# 1

# Perspectives on Supervision

*"There is divine beauty in learning. . . . To learn means to accept the postulate that life did not begin at my birth. Others have been here before me, and I walk in their footsteps."*

—Eli Wiesel

*"The mind is not a vessel to be filled, but a fire to be kindled."*

—Plutarch

*"The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires."*

—William Arthur Ward

## Historical Overview of Supervision

For as long as work has existed, there has been supervision, whether in the form of a father passing down his craft to his son, a more formalized apprenticeship program to become certified to perform a trade, or the highly structured training programs that many professional disciplines and businesses have today. In the apprenticeship model, the goal is for the novice to learn from a more experienced or expert clinician by observing, assisting, and receiving feedback. Milne (2009) ironically notes that the Zen Buddhist training of monks, in which trainees are routinely rejected as they try to gain access to training and are subjected to hardships and humiliation, is unfortunately not unlike the experience some graduate students in mental health professions face, given the highly competitive nature of many programs and the arduous journey toward licensure. However, although observing experienced clinicians can be a very useful component of training (and probably should be used more than is customary today), becoming proficient in delivering mental health services requires much more than simply observing the practice of more senior clinicians (Falender & Shafranske, 2004).



*Copyright Springer Publishing Company. All Rights Reserved.*
*From: Strength-Based Clinical Supervision*
*DOI: 10.1891/9780826107374.0001*

The importance of supervision in developing clinical proficiency seems to have been recognized from the dawn of psychotherapy. Freud routinely held Wednesday evening meetings in his house with other therapists, consisting of both theoretical and case discussions, in effect conducting group supervision (Hess, Hess, & Hess, 2008). This de facto supervision appears to be predated by social workers, who in the 19th century offered guidance to volunteers who provided assistance and comfort to the poor (Harkness & Poertner, 1989). Milne (2009) notes that the apprenticeship system of supervision in the helping professions has been relied upon heavily since ancient Greek times.

This chapter presents an overview of supervision and a brief introduction to several models of clinical supervision. The essential tasks and functions of supervision and the roles of the supervisor are also discussed.

## Definitions and Importance of Supervision

Even if you have had no formal training at all in supervising people (which is frequently the case among practicing supervisors), you probably still have a working understanding of supervision from your own experience of being supervised in various activities, likely ranging from part-time jobs held as a teenager to more formal and focused clinical supervision. A broad definition of supervision usually roughly equates with "overseeing" and assuming responsibility for both the development of the trainee and the quality of the work done. Bernard and Goodyear (2004) note that clinical supervision has similarities to and overlaps with teaching, counseling, and consultation but is also unique from each of these functions. They define supervision as "an intervention provided by a senior member of a profession to a more junior member or members. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person or persons, monitoring the quality of professional services offered to clients, and serving as a gatekeeper to those attempting to enter the profession" (p. 8).

Falender and Shafranske (2004) offer a slightly different definition of clinical supervision: a "distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involves observation, evaluation, feedback, and facilitation of supervisee self-assessment, and the acquisition of knowledge and skills by instruction, modeling, and mutual problem solving" (p. 3). Although their model emphasizes a competency-based orientation, they acknowledge the benefits of a strength-based approach, noting that "by building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy" (p. 3). It is generally acknowledged that effective supervisors tend to adopt a number of roles, such as observing, mentoring, coaching, and inspiring, and create an atmosphere that promotes self-motivation, learning, and professional development (Center for Substance Abuse Treatment, 2007, p. 7).

## Functions and Responsibilities of Supervision

Although supervisors have many responsibilities, supervision can be conceptualized as encompassing two broad functions: fostering the supervisee's professional development and ensuring client welfare (monitoring client care and serving as a gatekeeper for the profession). Regarding supervisee development, Bernard and Goodyear (2004) note that supervisors have the advantage of being able to view the clinical process with a clarity of perspective, because unlike the individual therapist, they are not involved in the clinical process. However, they caution that this "rarified air" can be seductive, and that insight naturally is much easier to come by as a "Monday morning quarterback" (p. 7).

Supervision has much in common with other professional roles but is also different in some important ways, and like most responsibilities in the provision of mental health services, it is important to be clear on the distinctions. The following are helpful guidelines regarding the similarities and differences between supervision and teaching, counseling, and consultation (Bernard & Goodyear, 2004, pp. 8–9):

**Supervision vs. Teaching**

*Similarities:*

Both impart new skills and knowledge and have an evaluative function.

*Differences:*

Teaching is driven by the need to meet the learning objectives of the curriculum for the entire class, whereas supervision is highly individualized and guided by the needs of the supervisee and the supervisee's clients.

**Supervision vs. Counseling or Therapy**

*Similarities:*

Both can address the recipient's problematic behaviors, thoughts, or feelings.

*Differences:*

Supervision is evaluative, counseling is not. Clients typically have more choice of therapists than supervisees have of their supervisors. Any therapeutic work done with a supervisee must only be to increase his or her effectiveness with clients, and only with careful attention to the potential for boundary concerns.

**Supervsion vs. Consultation**

*Similarities:*

Both are concerned with helping the recipient work more effectively as a professional. For more advanced trainees, the overlap between supervision and consultation becomes greater.

*Differences:*

Consultation is a relationship between equals (and, in fact, the recipient usually can fire the consultant), whereas the supervisory relationship is hierarchical, and as with teaching, supervision is evaluative, whereas consultation is not.

Although supervision has important commonalities with these other professional roles, problems can easily occur if supervision becomes too focused on teaching (overly didactic), too focused on therapeutic endeavors (potential ethical concerns), or too focused on consultation (as there is always an inherent power and responsibility differential).

The commonalities between therapy and supervision probably warrant a little additional discussion. There are certainly many areas of overlap. Both supervision and therapy should ideally involve increasing perspective, developing heightened awareness of the self, increasing the range of options and possibilities, and exploring specific behavioral alternatives. However, the therapeutic realm must be approached with great intentionality and clear respect for appropriate boundaries. Although good supervision will at times involve making the supervisee aware of aspects of the self that may hinder effective therapy and exploring ways to use more effective behavior, supervision and therapy must not be confused. (If you are asking your supervisee about his mother, you are on the wrong track.) Again, the power differential is crucial here; whereas clients can stop the therapy process at any time (at least voluntary clients), supervisees cannot.

Flexibility is central. Effective supervision depends upon the ability of the supervisor to accurately assess the various developmental and immediate needs of the supervisee, combined with the client needs and situational factors, and adjust accordingly.

## Approaches to Supervision

The next section will provide a brief overview of some of the more influential clinical supervision models. This is not meant to be an exhaustive list or a full explanation of each model, but rather merely to quickly acquaint the reader with some of the more noteworthy, different approaches to supervision.

### *Therapy-Based Models*

Morgan and Sprenkle (2007) noted that early clinical supervisors often had little or no formal training in supervision and tended to merely apply clinical theories to the supervision process. It is generally accepted that the assumptions therapists have of human nature will also impact how they construe all interpersonal behavior, including supervision. Moreover, although there are important

differences between therapy and supervision, many of the techniques used in therapy are used in supervision as well (Bernard and Goodyear, 2004, p. 76).

Psychotherapy-based supervision models can feel like a natural extension of the therapy model, often heavily sharing the same concepts, areas of focus, and terminology. Even today, it is still very common practice to apply theories of therapy to supervision. This has to be done thoughtfully and intentionally, however, given that the supervisory relationship is not equivalent to the client–therapist relationship, and the skills and areas of emphasis differ.

### *Psychodynamic Therapy*

Given the prevailing influence of Freudian concepts during the formative years of psychology as a profession, the psychodynamic model heavily influenced the early years of supervision. This approach required the supervisee to undergo psychoanalysis so that the therapist would not be reactive to the client and hinder the therapeutic process. (Although most training programs today do not formally require students to have personal experience with psychotherapy, we highly encourage it. As we frequently tell our students and supervisees, it feels very different in the client chair than in the therapist chair, and often what feels comfortable from the perspective of the therapist is not necessarily what feels comfortable or helpful from the client's perspective. Although it is possible to become a good therapist without having personal therapy experience, it is akin to expecting someone to become an exceptional basketball coach without ever having played the game—certainly possible, but likely the exception.)

Psychodynamic supervision focuses on client processes from the psychodynamic orientation, viewing the supervisee through the lens of Freudian psychological processes, such as transference and countertransference, defense mechanisms, conflict, and so on. Commenting on the parallels between psychodynamic therapy and supervision, Dewald (1997) noted that both processes need a solid alliance and the feeling of safety, as well as empathic understanding and attunement to the processes of transference and countertransference. Given the similarities, Dewald stated that "if one were a skilled analyst, one would be able to do skilled supervision" (p. 41). However, it is likely that just as good therapists do not necessarily make good clinical faculty members, their ability to make good supervisors is also probably subject to individual differences.

Psychodynamic supervision is broadly classified into three categories depending upon the area of focus: patient-centered, supervisee-centered, and supervisory-matrix-centered (Frawley-O'Dea & Sarnat, 2001):

- Patient-centered psychodynamic supervision focuses on the patient's presentations and concerns. Reflecting the expert role of the therapist in psychodynamic therapy, psychodynamic supervision is primarily didactic, focusing on helping the supervisee understand the patient's dynamics and content.

- Supervisee-centered psychodynamic supervision focuses on the content and process of the supervisee's experience, examining the supervisee's resistances and anxieties (Falender and Shafranske, 2004). Because the focus of supervision is more on the supervisee and gaining understanding of his or her psychological processes, the process is more experiential than patient-centered supervision.
- The supervisory-matrix-centered approach incorporates examining the supervisor–supervisee relationship. This shifts the role of the supervisor away from that of a detached expert (in the patient-centered approach), and moves the focus to examining the supervision process and relationship and its parallel process, meaning the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist (Haynes, Corey, & Moulton, 2003).

### *Person-Centered Supervision*

Person-centered supervision is based on the application of Carl Rogers's (1957) facilitative conditions of psychotherapy to the practice of supervision. Rogers regarded his counseling theory as influencing his supervisory approach and believed that the facilitative conditions of genuineness, warmth, and empathy are essential for effective supervision, just as they are central to psychotherapy. Regardless of theoretical orientation, the underpinnings of most counseling skills training programs in most countries today (e.g., microskills training) rests upon Rogerian foundations and acknowledges the importance of creating an atmosphere of safety, understanding, and authenticity.

Person-centered supervision assumes that the supervisee has the innate ability and resources to develop as a therapist, and the task of the supervisor is to create a collaborative partnership with the supervisee to provide the conditions in which the supervisee can be present to the client's experience and be fully engaged with the client (Lambers, 2000). The "attitudes and personal characteristics of the therapist and the quality of the client–therapist relationship" are regarded as the prime determinants of the therapeutic outcome in psychotherapy (Haynes, Corey, and Moulton, 2003, p. 118), and in supervision, the working alliance is regarded as the primary vehicle to facilitate the trainee's learning and growth.

Rogers's conceptualization of supervision leans more toward the therapy end of the continuum than many other supervision approaches. In an interview with Goodyear, Rogers stated "I think my major goal is to help the therapist grow in self-confidence 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 is a modified form of the therapeutic interview" (Hackney and Goodyear, 1984, p. 283).

### *Cognitive Behavioral Supervision*

As with psychodynamic and person-centered supervision, cognitive behavioral supervision infuses the supervision process with many of the techniques and theoretical concepts of the underlying theoretical orientation. Padesky (1996) asserted that the same processes and methods that characterize the cognitive behavioral therapy (CBT) process can be used to teach and supervise therapists (p. 289), and noted that both therapy and supervision incorporate many similar activities, such as goal setting, checking-in, and eliciting feedback.

CBT-oriented supervisors typically negotiate an agenda with the supervisee at the beginning of each session and continuously assess and monitor the supervisee's progress. Behavioral practice may be stressed during both counseling and supervision sessions, including through such means as behavioral rehearsals and role playing. CBT-focused supervisors rely heavily on Socratic questioning and challenging the supervisees' misconceptions. Other areas of focus include establishing a strong working relationship, skill analysis, and assessment; setting supervision goals and strategizing and implementing methods to achieve the goals; follow-up evaluation and generalization of learning; and, at times, assigning homework to the supervisee (e.g., Liese & Beck, 1997; Rosenbaum and Ronen, 1998). Cognitive behavioral supervision also emphasizes the use of the trainee's observable cognitions and behaviors, especially regarding reactions to the client (Hayes et al., 2003).

### *Systemic Supervision*

Systemic supervision, based upon the theoretical perspective of systemic family systems therapy (e.g., Haley, 1987; Watzlawick, Weakland, and Fisch, 1974), is characterized by focusing importance and attention on the similarities between family systems and supervisory systems. Consequently, issues such as structure and boundaries take on special importance in supervision.

Within the systemic model, which is widely used by marriage and family therapists and supervisors, among others, it is believed that there should be a close correspondence and theoretical consistency between therapy and supervision (e.g., McDaniel, Weber, & McKeever, 1983). This close correspondence between therapy and supervision is referred to as *isomorphic translation* (Rigazio-DiGilio Daniels, & Ivey, 1997, p. 224) or *parallel processes*. One implication, grounded in structural family therapy, is that supervision should maintain clear boundaries between the supervisor and supervisee, similar to the clear boundaries a marriage and family therapist would want to maintain with families in therapy.

The systemic supervision process, as with systemic therapy, is also premised upon collaboratively establishing clear, meaningful, and effective goals (e.g., Haley, 1987; Watzlawick, Weakland, & Fish, 1974). This "coconstructive process" is based upon the emerging and evolving relationship between supervisor and supervisee

(Milne, 2009, p. 30). Haley (1987) and Liddle, Breunlin, and Schwartz (1988) stress the importance of a successful first session to serve as the foundation for both successful therapy and clinical supervision.

A key principle is that as the structure of the supervision process is constructed and solidifies, this emerging structure becomes the vehicle through which the supervisee will learn and develop. Mirroring typical family therapy, the supervisor takes on an active, directive, and collaborative role (Liddle et al., 1997, p. 413). Papadopoulos (2001) notes, similar to Yalom and Leszcz's (2005) seminal distinction between a process and content orientation, that systemic supervision distinguishes between *information* and *data*. One of the primary tasks of supervision is to help the supervisee realize that not everything heard in session is helpful to the therapeutic process and to learn to "discriminate between information and data and to increase their effectiveness in eliciting appropriate information" (pp. 406–407).

## *Developmental Supervision*

Developmental models of supervision are based on the assumption that clinicians in training pass through predictable stages of development as they gain increased knowledge and skill. The task of the supervisor is to identify the stage of the supervisee and to tailor the focus and approach of supervision in accordance, with the general assumption that a beginning therapist needs more structure and guidance, whereas a more advanced clinician benefits from a more collaborative and conceptual focus. The stages of growth and learning are qualitatively different from each other, and each stage of development requires different approaches and emphases in supervision. Developmental supervision models became particularly prominent in the 1980s, prompted especially by the work of Cal Stoltenberg (1981) and Ursula Delworth (Stoltenberg & Delworth, 1987).

Influential developmental psychologist Lev Vygotsky (e.g., Vygotsky, 1978) regarded it as important for supervisors to provide tools and models designed through carefully "scaffolding" their supervisees' training experiences to meet their developmental needs. He coined the term "zone of proximal development" (ZPD) to describe the difference between what learners can do on their own and what they can do with assistance. Development occurs though the use of scaffolding offered by someone with more knowledge and experience who provides increasingly challenging experiences as the learner acquires greater mastery. The supervisor helps to elicit and clarify what the supervisee already knows, building upon these strengths and drawing out the supervisee's understanding. Milne (2009) likens the scaffolding process to the metaphor of taking a journey with a guide. The supervisee must exert effort and take some chances, thereby contributing to what is undertaken and achieved, but the process works best with a supervisor who behaves like an experienced guide who can draw on the experience of already having traveled the path (p. 131).

Developmental models such as Stoltenberg and Delworth's (1987) focus on tailoring the supervision process to meet the supervisees' current level of development, based on the premise that supervisees go through predictable stages of development. As the supervisee develops competence or mastery, the supervisor gradually moves the scaffolding to encourage the supervisee to apply the learning to the next and more difficult stage.

Developmental models of supervision typically define progressive stages of supervisee development (e.g., from novice to expert), and describe specific characteristics, tasks, and skills expected for each stage. Developmental supervision depends upon the supervisor accurately identifying the supervisee's current stage of development and adapting the supervision focus and approach to appropriately meet both the competencies and the interpersonal needs of the supervisee. The supervisee is ideally both supported (which provides a sense of security) and challenged to stimulate growth and learning.

Heppner and Roehlke (1984) studied supervisees over a 2-year period to examine the implications of supervisee development on the supervision process. Beginning-level practicum students reported valuing support combined with skills training, essentially wanting to know the "right way" to conduct therapy. As supervisees gained more experience, they gained more of an appreciation for conceptualizations and a deeper understanding of the therapy process. Beginning practicum students identified issues of support and self-awareness as "critical incidents," whereas the most advanced trainees (doctoral interns) tended to report more critical issues around personal issues and defensiveness affecting therapy.

Although developmental models are intuitively appealing to both supervisors and supervisees, in actual practice, supervisors appear to provide the same sort of supervision to all supervisees regardless of their level of experience (Sumerall et al., 1998). Fortunately, supervisees seem not to mind. In a study of 100 supervisees, Ladany, Marotta, and Muse-Burke (2001) found no differences in supervisee preferences based on level of clinical experience and asserted that the concept of developmentally different levels of supervision may be "based more on clinical lore than on research" (p. 215).

## Developmental Supervision Models

The next section will detail two of the more influential and complete developmental supervision models. Although most models present their unique stages, Hess (1987) defined a four-stage sequence that seems to provide a helpful understanding of the common developmental sequence:

*1.* Inception Stage—supervisees tend to feel insecure and value basic skill building, role definitions, and boundary setting. The demystification of therapy is important at this stage.

2. Skill Development Stage—supervisees become more adept at identifying clients' particular needs and selecting appropriate strategies. Supervisees begin to identify with a system of therapy and a philosophy of human nature. This stage involves a shift to the apprenticeship model, with supervisees developing greater autonomy.
3. Consolidation Stage—supervisees (and others) begin to recognize individual skills and talents. The previously acquired building blocks are integrated. The role of the therapist's personality emerges, and skill refinement and competence more fully emerge.
4. Mutuality Stage—the supervisee role in supervision becomes more of an autonomous professional seeking consultation, similar to peer consultation. The supervisee becomes more comfortable and proficient problem solving and creating solutions. (pp. 251–252)

One of the most influential and researched developmental models of supervision is the integrated developmental model (IDM). First developed by Stoltenberg (1981), it has been updated by Stoltenberg and Delworth (1987) and then by Stoltenberg and McNeill (1997). The IDM categorizes three levels of counselor development:

- Level 1—beginning supervisees with little or no experience; generally eager and motivated but anxious and fearful of evaluation
- Level 2—mid-level regarding experience; fluctuating confidence and motivation
- Level 3—more advanced experience; feeling more secure in their abilities; are able to use self in the therapy process

Across each stage of development, three main factors or structures are progressing and growing:

- Self–other awareness (both cognitive and affective)
- Motivation
- Autonomy

As with other developmental theories, the basic premise is to match learning characteristics with the optimal learning environment. In other words, supervision should be designed to optimize the supervisee's learning at each stage of development. The Stoltenberg IDM model emphasizes the importance of professional development in various domains, such as intervention skills, assessment techniques, interpersonal assessments, client conceptualization, theoretical understanding, professional ethics, diversity awareness, and treatment planning and goal setting.

The emphasis is on the supervisor using skills and approaches that correspond with the supervisee's level of development. For example, beginning-level

supervisees need more support and guidance, whereas experienced supervisees would more likely benefit from supervision that is more collegial and challenging. Mismatches can be problematic; for example, a supervisor who expects autonomy from a beginning-level supervisee will very likely intensify the supervisee's anxiety, and a supervisor who is too prescriptive with an experienced trainee will likely hinder the development of autonomy, as well as likely create a frustrating supervision environment.

Unlike other models that are linear, the Loganbill, Hardy, and Delworth (1982) model assumes that therapists will re-cycle through the stages, increasing their level of integration each time. The three repeating stages of development they identify are:

- Stagnation—"stuckness" or blind spots for experienced clinicians; unawareness of difficulties for beginning supervisees. This stage is characterized by simple black-and-white thinking and lack of insight.
- Confusion—this stage is characterized by instability, disorganization, confusion, and conflict. During this stage, the supervisee realizes that the answers will not come from the supervisor, which can be disconcerting.
- Integration—this stage is characterized by calmness, new understanding, and flexibility, and the supervisee takes more responsibility for the supervision process and meaningful use of the supervision time.

Rønnenstad and Skovholt (2003) developed a model of supervision based on interviews with 100 therapists ranging in experience from novice to senior clinicians with decades of experience. Their model is unique in that it focuses on therapist development throughout the life span of one's career. They proposed the following six stages of development:

- Phase 1: The Lay-Helper Phase—although individuals in this stage have had some experience helping others (e.g., friends and family), they are prone to boundary problems and becoming overly involved.
- Phase 2: The Beginning-Student Phase—supervisees feel anxious and dependent and value their supervisors' support and encouragement. They typically are looking for models and role models to emulate.
- Phase 3: The Advanced-Student Phase—supervisees at the advanced-practicum or internship stage feel pressure to operate at a level of professional competence. Supervision helps supervisees feel confirmed in their skill-attainment level and helps to consolidate learning.
- Phase 4: The Novice-Professional Phase—new therapists typically begin integrating their personalities more into treatment and feel more comfortable in their professional roles.

- Phase 5: The Experienced-Professional Phase—the challenge is to find a style that feels authentic and congruent with their values and identity.
- Phase 6: The Senior-Professional Phase—they have more than 20 years of experience. Therapists at this stage of practice often become more modest about their impact on clients. Loss can become a theme at this stage (looking ahead to their own retirements, loss of their professional elders, etc.).

The first three stages roughly correspond with the levels of the IDM; however, the later three stages expand development into the professional realm postgraduation.

Based on the results of their cross-sectional and longitudinal quality study, Rønnestand and Skovholt (2003) formulated the main findings into 14 themes of counselor development, as follows:

1. Professional development involves an increasing higher-order integration of the professional self and the personal self.
2. The focus of functioning shifts dramatically over time from internal to external and back to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.
4. An intense commitment to learn propels the developmental process.
5. The cognitive map changes: Beginning practitioners rely on external expertise; seasoned practitioners rely on internal expertise.
6. Professional development is a long, slow, continuous process that can also be erratic.
7. Professional development is a lifelong process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, most master this anxiety.
9. Clients serve as a major source of influence and serve as primary teachers.
10. Personal life influences professional functioning and development throughout the professional life span.
11. Interpersonal sources of influence propel professional development more than impersonal sources of influence.
12. New members of the field view professional elders and graduate training with strong affective reactions.
13. Extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability.

*14.* For the practitioner, there is a realignment from self as hero to client as hero. (pp. 27–38)

Throughout the stages of development, Rønnestad and Skovholt emphasize the importance of continuous reflection on the part of the supervisee for growth to occur.

## Other Models of Supervision

Several other approaches have had an influence on the field of supervision as well. Social role models provide a framework for organizing the different functions and roles of supervision. Bernard's (1979) discrimination model is a 3 × 3 conceptualization that matches functions of supervision (helping supervisees learn the skills of process, conceptualization, and personalization) with the supervisor role (teacher, counselor, and consultant). Each cell suggests different ways a supervisor might help supervisees master specific skills. For example, the supervisor might take on the role of consultant with an experienced supervisee to consider different ways to conceptualize a challenging client.

Holloway (1995) proposed a more complex and comprehensive model of supervision, creating a 5 × 5 grid of supervision, again combining supervision functions with tasks or areas of focus of supervision. Her five functions are: (a) monitor and evaluate, (b) instruct and advise, (c) model, (d) consult, and (e) support and share. The five tasks or areas of focus of supervision are: (a) counseling skills, (b) case conceptualization, (c) professional role, (d) emotional awareness, and (e) self-evaluation. She terms her functions and tasks grid the "process matrix." In addition, she encourages supervisions to also consider the impact of the following contextual factors: (a) the supervisor, (b) the supervisee, (c) the client, and (d) the setting where the supervision takes place. Holloway also emphasizes the centrality of the working relationship in the supervision process, framing it as the core around which the functions and tasks of supervision and contextual factors all connect.

Outcome-oriented supervision, advocated by Worthen and Lambert (2007), aims to pragmatically focus on feedback data, relying upon tracking clinical outcomes, namely the progress or lack of progress experienced by clients, to guide the supervision process. Consistently collected data, such as the use of short feedback measures each session, serve to provide feedback to both the supervisee and supervisor, highlighting both successes and failures. Competency-based models such as Falender and Shafranske's competency-based approach (2004), the discrimination model (Bernard, 1997), and the task-oriented model (Mead, 1990), also focus on measurable outcomes, with strategies to operationalize, assess, and reach these goals.

### *Common Factors Approach*

Despite the many different supervision models that exist, there is no evidence to suggest that any one model of supervision is in any way superior to any other (Morgan and Sprenkle, 2007). Goodyear and Bradley (1983) examined the similarities and differences between the five most dominant clinical supervision theories at the time (rational emotive, behavioral, client-centered, developmental, and psychoanalytic), and stated they were "struck with the extent to which supervision techniques must be similar across supervisors, regardless of theory" (Goodyear & Bradley, 1983, p. 63). Noting the absence of superiority of any one model, Sprenkle (1999) argued for the need to examine the aspects of supervision that transcend the various different approaches. With increased experience, clinical supervisors seem to focus less on the differences between theoretical approaches and to gravitate toward the common factors in their practice. Less experienced supervisors tend to differ in ways based on their theoretical orientation, whereas more experienced supervisors share much more of their emphases in common (Goodyear and Robyak, 1982).

Morgan and Sprenkle (2007) note that whereas the common-factors approach in psychotherapy emerged from empirical studies on clinical outcomes, there is not yet a comparable body of research in supervision from which the common factors of supervision can be drawn. However, they suggest that this does not negate the potential benefits of identifying important elements shared by supervision models (p. 6). And, as there is a lack of empirical support for adopting one theoretical model to the exclusion of others (Storm, Todd, Sprenkle, and Morgan, 2001), it seems only reasonable to focus on the common factors. "We believe that it is unlikely that any one model, common factors or otherwise, will ever emerge as the best way to supervise everyone under every situation. Human beings and the process of supervision are too complex to brook such hubris. But there are likely a set of elements that most good supervision will have in common" (Morgan & Sprenkle, 2007, p. 7).

The results of the review by Morgan and Sprenkle (2007) identified a number of general supervision domains:

- Develop clinical skills
- Acquire knowledge about client dynamics, clinical theories, intervention strategies, and other issues
- Learn to function as professionals and comply with professional practice and ethical standards
- Personal growth, awareness, and emotional management
- Supervisee autonomy and confidence
- Monitoring and evaluating the supervisee

The literature also finds commonalities regarding a variety of areas to which supervisors must attend during supervision. These include the following responsibilities:

- Needs of the individual supervisee
- Needs of the specific client
- Profession or field as a whole—maintaining standards and protecting the public

A third element widely regarded as important to supervision is the quality of the supervisory relationship, which was almost universally described as a critical element. This seems to apply whether the relationship is collaborative or more hierarchical and directive. However, the research from a variety of studies seems to suggest that supervisees prefer to have a high degree of support from their supervisors, regardless of how directive or collaborative the relationship is (p. 10).

The review of literature on common factors suggests four frequently identified supervision roles, as follows:

- Coach—involves an emphasis on clinical competence at the idiosyncratic level, with the supervisor assisting the supervisee's direct work with the supervisee's clients, helping the supervisee apply and refine clinical skills. This includes activities such as helping supervisees attend to the therapeutic relationship, applying assessment skills, developing case conceptualizations, and offering feedback on the supervisee's clinical work.
- Teacher—emphasizes clinical competence as well, but at a more general level. The supervisor encourages the acquisition of broadly applicable knowledge and information about clinical work, such as general skills and theories.
- Mentor—focuses on the personal development of the supervisee as a growing professional, including helping the supervisee identify and address his or her own contribution to the therapeutic alliance, recognizing personal strengths and limitations, and helping the supervisee to develop a role as a practicing member of the professional community.
- Administrator—focuses on the broad professional, ethical, legal, and other standards that guide clinical practice. The supervisor ensures that the supervisee meets minimum standards, thus protecting clients. This role involves evaluation and feedback. (Morgan & Sprenkle, 2007, pp. 11–12).

Good supervision involves flexibility and the ability to work from within multiple supervisory roles (Morgan & Sprenkle, 2007, p. 12). It should also be noted that although many theoretical models exist, as with the application of psychotherapy, practice is often very eclectic. Probably resulting from the fact that formal training in supervision is often the exception and not the rule, surveys indicate that the most popular supervision model actually used is simply to draw upon one's own supervision experiences (Falender and Shafranske, 2004).

Although drawing from one's own experience can be a valuable and important component of the practice of supervision, it is doubtful that anyone would argue that is the method of choice for any professional activity, ranging from flying a plane to performing medicine to offering supervision. Given the importance and influence of supervision, hopefully formal training in supervision will soon become the norm and the expectation.

## Conclusion

We believe that all respected supervision models and approaches have valuable contributions to offer, and that likely no single model, even ours, will meet the needs of all supervisors and all supervisees in every situation. The story of the three blind men asked to describe an elephant seems appropriate. The first blind man walked up to the head, and feeling the head, ears, and trunk described these features to the other two men. The second blind man walked up to the midsection, and feeling this region of the elephant, dutifully reported this to the others. The last blind man (sometimes it pays not to be last) walked up and felt the backside of the elephant and reported his findings. Needless to say, each description of the elephant, based on reporting the empirical findings and grounded in truth, was radically different, depending upon the point of reference of the teller. Hopefully, our model of strength-based supervision, grounded in the constructs and research findings of positive psychology, will add useful information and perspective to the understanding of the supervision process. However, it is also offered with a spirit of deep gratitude to the volumes of research and clinically based knowledge that already exists.

## Questions to Consider

- Reflect on some of your best experiences being supervised. Describe your supervisor.
- What did your supervisor do to make the supervision experience work so well?
- Reflect on some of the times that you were at your best as a supervisee. What helped to make this happen? What specifically were *you* doing to make it such a good experience?
- If you imagine yourself supervising exactly as you would want to, what is happening? How are you interacting with your supervisee? What are you emphasizing?
- What values do you want to make sure that you exemplify and pass on to your supervisees?

- How do you anticipate that your theoretical orientation as a clinician will influence your approach as a supervisor?
- What do you regard as the similarities between supervision and therapy? What are the key differences?

---

## Recommended Readings

### *Books*

Bernard, J. M., & Goodyear, R. K. (2013). *Fundamentals of clinical supervision* (5th ed.). Boston, MA: Allyn and Bacon.

Everett, C. A., & Lee, R. E. (2005). *The integrative family therapy supervisor: A primer*. New York: Routledge.

Falender, C.A., & Shafranske, E.P. (2004). *Clinical supervision: A competency-based approach.* Washington, DC: American Psychological Association.

Holloway, E. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage Publications.

Lee, R. E., & Nelson, T. S. (2013). *The contemporary relational supervisor*. New York: Routledge.

Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice.* New York: Wiley-Blackwell.

Stoltenberg, C. D., & Delworth, U. (1998). *Supervising counselors and therapists: A developmental approach.* San Francisco, CA: Jossey-Bass.

### *Articles and Book Chapters*

Harkness, D., & Poertner, J. (1989). Research on social work supervision: A conceptual review. *Social Work, 34,* 115–199.

Morgan, M. M., & Sprenkle, D. H. (2007). Toward a common-factors approach to supervision. *Journal of Marital and Family Therapy*, *33*(1), 1–17.

Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development*, *30*, 5–44.

Stoltenberg, C. D., & McNeill, B. W. (1997). Clinical supervision from a developmental perspective: Research and practice. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 184–202). New York: John Wiley & Sons.

## References

Bernard, J. M. (1979). Supervisor training: A discrimination model. *Counselor education and supervision*, *19*(1), 60–68.

Bernard, J. M. (1997). The Discrimination Model. In C. E. Watkins, *Handbook of psychotherapy supervision* (pp. 310–327). New York: Wiley.

Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). Boston, MA: Allyn and Bacon.

Bernard, J. M., & Goodyear, R. K. (2013). *Fundamentals of clinical supervision* (5th ed.). Boston, MA: Allyn and Bacon.

Center for Substance Abuse Treatment. (2007). *Competencies for substance abuse treatment clinical supervisors.* Technical Assistance Publication (TAP) Series 21-A (Rep. No HHS Publication No. (SMA) 07-4243). Rockville, MD: Substance Abuse and Mental Health Services Adminstration.

Dewald, P. A. (1997). The process of supervision in psychoanalysis. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 31–43). New York: John Wiley & Sons.

Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach.* Washington, DC: American Psychological Association.

Frawley-O'Dea, M. G., & Sarnat, J. E. (2001). *The supervisory relationship: A contemporary psychodynamic approach*. New York: Guilford Press.

Goodyear, R. K., & Bradley, F. O. (1983). Supervision in counseling: II. Integration and evaluation: Theories of counselor supervision: Points of convergence and divergence. *The Counseling Psychologist, 11,* 1983, 59–67.

Goodyear, R. K., & Robyak, J. E. (1982). Supervisors' theory and experience in supervisory focus. *Psychological Reports*, *51*(3), 978.

Hackney, H. L., & Goodyear, R. K. (1984). Carl Rogers' client-centered supervision. In R. F. Levant & J. M. Schlien (Eds.), *Client-centered therapy and the person-centered approach* (pp. 278–296). New York: Praeger.

Haley, J. (1987). *Problem-solving therapy*. San Francisco, CA: Jossey-Bass.

Harkness, D., & Poertner, J. (1989). Research on social work supervision: A conceptual review. *Social Work, 34,* 115–199.

Haynes, R., Corey, G., & Moulton, P. (2003). *Clinical supervision in the helping professions: A practical guide.* Pacific Grove, CA: Brooks/Cole.

Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. *Journal of Counseling Psychology*, *31*, 76.

Hess, A. K. (1987). Psychotherapy supervision: Stages, Buber, and a theory of relationship. *Professional Psychology: Research and Practice, 18,* 251–259.

Hess, A. K., Hess, K. D., & Hess, T. H. (2008). *Psychotherapy supervision: Theory, research, and practice*. New York: John Wiley & Sons.

Holloway, E. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage Publications.

Ladany, N., Marotta, S., & Muse-Burke, J. L. (2001). Counselor experience related to complexity of case conceptualization and supervision preference. *Counselor Education and Supervision*, *40*(3), 203–219.

Lambers, E. (2000). Supervision in person-centered therapy: Facilitating congruence: In E. Mearns & B. Thorne (Eds.), *Person-centered therapy today: New frontiers in theory and practice* (pp. 196–211). London: Sage Publications.

Liddle, H. A., Becker, D., & Diamond, G. M. (1997). Family therapy supervision. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 400–418). New York, NY: John Wiley & Sons.

Liddle, H. A., Beunlin, D. C., & Schwartz, R. C. (Eds.). (1988). *Handbook of family therapy training and supervision*. New York: Guilford Press.

Liese, B. S., & Beck, J. S. (1997). Cognitive therapy supervision. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 114–133). New York: John Wiley & Sons.

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *Counseling Psychologist, 10,* 3–42.

McDaniel, S., Weber, T., & McKeever, J. (1983). Multiple theoretical approaches to supervision: Choices in family therapy training. *Family Process, 22,* 491–500.

Mead, D. E. (1990). *Effective supervision: A task-oriented model for the mental health professions*. New York: Brunner/Mazel.

Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice.* Chichester, UK: Wiley-Blackwell.

Morgan, M. M., & Sprenkle, D. H. (2007). Toward a common-factors approach to supervision. *Journal of Marital and Family Therapy*, *33*(1), 1–17.

Padesky, C. A. (1996). Developing cognitive therapist competency: Teaching and supervision models. In P.M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 266–292). London, UK: Guilford Press.

Papadopoulos, R. K. (2001). Refugee families: Issues of systemic supervision. *Journal of Family Therapy, 23*, 405–422.

Rigazio-DiGilio, S. A., Daniels, T. G., & Ivey, A. E. (1997). Systemic cognitive-developmental supervision: A developmental-integrative approach to psychotherapy supervision. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 223–245). New York: John Wiley & Sons.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95.

Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development*, *30*, 5–44.

Rosenbaum, M., & Ronen, T. (1998). Clinical supervision from the standpoint of cognitive-behavior therapy. *Psychotherapy: Theory, Research, Practice, Training*, *35*, 220.

Sprenkle, D. H. (1999). Toward a general model of family therapy supervision: Comment on Roberts, Winek, and Mulgrew. *Contemporary Family Therapy*, *21*(3), 309–315.

Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology*, *28*, 59.

Stoltenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists: A developmental approach*. San Francisco, CA: Jossey-Bass.

Stoltenberg, C. D., & McNeill, B. W. (2009). *IDM supervision: An integrative developmental model for supervising counselors and therapists*. New York: Taylor & Francis.

Storm, C. L., Todd, T. C., Sprenkle, D. H., & Morgan, M. M. (2001). Gaps between MFT supervision assumptions and common practice: Suggested best practices. *Journal of Marital and Family Therapy*, *27*(2), 227–239.

Sumerall, S. W., Barke, C. R., Timmons, P. L., Oehlert, M. E., Lopez, S. J., & Trent, D. D. (1998). The adaptive counseling and therapy model and supervision of mental health care. *The Clinical Supervisor*, *17*(2), 171–176.

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: WW Norton.

Worthen, V. E., & Lambert, M. J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling and Psychotherapy Research, 7,* 48–53.

Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.