Pearson New International Edition

Fundamentals of Clinical Supervision

Janine M. Bernard Rodney K. Goodyear

Fifth Edition

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Introduction to Clinical Supervision

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Many professions have a *signature pedagogy* (Shulman, 2005a), a particular instructional strategy that typifies the preparation of its practitioners. In medicine, for example, a team of physicians and medical students visit a prescribed set of patients during clinical rounds, discussing diagnostic and treatment issues related to each patient, along with what has happened since the team last discussed that patient. In law, students come to class prepared to be called on at any moment to describe the essential arguments of a particular case, or to summarize and respond to the arguments another student has just offered. During these interactions, their professor engages them in a type of Socratic dialogue.

Clinical supervision is the signature pedagogy of the mental health professions (Barnett, Cornish, Goodyear, & Lichtenberg, 2007; Goodyear, Bunch, & Claiborn, 2005). Like the signature pedagogy of other professions, it is characterized by (a) engagement, (b) uncertainty, and (c) formation (Shulman, 2005a): *engagement* in that the learning occurs through instructor–learner dialogue; *uncertainty* because the specific focus and outcomes of the interactions typically are unclear to the participants as they begin a teaching episode; and *formation* in that the learner's thought processes are made clear to the instructor, who helps shape those ideas so that the learner begins to "think like a lawyer (Shulman, 2005b, p. 52), a physician, a psychologist, and so on. In this text, we also are concerned with a higher level shift, which is to that of thinking like a supervisor (cf. Borders, 1992).

> *Shulman (2005a) notes that signature pedagogies are "pedagogies of action, because exchanges typically [end] with someone saying, 'That's all very interesting. Now what shall we do?'"* (p. 14)

Clinical supervision qualifies as a signature pedagogy against all these criteria; criteria that underscore both supervision's importance to the mental health professions and its complexity. This text is intended to address that complexity by providing the technical and conceptual tools that are necessary to supervise.

We assert that every mental health professional should acquire supervision skills, because virtually all eventually will supervise others in the field. In fact, supervision is one of the more common activities in which mental health professionals engage. For example, in each of the three surveys conducted over a 20-year span (summarized by Norcross, Hedges, and Castle [2002]), supervision was the third most frequently endorsed professional activity (after psychotherapy and diagnosis/assessment) by members of the American Psychological Association's Division of Psychotherapy. Surveys of counseling psychologists (e.g., Goodyear et al., 2008; Watkins, Lopez, Campbell, & Himmell, 1986) show similar results.

This is true internationally as well. In a study of 2,380 psychotherapists from more than a dozen countries, Rønnestad, Orlinsky, Parks, and Davis (1997) confirm the commonsense relationship between amount of professional experience and the likelihood of becoming a supervisor. In their study, the number of therapists who supervised increased from less than 1% for those in the first 6 months of practice to between 85% and 90% for those who have more than 15 years of practice.

In short, this text is for all mental health professionals. Its focus is on a training intervention that is not only essential to, but also defining of those professions; an intervention that has developed in a complementary way to psychotherapy and so now has more than a 100-year history (Watkins, 2011).

FOUNDATIONAL PREMISES

One challenge in writing this text has been our recognition that almost anyone who reads it does so through a personal lens that reflects beliefs, attitudes, and expectations about supervision that they have formed through their own experiences as supervisees; perhaps also as supervisors. Such foreknowledge can make the reading more relevant and personally meaningful, but it can also invite critical responses to material that readers find dissonant with their beliefs. We hope readers who have that experience find we have presented material in a manner that is sufficiently objective so that they may evaluate dispassionately any dissonance-producing content or ideas.

Three premises are foundational to what follows:

- *Clinical supervision works.* As we discuss later, the data show that supervision has important positive effects on the supervisees and on the clients they serve.
- *Clinical supervision is an intervention in its own right.* It is possible, therefore, to describe issues, theory, and technique that are unique to clinical supervision. Moreover, as with any other psychological intervention, the practice of supervision demands that those who provide it have appropriate preparation.
- *The mental health professions are more alike than different in their practice of supervision, regardless of discipline or country.* Most supervision skills and processes are common across these professions. There are, of course, profession-specific differences in emphasis, supervisory modality, and so on. These might be considered the unique flourishes each profession makes on our common signature pedagogy, but we assume there are core features that occur (a) whether the supervision is offered by psychologists, counselors, social workers, family therapists, psychiatrists, or psychiatric nurses and (b) regardless of the country in which it is offered (see, e.g., Son, Ellis & Yoo, in press). Therefore, we have drawn from both an interdisciplinary and international literature to address the breadth of issues and content that seems to characterize clinical supervision in mental health practice.

In keeping with our interdisciplinary focus, we most often use the term *clinical supervision* (versus such alternatives as *counselor supervision, psychology supervision,* or *social work supervision*). Figure 1 draws from Google's database of more than 5.2 million scanned books spanning 200 years (available through ngrams.googlelabs.com) and depicts the relative frequency with which *clinical supervision* and several alternatives have been used as a term in English-language books between 1940 and 2009. Because the black and white rendering of this graphic makes it difficult to differentiate categories, we note that *clinical supervision* is depicted in the top line, showing it to be the most widely used term. Notable too is the slow linear growth in the use of the term between the mid-1940s and the late 1960s, when the frequency of its use began to increase substantially (interestingly, it also shows some dropoff in the past several years).

Our Convention on the Use of Key Words

We use *counseling, therapy,* and *psychotherapy* interchangeably, because distinctions among

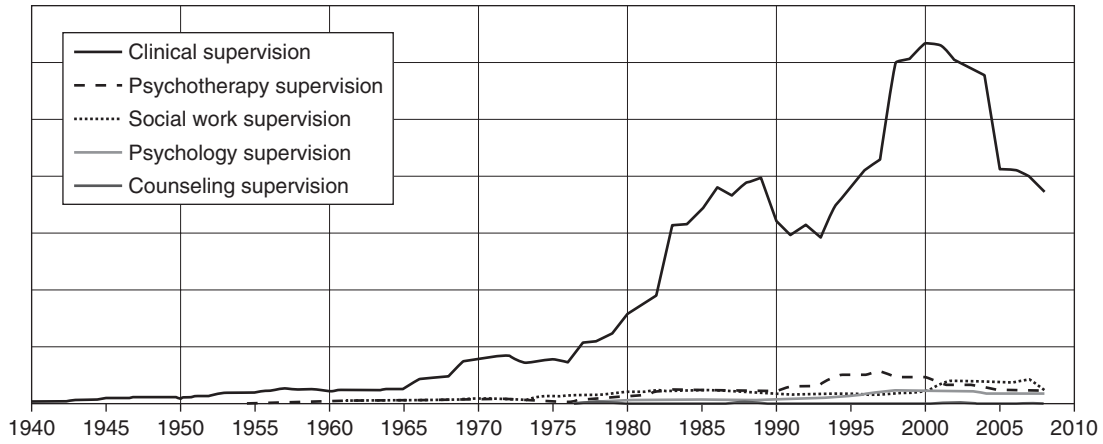

FIGURE 1 Occurrence of *clinical supervision* and related terms in English-language books: 1940–2008

these terms are artificial and serve little function. We also follow the convention first suggested by Rogers (1951) of referring to the recipient of therapeutic services as a *client*.

We distinguish between supervision and training as well. *Training* differs from *supervision* in being "structured education for groups of trainees . . . [and] involves a standardized set of steps" (Hill & Knox, in press, msp. 3). The trainer's primary role is that of teacher (see our discussion later in this chapter distinguishing the roles of *teacher* and *supervisor*).

Paralleling this *training-versus-supervision* distinction is the one that we make between *trainee* and *supervisee.* We believe that *supervisee* is the more inclusive term—that is, *trainee* connotes a supervisee still enrolled in a formal training program and so seems less appropriate for postgraduate professionals who seek supervision. In most cases, we use *supervisee.*

SUPERVISION'S CENTRALITY TO THE PROFESSIONS

Supervision's crucial role in the preparation of professionals has been recognized for thousands of years, as is suggested in the first few lines of the famous Hippocratic Oath:

> *I swear by Apollo the physician, and Asclepius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation* ***—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers****.* (Hippocrates, ca. 400 BC, from Edelstein, 1943; bold ours for emphasis)

In this oath, the veneration being accorded a teacher or supervisor is clear; moreover, the comparison of that teacher to one's parents suggests the power and influence the neophyte physician cedes to the teacher. To appreciate that power and influence requires an understanding of the nature of the professions (see, e.g., Goodyear & Guzzardo, 2000), especially of the ways in which they are distinct from other occupations. Those distinctions include that (a) professionals work with substantially greater autonomy; (b) professionals need to make judgments under conditions of greater uncertainty (Sechrest et al., 1982), an attribute of the work that Schön (1983) vividly characterized as "working in the swampy lowlands" (p. 42) of practice (this is in contrast to technicians who work from a prescribed protocol on situations that typically are carefully

constrained); and (c) professionals rely on a knowledge base that is sufficiently specialized so that the average person would have difficulty grasping it and its implications (Abbott, 1988).

Because of these qualities of professions, it is generally understood that laypersons would not have the knowledge necessary to oversee them, and so society permits the professions to self-regulate. The implicit contract, however, is that this self-regulation is permitted in return for the assurance that this profession will place the welfare of society and of their clients above their own self-interests (see, e.g., Schein, 1973; Schön, 1983). This self-regulation includes controlling who is admitted to practice, setting standards for members' behavior, and disciplining incompetent or unethical members.

Within the mental health professions, three primary mechanisms of self-regulation are (a) regulatory boards, (b) professional credentialing groups, and (c) program accreditation. Supervision is central to the regulatory functions of each, because it provides a means to impart necessary skills; to socialize novices into the particular profession's values and ethics; to protect clients; and, finally, to monitor supervisees' readiness to be admitted to the profession. In short, "supervision plays a critical role in maintaining the standards of the profession" (Holloway & Neufeldt, 1995, p. 207).

Regulatory Boards

State and provincial—and in some countries (e.g., Australia, England, Korea), national—regulatory boards codify the practice of supervision. They often stipulate (a) the *qualifications* of those who supervise; (b) the *amounts* of supervised practice that licensure or registration candidates are to accrue; and (c) the *conditions* under which this supervision is to occur (e.g., the ratio of supervision to hours of professional service; what proportion of the supervision can be in a group format; who can do the supervising; as an example, see the practicum supervision guidelines adopted by the Association of State and Provincial Psychology Boards, www.asppb.net/files/public/Final_Prac_Guidelines_1_31_09.pdf). Some require that members of a particular profession who wish to supervise obtain a separate license in order to do so (e.g., Alabama licenses counseling supervisors).

Professional Credentialing Groups

Independent groups, such as the Academy of Certified Social Workers (ACSW), the American Board of Professional Psychology (ABPP), the National Board for Certified Counselors (NBCC), the American Association for Marriage and Family Therapy (AAMFT), the British Association for Counselling and Psychotherapy (BACP), and the Korean Counseling Psychology Association (KCPA) also credential mental health professionals, usually for advanced practitioners and to certify competence above the minimal level necessary for public protection (the *threshold level of competence for licensure* is the reasonable assurance that the person will do no harm). Like the regulatory boards, these credentialing groups typically stipulate amounts and conditions of supervision a candidate for one of their credentials must have. In some countries (e.g., Korea), these groups serve as de facto regulatory boards.

Some groups (e.g., AAMFT, NBCC, BACP) also have taken the additional step of credentialing clinical supervisors. In so doing, they make clear their assumption that supervision is based on a unique and important skill constellation.

Accrediting Bodies

Whereas licensure and credentialing affect the individual professional, accreditation affects the training programs that prepare them. Each mental health profession has its own accreditation body, and their guidelines address supervision with varying degrees of specificity. For example, the American Psychological Association (APA, 2008) leaves it to the individual training program to establish that supervised training has been sufficient. However, other groups are very specific

about supervision requirements. For example, any graduate of an AAMFT–accredited program is to have received at least 100 hours of face-to-face supervision, and this should be in a ratio of at least 1 hour of supervision for every 5 hours of direct client contact (AAMFT, 2006). The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001) requires that a student receive a minimum of 1 hour per week of individual supervision and 1.5 hours of group supervision during practicum and internship; CACREP doctoral program standards also specify requirements for supervision-of-supervision.

FOSTERING SUPERVISEES' PROFESSIONAL COMPETENCE

Our remarks thus far speak to the role supervision plays in the professions and to the broader society they serve. This section addresses supervision as a mechanism to ensure that supervisees develop necessary competencies, as well as to the less-direct effects of supervision that occur through supervisees' exercise of those competencies.

Integration of Research and Theory with Practice

During their training, novice mental health professionals obtain knowledge from (a) formal theories and research findings, and (b) the practice-based knowledge of expert practitioners. However, there is a third type of knowledge as well—about themselves. For example, they identify aspects of their own personality and interpersonal behavior that affects their work as professionals. Skovholt (2012) refers to this last as an inevitable "loss of innocence" (p. 286).

Clinical supervisors are key to the integration of these several types of knowledge. Supervised practice provides the crucible in which supervisees can blend them, and it is the supervisor who can help provide a bridge between campus and clinic (Williams, 1995), the bridge by which supervisees begin to span what often is a "large theory–practice gulf" (Rønnestad & Skovholt, 1993, p. 396).

Practice is absolutely essential if supervisees are to develop professional skills. This is Peterson's (2002) point when he tells the joke about a New York City tourist who, lost, stops a cabbie and asks, "How can I get to Carnegie Hall?" The cabbie's response is, "Practice, practice, practice!" Peterson notes that this joke's punch line is significant in that the cabbie does not say, "Read, read, read!"

However, practice alone is an insufficient means to attain competence: Unless it is accompanied by the systematic feedback and guided reflection (the operative word being *guided*) that supervision provides, supervisees may gain no more than the illusion that they are developing professional expertise. Dawes (1994) asserts:

> *Two conditions are important for experiential learning: one, a clear understanding of what constitutes an incorrect response or error in judgment, and two, immediate, unambiguous and consistent feedback when such errors are made. In the mental health professions, neither of these conditions is satisfied.* (p. 111)

Dawes' assertions about the two conditions necessary for experiential learning are compelling. Yet we believe his assertion that *neither* condition is met in the mental health professions is overstated. We predicate our writing of this text on the assumption that supervision can satisfy these and other necessary conditions for learning.

It is true a *supervisor* (by whatever name) may be unnecessary for attaining many motor and performance skills. In these domains, simply performing the task may provide sufficient feedback for skill mastery. Learning to type is one example. Learning to drive an automobile is another (Dawes, 1994): When driving, the person who turns the steering wheel too abruptly receives immediate feedback from the vehicle; the same is true if he or she is too slow applying the brakes when approaching another vehicle. In these and other ways, experience behind the wheel gives the person an opportunity to obtain immediate

and unambiguous feedback. Driving skills are therefore likely to develop and improve simply with the experience of driving.

However, psychological practice skills are of a different type. These skills require complex knowledge for which experience alone is rarely able to provide either of the two conditions that Dawes stipulated as necessary for experiential learning to occur. Practitioner skill development requires intentional and clear feedback from another person, such as is available through supervision. Research data confirm that unsupervised counseling experience does not accelerate the clinical progress of trainees (Hill, Charles, & Reed, 1981; Wiley & Ray, 1986), a conclusion complemented by that of educational psychologists who examined the broader domain of instruction (see especially Kirschner, Sweller, & Clark, 2006).

COMPETENCE TO SUPERVISE

Whereas the literature gives a great deal of attention to fostering the competence of new professionals, a great deal less attention has been given to the development of competence in the supervisors themselves. Milne and James (2002) comment that this has been something of a paradox that the field must address.

Developing supervisor competence implies systematic training. It was disappointing, therefore, to see that internship supervisors responding to the Rings, Genuchi, Hall, Angelo, and Cornish (2009) survey gave only lukewarm endorsement for the two items, "Supervisor has received supervision of his or her supervision, including some form of observation (audio or video) with critical feedback," and "Supervisor has completed coursework in supervision." In contrast, Gonsalvez and Milne (2010) note that "expert opinion is unanimous in identifying the need for supervisor training, often in forceful terms" (p. 234). It is increasingly rare to encounter people who believe that being an effective therapist is a sufficient prerequisite to being a good supervisor; analogous, we believe, to assuming that if a person is a good athlete, she or he inevitably will make a good coach or sports announcer.

Research literature that focuses on the effectiveness of supervisor training is still small and developing. Importantly, though, it does document positive outcomes.

Availability of Training for Supervisors

In the early 1980s, several authors (e.g., Hess & Hess, 1983; McColley & Baker, 1982) comment on what seems the limited availability of supervision training for mental health professionals. Fortunately, circumstances have changed quite significantly since then (except, perhaps in the case of psychiatry; e.g., Rodenhauser, 1996). Accrediting bodies (i.e., APA, CACREP, and AAMFT) have been important in this shift, through their stipulations that students in doctoral programs they accredit should receive at least some preparation to supervise.

Some organizations also have specified levels and type of training for those mental health professionals who do move into supervisory roles. For example, the Association for Counselor Education and Supervision (ACES) endorses Standards for Counseling Supervisors (ACES, 1990), a variant of which later was adopted by the Center for Credentialing and Education as the basis for its Approved Clinical Supervisor credential. AAMFT, too, has a supervisor membership category that requires specified training.

Regulatory boards also are beginning to require that mental health professionals who provide supervision receive supervision training. For example, psychologists licensed in California who want to supervise must to participate in one 6-hour supervision workshop during every 2-year licensure cycle; at this writing, several other state and Canadian provincial psychology boards either mandate some level of supervision training or are considering doing so (Janet Pippin, personal communication, September 13, 2011). Sutton (2000) reports that 18% of counselor licensure boards require a course

or its equivalent for persons providing supervision, and another 12% require training in supervision.

Similar trends in supervision training are evident in other countries as well. For example, programs accredited by the Canadian Psychological Association are to provide supervision training. In Britain, supervision training is readily available to qualified professionals through a number of freestanding training "courses" (i.e., programs), and the National Health Service's Improving Access to Psychological Therapies (IAPT) group developed a proposal to create structures to permit briefer (e.g., 5–7 day) supervision training (IAPT, 2011); to inform that training, it also commissioned the development of a document to identify supervision competencies (Roth & Pilling, 2008). Korean counselors and psychologists often can obtain supervision training in their academic programs, although not universally (see Bang & Park, 2009).

The Competence Movement and Its Implications for Supervisor Training

Regulatory boards always have been concerned that the practitioners they certify for practice are competent. A relatively recent development, however, has been the attention being given to operationalizing, training for, and assessing competencies. The emergence of what has been called "the competence movement" (Rubin et al., 2007, p. 453) roughly coincides with the increasing demands for accountability seen in higher education in, for example, U.S. accreditation and in Europe's Bologna Process (Adelman, 2008). Essential to that movement is some common working definition of *competence*. It is useful, then, to consider the definition put forth by Epstein and Hundert (2002):

> *the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served; [it relies on] habits of mind, including attentiveness, critical curiosity, awareness, and presence.* (p. 227)

Their definition of *medical competence* has been sufficiently useful to have been embraced as well in the mental health professions (see, e.g., Rubin et al., 2007). It makes clear that competence is not merely a disparate collection of knowledge and skills, but rather something that requires the exercise of judgment. It seems highly similar to Aristotle's concept of *phronesis,* or practical wisdom, which "concerns how individuals 'size up' a situation and develop and execute an appropriate plan of action" (Halverson, 2004, p. 94).

The 2002 Competencies Conference (Kaslow et al., 2004) was something of a watershed in U.S. psychology. Although competencies had been an explicit aspect of the National Schools of Professional Psychology's training model (Peterson, Peterson, Abrams, & Stricker, 1997), this conference signaled broad embrace of competencies. Important to note is that there was clear consensus among conference attendees that *supervision* is a core competence of psychologists. In fact, a task group of supervision experts attending that conference articulated competencies they believed supervisors should attain and demonstrate (Falender et al., 2004).

However, all conceptions of competence are grounded in expert opinion, and these opinions can differ across groups of experts or across time within a group of experts, and so are inherently value laden. Understandably, then, authors have varied some in the focus and specificity with which they have addressed competencies (see, e.g., Falender et al., 2004; Roth & Pilling, 2008; Tebes et al., 2010).

Deist and Winterton's (2005) assertion that *competence* is a fuzzy concept seems borne out to some extent in these several conceptions of supervision competence. This is not to say that these conceptions are contradictory or unimportant; in fact, despite its fuzziness, we absolutely embrace the importance of competence as a central focus of this text.

DEFINING SUPERVISION

We assume that anyone reading this text is bringing some understanding of what *supervision* is. However, an important next step is to provide a

more formal definition, and then to address the aspects of this definition.

In parsing the term, it is possible to infer that its practitioners exercise *super vision*. In fact, supervisors have the advantage of a clarity of perspective about counseling or therapy processes precisely because they are not an involved party. Levenson (1984) speaks to this when he observes that, in the ordinary course of his work as a therapist, he spends considerable time perplexed, confused, bored, and "at sea," but, "When I supervise, all is clear to me!" (p. 153).

Levenson (1984) also reports finding that theoretical and technical difficulties were surprisingly clear to him. Moreover, he maintains that people he supervised and who seemed confused most of the time that they were supervisees reported that they attained a similar clarity when they were supervising. He speculates that this is "an odd, seductive aspect of the phenomenology of the supervisory process itself" (p. 154) that occurs at a different level of abstraction than therapy. Perhaps this is the perspective of the "Monday-morning quarterback."

The Merriam-Webster (n.d.) online dictionary reports, however, that the etymological definition of *supervision* is simply "to oversee," from the Latin word *supervises,* and that the first known use of the term in English occurred in about 1645. *To provide oversight* is a key function of supervisors in virtually *any* occupation or profession. Yet as important as this is, it is an insufficiently precise description of what occurs during the clinical supervision of trainees and practitioners in the mental health professions.

Definitions of *supervision* offered by various authors differ from one another as a function of such factors as the author's discipline and training focus. Our intent is to offer a definition that is specific enough to be helpful, but at the same time broad enough to encompass the multiple roles, disciplines, and settings associated with supervision.

We have offered, with only the slightest of changes, the following working definition of *supervision* since the first edition of this text (Bernard & Goodyear, 1992):

> Supervision *is an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship*
>
> - *is evaluative and hierarchical,*
> - *extends over time, and*
> - *has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter.*

The earlier version of this definition has been informally adopted as the standard in both the United States and the United Kingdom (see, e.g., Milne, 2007). In this edition, we make two changes to that definition:

1. Whereas the definition we use in prior editions asserts that supervision is a relationship between two people of the same profession, this revised definition acknowledges that this is not always true.
2. Whereas the final clause stipulates that supervisors serve as gatekeepers for those *entering* the profession, the revised version acknowledges that gatekeeping can occur at other points as well.

Because this definition is succinct, it merits further explication. Each of the following sections addresses a specific element of this definition.

Supervision Is a Distinct Intervention

Supervision is an intervention, as are teaching, psychotherapy, and mental health consultation. There are substantial ways in which supervision overlaps with and draws from these other interventions (see, e.g., Milne, 2006), yet still remains unique. Table 1 summarizes what we believe to be the most salient similarities and differences.

Teaching versus Supervision. Teaching is central to supervision, and the supervisee's role of learner is suggested in the title of the classic supervision book, *The Teaching and Learning of*

TABLE 1 Supervision versus Teaching, Counseling, and Consultation

	SIMILARITIES	DIFFERENCES
Teaching	• Both have the purpose of imparting new skills and knowledge. • Both have evaluative and gatekeeping functions.	• Whereas teaching is driven by a set curriculum or protocol, supervision is driven by the needs of the particular supervisee and his or her clients.
Counseling or Therapy	• Both can address recipients' problematic behaviors, thoughts, or feelings.	• Any therapeutic work with a supervisee must be only to increase effectiveness in working with clients. • Supervision is evaluative, whereas counseling is not. • Counseling clients often have a greater choice of therapists than supervisees have of supervisors.
Consultation	• Both are concerned with helping the recipient work more effectively professionally. For more advanced trainees, the two functions may become indistinguishable.	• Consultation is a relationship between equals, whereas supervision is hierarchical. • Consultation can be a one-time event, whereas supervision occurs across time. • Consultation is more usually freely sought by recipients than is supervision. • Supervision is evaluative, whereas consultation is not.

Psychotherapy (Ekstein & Wallerstein, 1972). Teaching and supervision also have in common an evaluative aspect reflected in their gatekeeping functions, regulating who is legitimized to advance further into training or into the workplace.

Teaching, however, typically relies on an explicit curriculum with goals that are imposed on everyone uniformly. However, even though the focus of supervision at its broadest level might seem to speak to common goals (i.e., to prepare competent practitioners), the actual intervention is tailored to the needs of the individual supervisee and the supervisee's clients. Eshach and Bitterman's (2003) comments about the challenges in preparing physicians to address the needs of the individual—and therefore about the need for an educational context that is flexible and adaptive to the needs of the trainee and the person she or he is serving—apply just as well to the training of mental health practitioners (and, notably, have the characteristics of a signature pedagogy).

> *The problems are often poorly defined. . . . The problems that patients present can be confusing and contradictory, characterized by imperfect, inconsistent, or even inaccurate information. . . . Not only is much irrelevant information present, but also relevant information about a case is often missing and does not become apparent until after problem solving has begun.* (Shulman, 2005a, p. 492)

Counseling versus Supervision. There are elements of counseling or therapy in supervision—that is, supervisors often help supervisees examine aspects of their behavior, thoughts, or feelings that are stimulated by a client, particularly as these may act as barriers to their work with the client. As Frawley-O'Dea and Sarnat (2001) observe, maintaining "a rigidly impenetrable boundary

between teaching and 'treating' in supervision is neither desirable nor truly achievable" (p. 137).

Still, there should be boundaries. Therapeutic interventions with supervisees should be made only in the service of helping them become more effective with clients; to provide therapy that has broader goals than this is ethical misconduct (see, e.g., Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Neufeldt & Nelson, 1999).

It also is worth noting that clients generally are free to enter therapy or not, and usually have a voice in choosing their therapists. However, supervision is not a voluntary experience for those who have committed to a training program, and they often have scant voice in whom their supervisor is to be. Given this circumstance, it is salient to note that Webb and Wheeler (1998) found in their study that supervisees who had chosen their own supervisors reported being able to disclose to their supervisors more information of a sensitive nature about themselves, their clients, and the supervisory process than supervisees who had been assigned a supervisor.

Page and Woskett (2001) differentiate supervision from counseling according to their respective *aims* (in counseling, to enable a fuller and more satisfying life, versus in supervision, to develop counseling skills and the ability to conceptualize the counseling process); *presentation* (clients present material verbally, whereas supervisees present in multiple ways, including not only verbally, but via audio and videotape, live observation, etc.); *timing* (clients choose the pace, whereas supervisees often must have new understanding or skills in time for their next counseling session); and *relationship* (in counseling, regression may be tolerated or even encouraged, whereas that is not so in supervision; although some challenging of boundaries is expected in counseling, there is no such expectation in supervision).

The single most important difference between therapy and supervision, however, may reside in the supervisor's evaluative responsibilities. This can create challenges to supervisors.

Consultation versus Supervision. For more senior professionals, supervision often evolves into consultation—that is, the experienced therapist might meet informally on an occasional basis with a colleague to get ideas about how to handle a particularly difficult client or to regain needed objectivity. We all encounter blind spots in ourselves, and it is to our benefit to obtain help in this manner.

Consultation, however, is more likely than supervision to be a one-time-only event, and the parties in the consultation relationship often are not of the same professional discipline (e.g., a social worker might consult with a teacher about a child's problem; Caplan, 1970). Two other consultation–supervision distinctions echo distinctions already made between *therapy* and *supervision.* One is that *supervision* is more likely imposed, whereas *consultation* typically is freely sought. More significantly, whereas evaluation is one of the defining attributes of supervision, Caplan and Caplan (2000) observe that consultation

> *is non-hierarchical. Our consultants reject any power to coerce their consultees to accept their view of the case or to behave in ways the consultants may advocate. . . . consultants have no administrative power over the consultees or responsibility for case outcome.* (pp. 18–19)

In summary, specific aspects of teaching, therapy, and consultation are present as components of supervision. Supervision should be thought of as an intervention composed of multiple skills, many of which are common to other forms of intervention. Yet their configuration is such as to make supervision unique among psychological interventions. Moreover, there is at least one phenomenon, that of *parallel* or *reciprocal processes* (e.g., Doehrman, 1976; Searles, 1955), that is unique to supervision and distinguishes it from other interventions .

Typically a Member of the Same Profession

The widely acknowledged purposes of supervision are to facilitate supervisees' development

and to protect clients. It is possible to accomplish these purposes when the supervisory dyad is composed of members of two different disciplines (e.g., a marital and family therapist might supervise the work of a counselor). In fact, almost all supervisees will be supervised by someone outside their immediate profession.

However, supervision also serves a professional socialization function missing in cross-disciplinary supervision dyads. Ekstein and Wallerstein (1972) speak to this when they note that it is possible for a training program to prepare its supervisees with all the basic psychotherapeutic skills, but that "what would still be missing is a specific quality in the psychotherapist that makes him [or her] into a truly professional person, a quality we wish to refer to as his [or her] professional identity" (p. 65). Crocket et al. (2009) found that supervisors who were providing interdisciplinary supervision reported many positive features of this arrangement, but also note the difficulties of working from different ethics codes and of having too-limited knowledge of the professional culture of the supervisee. Kavanagh et al. (2003) found that Australian public mental health workers perceived that the extent of supervision they received was related to its impact on them, but *only* when the supervisor was of the same profession.

In a cautionary tale concerning the use of members of one profession to supervise neophyte members of another profession, Albee (1970) invokes the metaphor of the cuckoo: The cuckoo is a bird that lays its eggs in the nests of other birds, which then raise the offspring as their own. His case in point was U.S. clinical psychology, which had used the Veterans Administration system as a primary base of training in the decades following World War II. From Albee's perspective, the clinical psychology fledglings were put in the nest of psychiatrists, who then socialized them into their way of viewing the world. Albee asserts that one consequence is that clinical psychology lost some of what was unique to it, as its members began incorporating the perspectives of psychiatry.

Notably, Gabbard (2005) expresses concern about social workers and psychologists supervising psychiatry residents. He acknowledges that they can be excellent therapists, but then observes that:

> *Children become what their parents do more than what their parents say. The same can be said of psychiatric residency training. If their professional role models treat psychotherapy as a marginal endeavor taught by allied professionals, residents will assume that psychiatrists are not really psychotherapists.* (p. 334)

In short, counselors and psychotherapists are supervised by people from different professions and often receive excellent training from them. Our point is not to argue against that practice, but rather to suggest that for the sake of professional identity development, it is important that the majority of supervision be done by someone who is in the profession that the supervisee is preparing to enter.

Supervision Is Evaluative and Hierarchical

We mentioned previously that evaluation stands as one of supervision's hallmarks, distinguishing it from both counseling or therapy and consultation. Evaluation is implicit in the supervisors' mandate to safeguard clients, both those currently being seen by the supervisee and those who would be seen in the future by the supervisee if he or she were to finish the professional program.

That supervisors have an evaluative function provides them with a tool, giving them an important source of interpersonal influence. For example, although most supervisees have a very high degree of intrinsic motivation to learn and to use feedback to self-correct, evaluation can provide supervisees with an additional, extrinsic motivation to use supervisory feedback.

However, despite its importance as a component of supervision, both supervisor and supervisee can experience evaluation with discomfort. Supervisors, for example, were trained first in the more non-evaluative role of counselor or therapist. Indeed, they may well have been attracted to

the field because of this feature of counseling. The role of evaluator therefore can be not only new, but uncomfortable as well.

> *The role of evaluator also affects the trainee's perception of the supervisor. Students are not only taught psychotherapy by their supervisors, they are also evaluated by them. . . . Supervisors are thus not only admired teachers but feared judges who have real power.* (Doehrman, 1976, pp. 10–11)

Supervision's evaluative function means that the relationship is hierarchical. To the extent that hierarchy recapitulates issues related to ethnicity and gender, this can be problematic. Feminists, for example, have wrestled with the best means by which to balance their collaborative stance of work between two equals with the fact of hierarchy in supervision (see, e.g., Prouty, Thomas, Johnson, & Long, 2001). Some (e.g., Edwards & Chen, 1999; Porter & Vasquez, 1997), in fact, suggest the term *covision* as an alternative to *supervision* to signal a more collaborative relationship. Yet hierarchy and evaluation are so intertwined with supervision that to remove them makes the intervention something other than supervision.

Evaluation is, then, an important and integral component of supervision, but it is one that often is the source of problems for supervisors and supervisees alike. Although there is no way in which evaluation could (or should) be removed from supervision, there are ways to enhance its usefulness and to minimize problems attendant to it.

Supervision Extends over Time

A final element of our definition of *supervision* is that it is an intervention that extends over time. This distinguishes supervision from *training,* which might be brief, for example, in a short workshop intended to impart a specific skill; it distinguishes supervision, too, from *consultation,* which might be very time limited, as one professional seeks the help of another to gain or regain objectivity in his or her work with a client.

The fact that it is ongoing allows the supervisor–supervisee relationship to grow and develop. Indeed, many supervision theorists have focused particular attention on the developing nature of this relationship.

Purposes of Supervision

Our definition suggests that supervision has two central purposes:

1. To foster the supervisee's professional development—a supportive and educational function
2. To ensure client welfare—the supervisor's gatekeeping function is a variant of the monitoring of client welfare

Vespia, Heckman-Stone, and Delworth (2002) show how central supervisors find these two purposes. When supervisors rated the extent to which each of 53 supervisee behaviors characterized individuals "who use supervision well" (p. 59), two of the three highest rated items corresponded to one of these purposes: "Implements supervisor's directives when client welfare is of concern to the Supervisor" and "Demonstrates willingness to grow." Each is an essential focus, although it is possible for a particular supervisor to emphasize one more heavily than the other. For example, a student working at a field placement might have both a university-based and an on-site supervisor. In this situation, it is possible for the university-based supervisor to give relatively greater emphasis to the teaching–learning goals of supervision, and the on-site supervisor to give relatively greater emphasis to the client-monitoring aspects. Feiner (1994) alludes to this dichotomy of goals when he suggests the following:

> *Some supervisors assume that their most important ethical responsibility is to the student's patient. This would impel them to make the student a conduit for*

> *their own expertise. Others make the assumption that their ultimate responsibility is to the development of the student. . . . Their concern is the possible lowering of the student's self-esteem when confronted by the supervisor and his rising fantasy that he should become a shoe salesman.* (p. 171)

It is important to acknowledge other possible purposes for supervision. For example, Proctor (1986) asserts that supervision serves three purposes that she labeled (a) *formative,* equivalent to our teaching–learning purpose; (b) *normative*, generally equivalent to ensuring client welfare; and (c) *restorative,* providing supervisees the opportunity to express and meet needs that will help them avoid burnout (see Hyrkäs, 2005, for results that provide preliminary support for this function). Howard (2008) extends the restorative purpose by drawing from positive psychology to suggest as well that supervision should also have the goals of enhancing work engagement, "flow" (see Csikszentmihalyi, 1990), and resilience.

Occasionally, too, supervision is mandated as a method to rehabilitate impaired professionals (see, e.g., Frick, McCartney, & Lazarus, 1995). This overlaps with both the training and client-protective purposes of supervision, but really should be considered an additional purpose. Although we do not specifically address this purpose of supervision in this text, interested readers might consult discussions by Cobia and Pipes (2002) and Walzer and Miltimore (1993).

Both the restorative and rehabilitative purposes of supervision are important. Knudsen, Ducharme and Roman (2008) found, for example, that being supervised reduced substance abuse counselors' emotional exhaustion and job turnover. However, restorative and rehabilitative purposes are not common across *all* supervision, whereas the two purposes that are part of our definition of supervision (i.e., client protection and development of supervisee competence) are. Each is addressed in turn in the two subsections that follow.

Before turning to those discussions, however, we add one additional, ultimate goal, which is to prepare the supervisee to self-supervise (Dennin & Ellis, 2003). At the point of licensure, practitioners, at least in the United States, no longer are required to be supervised and so must be able to monitor their own work, knowing how to learn from it and also when to seek consultation. Supervisees work with a number of supervisors; a psychologist will work with about eight supervisors prior to obtaining a doctorate (M. V. Ellis, personal communication, August 31, 2006, from data obtained as part of an instrument validation study). In the process of that work, they should develop a sort of *internal supervisor* that incorporates what they have learned from each of their supervisors.

Fostering the Supervisee's Professional Development. We state the teaching–learning goal simply as "to enhance professional functioning." This is a pragmatic definition that meets our need to provide a succinct and generally applicable definition of supervision. It is silent about any performance criteria that supervisees are to meet or even about the content of learning. To that end, however, the APA's competency benchmark task group (Fouad et al., 2009) performed important work in articulating those expected performance criteria, breaking them out by level of training.

To enhance professional functioning speaks to the development of supervisee competence. The form of that competence typically derives from some combination of the supervisor's own theory or model, the supervisee's particular developmental needs, and the supervisee's expressed wishes.

In addition, the supervisor almost certainly wants the supervisee to develop skills and competencies necessary for eventual licensure or certification. This utilitarian goal has the virtue of specificity—that is, supervisors generally know what competencies the supervisee must demonstrate for licensure, at least in his or her own state. Moreover, this is a logical target in that to attain licensure is, at least in the United States, the point at which the supervisee makes the transition to an autonomously functioning professional who no longer has a legal mandate to be supervised.

> *The truth is that no one knows or tracks in any systematic way what transpires between therapist and client once the therapist escapes the onus of training and supervision, and unlike most medical procedures of significant consequence, there's generally no one present to observe other than the provider and the recipient—neither of whom is apt to be vested with an unbiased view or recollection.* (Gist, 2007, personal communication via email)

The assumption undergirding this right to practice without supervision is that the person has developed *metacompetence* (Roth & Pilling, 2008), or "the ability to assess what one knows and what one doesn't know" (Falender & Shafranske, 2007, p. 232). It is a professional's metacompetence that allows him or her to seek consultation when faced with an issue beyond his or her expertise; to engage in the self-supervision to which we alluded earlier.

In a now-famous statement to the press, U.S. Secretary of Defense Donald Rumsfeld (2002) describes "known knowns," "known unknowns," and "unknown unknowns." Metacompetence reduces the number of "unknown unknowns" a professional will face; however, until they develop it, they must rely on their supervisors. We suppose it should go without saying that it is essential that supervisors' own metacompetence is an important means of helping to ensure that supervisees develop that in themselves.

Whereas it is the norm in the United States to permit licensed professionals to work without formal supervision, this is not true in other countries, which may be wise given Gist's observation earlier. In the United Kingdom, for example, many mental health professionals are expected to continue receiving supervision throughout their professional lives (West, 2003). This is codified in the British Association for Counselling and Psychotherapy's (BACP) ethical code, which stipulates: "There is an obligation to use regular and ongoing supervision to enhance the quality of the services provided and to commit to updating practice by continuing professional development" (BACP, 2007, p. 3). BACP expectations are that practitioners will participate in supervision at least 1.5 hours per month. Australia has a similar rule (see Grant & Schofield, 2007). This convention recognizes that professional development is ongoing and extends even after a professional develops expertise; supervision in this context is understood to have more than a training function.

Fried (1991) offers the folk wisdom that it takes 10 years to become a really good psychotherapist. In fact, Hayes (1981) estimates that it requires about 10 years to become an expert in *any* skill domain, an assertion that others (e.g., Ericcson & Lehmann, 1996) document as well. Yet, for many professionals, time alone is insufficient to attain expert status or clinical wisdom. However, even if a mental health professional attains expertise or wisdom, it still is useful for him or her to have continuing supervision to foster lifelong learning and help address our field's knowledge half-life (see, e.g., Lichtenberg & Goodyear, 2012).

In fact, many—perhaps most—postgraduate, credentialed practitioners *want* and do continue some level and type of supervision, even if it is not mandated (see, e.g., Borders & Usher, 1992; McCarthy, Kulakowski, & Kenfield, 1994; Wiley, 1994). This is good not only for them, but for their clients as well. Slater (2003, p. 8) states: "I remember a patient once asking me, 'Who do you talk about me with?' He wasn't asking out of fear, but hope. What suffering person doesn't want many minds thinking about how to help?"

Monitoring Client Care. In addition to their responsibilities to the supervisees' professional development, supervisors must also ensure that supervisees are providing adequate client care. In fact, this was the original purpose of clinical supervision. Supervision in the mental health disciplines almost certainly began with social work supervision, which "dates from the 19th-century Charity Organization Societies in which paid social work agents supervised the moral treatment of the poor by friendly visitors" (Harkness & Poertner, 1989, p. 115). The focus of this supervision was on the client.

Eisenberg (1956) notes that the first known call for supervision to focus on the professional,

rather than exclusively on the client, was in 1901 by Zilphia Smith. This supervisory focus became more prominent two decades later, when, as Carroll (2007) observes, "Max Eitington is thought to be the first to make supervision a requirement for those in their psychoanalytic training in the 1920s" (p. 34).

However, the need to ensure quality of client care is one job demand with particular potential for causing dissonance in the supervisor. Most of the time, supervisors are able to perceive themselves as allies of their supervisees. Yet they also must be prepared, should they see harm being done to clients, to risk bruising the egos of their supervisees or, in extreme cases, even to steer the supervisee from the profession—an ethical obligation we have to the public.

PERSON-SPECIFIC UNDERSTANDINGS OF SUPERVISION

A formal definition of *supervision* is important, but it is inevitable that supervisors and supervisees also will operate according to their own idiosyncratic and personally nuanced definitions. Because these more individualized—and usually implicit—definitions can affect supervision processes in important ways, they too should be acknowledged as complements to the more formal definition.

To consider these nuanced definitions, it is useful to invoke the concept of the *schema* (in the plural, *schemata*) that Bartlett (1932, 1958) introduces and that now is widely used among cognitive psychologists and mental health professionals. A *schema* helps us interpret our world by providing a mental framework for understanding and remembering information. More formally stated, a *schema* is a knowledge representation based on our past experiences and inferences that we use to interpret a present experience. In short, people have a tendency to understand one domain of life experience in terms of another. Our perceptions and responses to a new situation are organized and structured as they were in a previous similar situation.

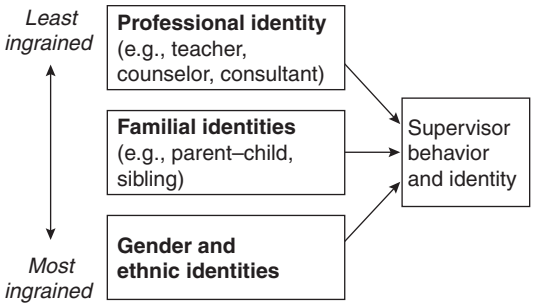

FIGURE 2 Life and Professional Roles That Affect Supervisory Role Behavior

Because of their apparent similarities, we respond to the new situation as if it were the earlier one. Moreover, the more ingrained the particular role we have learned, the more it is likely to intrude on later learned roles. The schema people develop for supervision is shaped in this manner. Figure 2 shows, for example, that gender and ethnicity roles are among the most ingrained, and therefore permeate much of our behavior, including supervision.

Professional roles are learned later and are therefore less an ingrained part of ourselves. Yet, even so, earlier learned professional roles (such as that of counselor) are likely to affect later learned professional roles. For those taking on the later learned roles, it is natural, perhaps inevitable, to attempt to understand them in terms of things we do know. It is merely human to attempt to understand that which is new in terms of that which is familiar.

It should be no surprise, then, that the roles of supervisor and supervisee are at least partially understood as metaphoric expressions of other life experiences. Proctor (1991), for example, invokes the concept of *archetypes,* which actually could be understood as *schemata:*

> *A number of my colleagues asked me what archetypes went into taking the trainer role; we immediately identified a number. There are the Guru, or Wise Woman, from whom wisdom is expected, and the Earth Mother—the all-provider, unconditional*

> *positive regarder. In contrast there is the Clown or Jester—enjoying performance, and cloaking his truth in riddles, without taking responsibility for how it is received. The Patriarch creates order and unselfconsciously wields power. The Actor/Director allocates roles and tasks and holds the Drama; the Bureaucrat demands compliance to the letter of the law. The Whore gives services for money, which can be indistinguishable from love, and re-engages with group after group. There is even the Warrior—valiant for truth; and of course the Judge—upholding standards and impartially assessing. The Shepherd/Sheep-dog gently and firmly rounds up and pens.* (p. 65)

These are some possible metaphors for the supervisor. There also are metaphors that speak to the process or experience of supervision, independent of other life roles. Therefore, a supervisee (or supervisor) might understand supervision as akin to a lighthouse beacon that provides one with bearings in often foggy situations. Participants in workshops led by our colleague, Michael Ellis, describe *supervision* as a shepherd and flock, as an oasis in the desert, and (more ominously) as going to the principal's office. Milne and James (2005) use the metaphor of supervision as tandem bicycle riding.

We believe that these metaphors exist at various levels of awareness, but they are often present and affect participants' expectations and behaviors. The following discussions of more frequently occurring metaphors are therefore in the service of making them available for consideration.

Family Metaphors

Family metaphors (middle of Figure 2) seem especially common in supervision. The most basic of these is that of the parent–child relationship. Lower (1972), for example, uses this metaphor in alluding to the unconscious parent–child fantasies that he believed are stimulated by the supervisory situation itself. In fact, Itzhaky and Sztern (1999) caution supervisors against allowing themselves to behave without awareness of what they term a *pseudo-parental role* (p. 247).

Of course, many theorists use this metaphor of parent–child relationship as a way to think about therapy. As it may apply to supervision, the metaphor is simultaneously both less and more appropriate than for therapy. On the one hand, it is *less* apt in that personal growth is not a primary goal of the intervention, as it is in therapy, but rather is an instrumental goal that works in the service of making the supervisee a better therapist. It is *more* apt, on the other hand, in that supervision is an evaluative relationship, just as parenting is—and therapy presumably is not.

Just knowing that they are being evaluated is often sufficient to trigger in supervisees an expectation of a guilt–punishment sequence that recapitulates early parent–child interactions. Supervisors can, through their actions, intensify such transference responses among supervisees, triggering perceptions of them as a good or bad parent. We have heard, for example, of instances in which supervisors posted publicly in the staff lounge the names of supervisees who had too many client "no-shows." The atmosphere created in situations such as this can easily establish supervisory staff as "feared parents."

Still another parallel between parent–child and supervisor–supervisee relationships is that status, knowledge, maturity, and power differences between the participants eventually begin to disappear. The parties who today are supervisor and supervisee can expect that one day they might relate to one another as peers and colleagues.

The parent–child metaphor is suggested, too, in the frequent use of developmental metaphors to describe supervision.

A second family metaphor that can pertain to supervision is that of older and younger siblings. For many supervisory dyads, this probably is more apt than the parent–child metaphor. The supervisor is further along on the same path being traveled by the supervisee. As such, she or he is in a position to show the way in a nurturing and mentoring relationship. However, as with siblings, issues of competence can sometimes trigger competition over who is more skilled or more brilliant in understanding the client.

The older–younger siblings metaphor is structurally similar to the relationship between master craftspersons and their apprentices. Such relationships have existed for thousands of years and are perpetuated in supervision. In these relationships, master craftspersons serve as mentors to the people who aspire to enter the occupation, showing them the skills, procedures, and culture of the occupation. In this manner, too, master craftspersons help perpetuate the craft. Eventually, after what is usually a stipulated period of apprenticeship, the apprentices become peers of the craftspersons.

These metaphors, particularly those of parent or sibling, occur at fundamental and often primitive levels. Because they influence in an immediate and felt way, they have a special and probably an ongoing influence on the supervisory relationship. Moreover, such metaphors probably operate outside the awareness of the supervisor.

If it is true that supervision is a unique intervention, then one might reasonably infer that there is a unique role characteristic of supervisors in general. In a broad sense, this is true, and we can identify at least two major components of this generic supervisory role. The first of these is the perspective from which the supervisor views his or her work; the second pertains to the commonly endorsed expectation that the supervisor will give feedback to the supervisee.

Liddle (1988) discusses the transition from therapist to supervisor as a role-development process that involves several evolutionary steps. An essential early step is for the emerging supervisor to make a shift in focus—that is, the supervisor eventually must realize that the purpose of supervision is neither to treat the client indirectly through the supervisee nor to provide psychotherapy to the supervisee, a point which Borders (1992) also makes. She maintains that the supervisor-to-be must make a cognitive shift as he or she switches from the role of counselor or therapist. To illustrate how difficult this often is for new supervisors, she gives the example of a neophyte supervisor who persisted for some time in referring to his supervisee as "my client." Until he was able to label the supervisee's role correctly in relation to himself, his perceptual set remained that of a therapist.

This shift, then, requires the supervisor to give up doing what might be thought of as *therapy by proxy, therapy by remote control,* or what Fiscalini (1997) calls *therapy by ventriloquism.* We would note, however, that the pull to doing this may always remain present, even if unexpressed in practice. In part, this is reinforced by the supervisor's mandate always to function as a monitor of client care and remain vigilant about how the client is functioning. Similarly, the longer the person has functioned as a therapist, the harder it may be for the supervisor to make the necessary shift in perspective. It is interesting to note, for example, that Carl Rogers talked about having occasionally experienced the strong impulse to take over the therapy of a supervisee, likening himself to an old fire horse heeding the call (Hackney & Goodyear, 1984).

Borders (1992), in fact, observes that untrained professionals do not necessarily make this shift on their own, simply as a result of experience as a supervisor. As a matter of fact, some "experienced" professionals seem to have more difficulty changing their thinking than do doctoral students and advanced master's students in supervision courses.

A CONCEPTUAL MODEL OF SUPERVISION

The conceptual model depicted in Figure 3, an adaptation of the competencies cube developed by Rodolfa and colleagues (2005), provides a complementary perspective that influenced our organization of this text. This is a three-dimensional model in which the three dimensions are what we have labeled *Parameters of Supervision, Supervisee Developmental Level,* and *Supervisor Tasks*.

Parameters of Supervision

The *parameters of supervision* are the features of supervision that undergird *all* that occurs in supervision, regardless of the particular supervisory function or the level of the supervisee. For example, the supervisor's model or theory is a factor at all times, as is the supervisory relationship and each of the other of the parameters listed in the figure.

Supervisee Developmental Level

We assume that supervisees need different supervisory environments as they develop professionally and that the manner in which supervisors intervene differs according to supervisee level. As well, the expression of each parameter (e.g., relationship, evaluation) is affected by the *supervisee's developmental level*.

Different supervision theorists suggest a different number of stages through which the supervisee progresses. Figure 3, however, is drawn in a way to suggest that we do not take a stand on exactly how many of these stages there actually are. We believe it is sufficient here simply to make clear that developmental processes affect all that we do as supervisors.

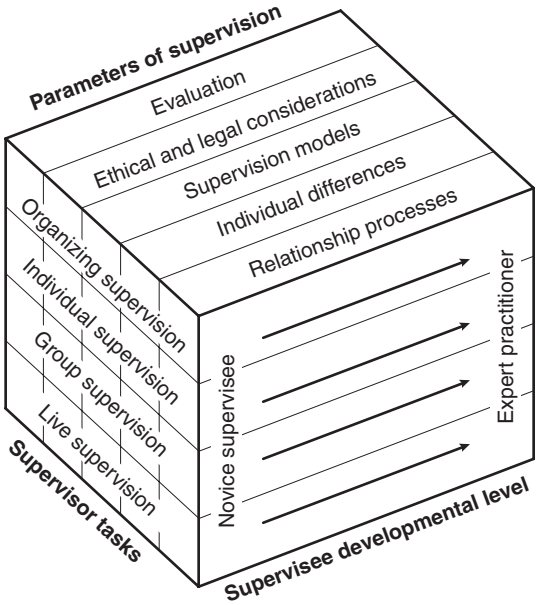

FIGURE 3 Conceptual Model of Supervision

Supervisor Tasks

Supervisor tasks are the actual behaviors of the supervisors. We discuss the four tasks depicted in Figure 3 (i.e., organizing supervision, individual supervision, group supervision, and live supervision). It is possible, of course, to think of more, but we believe these four are the most frequently used.

Using the Model

We assume that the three dimensions interact with one another. To illustrate, consider the supervisor using individual supervision: He or she does so within the context of a relationship, and that work is guided by the supervisor's particular theory or model, attention to supervisee's individual differences (e.g., ethnicity, gender), and ethical and legal factors; the fact of evaluation affects it as well. The developmental level of the supervisee, then, moderates each of these things.

We should note that we are not attempting in this model to capture *all* that occurs in supervision. This is especially true with respect to our discussion of supervisor tasks. We recognize, for example, that individual, group, and live supervision are not the only modalities. Kell and Burow (1970), for example, discuss the use of conjoint treatment as a supervision modality. However, although this is not a modality included in Figure 3, it is easy enough to see how conjoint treatment might fit into the conceptual model.

CONCLUSION

We hope we have been effective in establishing the basis for and importance of supervision by offering a formal definition of supervision and considering possible idiosyncratic definitions of supervision that occur at less manifest levels. We also hope our conceptual model will be useful in thinking about supervision and the ways its various aspects relate to one another.

We also addressed the historical context, importance, and prevalence of supervision. We then considered definitions, both formal and more personal. We concluded by presenting the conceptual model that both informs our understanding about supervision and guides the organization of this text.

We alluded early in the chapter to the two realms of knowledge (Schön, 1983) that are the basis of professional training: the theory and research that are the focus of university training and the knowledge derived from practitioners' experience. We asserted, too, that these actually are complementary knowledge domains (e.g., Holloway, 1995). Because of this conviction, material in this text is drawn from both realms of knowledge, with the belief that each informs the other. That is, in the course of our work, we draw both from theoretical and empirical literature as well as from literature that describes the insights and practices of supervisors themselves.

Supervision Models

The supervisor who is learning to venture out on his or her own has, in the core model, a safe and certain "parent" to return to and look back upon when a steadying presence is needed. Beginning supervisors will inevitably lose their footing on occasion and need to know that when this happens they can fall back on and be guided by a tried and trusted model. (Woskett & Page, 2001, p. 14)

There is a classic East Indian story of six blind men who, encountering an elephant for the first time, attempted to understand it. Each, having touched a different part of the elephant, made his own inferences about its nature—for example, the man who touched its side likened the elephant to a wall, the man who touched its tusk likened it to a spear, the man who touched its knee likened it to a tree, and so on (Saxe, 1865).

Both Woskett and Page's comments and the parable of the six blind men and the elephant are relevant to our discussion of supervision models. In fact, models fulfill the function of grounding the supervisor (the certain *parent*); at the same time (not unlike parents), the models give one perspective well to the exclusion of other important perspectives. We hope in this chapter to discuss both of these characteristics of models.

Models of supervision provide a conceptual framework(s) for supervisors. As such, they help make supervision cohesive and guide supervisors toward providing supervision that addresses their supervisees' needs. They can also attend to the organizational contexts as well as societal and professional contexts. Models have also been developed that attend to supervision of therapy with specific client populations. Because of the complexity of both psychotherapy and supervision, no one model could succeed in addressing all of these important areas lest it topple from its own weight. Therefore, as the specialty of supervision evolved, models that attend to different aspects of supervision emerged.

Garfield (2006) reports that there were more than 1,000 approaches to counseling and psychotherapy described in the mental health literatures. As noted in the early 1980s, the area of supervision tends to follow the lead of psychotherapy (Leddick & Bernard, 1980) in terms of theoretical development (e.g., postmodern approaches), professional development (e.g., ethical codes), and key issues (e.g., expertise in multicultural therapy and supervision). Although we are not yet approaching the millennial mark for supervision models, it is the case that new models continue to appear and older models continue to be refined. Our goal in this

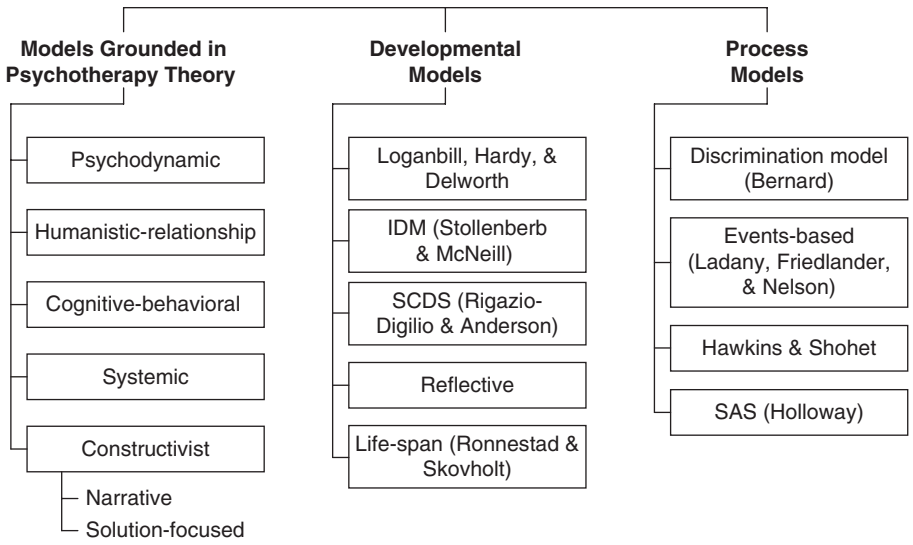

FIGURE 1 Major Categories of Clinical Supervision Models

chapter is to offer the reader an organizational map for models and to explain some of the key characteristics of each category of models. We also provide a more detailed description of particular models. Before we begin, we define some key terms and also express our belief about how supervisors are informed by various supervision models.

We prefer the word *model* to *theory* when describing supervision. Whereas all *theories* of counseling and psychotherapy attempt to cover fairly comprehensive worldviews of problem etiology, maintenance, and resolution, *models* of supervision can be simple or complex, and may not be intended as stand-alone entities. Therefore, the word *model* seems to be a better fit and is most commonly used in the supervision literature. We also choose to veer away from the word *integrate* when discussing the practice of combining models of supervision (which we believe is common), as *integrating* and *integrationist,* as well as *eclectic,* are generously used to describe psychotherapy and counseling approaches. Therefore, we use the term *integrate* only when referring to combining psychotherapies, not in reference to supervision.

Our organization, as depicted in Figure 1, recognizes three broad categories of supervision models: the first category of models is composed of those based on *psychotherapy theories;* the second category depicts *developmental models* as well as empirical contributions regarding the development of cognitive complexity in supervisees; and the final major category is that of *supervision process models,* those models that attempt to explain the activity of supervision itself from a variety of vantage points. Once we describe several leading models in each of these categories, we move on to what we call *second-generation models* because they are more recent and because they tend to draw from the work of those listed within the major categories. These second-generation models include combined models, target models, and common factors models. *Combined models* combine two established models either from the same category or across two categories. *Target models* are those that have been developed to focus on important issues such as multicultural expertise. They may or may not infuse an existing model from a primary category. Typically, these models are not meant to be used exclusively by supervisors but are to be included in their conceptual repertoire so that they can offer supervision that does justice to a specific issue. *Common factors models* are proposed by those who attempted to look at major supervision models to determine what characteristics they all have in common.

Having introduced our categories for positioning models and before we embark on further description of each, we suggest that, in practice, supervisors do not practice *within* categories but *across* categories, often interfacing aspects of models from all three categories. Our defense of this position is as follows: Just as all counseling and psychotherapy reflects theory, so too does supervision of that therapy. In other words, good supervision must include the oversight of whether the counseling or therapy being offered is theoretically grounded. Therefore, despite how a supervisor describes him- or herself, he or she is, at some level, supervising in a manner consistent with a psychotherapy-based supervision model. In addition, intentionally or not, supervisors often rely on their own theoretical orientation to understand their supervisees and to arrive at supervision interventions. In a similar manner, every supervisor makes an assessment of where her or his supervisee is situated developmentally. Training programs understand that students enrolled in a first practicum are different in their supervision needs that those in a final internship. It would be folly to ignore developmental level when conducting supervision. Therefore, even if one describes oneself as a cognitive–behavioral supervisor (or another primary identity), he or she is borrowing from the decades of work of those who have focused on developmental models. Finally, increasingly more supervisors, especially those trained in clinical supervision, also adopt a supervision process model that gives them insight into the choices they have as supervisors regarding the focus of a particular session, the interventions available to them, the context within which supervision operates, and so forth. In summary, as noted previously, at this point in the evolution of supervision knowledge and practice, we believe most trained supervisors interface models across categories to arrive at a supervision practice that attends to psychotherapy theory, development, and supervision process. This position is argued by others (e.g., Watkins, 2011) as well.

The rest of this chapter describes each of the three primary categories more fully, giving examples of these from the literature; we also give examples of the three second-generation categories we have identified.

Finally, before beginning our discussion of the models, we believe it important to note that whereas entire books are devoted to some of these models, our space is limited to such an extent that we are able to cover each of these at only a relatively general level. With this disclaimer, we begin our overview with those models that most directly tie supervision to therapy.

PSYCHOTHERAPY-BASED MODELS OF SUPERVISION

Clinical supervisors first were counselors or therapists. It is almost inevitable, then, that the lens they learned to use in understanding their work in that role would generalize to their work in the role of supervisor as well. By many estimates, there are several hundred such lenses (i.e., theories) through which to view therapy. Supervision has been described from a number of these perspectives, including Adlerian (e.g., Kopp & Robles, 1989), reality (e.g., Smadi & Landreth, 1988), Gestalt (Hoyt & Goulding, 1989; Resnick & Estrup, 2000), and Jungian (Kugler, 1995). In the interest of space, however, we cover six psychotherapy-based models of supervision: psychoanalytic, client-centered, cognitive–behavioral, systemic, constructivist, and integrative models.

Before discussing these models, it is important first to contextualize this discussion, beginning with the inevitable continuity in how supervisors conceptualize their work as therapists versus work as supervisors. As Shoben (1962) argues and others (e.g., Arthur, 2000; Topolinski & Hertel, 2007) since have corroborated empirically, therapists work from an implicit theory of human nature that also must influence how they construe reality, including interpersonal behavior, normal personality development (or family development), and abnormal or dysfunctional development. Friedlander and Ward (1984) refer to this as the *assumptive world* of the therapist, and propose that this affects the therapist's choice of theory.

It is reasonable to assume that this assumptive world is constant across situations. Therefore, it

would be manifest in professionals' work as both therapist *and* supervisor (see, e.g., data from Friedlander & Ward, 1984; Goodyear, Abadie, & Efros, 1984; Holloway, Freund, Gardner, Nelson, & Walker, 1989). Moreover, many of the techniques used in therapy are used in supervision as well.

In their survey of 84 psychology interns from 32 sites, Putney, Worthington, and McCulloughy (1992) document the extent to which theories of therapy affected supervisors' focus and behavior. They found that supervisees perceived cognitive–behavioral supervisors to use a consultant role and to focus on supervisees' skills and strategies more than humanistic, psychodynamic, and existential supervisors (see, also, Goodyear & Robyak, 1982). Supervisees perceived supervisors who adhered to these latter models, however, as more likely to use the relationship, to use something of the therapist role during supervision, and to focus on conceptualization of client problems. Thus, it appears that the theory of the supervisor does indeed affect supervision.

Maher's (2005) discovery-oriented (constructivist) model of supervision is one exception; this model focuses on helping supervisees discover their own implicit models of practice. This is a minority position—and one that would be absolute anathema to adherents of evidence-based practice whose focus usually is on helping the supervisee learn to deliver a particular treatment with fidelity. Interestingly, however, Maher was able to locate a statement from Rogers (1957) that is consistent with his position.

> *I believe that the goal of training in the therapeutic process is that the student should develop his own orientation to psychotherapy out of his own experience. In my estimation every effective therapist has built his own orientation within himself and out of his own experience with his clients or patients.* (p. 87)

The constructivists adhere to the position stated in this quote, but that position is unique among the psychotherapy-based models we cover in this chapter.

We begin our coverage of the psychotherapy-based models of supervision with psychodynamic supervision. We then cover, in turn, humanistic-relationship oriented, cognitive–behavioral, systemic, constructivist, and integrative approaches.

Psychodynamic Supervision

Psychoanalytic conceptions of supervision have a long history. Arguably, these conceptions have affected supervision theory and practice more than those of any other model. For example, the two psychodynamically derived concepts of working alliance and parallel processes are dominant supervision concepts that have informed the work of supervisors of all orientations.

Freud seems to deserve credit not only for developing the *talking cure,* but also for being the first psychotherapy supervisor. Freud supervised actual therapeutic practice and reports that supervision began in 1902 with "a number of young doctors gathered around me with the express intention of learning, practicing, and spreading the knowledge of psychoanalysis" (Freud, 1914/1986, p. 82).

Frawley-O'Dea and Sarnat (2001) note that

> *Freud was the first supervisor and thus represents the archetypal supervisor to whom we all maintain a transference of some kind. In his model of supervision, he combined a positivistic stance analogous to his model of treatment with a personal insistence on maintaining a position as the ultimate arbiter of truth, knowledge, and power.* (p. 17)

Supervision soon became an institutionalized aspect of the psychoanalytic enterprise and enjoyed a long and rich history of advancement. Caligor (1984) notes that as early as 1922, the International Psychoanalytic Society adopted formalized standards that stipulated formal coursework and the treatment of several patients under supervision.

During the 1930s, two competing views developed concerning the place of *control analysis,* the psychoanalytic term for supervision. One group (the Budapest School) maintained that it should be a continuation of the supervisee's personal analysis (with the same analyst in each case) with

a focus on transference in the candidate's therapy and countertransference in his or her supervision. The other group (the Viennese School) maintained that the transference and countertransference issues should be addressed in the candidate's personal analysis, whereas supervision itself should emphasize didactic teaching.

Ekstein and Wallerstein (1972) were the first to articulate a model of supervision that most psychodynamic (and many other) supervisors accepted. They portray supervision as a teaching and learning process that gives particular emphasis to the relationships between and among patient, therapist, and supervisor and the processes that interplay among them. Its purpose is not to provide therapy, but to teach, and the reason for working closely with the supervisee is to have him or her learn how to understand the dynamics of resolving relational conflicts between supervisor and supervisee (cf. Bordin, 1983; Mueller & Kell, 1972) for the benefit of future work with clients.

Because of the diversity within the psychoanalytic perspective and the richness of its conceptualizations, it has continued to provide ideas and concepts that have been infused throughout supervision. Psychoanalytic writers have been prolific contributors to the supervision literature. This continues as psychodynamic supervision evolves (Frawley-O'Dea & Sarnat, 2001; Gill, 2001; Jacobs, David, & Meyer, 1995; Rock, 1997; Sarnat, 2010, 2012) and attempts to grapple with a fundamental challenge—as stated by Tuckett (2005)—to identify a framework for supervisees that is broad enough and sensitive enough to "take cognizance of the twin facts that there is more than one way to practice psychoanalysis and that it is necessary for the legitimacy of the field to avoid an 'anything goes' stance" (p. 31). Building on Tuckett's work, Sarnat (2010) identified four categories of supervisee competence that supervisors must promote:

1. The ability to be in relationship with clients and, by inference, with supervisors, "because a psychodynamic psychotherapist views the relationship as the crucible of psychotherapeutic change, not just as a preliminary to effective interventions, relationship competency implies developing relationship skills that go beyond these capacities" (p. 23).
2. The ability to self-reflect, which includes "a highly developed capacity to bear, observe, think about, and make psychotherapeutic use of one's own emotional, bodily, and fantasy experiences when in interaction with a client" (p. 23).
3. Assessment and diagnosis from a psychodynamic framework
4. Interventions that are theoretically consistent and in keeping with the centrality of the therapeutic relationship

Knowing what supervisees must learn is only half the equation. Frawley-O'Dea and Sarnat (2001) articulate a supervision model that describes key supervisory dimensions that serve as the context for psychodynamic supervision.

To set the stage for their model, Frawley-O'Dea and Sarnat reviewed the development of psychodynamic supervision. They observe, for example, that the earliest supervision was *patient-centered,* focusing on the client's dynamics and employing a didactic role. Later psychodynamic supervisors, beginning with Ekstein and Wallerstein (1972), began to conduct *supervisee-centered* supervision, giving greater attention to the supervisee's dynamics.

Both types of supervision place the supervisor in the role of an *uninvolved expert* on theory and technique. In contrast, the relational model proposed by Sarnat (1992) and further developed by Frawley-O'Dea and Sarnat (2001) allows the supervisor to focus either on the therapeutic or on the supervisory dyad. The supervisor's authority stems less from the role as expert on theory and practice and more from the role "as an embedded participant in a mutually influencing supervisory process" (p. 41). In this manner, these authors are modeling a key competence (relationship) that they consider foundational for psychodynamic therapy.

Frawley-O'Dea and Sarnat propose three dimensions as the context for psychodynamic supervision:

Dimension 1: **The nature of the supervisor's authority in relationship to the supervisee.** Supervisors' authority can be understood as existing somewhere on a continuum between two poles. On one end is authority that derives from the knowledge that the supervisor brings to supervision. His or her stance is that of the objective and uninvolved expert who helps the supervisee know "what is 'true' about the patient's mind and what is 'correct' technique" (p. 26). On the other end of the continuum is authority that derives from the supervisor's involved participation. He or she certainly has more expertise than the supervisee, but makes no absolute knowledge claims. His or her authority resides in supervisor–supervisee relational processes. Frawley-O'Dea and Sarnat clearly endorse this end of the continuum. Sarnat (2010, 2012) reiterates the importance of being in relationship with the supervisee, including appropriate self-disclosure and open discussion of countertransference.

Dimension 2: **The supervisor's focus.** This concerns the relevant data on which supervision is based. Specifically, the supervisor can focus attention on (a) the client, (b) the supervisee, or (c) the relationship between supervisor and supervisee.

Dimension 3: **The supervisor's primary mode of participation.** This final dimension concerns roles and styles that supervisors might adopt. Among those that the authors describe are didactic teacher, Socratic "asker of questions," a container of supervisee affects, and so on. More recently, Sarnat (2012) argues for a relational approach to supervision over the didactic.

It should be noted that the influence of supervision process models is clearly evident in Frawley-O'Dea and Sarnat's model in that they have moved beyond a focus on transmitting the execution of a theory and are considering the dynamics and processes of supervision per se.

In summary, it is safe to assert that psychoanalytic or psychodynamic models have influenced supervision as have no other. They certainly have historical importance. However, they have also served as a rich source of observations and as a springboard for various conceptions of supervision.

Humanistic-Relationship Oriented Supervision

Models such as that of Frawley-O'Dea and Sarnat (2001) stand as evidence of the influence of humanistic- and relationship-oriented tenets across all schools of psychotherapy. Central to humanistic-relationship approaches is increasing experiential awareness and using the therapeutic relationship to promote change. Supervision, therefore, focuses on helping the supervisee to expand not only their knowledge of theory and technique, but also their capacity for self-exploration and their skill in the use of self as a change agent (Farber, 2010, 2012). *Use of self* includes their ability to be fully present, transparent, genuine, and accepting with their clients.

No other theorist is more identified within this theoretical school than Carl Rogers. Supervision was a central and long-standing concern of Rogers, as it was for those who later identified with his person-centered model. Rogers (1942) and also Covner (1942a, 1942b) were among the very first to report the use of electronically recorded interviews and transcripts in supervision. Until then, supervision had been based entirely on self-report of supervisees, as it still often is in psychoanalytically oriented supervision, despite appeals for change in that regard (Sarnat, 2012).

Rogers (1942) concluded from listening to these early recordings of therapy interviews that mere didactic training in what then was called *nondirective methods* was insufficient. Only when students had direct access to the content of their interviews could they identify their natural tendencies to provide advice or otherwise control their sessions. This is consistent with Patterson's (1964) contention two decades later that client-centered supervision was an influencing process that incorporated elements of teaching and therapy, although it was neither.

Rogers's own conception of *supervision* leaned more toward therapy and is in line with current understanding of humanistic–existential supervision. In an interview with Goodyear, he states:

> *I think my major goal is to help the therapist to grow in self-confidence and to grow in understanding of himself or herself, and to grow in understanding the therapeutic process. And to that end, I find it very fruitful to explore any difficulties the therapist may feel he or she is having working with the client. Supervision for me becomes a modified form of the therapeutic interview.* (Hackney & Goodyear, 1984, p. 283)

Later, when he was asked how he differentiated supervision from therapy, Rogers answers:

> *I think there is no clean way. I think it does exist on a continuum. Sometimes therapists starting in to discuss some of the problems they're having with a client will look deeply into themselves and it's straight therapy. Sometimes it is more concerned with problems of the relationship and that is clearly supervision. But in that sense, too, I will follow the lead, in this case, the lead of the therapist. The one difference is I might feel more free to express how I might have done it than I would if I were dealing with a client.* (p. 285)

It is clear from Rogers's words that his counseling theory informed his supervision in a relatively direct way. He believed the facilitative conditions (e.g., genuineness, empathy, warmth) were necessary for supervisees and clients alike. Rice (1980) describes person-centered supervision as relying on a theory of *process* in the context of *relationship*. The successful person-centered supervisor must have a profound trust that the supervisee has within himself or herself the ability and motivation to grow and explore both the therapy situation and the self. This is the same type of trust that the therapist must have (Rice, 1980). Patterson (1983, 1997), too, emphasizes the similarity between the conditions and processes of therapy and those that occur during supervision.

Patterson and Rice both outline the attitudes toward human nature and change and the attitude toward self that the supervisor must model for the supervisee. More recently, these have been echoed by Farber (2010, 2012). First and foremost is the supervisor's basic respect for the supervisee as an individual with unique learning needs. This is communicated by a supervisory stance that is collaborative, relational, and emphasizes the development of the person of the supervisee (Farber, 2012). According to Farber, such a supervisory context "offers the trainee an experiential reference point for cultivating skill in the use of self in psychotherapy to support and encourage change in the client" (p. 175).

With a few notable exceptions (Bryant-Jeffries, 2005; Farber, 2010, 2012; Lambers, 2007; Tudor & Worrall, 2004, 2007), humanistic-relationship oriented approaches to supervision are more often blended with other constructs to provide a combined model (e.g., Pearson, 2006) or infused into a supervision process model (e.g., Ladany, Friedlander, & Nelson, 2005) than advanced as a singular approach to supervision. Still, the impact of especially the Rogerian perspective on mental health training programs has been profound and enduring. All training programs that introduce students to basic interviewing skills are using procedures that have a direct lineage to Rogers. Rogers and his associates (e.g., Rogers, Gendlin, Kiesler, & Truax, 1967) developed rating scales to assess the level at which therapists demonstrated use of Rogers' (1957) relationship variables. To operationalize these relationship attitudes or conditions then enabled two of Rogers's research associates, Robert Carkhuff and Charles Truax, to propose procedures to teach these relationship attitudes as specific skills (e.g., Carkhuff & Truax, 1965). This skill-building approach and its variants are now in nearly universal use.

Cognitive–Behavioral Supervision

Behavioral therapy and the rational and the cognitive therapies had separate origins. Behavioral therapy focused on observable behaviors and a reliance on conditioning (classical and operant) models of learning; rational and cognitive therapies were concerned with modifying clients'

cognitions, especially those cognitions that were manifest as *self-talk* (e.g., Beck, Rush, Shaw, & Emery, 1979; Ellis, 1974; Mahoney, 1974, 1977; Meichenbaum, 1977). As the models have become more blended (see, e.g., most of the chapters in Barlow, 2001), the convention has become one of grouping them into the broader category of *cognitive–behavioral therapy* (CBT) models. Among the psychotherapy-based supervision models, CBT supervision has experienced the most continual development and expansion (Milne, 2008; Milne, Aylott, Fitzpatrick, & Ellis, 2008; Pretorius, 2006; Reiser & Milne, 2012; Rosenbaum & Ronen, 1998).

Cognitive–behavioral therapists operate on the assumption that both adaptive and maladaptive behaviors are learned and maintained through their consequences. It is probably no surprise that behavioral supervisors have been more specific and more systematic than supervisors of other orientations in their presentation of the goals and processes of supervision (Pretorius, 2006). Specifically, CBT supervisors are advised to set an agenda for each supervision session, set homework collaboratively with the supervisee, and assess what has been learned from session to session continuously (Beck, Sarnat, & Barenstein, 2008; Liese & Beck, 1997; Newman, 2010; Pretorius, 2006; Reiser & Milne, 2012; Rosenbaum & Ronen, 1998).

Common to most CBT supervision is a list of propositions first articulated by Boyd (1978):

1. *Proficient therapist performance is more a function of learned skills than a "personality fit." The purpose of supervision is to teach appropriate therapist behaviors and extinguish inappropriate behavior.*
2. *The therapist's professional role consists of identifiable tasks, each one requiring specific skills. Training and supervision should assist the trainee in developing these skills, applying and refining them.*
3. *Therapy skills are behaviorally definable and are responsive to learning theory, just as are other behaviors.*
4. *Supervision should employ the principles of learning theory within its procedures. (p. 89)*

The following structure for CBT supervision first suggested by Liese and Beck (1997) continues to serve as a template for CBT supervisors:

- *Check-in.* This serves as an ice-breaker and offers a personal link.
- *Agenda setting.* The supervisee is first asked what they would like to work on; the supervisor may add to the agenda.
- *Bridge from previous supervision session.* The supervisor asks what the supervisee learned from the last supervision session, and may ask how this was helpful.
- *Inquire about previously supervised therapy cases.* This brief step serves a case management function.
- *Review of homework.* This is considered a key aspect of CBT supervision. Supervisees and supervisors assign homework collaboratively for the supervisee between each session, and reviewing the outcome of this homework, which may include attempting new techniques, is essential.
- *Prioritization and discussion of agenda items.* The majority of CBT supervision revolves around this item. Supervisors are encouraged to listen to recordings of the supervisee's work prior to supervision, and engage in direct instruction, role-playing, and soliciting supervisees' questions and concerns at this time.
- *Assign new homework.* Based on what has transpired thus far, the supervisor attempts to identify what might be fruitful homework for the supervisee.
- *Supervisor's capsule summaries.* This serves as an opportunity for the supervisor to emphasize important points, summarize, and reflect on the session.
- *Elicit feedback from the supervisee.* Although supervisors seek feedback throughout the session, this is a final opportunity to make sure that the supervisee's questions have been answered and their opinions heard.

Despite the focus on overt behavior, didactic learning, and cognition, the supervisee's affect is

also addressed within CBT supervision. As with the therapy model, irrational or unhelpful thoughts (e.g., "I must be the best counselor in my supervision group") are addressed in supervision for the stress and negative emotions they produce and the effect they have on the supervisee's ability to accomplish learning goals (Liese & Beck, 1997). Newman (2010) underscores the importance of creating a safe environment for supervisees, thus reflecting the development of CBT supervision to, as noted by Safran and Muran (2000), include working alliance assumptions. This, it seems to us, is an example of supervision models influencing each other in ways that make each tradition richer. More recently, Reiser and Milne (2012) call for more integration of, for example, developmental models with CBT supervision.

The evolution of CBT (therapy, and by extension, supervision) does not nullify its emphasis on assessment and close monitoring. CBT dominates the list of empirically validated treatments (see, e.g., Chambless & Ollendick, 2001), all of which use treatment manuals. CBT manuals tend to be much more specific and detailed than those of other models (cf. Barlow, 2001) because the essential premise of these models is that specific interventions result in specific client outcomes. Treatment fidelity (i.e., whether the therapist is adhering to what the manual dictates) is a very important matter. For this reason, CBT authors suggest that supervisors listen to recordings of entire sessions of their supervisees' therapy (Liese & Beck, 1997; Newman, 2010). Therefore, in a wide range of contexts, CBT supervisors are more engaged in assessment and monitoring than supervisors overseeing other therapies. It also might be suggested that, because of this, the distinctions between training and supervision can become more blurred in this form of supervision than in others.

In summary, behavioral supervisors define the potential of the supervisee as the potential to learn. Supervisors take at least part of the responsibility for supervisee learning, because they are the experts who can guide the supervisee into the correct learning environment. Perhaps more than most supervisors, they are concerned about the extent to which supervisees demonstrate technical mastery and that their work has fidelity to the particular mode of treatment being taught.

Systemic Supervision

Systemic therapy is virtually synonymous with *family therapy.* As is the case with individual psychotherapy, family therapy is characterized by a number of different theoretical approaches, including the structural, strategic, Bowenian, and experiential schools. Early on, systems supervision was therapy-based, that is, supervision paralleled the particular tents of the therapy being used. Therefore, the structural family therapist supervisor would assist the supervisee to establish a clear boundary between parents and children and would also maintain a clear boundary between him- or herself and the supervisee (McDaniel, Weber, & McKeever, 1983). The more recent trend has been for integration in family therapy theory and therefore also in supervision and training (Beck, Sarnat, & Barenstein, 2008; Celano, Smith, & Kaslow, 2010; Fraenkel & Pinsof, 2001; Kaslow, Celano, & Stanton, 2005; Lee & Everett, 2004; Storm, Todd, & Sprenkle, 2001). Our discussion here follows this trend in our reference to *systemic supervision* rather than any reference to a particular therapy approach.

All systems therapies are characterized by attention to interlocking system dynamics. A particular contribution of systems therapy is the understanding that therapists and their supervisors are "active agents of the system in which they are intervening" (Beck et al., 2008, p. 80). As systems specialists, supervisors stay attuned to dynamics within the family system, between the family and the therapist (supervisee), and within the supervisor–supervisee dyad. If supervision involved a reflecting team doing live supervision, the system dynamics become more complex and the supervisor's responsibility is expanded.

Celano et al. (2010) describe the essential components of integrated couples and family therapy supervision as follows:

1. Developing a *systemic formulation* (i.e., conceptualizing the problem in terms of recursive family processes)
2. Helping the supervisee forge a *systemic therapeutic alliance* (i.e., a working alliance with each member of the family)
3. Introducing and reinforcing the process of *reframing* (to relabel or redefine problems so that they can be resolved more productively)
4. Assisting the supervisee in managing negative interactions that occur within therapy, building cohesion among family members, and assisting with family restructuring and parenting skills
5. Understanding and appying existing evidence-based family therapy models

One additional hallmark of systemic supervision is the focus on the supervisee's family-of-origin issues (Celano et al., 2010; Storm, McDowell, & Long, 2003). In fact, Montgomery, Hendricks, and Bradley (2001) elaborate on that point, noting that

> *[t]he activation of family-of-origin dynamics is a supervision issue because they affect the degree of objectivity and emotional reactivity that counselors have with their clients and hence their therapeutic capabilities. . . . Therefore, supervision should provide trainees with opportunities to attain higher levels of differentiation and emotional maturity.* (p. 310)

This focus seems a more specific instance of the broader issue of whether supervisees should themselves participate in therapy as a means of better understanding themselves (cf. Orlinsky, Botermans, & Rønnestad, 2001). It also raises the sometimes-tricky issue of where the boundary is or should be between supervision and therapy for the supervisee (Thomas, 2010).

Several other hallmarks of systemic supervision have been incorporated into the broader domain of clinical supervision. The constructivist approaches to supervision discussed in the section that follows often are embedded in a family-therapy supervision context.

Constructivist Approaches

A significant development in the human sciences has been the emergence of a worldview that has been characterized as *postmodern, postpositivist,* or *constructivist.* The terms are not completely synonymous, but have in common the position that reality and truth are contextual and exist as creations of the observer. For humans, *truth* is a construction grounded in their social interactions and informed by their verbal behavior (Philp, Guy, & Lowe, 2007).

Constructivism has been adopted as an approach to science, but also increasingly informs thinking about psychotherapy. George Kelly (e.g., 1955) generally is credited as having developed the most formal expression of constructivism in psychotherapy. However, more recently, a number of other models have been developed that are informed by a constructivist perspective.

> *What joins constructivists is their commitment to a common epistemology, or theory of knowledge. . . . [C]onstructivists believe that "reality" . . . lies beyond the reach of our most ambitious theories, whether personal or scientific, forever denying us as human beings the security of justifying our beliefs, faiths, and ideologies by simple recourse to "objective circumstances" outside ourselves.* (Neimeyer, 1995, p. 3)

In short, "knowledge is not only *shared* in interaction, it is *created* in interaction" (Whiting, 2007, p. 141; italics in original). Counselors and therapists must engage with clients to help them construct what is true and accurate for them, including their cultural reality. Both problem identification and therapeutic goals must remain faithful to these constructions.

Common among constructivist approaches to supervision is a heavy reliance on a consultative

role for the supervisor, an attempt to maintain relative equality between participants (i.e., a downplaying of hierarchy; Behan, 2003), and a focus on supervisee strengths. Whiting (2007) includes the following admonition:

> *For example, there is irony in a supervisor who expertly dispenses knowledge about how to be collaborative and non-directive. Also, the power difference of supervision makes it tempting for supervisors to become recruited into trying to sound smart, or dazzle underlings with elegant postmodern philosophical pronouncements about the family. More commonly, supervisors may inadvertently recruit the therapist to one "right way" of seeing.* (p. 142)

Narrative and solution-focused approaches fall under the larger constructivism umbrella. In the sections that follow, we briefly summarize each.

Narrative Approaches to Supervision. Therapists who work from a narrative model perspective assume that people inherently are "storytellers" who develop a story about themselves that serves as a template both to organize past experience and to influence future behavior (Bob, 1999; Parry & Doan, 1994; Polkinghorne, 1988). This story is populated with characters who are chosen for, or who are influenced to perform, certain roles in the story.

Parry and Doan (1994) developed what may be the most fully articulated version of the narrative approach. Clients come to therapy with a story about themselves that they have developed over a lifetime. The therapist's role is to help the person to tell his or her story, while being careful not to "be violent" with the client by insisting that she or he accept a particular point of view. The therapist serves as a story "editor." In this role, the therapist is careful to ask questions in the subjunctive ("As if") rather than the indicative ("This is the way it is") mode.

Although clients generally have a developed story of self that they are seeking to modify, supervisees are just beginning to develop their own stories of self-as-professional. The supervisor's role, then, is both to assist supervisees in the editing of clients' stories and also to help them to develop their own professional stories. Supervisors, therefore, must also substitute a stance of *knowing* (which is manifest as straightforward declarations of fact) with a stance of *curiosity* (which is expressed in a questioning or wondering way). For example, "At that moment with the client, you seemed to be feeling overwhelmed" (knowing) versus "I am wondering what you were feeling at that moment with the client" (curiosity). As Whiting (2007) notes, this posture of curiosity requires that the supervisor forfeit much of his or her expert status; this can be a challenge for some supervisors. It may also frustrate a novice supervisee, as we discuss when we cover developmental supervision models.

Solution-Focused Supervision. *Solution-focused therapy* (e.g., Molnar & de Shazer, 1987) focuses on enabling clients to get what they want, rather than on what is wrong with them. It is grounded in the assumptions that

1. Clients know what is best for them.
2. There is no single, correct way to view things.
3. It is important to focus on what is possible and changeable.
4. Curiosity is essential.

One of the best-known features of the model is what its adherents call the *miracle question,* which has this basic form: "Imagine that a miracle has occurred: the problems for which you are seeking treatment magically disappear. What, specifically, will you notice that will tell you that this has occurred? What else? (and so on)." This question has both a goal-setting intent and a focus on the positive.

An increasing number of authors have begun to discuss *solution-focused supervision (SFS)* (see, e.g., Gray & Smith, 2009; Hsu, 2009; Juhnke, 1996; Presbury, Echterling, & McKee, 1999; Rita, 1998; Thomas, 1996; Triantafillou, 1997; Wasket, 2006). Hsu's qualitative study of SFS identified seven components of SFS:

1. A positive opening followed by a problem description.
2. Identifying positive supervision goals.