Montana Board of Social Work Examiners & Professional Counselors

CLINICAL SUPERVISION LOG - FOR SOCIAL WORK EXAMINATION APPLICANTS ONLY

You will need a basic understanding of the Excel computer program in order to use this form. Please save the form to your computer for use in documenting your clinical hours. This form is designed for electronic submission to the Board office upon completion of clinical internship. The entries included in this form are examples of how to capture the content required in administrative rule. Please delete the information replacing it with your work. Applicants must insert rows horizontally as time is accumulated. The form includes formulas that total direct client care hours, indirect hours, individual supervision, group supervision and direct observation hours at the end of the form.

Applicants are required to complete 3000 post degree hours of clinical experience to be done in the past five years in not less than 24 months. Though you may use this form for tracking your 3000 hours you are only required to submit 100 hours of individual and/or group supervision. 50 of these hours shall be individual and face-to-face by an LCSW and include 10 hours of direct observation of the service delivery. No more than 160 hours of experience shall transpire without at least two (2) hours of supervision.

If you have multiple Supervisors, a form must be completed for each Supervisor. Supervisors are not required to sign each and every log rather they shall submit a signed and dated affidavit attesting to the hours completed.

Supervision summary notes must document applicants' minimal competencies in the areas of an identified theory base, application of a differential diagnosis, establishing and monitoring a treatment plan, development and appropriate use of the professional relationship, assessing the client for risk of imminent danger, and implementing a professional and ethical relationship with clients and colleagues.

Please note that while the samples offer examples of how to address all the required elements for the supervision logs, it is not mandatory for each log entry to cover every required item. Some entries might only cover differential diagnoses, other entries may cover treatment plans and risk assessments, etc.

Definitions:

Direct Client Care: Physical presence, telephonic presence, or interactive video link presence of the client, client family member, or client representative.

Direct Observation of Service Delivery: Supervisors participate in the service delivery by observation through a two-way mirror, observation of a video or audiotape of the service delivery, or observation through an interactive video link of the service delivery. Social work candidates are required to document 10 hours

Group Supervision: A qualified supervisor shall host supervision sessions with no more than six supervisees.

Indirect Hours: Hours devoted to file management, research, consultation, staffing, education. Etc.

Applicant's Name (Last, First, Middle)_____

Supervisor, Name, credential, & license number:_____

Today's Date	Date Span	# of Hours in this Date Span				Length of supervision time in 15 minute units: 15 minutes = .25, 30 minutes = .50					
			# of Direct Client Care Hours		# of Indirect Hours		Individual Supervision		Group Supervision		Direct observation of service Delivery
6/8/2012	6/4/12 - 6/8/12	10		30		2.25		1.5		1	

Example 1: We discussed dynamics of family session with 34 year old mother and 16 year old daughter. Family has experienced domestic violence and both client and daughter have PTSD symptoms. Daughter has also experienced depression. We discussed symptoms of PTSD vs. Generalized Anxiety Disorder as well as the emotional fatigue of depression after sustained exposure to violence and alienation from loved ones. Also discussed possible countertransference elements and insight into family dynamics I may be experiencing. We discussed value, scope and potential use of self disclosure and risks if applied without integrity and professional boundaries. We also reviewed function of daughter's dependent behaviors and mother's resistance to allowing age appropriate developmental tasks with daughter. Reviewed elements of cognitive restructuring as well as behavioral interventions. Joining and attunement strategies were reviewed also.

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6/15/2012	6/11/12 - 6/15/12	15		25		0		0.5		1	

Example 2: Today e discussed individual sessions with individual clients including two adolescent males, a third grade female and a 13 year old middle schooler. We reviewed the developmental stages of each client as well as the chronological (life stage) tasks that each would be expected to be demonstrating. We then reviewed the developmental functioning of each client in the realms of their families, their milieu (both in treatment and in the academic setting and socially) and in the community in general. We then discussed interventions that would sustain the clients' existing skills and move them to a higher ability in self assessment and mood and behavior regulation. We also discussed object relations and psychodynamic basic theory and how each client is developing vulnerability tolerance and interactional skills with others in their environment as they become more able to navigate both their internal and external worlds. Our discussion was also about my assumptions as a therapist and the value of obtaining feedback from my clients to expand my understanding of their perception of their problems. We also explored my anxiety regarding family therapy and my obstacles to being consistently in contact with my clients' families/guardians.

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6/29/2012	6/18/12 - 6/29/12	15		25		1.25		2		0	

Sample 3: Reviewed the Dx and Tx plan of Martha S whom I differentially diagnosed with Major Depression, recurrent, mild severity. Her chief complaint was "feeling hopeless about everything". Five of the following Sx have been present during the same two-week period and represent a change from previous functioning: reports feeling sad nearly every day; does not take pleasure in any activity; suffers from insomnia at night; complains of continual lack of energy; complains of feeling worthless every day. I made the differential Dx between dysthymia and Major Depression because client's symptoms are more severe than the symptomatology of dysthymia. In my mental status exam of Martha S, she presented as a 28 y.o. white woman, married with 2 children, ages 3 and 5. Manner was pleasant. Speech somewhat pressured. Mood dysphoric. Affect somewhat flat. Thought processes intact. Stated that she occasionally thinks about suicide but she does not have a plan and said she would never do that to her children, therefore she does not pose a risk for imminent danger of suicide. No homicidal ideations. Judgment good. Insight fair. Client has agreed to the Tx plan of weekly individual therapy. Cognitive-behavioral therapy will be utilized to treat her global, negative thinking which shapes her feelings of worthlessness, her relentless sadness, and her inability to experience pleasure in everyday activities.

She is also taking an SSRI and understands that the combination of antidepressant medication and therapy often yields the higher level of clinical efficacy.

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7/6/2012	7/2/12 - 7/6/12	20		20		2.25		1.5		1	

Sample 4: Reviewed the Tx of Henry M whom I have been seeing bi-weekly for the past 6 weeks. I've diagnosed Henry with Specific Phobia, fear of flying. Have been utilizing Systematic Desensitization. We begin every session with relaxation strategies which include deep breathing and visualization. Henry continues to take shallow breaths as he gets more anxious. He is learning to become more aware of his breathing and how to switch to deeper breathing at those times. He initially had trouble with visualizing a peaceful scene because he was afraid that I "would find (his) images silly". Although I am not doing psychodynamic therapy with him, I nonetheless am aware of his transference that sees me as a harsh mother figure. I simply told him that whatever images he came up were absolutely fine, a response in keeping with a brief therapy approach.

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7/13/2012	7/9/12 - 7/13/12	20		20		2.25		1.5		1	

Sample 5: Reviewed the Tx of Andy G and his foster mother Carol whom I have been seeing weekly for strategic family therapy and non-directive play therapy for the past 7 months. The child has been diagnosed with Reactive Attachment Disorder. In our last session, Andy was very hyperactive and refused to talk about the lies he had been telling his foster mother this past week. Carol became quite irritated with Andy and told him he was grounded until he was ready to tell the truth. I empathized with mother and her frustration. I suggested to Andy that he come to the dollhouse and show a story of a boy who gets in trouble. Andy enjoys playing with the dollhouse figures and immediately sat down at the table and found the figures he wanted. He portrayed a theme of a child misunderstood by the parents. He reluctantly sat down on the couch with mother afterwards. With much encouragement, he started telling mother that he didn't like it when she yelled so much. With some help from me, she was able to tell Andy that she was glad he could tell her the truth about how he felt. She then revised his punishment of indefinite grounding to 2 days which would be shortened if he told the truth about what had happened yesterday. My counter transference towards the foster mother kicks in when I hear her pronounce unreasonable consequences. I am able to keep it in check when I empathize with her. I also recognize the danger of Andy splitting mother and me, making him feel even more grandiose. I will make it clear that Carol is the boss. I have also been in regular contact this month with Andy's teacher, discussing Andy's good days and bad days.

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TOTAL	**80**	**120**	**8**	**7**	**4**