohol and drug treatment facility. These types include: audiotaping, videotaping, co-therapy with the supervisor, live session while the supervisor is observing, live session while the supervision team is observing, and live session with the supervision team interacting. The following are brief descriptions of these methods and how they can be utilized to work with transference and countertransference issues. Todd and Storm (2002) and Campbell (2000, 2007) provide additional information on live supervision techniques.

Audiotaping

This is the simplest form of live supervision that can be utilized when the supervisor is not present. Although it is more easily used for individual counseling sessions, if the counselor is able to discern the voices of different clients, it can also be utilized for the supervision of group counseling. This method simply involves the use of a tape recorder to record the counseling session. The following are some items to listen for when exploring transference and countertransference issues – how the counselor reacts and responds to silence, language used by both counselor and client (i.e. judgments, criticisms, blurred boundaries), tone of voice, how the counselor responds when challenged or praised by the client, if the counselor sounds appropriately attuned with the client's current emotional state (Is the counselor making light of the client's anger/depression or is the communication fitting?), the client's response to the counselor's interventions, the counselor's ability to remain theoretically consistent (such as with motivational interviewing) or if the theory is abandoned due to lack of immediate results, and if the counselor is able to keep the conversation on track or finds it difficult to stay on topic and appropriately interrupt the client if indicated.

Videotaping

Videotaped sessions are useful for a variety of reasons. While viewing the tape with the counselor, the supervisor is able to touch on all the items mentioned for audiotaping in addition to body language, posturing, facial expressions, and physical reactions to communication and interventions. This tool is also helpful because the counselors are able to watch themselves and notice reactions they may have not been aware of in the moment as well as general areas for improvement, such as questions they may have asked differently or information that would be helpful to explore further in future sessions. Additionally, especially with beginning counselors, they may not be as aware of the client's non-verbal behaviors because they are so self-focused during session. By reviewing the videotapes they may gain awareness into their own anxiety and insecurities which also may be linked to countertransference issues. Finally, counselors may be aware of transference issues occurring in session, but uncertain how to address these. By reviewing the videotape during supervision, the supervisor will have more information and be able to provide greater assistance in guiding the counselors through that process. When videotaping a therapy session, the camera can be focused on the counselor, client, or (if possible) both.

Co-therapy with the Supervisor

Unlike typical co-therapy this form of supervision involves the supervisor sitting in on one or two sessions a counselor has with a particular client. Usually this type of supervision is most useful when counselors report being stuck with a client, having difficulty addressing a particular issue with their clients, or having trouble utilizing a particular theoretical framework during treatment. The purpose of this form of supervision is to provide additional support for counselors so they will feel better prepared to move past the place where they find themselves stuck. Additionally, this type of supervision is best followed up with other live supervision techniques in order to determine if the counselor, after observing the supervisor, is able to successfully manage the original problem. If it appears the counselor is still unable to navigate the situation it would be appropriate to explore possible countertransference issues.

Live Session with the Supervisor Observing

This form of live supervision may be utilized if the program does not have funding for audio/video equipment or a one-way mirror. It should be made explicit to the client that the purpose of such a session is for the development of the counselor as the client may feel uncomfortable with the supervisor observing and not taking an active role during the session. A useful component to add to this form of supervision is a predetermined break in the middle of the session for the supervisor to privately provide feedback on the first part of the session to the counselor. The counselor would then have the opportunity to integrate the supervisor's feedback into the second half of the session. Again, the client should be informed of the break at the beginning of the session as well as its purpose in order to ease discomfort and suspicion. As with the other forms of live supervision already discussed, the supervisor will be able to gain greater awareness of possible transference and countertransference issues present within the therapeutic relationship that may not become apparent with case presentations alone.

Live Session while the Supervision Team Observes

This method of supervision is typically conducted behind a one-way mirror. One-way mirrors or security windows/mirrors are easily installed into offices where a window is already present. Typically a method of listening to the session occurring is also needed in the other room, such as through a baby monitor. Although the client is fully aware the supervision group is sitting behind the mirror, he or she is unable to actually see the group. Prior to the session, the counselor may ask the supervision group to pay attention to a particular area he or she feels stuck with the client. Another option, prior to the start of the session, is for the supervisor to instruct the supervision group to watch and listen for any signs of transference or countertransference they might recognize throughout the session. At times, it is easier for beginning counselors to pick up indicators of transference and countertransference when they are observing another counselor conduct a session, rather than when they are in the midst of a counseling session. Following the session, the group is able to provide feedback to the counselor regarding what they observed. A group discussion could center on how they would work with the client on any transference issues that arose during the session as well as if they believe they would experience any countertransference issues if they were the client's primary counselor. Additional supervisory conversations could focus on general counseling skills and theory.

Live Session with the Supervision Team Interacting

There are multiple ways to add an interactional component to live supervision when the supervision team is present. There are two general ways for the team to actively interact with the counselor simultaneously while the session is taking place and they are behind a one-way mirror. The first involves the counselor being provided with an ear piece which will allow the team to provide feedback and direction, as necessary, from the other room. The second method is to set up instant messaging through the program's computer system so the team could message their thoughts to the counselor during the session. The computer system tends to be less disruptive than the ear piece. If this technology is not present, the counselor may also take a predetermined break in the middle of the session to receive feedback from the supervision group and integrate it into the second half of his or her session. Similar topics as the ones addressed in the previous supervision modality can be utilized with this form as well. Reflecting teams and outsider witness groups are two other options when the supervision team is present during live supervision. This approach provides the opportunity for the client to participate in the process as well. Generally, additional training is needed for these two options to be conducted successfully. Helpful readings for additional information include Anderson (1996) and Fox & Tench (2002).

Supervision Questions Related to Transference and Countertransference

Below are nonjudgmental, useful questions for the supervisor to ask in order to elicit transference and countertransference issues.

1. What thoughts/emotions came to your mind when your client spoke about _____ (particular topic – i.e. death, rape, relapse, etc)?
2. Is your client's situation reminiscent of any experiences you have had during your life? If so, how does that impact or alter your work?
3. Are you finding it difficult to establish or maintain boundaries with your client?

4. Do you ever get the feeling that you are becoming more invested with this client than others in your caseload? If so, what is it about this client that leads you to want to put in additional effort?
5. Are you aware of any difficulties you have working with clients from a particular gender, ethnicity, sexual orientation, religious background, socio-economic status, age group, or other cultural group? (Explore one at a time.)
6. Do you believe that your client is reacting to you in a particular way (positively or negatively) because you are part of a particular gender, ethnicity, sexual orientation, religious background, socio-economic status, age group, or other cultural group? (Explore one at a time.)
7. Are you aware of any transference issues the client might be experiencing with you? If so, how are you managing it session? If not, do you feel I have provided you with adequate training to recognize signs of transference?

Addressing Transference Issues with a Client

When assisting counselors in learning how to address transference issues with a client, it is best to encourage them to create a similar atmosphere as the one described to work on countertransference issues. The counselor may choose to confront the client about the transference issue; this may work for some clients, however other clients may feel attacked and withdraw instead of being willing to explore the situation. A more collaborative approach involves the counselor making a tentative observation of the transference issue which appears to be present. Then the client is asked to explore the possibility of such an issue with the counselor. For a variety of reasons, sometimes it can be difficult for the client to accept the observation provided by the counselor. If the client denies the presence of the transference issue, and the counselor and supervisor are in agreement that it is indeed a transference issue as well as a treatment concern, the same tools utilized for live supervision may be useful. The counselor can play the section of the tape where the transference issue is being demonstrated and supportively ask the client if he or she sees it as well and could explore it further with the counselor.

Self Reflection

If the counselor's countertransference issues appear to necessitate more attention than can be provided during individual or group supervision, many other tools are available for continued exploration, development, and growth. The following are accepted practices and innovative ideas to work with countertransference issues along with a brief description of each:

- Case reflections – The counselor writes down his or her personal reactions immediately following a counseling session.
- Journaling – At the end of the day, the counselor writes about countertransference issues that arose for him or her and attempts to explore these through writing.
- Peer consultation – The counselor speaks about countertransference and other clinical concerns with his or her peers to develop an awareness of how they would react to a similar issue differently.
- Reviewing accepted practices – The counselor reviews the program rules and type of counseling/theory practiced at the program. The counselor is asked to note areas where he or she is deviating from accepted practices and then to explore the reasons behind the

digression. It is best used in conjunction with journaling.
- Reviewing taped sessions – The counselor is asked to videotape his or her sessions more frequently and review these for verbal/nonverbal cues, theory consistency, and transference/countertransference issues.
- Personal counseling, Twelve-Step, or other sobriety/personal growth work – At times a counselor may need assistance which is beyond the scope of supervision and should be referred to an outside professional or group to explore countertransference issues more in depth.

Awareness and Reduction of Countertransference

One of the most significant ways to assist counselors in becoming more aware of transference and countertransference issues is to continuously expose them to these issues through making it a central theme during both group and individual supervision meetings. As stated throughout this section, as the supervisor it is important to normalize the experience of transference and countertransference, assist the counselors with appropriate boundary setting and maintenance, and provide a variety of tools to bring about awareness, understanding, and growth (Wallin, 2007). Also, as stated previously, the supervisor should encourage the counselor's personal recovery and growth process through Twelve-Step or other sobriety and/or harm reduction support, individual/couple/family/group therapy, and continued education. Further ways to encourage counselor well-being will be discussed in the following section on compassion fatigue and developing a personal wellness plan. Focusing on transference, countertransference, compassion fatigue, and personal wellness will contribute to the process of promoting counselors to develop strong ethical and clinical skills and helping to create the type of program environment where clients will receive quality alcohol and drug treatment.

Helping supervisees develop a personal wellness plan

It can be argued that a major component of a counselors' role is to be engaged in the care giving of a client. Counselors often are motivated to relieve their clients' pain and suffering. As counselors evaluate their clients' needs they may want to teach them ways to cope with their problems in order to promote growth. As counselors continue to care for their clients, they can become adversely affected by the daily stress involved in helping others. Counselors who do not possess appropriate skills to cope with job stress can develop compassion fatigue as well as suffer from burnout. Consequently, counselors need to find balance within their role of giving care to others with nurturing themselves with self-care practices.

Contemplative Supervision

Supervisors play an important role in helping counselors become aware of the possible negative impacts of work, how it may affect them, and potential impacts on client care. Supervisors can help supervisees develop a thorough wellness plan which may reduce the occurrence of compassion fatigue and burnout. The framework of Contemplative Supervision (Powell, 2004) will be utilized as a recommended approach to promote supervisees' self care. The development and practice of mindfulness techniques by both supervisor and supervisee lies at the heart of this particular supervision approach.

Mindfulness

Mindfulness involves attention on the present moment with a nonjudgmental and respectful attitude. Mindfulness is a skill that increases interpersonal attunement, such as within the client and counselor relationship, and intrapersonal awareness of the supervisee. The main focus of this section will be on intrapersonal awareness and the use of mindfulness as a central feature in promoting personal wellness. It is assumed that counselors who remain aware of their thoughts, feelings, and physical health invest more time in self care which leads to less burnout and greater effectiveness with clients.

The origins of mindfulness based practices date back 2,500 years with its development found in Buddhism and Buddhist psychology. Mindfulness has been adapted over the centuries and is currently widely used to foster human development in contemporary society (Siegel, 2007). For example, research has shown mindfulness practices to be effective in the reduction of chronic pain via the use of mindfulness based stress reduction (MBSR) (Kabat-Zinn, 1990). Additionally, Mindfulness Based Cognitive Therapy (MBCT) has been successful in preventing relapse in depression (Williams, Teasdale, Segal, and Kabat-Zinn, 2007). Similarly, Mindfulness Based Relapse Prevention (MBRP) uses a cognitive behavioral approach as a tool to maintain sobriety. Mindfulness Based Relapse Prevention is practiced in two steps. First, clients are taught techniques designed to develop awareness and acceptance of their thoughts, feelings, and physical sensations through mindfulness. Next, clients learn to utilize those skills of awareness and acceptance to manage situations that trigger the use of alcohol or substances (Witkiewitz, Marlatt, and Walker, 2005).

Supervisees can use mindfulness techniques to develop and refine their compassion with themselves and their clients. When supervisees experience compassion within the therapeutic relationship, they feel the emotions of their clients, such as the pain of their addiction as well as the gratitude of their recovery. Many alcohol and drug counselors have chosen their profession because, through their personal experiences with recovery, they can relate to the pain and suffering addiction causes. Other alcohol and drug counselors may have felt the impact of addiction by way of a family member, spouse/partner, or friend. Compassion connects supervisees to their clients on a deep emotional level. Jack Kornfield, a Buddhist practitioner and clinical psychologist, states that a core belief within Buddhist psychology is that compassion is rooted in our interconnection with all things. Compassion is defined as the “quivering of the heart in the face of pain” (Kornfield, 2008, p.23). Research within the field of neurobiology has demonstrated that mirror neurons exist in the human brain and their role involves sensing, interpreting, and connecting us with the emotions of others (Siegel, 2007). This may be understood as the neurobiological foundation of compassion. Siegel (2007) reports that mirror neurons are found within the social part of the brain which connects humans with each other. He states that “our minds connect with another via neural circuitry in our bodies that is hard wired to take in other’s signals” (p.48).

Compassion

Supervisors can act as a guide to help supervisees enhance the capabilities of their mirror neurons and cultivate compassion. The approach of Contemplative Supervision assumes that supervisors will maintain a mindfulness practice in order to be a true guide for their supervisees.

Additionally, this method keeps the supervisor grounded in daily mindfulness practices. Daily practice will deepen the supervisor's level of compassion toward self, supervisees, and others.

Mindfulness practiced by supervisees involves an acceptance of their feelings and thoughts as these arise in the present moment. Supervisees who develop their compassion learn to view their problems with an open heart and calm mind. Awareness creates a sense of detachment from their mental and emotional states. It can reduce personal reactivity and distress. Since they do not feel consumed with the problem, supervisees can explore more available options to address and cope with stress than they would have been able to if they felt overwhelmed.

Empathy

Empathy is another way supervisees can relate to and develop an understanding of their clients. Carl Rogers (Smith, 1997, 2004) believed empathy was a core condition of the therapeutic alliance. He described a counselor who displayed empathy as someone who responds with a full awareness of the client and with an accurate understanding of the client's underlying emotions. Empathy and compassion are interwoven qualities which impact rapport and the therapeutic relationship as a whole. Supervisees can also direct self-empathy toward themselves by reducing their judgments and self-criticism about their own thoughts, feelings, and behaviors. As previously discussed, empathy and compassion are fostered with mindfulness. Supervisees who practice mindfulness can view it as a way to establish gentleness and kindness towards themselves which are forms of self care.

Assessment Tool

It is typically helpful to provide tools to supervisees for them to assess how they manage job-related stress and its impact on their personal lives. Supervisees can also assess their level of compassion, compassion fatigue, and burnout. The Professional Quality of Life (ProQOL) Version 5 (2009) by B. Hudnall-Stamm measures these three areas (see Appendix A). When completing the tool, supervisees will be asked to evaluate themselves by responding to 30 statements. Following the completion of the tool it is strongly recommended that they discuss the results with their supervisor. Together the supervisor and supervisee can build on areas of strength and explore areas where improvement may be needed. The results of this tool can be useful to counselors when they are asked to develop their personal wellness plan.

Types of Compassion

Hudnall-Stamm (2009) described compassion satisfaction as the degree of pleasure supervisees feel when working. Examples of phrases that rate compassion satisfaction are: "I get satisfaction from being able to help people", "I believe I can make a difference through my work", and "I have happy thoughts and feelings about those I help and how I could help them" (see Appendix A). Compassion satisfaction covers pleasure from work, being a caregiver, being part of a team, and contributing to the betterment of society. Hudnall-Stamm (2009) described compassion fatigue (CF) as secondary exposure that supervisees, and counselors in general, have when clients describe their trauma histories. Consequently, supervisees may be exposed to secondary trauma (STS) due to their role as caregivers to clients with substance abuse/dependence disorders who are also trauma survivors. Examples of phrases that rate CF include: "As a result of my helping, I have intrusive, frightening thoughts", "I feel depressed

because of the traumatic experiences of the people I help as a result of my work as a helper", and "I find it difficult to separate my personal life from my life as a helper" (see Appendix A).

This experience of secondary trauma is not unusual as Alcohol and Drug counselors are exposed to clients with challenging issues that extend beyond substance use. Clients who are diagnosed with a substance use disorder tend to present with a higher percentage of mental health disorders. Studies completed during the 1980s and 1990s reported that substance abuse programs found that 50 to 75 percent of their clients met the criteria for a co-occurring mental disorder (Sacks and Ries, 2005). Jerry A. Boriskin (2008) found that 25 to 50 percent of clients with a substance use disorder also meet the conditions for a diagnosis of post traumatic stress disorder (PTSD). These particular clients, who would be classified as possessing a co-occurring disorder, are more likely to experience complex PTSD, which may develop when a person experiences repeated or prolonged trauma.

Supervisees demonstrate courage daily when facing their clients' pain and suffering. This recurrent exposure to their clients' stressors can lead counselors to overly identify with their clients' experiences and develop their own stress responses. Additionally, there is a possibility that clients' stories may trigger memories of supervisees' own painful experiences, which can lead to countertransference. The experience of countertransference can lead counselors to have difficulty maintaining healthy boundaries between their "therapeutic self" and the client. When supervisees take on and internalize their clients' pain, they can have strong reactions of either caring too intensely or emotionally distancing themselves from their client. Supervisees' hearts can close off. Circumstances such as these are instances when mindfulness is particularly useful. Mindfulness allows supervisees to stay aware of their feelings of compassion and notice when there is an imbalance. This intrapersonal awareness is a critical element in counselor self care.

It is important for supervisors to convey a nonjudgmental attitude with supervisees as they process the experiences they are having with clients during supervision. Supervisors can point out supervisees' development of compassion satisfaction and alert them to signs of compassion fatigue. As part of this form of supervision, supervisors engage in a parallel process of showing compassion towards supervisees which models for supervisees the ways to extend genuine caring and compassion to themselves and their clients.

Burnout

Compassion opens up the heart and calms the mind. Jack Kornfield wrote, "A peaceful heart gives birth to love. When love meets suffering, it turns to compassion. When love meets happiness, it turns to joy" (2007, p. 387). Passion is part of the word "compassion." What happens when supervisees lose their passion to help others? Burnout. The ProQOL (2009) describes burnout as negative feelings about work during which feelings of hopelessness and feeling worn out are present. Burnout is viewed as being related to unresolved feelings of compassion fatigue. Work environments with high caseloads or poor support lend itself to burnout, which in turn can contribute to high rates of staff turnover. Examples of phrases from the ProQOL that describe burnout include: "I feel trapped by my job as a helper," "I feel worn out because of my work as a helper", and "I feel bogged down by the system" (see Appendix A).

When experiencing burnout, supervisees may lose perspective and motivation; furthermore, the work-related stress can impact their personal lives.

Personal Wellness

It is important for supervisors to stress wellness as part of professional development which the supervisees are ultimately responsible for. This is because supervisees will benefit by practicing self care at work as well as outside of work. Self care must be viewed as an essential, ongoing practice to reduce burnout. Supervisors can assist their supervisees by finding out what they do to take care of themselves on the job and supportively affirming any current practices of self-care. When appropriate, supervisors can share what they do personally to practice self care when at work and in other situations. It is important to remember that self care practices on the job should be simple, not time consuming, and easily integrated into a daily routine. Some examples include: taking breaks away from the desk, getting up and stretching, going for a brief walk, debriefing with a colleague about client cases, asking for help, learning to say "no" and maintain boundaries, celebrating successes, and putting disappointments into perspective. Supervisors can have the supervisees collaborate with each other. This is important because other counselors may be going through similar problems or may have learned ways to cope with a problem another supervisee is struggling with. A supervisor who recognizes the developmental level of a supervisee can suggest he or she talk to a supervisee at a more advanced stage of development which can build cohesiveness among colleagues. A supervisor should seek outside supervision themselves when they feel stuck in finding techniques that would be helpful to their supervisees.

Creating a personal wellness plan that can also be practiced at home will continue to nourish growth within the supervisees. The following are some mindfulness-based practices which may be useful in cultivating positive emotional states within the supervisees and clients.

Meditation for Compassion

Sit is comfortable position. Pay attention to your body, your heartbeat, and your breath. Take time to reflect on what you do to care for yourself when you feel sad. Focus on your heart area as you breathe in and out into the heart. Repeat these phrases:

May I be held in compassion.
May my pain and sorrow be eased.
May I be at peace.

Take as long as you need. Next extend compassion to someone you love. Visualize them. Be aware of any suffering they experience. Greet their pain with compassion. Recite these phrases:

May you be held in compassion.
May your pain and suffering be eased.
May you be at peace.

You can spread your compassion out to others—a friend, neighbor, co-worker, or a client. Feel a heartfelt connection with each person as you repeat these phrases.

Mindfulness and the Breath

Breath is with us all the time. Paying attention to our breath forms the basis of an ancient practice of meditation. Sit in a comfortable position. Close your eyes if you feel comfortable. Attend to the natural rhythm of breathing in and out. Allow the breath to find its own rhythm. Surrender to your breath. Next be aware of where you feel the sensation of breathing. You might feel it in your chest or belly area. Some people feel the breath as the flow of air in and out of their nose. Once you identify where you feel your breath, stick to this area. Breath is felt as either air flow in the nostrils, in the chest, or in the abdomen.

Soon you will notice your mind wander. This is normal. There is no need to fight it. As you become aware that your attention has left your breath, gently and kindly bring it back to the object of concentration which is your breath and where you feel it in your body.

Meditation is a process of beginning again, over and over. It helps to identify the content of thoughts with a one word phrase - planning, judging, or thinking. It is possible to identify emotions, both pleasant and unpleasant, in the same way by giving these a label such as sad, happy, or worried. After you label the thought or feeling, return back to your breath. There is no need to pursue the thought or feeling. Mindfulness embraces the moment with no judgment. Return your attention over and over again to your breath. Mindfulness teaches kindness and compassion.

A good goal to aim for in the beginning is 10 to 15 minutes of practice daily.

While at work, become mindful of your breath. Pick a routine activity and be conscious of the in and out breaths that you have while participating in this activity. A way to easily integrate this practice into a busy routine would be to focus on your breathing when walking to and from the bathroom. Other possibilities include before picking up the phone take a conscious breath, before seeing a client or beginning a group take a few deep breaths, when feeling ungrounded in a client or group session attend to your breathing as you listen to the dialogue. Remember that your breath connects you to your moment to moment experience.

The Compassion Fatigue Project (2009) suggests other forms of self care which may be included in the supervisees' plan. Recommendations include paying attention to healthy eating through the consumption of more whole grains, legumes, fruits, and vegetables as well as drinking plenty of water. Another proposal is for supervisees to practice yoga, tai chi, or other exercise routines to reduce stress. Furthermore, supervisees can volunteer for an organization or cause they feel passionate about. Supervisees who are in recovery can maintain regular 12 Step or other recovery-related meetings. An emphasis may also be placed on keeping connected with family and friends as social support. A final idea involves enjoying a hobby or exploring new areas of interest.

It is important for supervisees to recognize that professional development means integrating skill development of counseling techniques with skills of interpersonal and intrapersonal development. Supervisees can nourish and sustain their passion which called them to the helping profession by investing time into their self care. A wellness plan can provide a structure

for ongoing self care that changes with counselors as they grow. Wellness provides a context to understand personal health care as more than the treatment of illness. Wellness cultivates positive states such as a growing and deepening compassion for supervisees and their clients.

Supervisors who follow a Contemplative Supervision model place high value on their own self care. They realize their passion for supervising is based on the urge to help others and give back to their profession. Supervisors and supervisees who interweave mindfulness into wellness demonstrate one way to practice wellness. Paths to wellness are as diverse as the people who practice it. One of the rewards of being a helping professional is that counselors can invest in their own growth and see how it provides grounding which reduces burnout and compassion fatigue. Compassion keeps the heart open and the mind calm fostering emotional and mental wellness.

Conclusion

Throughout this article the subjects of transference, countertransference, compassionate fatigue, and burnout have been explored. Multiple ways to educate, understand, and integrate these concepts have also been provided. By allowing these concepts to be central themes throughout the supervision process, supervisees will be given the opportunity to grow interpersonally and intrapersonally, as counselors and as humans. The impact of doing so will be beneficial for the supervisees, clients, program, community, and profession.

Supervisors can promote supervisees ongoing development of core clinical skills strengthened and grounded by genuine self-care skills. Supervisors can integrate interpersonal and intrapersonal development into the supervision process to foster well-balanced counselors during their various stages of growth. Supervisors, in a parallel fashion, need to remain mindful of cultivating their interpersonal and intrapersonal skill sets. Supervision provides a wonderful dynamic learning environment between supervisors and supervisees. Supervisors and supervisees who value their growth as professionals and as compassionate human beings enrich the profession. Like dropping a pebble in a still pond, attention and awareness to this growth process produces ripples of caring and kindness to supervisors, supervisees, and to clients.

“Compassion is the ultimate and most meaningful embodiment of emotional maturity. It is through compassion that a person achieves the highest peak and deepest reach in his or her search for self-fulfillment.” Arthur Jersild

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