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THE HISTORY AND TRADITIONS OF CLINICAL SUPERVISION

The traditional literature of counselling supervision seems to lack uncertainty and timidity. It is mostly written from the supervisor's, or supervisor trainer's perspective and seems to be full of models, structures, checklists and frameworks. It is not a humble or exploratory literature.

—Jane Speedy (2000, p. 3)

From the early medical models of supervision, such as the psychoanalytic models of learning while being analyzed, to the “study one, watch one, do one, teach one” method that medical schools have used, our early models are still embedded in the supervision and training models of our sisters and brothers in medicine. Even our educational models that teach concepts and then spend time pointing out mistakes for remediation more than praising strengths are solidly in this camp. Linked to a hierarchical arrangement and aimed at problem-focused evaluation and change, our roots have mirrored those early modernist days. Miller, Hubble, and Duncan (2007) stated that the usual focus on what a clinician did wrong, rather than looking for what might be more effective, is a terrible fault of our more traditional thinking (Miller et al., 2007). This chapter looks at what history has provided us as a base for our practice, as well as an assembly of the nuts and bolts of how the field of clinical supervisor practices in its various forms, styles, and models. I also offer

my own second opinions with regard to how they fit with strengths-based supervision. Along the way, I offer that other component—the supervisee's point of view—as a vehicle to fill Jane Speedy's (2000) critique for a more holistic point of view.

Long-time author and a leader in the field of supervision, Janine Bernard (see, e.g., Bernard, 1981, 1989, 1992, 1997, 2004, 2005), retrospectively reviewed one of her earlier works with George Leddick and noted that it was easy to review the literature of professional supervision back then, when compared to today (Leddick & Bernard, 1980). Clinical supervision has become a large and expanding field, as we have seen already. In reviewing the field, however, I have noticed that there is little specific literature about clinical supervision per se, and as with many specific fields, the new branches off the base are growing strong and varied, with offshoots that parallel the growth of our field of clinical work. Today, we have models, methods, and points to remember about clinical supervision, and they

all have a synergy to them that keep them in flow. Leddick (1994) addressed the issue of models of supervision, indicating that one could categorize them in three general models: developmental, integrated, and orientation specific. “The systematic manner in which supervision is applied is called a ‘model,’” (Leddick, 1994, p. 1) and this indicates that specific knowledge of a model, such as practices, routines, and beliefs (social constructions), are critical to understanding clinical supervision. I want to remind the reader again that from my point of view, the decision to use either a strengths-based meta-model or a problem-focused model is the most important “practice” a supervisor and clinician can make up front. There is a lot to know about before practicing clinical supervision, but I don’t think it is daunting. I will take care to walk you through it all.

Methods of supervision include the nuts and bolts of providing supervision, from the initial supervisory contracting, to methods of observation or data gathering such as live, audio, or video tape and interpersonal process recall, utilized in one-on-one, group, cotherapy, or triadic supervision formats, as well as case presentation, modeling, feedback, intervention, and evaluation. These are the day-to-day or session-to-session mechanics that frame supervisory work, and they allow for a smooth process.

There is a fine line, I believe, between what we do with our clients and what we do with our supervisees. This book’s manuscript has been sent out to a gaggle of other professionals—all from academia I must add—and many have had difficulty with my grouping clients and supervisors under the term “client.” It is my contention that anyone we see in a professional capacity, be they coming for clinical work, supervision, or consultation, are clients. According to Merriam-Webster, a client is “1) one that is under the protection of another, 2) a person who engages the professional advice or services of another” (see <http://www.merriam-webster.com/dictionary/client>). So I hope that clears up any faulty perceptions. Again, I call anyone we are working with a client, be they a person who comes to see

us for clinical work, consultation, or supervision. Of course there are differences, but they are still clients of ours, regardless. We are about protecting and providing a profession service to both clients who come for clinical work, as well as our supervisees. The term supervisor, as we shall come to see, entails many conflicting as well as complimentary behaviors and social constructs. What a clinically trained cognitive behavioral psychologist may believe about supervision will be different in many ways from what a Narrative Therapy social worker or even psychiatrist may act and think, and a brand new doctoral level counselor educator may have even a different view. These beliefs about how to supervise someone are socially constructed and learned both from their own experience, as well as in their education. What follows is some of the history of clinical supervision and the methods and beliefs attached, followed by, in Chapters 4 and 5, a strengths-based perspective that varies by degrees and also by kilometers.

Finally, points of interest that include adhering to a multicultural context, philosophy of training (pedagogical vs. andragogical and modernist vs. postmodernist), and all the currently applied and researched adjoining components that inform us of what connects with good clinical supervision, are covered.

HISTORY: SOMEWHAT BRIEFLY

Predating many of the deep tomes on supervision are an edited book called *Social Work Supervision* by Munson (1979) and another called *Supervision in Social Work* by Kadushin and Harkness (1976). Kadushin and Harkness point out that, prior to the 1920s, the literature that cited supervision meant something completely different than what we now associate with the noun. The first text about social work supervision was published in 1904. It was called *Supervision and Education in Charity* and was authored by Jeffrey Brackett (as cited by Kadushin & Harkness, 2002). Brackett’s book was about the supervision of institutions of welfare organizations and Kadushin and Harkness

stated the following: “Supervision referred to the control and coordination function of a State Board of Supervisors, a State Board of Charities, or a State Board of Control” (2002, p. 1). Interestingly, social work apparently had a hand in administrative supervision long before the texts on it were published by the American Counseling Association (Henderson, 2009). Of even more interest to me is the statement that as supervision moved from that of administrative focus to direct supervision, it took on the meaning and action of “helping the social worker develop practice knowledge and skills, and providing emotional support to the person in the social work role” (Kadushin & Harkness, 2002, p. 2). Nowhere is it mentioned that supervision also required or focused on the evaluation of deficits that can be associated with the field today. These days, those who have been gatekeeping the profession have morphed this view to one where “hierarchy and evaluation are so intertwined with supervision that to remove them makes the *intervention* [emphasis added] something other than supervision” (Bernard & Goodyear, 2004, p. 12) and “supervision plays a critical role in maintaining the standards of the profession” (Holloway & Neufeldt, as cited in Bernard and Goodyear, 2004, p. 2). I wonder how it is that supervision became an intervention rather than “providing emotional support” (Kadushin & Harkness, 2002, p. 2).

Social work has a long and proud tradition of providing supervision to those in the trenches rather than doctoral students, with a literature that is equally rich and tracks issues common to every guild. See, for example, the history of social work supervision (Tsui, 1997), a retrospective look from one of the first to study this topic (Kadushin, 1992), along with issues of parallel process in supervision (Kahn, 1979), client satisfaction in supervision (Harkness & Hensley, 1991), the usual regrouping and reporting of social work supervision (Tsui, 2005), the use of team supervision (Shamai, 2004) as leadership (Cohen & Rhodes, 1978), and finally, way back in 1999, strengths-based social work practices (Cohen, 1999).

Allen Hess wrote his “seminal” book, *Psychotherapy Supervision*, in 1980, 1 year after Munson (1979) and 4 years after Kadushin and Harkness (1976) published their works on supervision in social work. To those of us outside the field of social work, Hess’s volume was a gift that put some sense to what we were doing; some of us went for years without any solid thought, other than the commonsense. Heath and Storm (1985) later pointed out, that most supervisors, at some level, use their own favorite clinical model to inform their clinical supervision practice.

Hess (2008) suggested that the very first clinical supervision occurred after the first therapy session, with a lone clinician observing the feedback, either positive or negative, from the interventions he provided, and correcting his work so that it was more effective—a self-reflective personal supervision, if you will. He also pointed to Breuer and Freud, as they worked on their ideas of hysteria and how it led to breakthroughs in their work as the first documented peer supervision, as well as the Wednesday evening group meetings in Freud’s home, where theories as well as case consultations were held (Breuer & Freud, as cited by Hess, 2008, pp. 3–4).

According to Goodyear and Bernard (1998), the literature on the practice of mental health supervision places its beginnings over 120 years ago, when social work was involved early on with supervision (Harkness & Poertner, as cited by Goodyear & Bernard, 1998, p. 6), in addition to the process and swell of psychoanalysis.

Supervision Literature in Historical Context

The literature on clinical supervision began to blossom with the advent of two major journals devoted exclusively to the topic. The *Counselor Education and Supervision Journal*, the flagship periodical of the Association for Counselor Education and Supervision, began with its first issue in 1961. Counselor Education and Supervision (CES) was originally dedicated to the

transmittal of information, training, and supervision of counselors for the American Personnel and Guidance Association (APGA), the forerunner of the American Counseling Association (ACA) and all of its divisions. Again, primarily geared toward academics who train and supervise any of the many counselor types (mental health counselors, couple and family counselors, school counselors, etc.), the journal is a much overlooked source of supervision thought and training, as well as a source for other guilds in the field of clinical supervision. A second journal, which began in 1983, is *The Clinical Supervisor*, dedicated to providing a cross-pollination of ideas and research of the supervision provided by all clinical guilds, including social work, psychology, counseling, couple and family therapy, and substance abuse counseling. It is just possible that these two journals are responsible for the dissemination of almost all of the current knowledge and direction that our field has up until now. Every book written since these journals' inception has relied on their fullness and richness of the breadth of our field to fill their pages. Anyone coming into our field should feel the pride of knowing that the shoulders we stand on are those of a diverse, dedicated, and interesting group of professionals who care to insure that clinical work has support and care beyond the managed care bosses.

In addition to the early literature, texts on clinical supervision informed those who wanted to learn and practice this craft. What follows is a look at the major books on clinical supervision in the aggregate. This is not an attempt to provide a microscopic look into these volumes but to place them in context historically in a large and ever growing field that is critical to those who learn, research, teach, and practice supervision. Every interested writer of clinical supervision since the "blossom" has explained their own view of what is meant by supervision, provides a framework for their particular manner of discussing the subject and then indicates that there have been several discrete changes or additions, if you will, to the supervision literature and methods throughout the early years, up

until now. Kadushin and Harkness' (1976, 2002) book on social work supervision begins with a definition, after a word about their particular history. Their definition breaks down its roots, indicating that it comes from the "Latin *super* (over) and *videre* (to watch, to see) . . . one who watches over the work of another with responsibility for its quality. Such a definition of supervision leads to the derisive phrase *snooper vision*" (pp. 18–19). I was pleasantly surprised to see the "pun" of one who snoops, as a part of the earlier view of supervision, and reflected on how I had earlier on changed the word to "co-vision," a word Bernard and Goodyear, trounced (2004, p. 12). Rather than taking the usual meaning of the term, Kadushin and Harkness (2002) defined it by looking at function, objectives, hierarchy, indirect process, and a means to an end, settling on the following definition: "A comprehensive definition of social work supervision attempts to combine all the elements noted in the five sections . . . an agency administrative-staff member to whose authority is delegated to direct, coordinate, enhance, and evaluate the on-the-job performance of the supervisees" (p. 23). Using the traditional social work model of ecological systems (Siporin, 1975, 1980), they indicated the complexity and interconnectedness of all these functions and provided a definition that is very different from that of other mental health groups' range of vision. What is most punctuated, however, is that social work supervision is for those in the trenches, as opposed to being almost entirely directed at doctoral students. They then went on to address the social work agency and unit, the demographics of social work supervision, the nature of education and how it is different from supervision and therapy, as well as the relationship between the supervisor and the supervisee. These sections are rounded out with chapters on supportive supervision, including thoughts on burnout, stress that includes both the client and the organization as contributing factors, the problems that come with becoming a supervisor, and evaluation and innovations that include what we will cover as modes of supervision. Clearly,

supervision for social workers is a comprehensive view of all the factors that are a part of the ecological process.

The current big three generalist books on supervision, written mostly for psychology and counseling doctoral students, are in the order of their first appearance: Allen Hess' *Psychotherapy Supervision: Theory, Research, and Practice* (1980, 2008), the duo of Janine Bernard and Rodney Goodyear's *Fundamentals of Clinical Supervision*—changing authorship position in the middle—(Bernard & Goodyear, 1992, 1998, 2004, 2006), and C. Edward Watkins' *Handbook of Psychotherapy Supervision* (1997). These volumes take a more unswerving look at clinical supervision than do the books on social work supervision. And although they are useful for those on a master's level, I wonder if any in-the-trenches supervisor ever looks for books on supervision. These three books are aimed at the training of doctoral-level supervisors and perhaps some master's-level students in programs that open their training to them.

Later, Hess enlisted the help of his wife Kathryn and daughter Tanya (Hess, Hess, & Hess, 2008) to update his original volume, which begins with a review of the supervision literature in Part 1 and then moves into the first four chapters in Part 2, which look at what it is like for supervisees to become professionals in the field. It then moves on to a personal perspective of being supervised, including supervising international students, to becoming a supervisor. From here, Part 3 discusses several psychotherapy models, or as they call them, orientations, such as psychoanalysis supervision and Narrative Therapy supervision. Then, for some reason, they move to Part 4, which includes a discussion of couple and family therapy supervision and hypnotherapy, which they consider special modalities. What is left out is the extensive literature on both the person centered and cognitive behavioral therapies. Part 5 is a discussion of developmental perspectives, and by this, they mean children, adolescents, and geriatric populations. Part 6 is a discussion of special populations, such as supervision of clinicians working

with abuse survivors, those who are severely mentally ill, those in a correctional setting, and even those in the fast-rising motivational interviewing model, so prevalent in the substance abuse community. Rounding this work out are three short parts, namely (1) research and professional issues; (2) race, sex, and gender; and (3) the state of the field. Hess passed away recently at the age of 64, and for a man so young, he has left behind a hefty legacy of supervision ideas for budding and practicing supervisors. But because of the range of topics, his work is more appropriate for doctoral students who are learning more about the field of clinical supervision. The book has breadth but is short on depth, and it is more useful as a piece of literature from which researchers and supervisors may find a beginning on specific types of supervision.

Longtime supervision authors, Janine Bernard and Rodney Goodyear (2004), provide a 12-chapter book (not an edited work) focused clearly on the process and modes of clinical supervision. This is a teaching book; that is quite clear. Laid out in form for a good syllabus, with chapters enough for the usual university setting, the book moves from an introduction to the field of supervision, right straight to their academic point, that supervision is always about evaluation. Chapter 3 has excellent information about ethical and legal issues that most in-the-trenches supervisors should know well, along with information about graduate training programs. Next they provide an adequate view of the most modernist approaches to the field, followed up by three chapters on the supervisory relationship and its many parts and parcels. Here they have moved into the nuts and bolts of supervision practice, including parallel processes, triadic supervision, and clarity about what is going on in supervision. The next few chapters introduce the reader to organization of supervision; the modes of supervising, that is, group, live, and so forth; and supervising and teaching supervision. This is a fine book for doctoral students learning about the field, and in fact, it ends with a section they call the Supervisors' Tool Box (Bernard & Goodyear, 2004, p. xii). As someone who has made the

transition from modernist to postmodernist, from objective reality to socially constructed reality, I understand but disagree with much of what they put forth. Their emphasis on hierarchy and evaluation from a single source who believes that he or she has special privileged knowledge that is *the* only truth leads to my finding fault with their premises a great deal of the time.

Finally, C. Edward Watkins' *Handbook of Psychotherapy Supervision* (1997), an edited book, covers all of the ground found in the previous two works, with an expanded section on supervision models. This 7-part, 31-chapter volume begins with a section on conceptual ideas and methods, defining supervision as they all have, as well as a chapter on evaluation and research. Part 2 has 12 chapters on what Watkins considers approaches (not models) to supervision, including all the big ones from psychodynamic to cognitive and rational-behavioral and developmental. Part 3 in Watkins' book is about training models for clinical supervision, while Part 4 lumps supervision of adolescents, children, and geriatric populations in with group and family therapy under specialized forms and modes. I would contend that the supervision of family therapy has its own special view of supervision thought, and it is really a modality, or as Watkins calls them, approaches. Bernard and Goodyear (2004) called this systemic supervision, while Hess et al. (2008) called it couples and family therapy and categorized it as a special modality. Next are sections on research and professional, legal, and ethical issues, and finally endnotes or thoughts. Each of these volumes is filled with the knowledge needed to know cognitively in order to provide solid clinical supervision from a modernist perspective.

Family Systems Supervision

One of the first books I purchased on supervision, other than Hess (1980), was Howard Liddle, Doug Breunlin, and Richard Schwartz's (1988a) edited work, the *Handbook of Family Therapy Training and Supervision*. After reading the existing literature on supervision, I see that this

book parallels some of the more traditional books but with the language and rock stars of the systems thinkers. If there was ever any doubt that the more traditional views on supervision and clinical work and the systems models speak and think differently, this book brings that message home, for sure. Thinking structurally or strategically, or applying the concepts of cybernetics to videotaping in supervision, makes me salivate, while I understand fully that these concepts are completely foreign to many clinicians who live in a positivist, modernist worldview. Today, these concepts are taught as history of a field that has been all but marginalized by contemporary clinical work that clicks with managed care and big pharma, I fear. But a lot has happened since those early days when training was done in addition, freestanding training facilities or adjacent to more traditional university settings without degree opportunities. Now, every guild's training has at least one class in couples and family therapy/counseling.

Preceding Liddle et al.'s (1988a) work by two years, Fred Piercy's (1986) edited work, *Family Therapy Education and Supervision*, has a full setting of chapters, with a different flavor of presentation. Nowhere in either of these two books are the usual discussions of what constitutes supervision. Instead, they focus on how systemic thinking, and the training and supervision of family systems clinical work, are different. Liddle et al. presented the following in a middle chapter (9), "Systemic Supervision: Conceptual Overlays and Pragmatic Guidelines" (p. 153), instead of the usual introduction to what supervision is in general. In Piercy's book, Robert Beavers' chapter is entitled "Family Therapy Supervision: An Introduction and Consumer's Guide." In it, he states the following: "Supervision in marriage and family therapy is both a legitimate offspring of individual psychotherapy supervision and a mutant, representing qualitative differences from the parent" (p. 15). He is saying that the supervision of marriage and family therapy is very different from the usual manner that supervision is perceived and practiced.

In Piercy and Sprinkle's (1986) conclusion to their chapter in Piercy's (1986) book, they state the following: "The key figures of family therapy were revolutionaries. They took strong, often unpopular, theoretical stands that ran counter to the Zeitgeist of their time and paved the way for the theoretical models taught today" (p. 12). That the American Association for Marriage and Family Therapy (AAMFT) had an approved supervisor status long before Professional Clinical Counseling or any of the other guilds speaks to the privileged knowledge it assumes AAMFT has as supervisors of family therapy. All candidates are expected to practice from a systemic orientation rather than the linear model of individual psychotherapy or counseling models, and unless one has had good training past a single class on family systems, it is hard to impart this special knowledge. AAMFT's requirements at first included the notion that special training in systems thinking was a prerequisite to supervise other family therapists properly. Today this notion is more lax as licensure has taken over and power struggles and turf wars have forced compromises as well as challenges to supervise, let alone practice systemically. Berger's (1988) chapter in Liddle et al. (1988a) speaks to this point prophetically when he stated that "the acceptance of family therapy theory as a way of thinking in psychology would require changes in psychologists' basic unit of conceptualization . . ." (p. 305). My experience has been similar, even for APA programs that are attached with a specialty program in child, adolescent, and family as a subspecialty. Supervision from a systemic perspective is very different from a traditional individual perspective. Appropriately enough, the AAMFT (2007) put forth its own book as a training tool for upcoming AAMFT-approved supervisors in training.

Some of the first recognitions of a cultural influence in clinical supervision appeared in these two books. Falicov's chapter, "Learning to Think Culturally," in Liddle et al.'s (1988a) book, is evidence that family therapists were out in front and aware of how culture influences systems and contextualizes treatment, thus

supervision early in the game of supervision literature and practice.

I can say the same thing about the AAMFT book as I did about Bernard and Goodyear's volume (2004); it is complete, with chapters ready to go for a semester's worth of reading. The book includes a chapter on models (yes, family therapy, like individual therapy, has its own abundance of models from which to choose), a chapter on developing one's own personal philosophy of supervision (what, no right way?), and chapters on the tripartite of interconnected relationships in isomorphic proportion, such as supervisors, therapists, clients, within structures, assessments, modalities, ethics, and other issues. Does this sound familiar?

Much of the field of mental health—psychology, social work, professional counseling—has tried to make family therapy a separate subpart of its own training in the field and disregards the unique supervision frameworks that AAMFT and its approved supervisory designation mandates. The question that still baffles most others in the field at large is, can it be a treatment specialty like cognitive therapy, used by social workers, psychologists, and counselors, or is it really a very different way and philosophy about how to treat people? Is systemic thinking and the postmodern, social constructionist ideas that are a part of the systemic view a specific part of our larger field that is here to stay, or is it only relegated to working within those who use family systems thinking? Gerald Cory (2008) placed postmodern and family systems therapy on the same level as cognitive behavioral, gestalt, person centered, and all the rest. I mention this because next I address the supervision of substance abuse counseling, and rather than seeing each of these as specialties, thus specialties of supervision, one has to wonder whether it is a practice issue or a title protection issue. I think this becomes a topic for our field of clinical supervision. The questions become these: Who has the right to supervise what groups in the larger field? Does the training of specific treatment populations also require specific supervision models?

Substance Abuse Counseling Supervision

Substance abuse (SA) and the counseling that treats it have always had their own unique and sometimes misunderstood ways of treating a problem that affects millions of people. The comorbidity/dual diagnosis with or because of other mental health problems makes SA a huge problem that has its own special treatments and myths. Substance abuse, in its many forms, also affects families with long-range concerns, some that last a life time. In addition, up until a decade ago, many SA counselors had little or no training, and then most of the training came from community colleges where the associate's degree was the terminal degree. I can't speak for all the training in the United States, but today in many states, the field has transitioned to insisting on master's degrees in some mental health field, and many physicians and psychologists are specializing in this field.

As with psychology, counseling, and other mental health fields, the field of substance abuse is also replete with multiple views on what causes SA and how to appropriately treat SA as a serious health concern. Having said that, it is interesting that there is only one book written on the supervision of counselors who practice in this area (Powell & Brodsky, 2004), while an examination of both Google Scholar and the PsycINFO database found a paltry few who even attempt articles on the subject (Anderson, 2000; Culbreth, 1999; Overholser & Ricciardi, 1992; Todd & Heath, 1992). Powell and Brodsky's (2004) book is laid out in similar fashion to the other leading works: There are three parts and an appendix with interesting forms and study information, with 17 chapters that establish a historical perspective, working definition, and traits of effective clinical supervision, evaluation, and feedback, contracting, ethics, and several models, while Chapter 3's section on leadership principles for supervision and organizational perspective is enlightening and exciting. "The principles and methods of clinical supervision espoused in this book are

founded on fundamental concepts of organizational leadership: servant leadership, stakeholders, participatory management, and effective working environment" (p. 20).

Here is a real book on supervision, written for those in the trenches, not some ivory tower training for a hierarchical view of their world. They champion a leadership/supervision that sees supervisees as stakeholders in the process—stakeholders in relationship with their clients as well as the organization. Inspired by new views of what it means to be a leader, they also believe that being a supervisor does not automatically mean that they will be respected. How different this model of clinical supervision is from many of the standard, revered literature that has been informing us for years. They take the road of the new management and organizational philosophy that no longer adhere to a "linear, hierarchical, quasi-military structure, with top-down communication and little employee empowerment" (p. 24). Quoting the words of 6th-century father of Taoism, Lao-tzu, they put forth the notion that, "The superior leader gets things done with very little motion. He imparts instruction not through many words, but through a few deeds. He keeps informed about everything, but interferes hardly at all" (Lao-tzu, cited in Powell & Brodsky, 2004, p. 22). This is a real book on clinical supervision for today, and it sounds exactly like what Mei Whei Chen and I put forth in 1999 (Edwards & Chen, 1999): Leave less footprints. When I began this viewing of the literature on clinical supervision I felt like Diogenes, and yet, in the most far-reaching place of supervision, in a place I would never guess might have what I desired, I have finally found two honest men.

HISTORICAL CHANGES IN MODELS AND MODES OF CLINICAL SUPERVISION

Neukrug (2003) defined the role of the supervisor as critical to a clinicians' professional responsibility, so much so that it is expected. He found it critical in a systemic way, so that the

supervision can create change for the supervisee, as well as for the clients. Indeed, clinical supervision has become one of the most important factors not only in training, as well as accountability, but as a vehicle of change in the clinical process. After all, two heads are better than one.

Models of Supervision

The models of supervision, “the systematic manner in which supervision is applied” (Leddick, 1994, p. 1), came about in several different ways. As I have said elsewhere, “Most traditional supervision has paralleled conventional counseling, looking for what the supervisee was doing incorrectly or not doing enough of, mostly in the area of technique, and attempting to devise remedial solutions” (Edwards & Chen, 1999, p. 350). Supervisors use their favorite model of clinical work as an adjunct to their clinical supervision; the facilitative counseling taken from Rogers (1951) will model empathy, warmth, and genuineness in their supervision, while those adhering to cognitive behavioral therapy will stress supervision that parallels that model, and so forth.

Heath and Storm (1985) pointed out quite a while ago that most supervisors at some level use their own favorite model or models to inform their clinical supervision practice. As the field progressed, providing better research and more additions to clinical supervision thought, many ideas of how to supervise well became part and parcel of how some supervisors were trained at the university level, and this added to the collective fund of ideas that informs clinical supervision today. Like the field of clinical practice, clinical supervision increased its range of models. From psychodynamic, to person centered, cognitive behavioral, and the generalist systemic frames, that is, strategic, structural, narrative, and solution focused, supervisors use their own favorite clinical model as a frame for their supervision. As stressed elsewhere, these models of supervision—what Leddick (1994) called orientation-specific models

and Hess et al. (2008) and Watkins (1997) called psychotherapy orientations—are case-specific types of supervision suggestions, and depending on the guild from where the author(s) or editor(s) comes from, this might include supervision of supervisees using special modalities like couples and family therapy, hypnotherapy, and paraprofessionals, or special populations such as abuse survivors, substance abusers, different sexual disorders, and so forth (Hess, et al., 2008). Does this confuse you? Are you asking the same questions as I, such as why is there such chaos of models among the different authoritative books? One needs to look no further than the various guilds’ insistence on turf and ownership of who does what. Most clinicians at some time or another, if they are practicing generalists in mental health, will come across any and all of these special populations, and hopefully, they will notice that there are many different ways to practice as well as supervise. It is also an indictment of our inability to learn from and accept one another that some find working with couples and families as modalities, while others see the same activity as a specialty. Several of these guilds have battled perception for a long time, longing to be seen as a separate profession (Fenell & Hovestadt, 1986), where a clinician can be called a Licensed Marriage and Family Therapist (LMFT), or a Licensed Clinical Professional Counselor (LCPC). These guild wars are an indication of our inability to learn from and accept one another. Turf wars and holdovers from our early days keep us from seeing our similarities and maintain our top-down views of each as discrete entities in a hierarchical pecking order from psychiatry, to psychology, to social worker, licensed clinical professional counselor, or licensed marriage and family therapist, and even on to addictions counselors. There has never been any concrete research which demonstrates that one group’s practice outcome is better than the other, and I suspect that this is also true when it comes to supervisors. It is important, however, to note that the current models of supervision almost always maintains a hierarchical, evaluative, remedial position (Edwards & Chen, 1999), indicative of the medical model that is

about “fixing” people. World-class social psychologist Elliot Aronson (2010), who has commented about his own field of psychology, said that his colleagues on the clinical side of the field are about “fixing” people, while he and his colleagues in social psychology are about change, saying, “Okay, you had a bad childhood, but let’s change your environment, change your motivation, and give you new opportunities, and you can transcend your origins, your self-defeating attitudes, your prejudices” (p. xiv). This is very different than the usual views of mental health as portrayed by some guilds and the common nomenclature as presented by the American Psychiatric Association’s (1994) *Diagnostic and Statistical Manual of Mental Health Disorders* (4th ed). This view is very similar to what is purported by strengths-based work, of sorting out and punctuating what people do well and by helping them stay on that course of development. Or like what Albert Bandura (1997), another great psychologist, called developing self-efficacy, whose methods are also a far cry from a medical model’s remediation.

Additional to the orientation models are what Leddick (1994) called developmental and integrative models. These two models make up the rest of the usual models of clinical supervision that is both taught and used in training centers around the country. Leddick (1994) and Bernard and Goodyear (2008) have different meanings regarding a developmental model, when compared with Hess et al. (2008). Hess et al. defined development according to the client system being discussed during supervision, with clinicians treating three separate populations—child, adolescent, and geriatric. Leddick and Bernard and Goodyear defined development according to the skill level of the clinicians under supervision with respect to their stage as a clinician. Anyone interested in clinical supervision reading these various authoritative offerings would be confused and perplexed. For a better look, let us briefly move into the developmental perspective as defined by Leddick.

Looking at the developmental perspective of the clinician (and isomorphically the supervisor in

training), the main proponents of what I came to understand as a helpful developmental perspective were Bernard’s (1979) discrimination model, and, beginning with Cal Stoltenberg (1981), a developmental model he called the counselor complexity model, which evolved into a unique and ever growing developmental approach coauthored with Ursula Delworth (Stoltenberg & Delworth, 1987) and recently Stoltenberg and McNeill (2009). Since I cover these two models as executive skills in Chapter 2, I do not dwell on the particulars of the model here, but I briefly talk about them and then discuss them in more depth, as well as what others might have written about them.

Despite the agreement in the field to think about the developmental stages of the supervisees with whom we work, and to adapt supervision accordingly, Kersey (1982) and Fisher and Embree (1980; as found in Marek, Sandifer, Beach, Coward, & Protinsky, 1994) suggested that supervisors generally do not take the developmental stages into account while they are supervising. This leads one to wonder if supervisors should even bother. However, by this time, thinking developmentally is part of the culture of informed clinical supervision. I can put forth my own personal experience. At least three or four times a year, during practicum and internship, students express their anxiety about not knowing where to go with their clients’ discussions or what to do, or most often, they say that they just don’t feel as if they have had enough training, thus they need more specific instruction (and when one speaks his or her anxious concerns, the other more timid ones will also chime in). A calming voice from what they perceive as a totally competent supervisor, stating that this is developmental and that this too will pass, quiets their fears. So, one of the issues of development is that of experience, rather than training or skill. I usually tell them a story from my favorite author, Malcolm Gladwell’s (2008) book, *Outliers: The Story of Success*, where he demonstrates over and over again that success is based on a large quantity of experience. From the Beatles’ luck at having a long-term gig in a German cave bar playing for eight hours at a time early in their career, to the

success of hockey players in Canada based on their very early youth club experiences, to the high school shenanigans of Bill Gates with computers, Gladwell documented that a large fund of experience from which to draw seems to make a huge difference in one's success. There is a magic number of 10,000 hours that seems to have a large bearing on great success, but I do not tell them this often for fear of losing a whole lot of late-term clinical students to other careers. Although it is useful to know this about them and to normalize their situation, the original intent of Stoltenberg's developmental model, the counselor complexity model, was to identify not only skills that may be lacking but also to move them onto "a course of development that will culminate in the emergence of a counselor identity" (1981, p. 59). What was originally intended was to bring forth complete clinicians who have integrated skills and theory, as well as an awareness of themselves in relationship with others. If this is the case, and I am sure my astute colleagues will disagree with me on this point, why is there always so much focus on making sure that audiotape and videotape content is exactly like the microskills dictate? With over 400 models to work with, how in the world is a supervisor supposed to know what his or her supervisee should say or do? One of the beauties of this developmental model is its focus on more than just skill development, as it takes into consideration in each of its four stages the development of a clinician's identity. This focus on identity is portable to any of the several guilds or professions that rest in our field.

Interestingly, Stoltenberg changed his four-level complexity model (1981) to a simpler three-level model (Stoltenberg & Delworth, 1987), as he and Delworth put forth an integrated developmental model (IDM) "that relied more directly on developmental theory and provided more specific details regarding changes in supervisees over time and the types of supervision environments, including supervisor interventions, that were seen as most appropriate for each of the three levels of development" (Stoltenberg, 2005, p. 859). Again, this is a training model, useful to those who are

watching to see where a supervisee—a clinician in training—is situated in his or her development. It is specific to the training of counselors and psychologists, however, that all clinicians move along a developmental path as they learn more about their craft or a specific model. By integration, this model means to provide a clearer and more complete "set of identifiable skills and behaviors" that fit within an integration of them with a more complete set of developmental stages, as I understand IDM. I am, however, troubled by their use of so-called interventions meant to provide a perfect climate for change of what the supervisor sees as appropriate. This way of working is not only mechanistic, but it leaves out any discussion or collaboration within the work or understanding of the context of where the clinical work is being done. The clinician and other multiple factors should be included in any discussion, using the notion of development as a theory (not real) that can be redeveloped or jettisoned as needed.

Lee and Everett (2004) produced a primer book on an integrative family therapy supervisor model that, of course, is directed at those who think systemically, and yet it references some of the same concepts that individual, or perhaps, traditional clinical supervision includes (see Table 1.1).

Aside from the useful principles given in Table 1.1, this model and others have different meanings for the word integrative. The word integrative as used in this model allows that there are many different models of family therapy (as there also are with individual clinical work), but it reaches for a central core with which supervisors might attend to unique systemic concepts or theories with their supervisees. As an old-time family therapist and counselor, I resonate with several of the concepts that are placed within their framework of principles; they are central to a strengths-based model, so they bear mentioning here. But before that, it bears witnessing again that the two models—individual clinical work and family systems clinical work—are from two very different eras, thus they have different philosophies at root. I have never understood the "why" of this difference, as I am sure that many who have done any serious training in both models must also

Table 1.1 Basic Principles of Integrative Family Therapy Supervision

1. Supervision must be respectful.
2. Supervision, like therapy, must be a safe place.
3. A working alliance must be developed.
4. A supervisor does not offer therapy to the clinical family.
5. A supervisor does not offer therapy to the therapist in training.
6. Supervision operates within a clearly defined clinical training system that includes intergenerational subsystems and dynamics.
7. The dynamics of supervision include hierarchy and power.
8. Supervision develops through predictable stages.
9. Supervision interventions are driven by theory.
10. Supervision should be competency based.
11. The supervisor has simultaneous responsibilities to the therapist, the clinical family, the clinical setting/ institution, and the self.
12. The supervisor, like the therapist, follows clear ethical principles of conduct and practice.
13. Supervision is unique within each training system.

Source: Adapted from Lee and Everett (2004, p. 4).

wonder. However, I do understand the how. We hold onto our theories, no matter that they are not real, as the only ways of thinking that have become imbued with not so subtle sociopolitical turf issues. As a personal aside, I remember being interviewed by two clinical psychologists in our department when I first applied for a job, some 20 years ago. They were very concerned that I might corrupt the students with my “radical” beliefs yet wanted someone that could teach the concepts they abhorred that proliferate the main family systems therapy texts. Strengths-based work, whether from systems concepts or the early works of psychology, all have a disdain for the traditional model that came from the medical field of deficit seeking and correcting. But I digress, so let us move back to the point I was making about Lee and Everett’s (2004) book on integrative family therapy.

Lee and Everett (2004) utilized, as one would expect, the careful and skillfully crafted language of postmodern thinking, as they

looked to “identify, and appreciated the unique qualities, resources, and constructions of reality of the many therapists and their clients . . .” so, first and foremost, “supervision must be respectful” and “supervision, like therapy, must be a safe place” (p. 4). This sort of care is found nowhere else as directly as it is here and in the family systems therapy literature on clinical supervision. The way in which this next principle attends to a major element and theory of family therapy, that “supervision operates within a clearly defined clinical training system that includes intergenerational subsystems and dynamics” (Lee & Everett, 2004, p. 7), references the systemic works of Murray Bowen (1966, 1971, 1974, 1976), Kerr and Bowen (1988), and Salvador Minuchin (1974, 1997), whose main theoretical thrusts are related to intergenerational perspectives and subsystems interactions. A point of order here is that Minuchin’s idea of hierarchy can be divided into two complementary parts, the hard side and

the soft side. Keim (1998) called these discipline and nurturance. The hard side of hierarchy is that part that makes and maintains the rules, while the soft side provides for the nurture, care, and health of those who are being cared for. For hierarchy to be effective, both sides must be rules working for organizational systems to function well, and Lee and Everett recognized and imparted this piece of systems logic into their model of supervision. Their model is isomorphic to the systems models they use in their supervision. But then, I believe this model is important to all of clinical work, and it cannot be isolated to one specific model alone. Finally, congruent with the later, postmodern models of clinical work, such as narrative, solution focused, or languaging systems models, all adhere to a competency-based frame. "Supervision should be competency based," and as systemically oriented, looking for interrelationships between and with the various components that make up the whole of the system, it is demonstrated by the natural synergy that arrives when "the supervisor has simultaneous responsibilities to the therapist, the clinical family, the clinical setting/institution, and the self" (p. 4).

Integration can mean many things to many different folks. In the case of Lee and Everett (2004), they referenced integration of different systemic models, while Stoltenberg (2005) and his many colleagues meant to integrate the various developmental views with the supervisory conditions they suggested are needed to produce good clinicians in the end.

I have left out Bernard's (1979, 1997) ridiculously wonderful discrimination model that set the bar for all clinical counselor supervisors, discussed at length in Chapter 2 of this book as what I call an executive skill. Bernard suggests that there are three areas of focus that supervisors must pay attention to: "process skills, conceptualization skills, and personalization skills" (1997, p. 310), as well as three spheres of influence which a supervisor makes use of: training, consultation, and counseling. She then placed these on a very useable grid in order for supervisors to track the supervisory process. If you are

not familiar with this work, you should read the originals or at least check out what I say about her work in Chapter 3.

Formats of Clinical Supervision

In addition to the various models, there are also different formats for providing clinical supervision to those who are in need of supervision, be they students in a clinical training site—usually a university or college, a newbie clinician just learning one of the skill sets from clinical models—or longtime skilled clinicians who feel the need to check out their own perceptions along with potential changes to their work. Each has his or her own uniqueness and also demands different sets of conditions and thoughts about how to be helpful. I want to say that again, because I think it is the most important part of providing supervision, that during the initial presupervision contracting, supervisors should check with their supervisee to ask how they might be helpful and what they might want to gain from their supervision. So, for supervision to be effective, and beyond that to provide excellent supervision, the work together must be perceived by the supervisee (the clinician) as helpful. Just like the use of clinical skills must meet the needs of the client's perception of being useful to be most effective (Lambert & Bergin, 1994), so, too, must clinical supervision be useful—helpful—to the person being supervised. Supervision usually means that persons who would like, or are in need of, input from a more advanced or skilled clinician for the purpose of case consultation, training in a model, or interpersonal change, are in some formal or informal social arrangement. In many cases, it is a remedial or deficit-based focus that a model takes, just like older, traditional clinical models. From individual one-on-one supervision, to group, triadic, live, videotaped, or audiotaped (now digital), interpersonal process recall, to reflecting teams, self-reports, and now online, texting, or other electronic means, each is discussed and commented upon. In addition, any of these models may also be used in a strengths-based model where the supervisee(s) will be seen as "at potential."

Formats or modes of clinical supervision include both the manner in which supervision feedback is provided to the supervisee, as well as the setting of the supervision. Feedback can include either positive exchanges or corrective exchanges, and both can be given in either a strengths-based manner or a top-down hierarchical manner. The method in which supervision feedback is provided includes such things as case presentations (Biggs, 1988), Interpersonal Process Recall (IPR; Kagan, Schauble, & Resnikoff, 1969), audiotaped supervision (Protinsky, 2003), videotaped supervision (Protinsky, 2003), cotherapy (Barnard & Miller, 1987; Hendrix, Fournier, & Briggs, 2001; Lantz, 1978; Roller & Nelson, 1991; Whitaker & Garfield, 1987), a bug in the ear (Boylston & Tuma, 1972), live supervision (Montalvo, 1973), a phone-in (Wright, 1986), a team break (Barthe, 1985), and reflecting teams (Andersen, 1992b; Stinchfield, Hill, & Kleist, 2007). Each of these methods of providing feedback or correction has its usefulness and drawbacks, and, as you will see, some may be dated as the times and the means have changed.

Case presentations are unequivocally the most used mode for presenting information about a clinician's case, either for help or to keep the clinician's supervisor up-to-date on his or her caseload, as well as getting suggestions and helpful consultation from the clinician's clinical supervisor. Biggs (1988) suggested that a case presentation format included looking at and identifying how to help a clinician make interferences from his or her observations to better use the clinical data presented, as well as talking about the process and expectations of the supervisory relationship. This could be considered the contracting phase, where goals and expectations of supervision are laid out for both parties to agree on. Finally, during the case presentation, goals for the client unit, including problems, personality, and factors that influence the problem, lead to an intervention strategy, according to Biggs. Bernard (1997) called this part of the supervision or consultation, and this can happen either during individual supervision, group supervision, or at a formal staffing of cases with

or without a consultant. Two issues always are present during supervision using a case presentation consultation format. First of all, memory fades—rapidly. So what might be talked about during a case presentation is always the clinician's own perceptions of a client system, and that is subjective. Depending on the relationship between the supervisor and the supervisee, the accuracy of the description can vary. People always want to put their best foot forward, and even within the best of clinical supervision sessions, the accuracy of the description of a past session or general progression of a specific client system will be filled with “writers' prerogative.” Also, there is no guarantee that the suggestions and requests to use a different approach will be taken or appropriate when the situation comes about the next time.

Interpersonal Process Recall (IPR), first written about by Kagan et al. (1969), is usually attributed to Norman Kagan (1972); it is a supervision strategy that is used to help clinicians understand and act on their perceptions of cases that they might have difficulty accessing, for all of the reasons I outlined in the previous section. It is important to note that the use of IPR is a tool to use Socratically with the supervisee being the one who has the “highest authority about the experiences in the counseling session” (Cashwell, 1994, p. 1). The supervisor process, as Bernard and Goodyear (2004) see it, is not to “adopt a teaching roll and instruct the supervisee about what might have been done” (p. 220). Instead, questions that are designed to increase the supervisee's insight into his or her own blind spots, thus increasing competency, are used. A short “CliffsNotes” version of what all should or might be done using IPR is, as of this writing, readily available online (see Cashwell, 1994). The steps used in conducting IPR as well as a handful of recommended leads the supervisor might use are available.

Audiotaped supervision has been around for many years; in fact, Protinsky (2003) cited Gill, Newman, and Redlich (1954) as crediting Earl Zinn for having recorded psychotherapy sessions on wax Dictaphone cylinders. Protinsky went on

to say that “it was generally agreed that Carl Rogers was most influential in the use of electronic recordings of the psychotherapy sessions” (2003, p. 298). Audiotaped supervision can be used with IPR or videotaped supervision. I have seen and heard about audiotaped supervision being utilized in several ways, including IPR. Early on in my career as a clinician, I used audiotapes as a means to discuss cases with my supervisors. I found that supervisors who used audiotapes as a means to help me with my case load usually asked me to bring a recording that demonstrated either a stellar moment in a session or a time when I was genuinely stuck and was looking for suggestions that were alternatives to my current way of engaging and working with a particular client. I found these times both uplifting and humbling. Depending on the clinical model of my supervisors, their interactions and “suggestions” might be helpful or shameful. I also know of supervisors and have had descriptions of supervision where the focus was on specific clinical responses and suggestions for alternative responses to client discussion. This sort of exchange may be appropriate for training in a specific model, but in my opinion, not for real-life cases where the situation changes in the week(s) before the next session. My guess on why this occurs later in clinical work is that supervisors are utilizing a training device they learned while in their own clinical training, and without forethought, they continue to use the same format when they are raised to the status of clinical supervisor. We all tend to replicate the sort of clinical work and supervision we learned in our own training. This can occur especially with those who have had a very positive relationship with their trainer or first supervisor. We can place our trainers on pedestals, and it can be a long way to fall for all, when we see that their ideas are not always useful or the best.

Videotaped supervision goes as far back as 1968 as a vehicle to allow “teachers to apply clearly defined teaching skills to carefully prepared lessons in a planned series of five to ten-minute encounters with a small group of real students, often with an opportunity to observe

the results on videotape” (Allen, 1967, p. 5). What the Stanford group found unique was its ability to provide immediate feedback by supervisors and colleagues, as well as the ability to demonstrate skill progress in a measured way. Feedback had come of age with the knowledge and expectation that more immediate feedback provides better learning opportunities and a chance for course corrections and practice. No longer were case consultations, even with IPR, considered to be the gold standard for supervision and training.

With the opportunity for peer colleagues in-training, in addition to clinical supervisors to interact and provide feedback, a new wave of influence was held to a higher standard. First of all, one needs to acknowledge that there is a distinct difference between training and supervision. I make this point repeatedly throughout this book: Our interns and clinicians, regardless of the program from which they come or the field of endeavor they call home, are some of the finest and best clinicians ever. However, training is the acquisition of skills and knowledge in preparation for real clinical work, while supervision is something else again; yet all too often, the literature for clinical supervision is set to accommodate both. Second, as Todd and Storm articulated (2002), videotape allows supervision groups to participate in the process and add their own perspectives; videotaped supervision allows for multiple perspectives, rather than a singular “correct” answer. In addition, this multiple perspective allows for a flattening of the hierarchy usually inherent with supervision. This flattening, when encouraged and allowed to grow, brings forth more accurate descriptions with regard to cultural and gender perspectives when supervisees (sometimes even seen as part of a team rather than students of the supervisee) are allowed to bring forth their own perspectives and views, creating a rich and thick description of the clinical work, with multiple perspectives from which to choose.

I remember learning to supervise this way while doing my supervision of supervision during my doctoral work in the late 1980s. I had previously

trained as a postmaster's student in one of the typical "family therapy free-standing" training programs that had sprung up around the country, and I was used to having one of my trainers step out from his or her perch behind the one-way mirror to knock on the consultation room and ask if he or she might join the session with my clients and myself. The use of the phone-in seemed more elegant to me than the suddenness of a knock and the intrusion of an "expert" joining us, but in retrospect, the clients knew that I was in training and expected some form of course correction from an outside source. They had been informed of the training protocol and even seemed to welcome this intrusion, as much as all of us in training dreaded the knock. The point of it all, however, seems to be consistent with learning theory, in that the shorter the time between when someone makes a mistake or misses an opportunity to move in a more productive manner and the correction, the better the connection. This is the core of Lewinian Action Research and laboratory training (Kolb, 1984). Interestingly, there is also research to suggest that live supervision is beneficial to the trainee or supervisee, but the clients do not seem to notice any more progress during their sessions than those who do not have live supervision (Silverthorn, Bartie-Haring, Meyer, & Tovietti, 2009). Since the early 1970s, there has been a plethora of research done on live supervision from investigating many of the aspects of its use and the many additional modalities used to provide feedback to the supervisor.

According to Champe and Kleist (2003), all of the guilds in the mental health field utilize live supervision for training, and many agencies are using it, with its different modalities, for treatment or serious internship training. We look at these modalities from an historical perspective, rather than a usage, as it demonstrates how technology has been instrumental in the provision of training and supervision.

Cotherapy is a wonderful experience for a trainee or new clinician to watch and learn at the side of a more senior clinician (Barnard & Miller, 1987; Hendrix, Fournier, & Briggs, 2001; Lantz, 1978; Roller & Nelson, 1991; Whitaker &

Garfield, 1987). It is usually implemented in the training and supervision of family therapy. MacLennan (1965), and much later Dugo and Beck (1997), also used cotherapy for the training of group work. Drawing on a "two heads are better than one" philosophy, cotherapy allows the new clinician to participate in actual sessions with a more skilled clinician and to feel the joys and shakes while feeling more secure than when all alone. Depending on the senior clinician's skills, personality, clinical model of choice, training or supervision intent, and relationship with the cotherapist, the experience has the potential to be really great or otherwise. I first used cotherapy at the state mental health clinic I worked at outside of Chicago, where we utilized it during our family and group clinical sessions. I was in group therapy training during my master's program, and at the Family Institute of Chicago's two-year, free standing marriage and family therapy training program, by a cotherapy team during both years of clinical training. When cotherapists are working well together, it is wonderful. One person can be working on content, while the other can work on process. When one becomes stymied, the other may have seen the session from a different perspective and be able to open up new, constructive dialog. It allows one to take a break and just watch what is happening during the clinical experience, while the other clinician may be fully engaged in the process, modeling good communication and discussing in front of the clients how both therapists are seeing what is going on. Again, the process is always to open up the session experience to new and multiple ways of understanding. I always liked working in a cotherapy team as long as we were collegial and open to the experience and feedback. Again, this is seen primarily as a training and supervising device, and at some point, even though it is believed to be more useful for the training of clinicians, it is more costly and complicated. In the early 1980s, it fell from grace as anything other than a training device, due to economic constraints in most clinics and agencies.

Bug in the ear (Boylston & Tuma, 1972; Crawford, 1994; Gallant & Thyer, 1989; Klitzke

& Lombardo, 1991; Mauzey, 1998; Smith, Mead, & Kinsella, 1998; Trepal, Granello, & Smith, 2008) is a remote system where the trainee or supervisee wears a receiving device much like a hearing aid, while providing clinical services. The supervisor or trainer sits behind the one-way mirror and provides feedback (sometimes called course corrections) to the trainee by speaking into a microphone that is connected to the bug in the trainee's ear. Feedback is directed to either provide additional input or correct a mistake in clinical procedure. I also learned how to supervise using this type of feedback modality during my doctoral program. It is just my perspective, but I found the use of a bug in the ear cumbersome and rather detrimental to the clinical process. I mean, after students have had several classes in techniques, how much damage can they do? And my experience is that students or most trainees in a new clinical method really focus on what they are doing wrong anyway, and they usually need feedback that gives them courage to continue and focus on what they have done well. They already know about any glowing mistakes. But again, this is a training method, more so than a supervisory tool.

Live supervision seems to have begun with the family therapists (Montalvo, 1973), and according to Hardy (1993), it was one of the salient components of the discipline that sets it apart from other disciplines. Selvini and Selvini Palazzoli (1991) credited Nat Ackerman and his staff at the Jewish Family Services for first watching "each other's therapeutic work using the one-way mirror" (p. 31). They went on to say that during the 1950s and 1960s, "much therapy theory building was characterized by the use of observation and team work, including Bateson's (1972) seminal research project, undertaken in collaboration with Haley, Weakland and later, Jackson, and The Multiple Impact Therapy group (MIT)" (p. 31). Live supervision is a training and supervision medium where the clinician is guided in the process through several discreet feedback modalities I discuss later. Montalvo's (1973) article is the earliest recorded literature I could find in any searchable database, and he described

it as having a supervisor behind a one-way mirror, occasionally making suggestions to the clinician via phone calls. But Montalvo was followed by a flood of other contributors to the field, such as Birchler (1975), Gershenson and Cohen, (1978), Smith and Kingston (1980), Berger and Dammann (1982), Liddle and Schwartz (1983), and Wright (1986), followed by those in psychology, such as Kivlighan (1991) and Heppner and Kivlighan (1994), and, in counselor education, Bubenzer (1991) and Champe and Kleist (2003).

Phone-ins during clinical supervision were one of the many novel and forward thinking ideas from the field of family therapy. Wright (1986) stated that the benefit of the phone-in component of live supervision is "that trainees are able to receive immediate feedback on the development of their skills" (p. 187). Again, during my doctoral studies in the mid-1980s, I was trained to use phone-ins as a method of providing supervisory input. It was, to me, a step above the bug in the ear or the knock on the door, but it could still be awkward and clumsy, as the supervisor had to make the choice of providing immediate feedback, thus stopping forward momentum of the clinical work, or waiting until there was a natural break in the flow of dialog, and then, perhaps missing the opportunity to help change the clinical course. I never did any research on this, and I have yet to find any, but I often wondered if I were to just let things be, might the session turn out just as well?

Team breaks are also a part of the varied history of family therapy that somehow filtered over to more traditional individual clinical work as well as group therapy. The Milan team, a psychiatry group practice from Milan, Italy (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978), devised a model of clinical work that utilized a team behind a one-way mirror and a cotherapy team providing the direct work with the family group. The Milan model went through several evolutions and revisions, as the original team split and group members refined their way of treating seriously disturbed people from a family systems model. Originally working with the systemic ideas of Gregory Bateson, they attempted

to see family life with the communications and game theory that had come from that work. Their model included five interlocking stages, pre-session, session, intersession, intervention, and postsession discussion (Boscolo, Cecchin, Hoffman, & Penn, 1987), and thus began the team concept. During the intersession, the whole team would take a midsession break and meet together to discuss what they saw and devise a strategic intervention that would be given to the family in the consultation room. It is most interesting to me that their version of a team break was of a clinical nature and led to many other versions of the use of team breaks with other clinicians. Sometimes the break is used as a training vehicle to help course corrections in the clinical exchanges. One advantage most teams pointed to is that the intervention strategy was always the team's message, rather coming directly from the clinicians, thus the clinicians working directly with the family, individuals, or groups could have a great deal of maneuverability, should the client(s) disagree. As part of a strategic intervention, the clinician could "blame" the team for not fully understanding or sometimes suggest that perhaps team members might have a better perspective because they are not so close to what is happening in the room. Strategically, this can give the team an opportunity to ask the family to refine their own view of themselves. My colleague Mei Chen uses the team as a way of providing input to groups in both a supervisory method as well as a training model (Mei Chen, personal communication, 2001). It has also been researched for use with group supervision of school counseling interns (Kellum, 2010), for clinicians treating comorbid alcohol and mental health problems (Copello & Tobin, 2007), as a means to help social workers who live in politically tumultuous times (Shamai, 1998), and back again to Europe, mostly Germany (Barthe 1985; Fatzer, 1986; Meidinger, 1991; Schott, 2007; Spiess & Stahli, 1990), as well as France (Kuenzli-Monard, & Kuenzli, 1999; Meynckens-Fourez, 1993).

Selvini and Selvini Palazzoli (1991), however, lamented the loss of the team in both training

institutions as well as in private practice. They posited that even though some have discussed the disadvantages of teams in terms of financial issues, there are more factors weighing in favor of the use of teams, such as how clearly and quickly teams have "striking results" because everything is clearer (p. 34). Emotional intensity is easier to deal with, because "a situation which is potentially so charged, with tensions can confuse an isolated therapist who will more or less consciously tend to defend against the intensity" (p. 35). Also, the use of a team tends to subjectify what team members are observing and the multiplicity of meaning—the polyvocal meanings of what is being seen becomes apparent, leading to more potential for outcomes rather than stymied situations. This honoring of multiple voices and meanings leads to a lessening of the hierarchical nature of our more traditional supervisory situations.

Reflecting teams have been a unique addition to training and supervision from the postmodern, social constructionist perspective. Most often affiliated with family therapy (Edwards & Chen, 1999; Hardy, 1993), they have also been used in group therapy training (Chen & Noosbond, 1997a; Chen & Noosbond, 1997b; Chen & Noosbond, 1999; Chen, Noosbond, & Bruce, 1998), as well as with individual skills training (Chen, Froehle, & Morran, 1997; Chen & Noosbond, 1997b).

I was introduced to this modality during my doctoral program while I was working toward my Approved Supervisor Designation for the AAMFT. For about half of the year, I worked with master's students using the typical phone in modality, then my supervisors of supervision Tony Heath and Brent Atkinson were introduced to the reflecting team, and they introduced it to their students. Credit for the reflecting team usually goes to Norwegian psychiatrist Tom Andersen, whom I met through my associations with Heath and Atkins, but Finnish psychiatrist Ben Furman and his associate Tapani Ahola were out to dinner with a group of us after they had given a lecture/workshop, and they had a much different perspective on the reflecting team beginnings. As they told it, during the early days

when the model of team breaks a la the Milan team moved from prescriptive messages to team reflections, Andersen and his group had more financing for their two-way mirrors, so that the lights might go down in the treatment room at the same time that the lights would go up in the adjoining team consultation room. “Those Norwegians had more money than us poor Fins,” said Furman. “We were so poor we used an old lady’s nylon stocking we put over our heads, instead of a one or two way mirror!” (Furman, personal communication, 1989). The intention was not lost on the rest of us sitting around the table—Andersen got the credit, instead of Furman and Ahola. We will never know whether this is a true story, but it is a funny story demonstrating the interest, competition, and revolutionary spirit that existed in those earlier days.

The reflecting team, comprised of a small group of colleagues, watches the clinician and client(s) from behind the one-way mirror, and then, after a little more than halfway through, group members switch by either having the lights go down in the clinical room and up in the team room, or they actually switch places. Then the members of the reflecting team talk about what they have seen, using their own reflections or thoughts. Andersen (1992b) started with the premise that reflecting team language “tended to move professional language towards daily language” (p. 58). Relying on Bateson’s (1972) concept of a difference that can make a difference, Andersen wanted language and ideas to be different from what the clients have already experienced, in order to make that difference, but not too different, so that the clients do not reject it. We talked previously about how the narrative function of the brain has top-down functioning that, in Siegel’s (2007) thinking, enslaves our meaning to the present set of values or “views.” This Batesonian manner of talking is a means to get around those settings by adding novelty that will make the difference. It is close enough to not create dissonance, yet different enough to make change—a difference that makes a difference. Andersen also said that clinicians using the reflecting team should always be flexible enough

to allow the clients to “turn away from that with which they feel uncomfortable,” and when talking in the reflecting team, “restrain themselves from giving negative connotations” (p. 60). When first observing the team at work, most clinicians and clients are surprised at the lack of “problem talk.” Many clients, upon returning to discuss what the team has said, comment that they were pleasantly surprised to find that the team didn’t flood them with talk about what is wrong with them but instead had much to say about how well they have been coping or trying. Life and our dilemmas and attempts to right them can be punctuated—viewed if you will—with either positive or negative valences, given context. However, we are, indeed, a society that is facing what we think is wrong, rather than perceiving what is right or going well.

The opening of the reflecting team clinical meeting situates how the clients would like to use the session and then explores the history of the dilemma with all its socially constructed parts. The clinician and clients talk for about half the session, then switch rooms with the team members. The team members then talk among themselves, while the clients and clinician watch and listen. They then switch rooms again, and the clinician asks the clients what they heard from the team while the members were talking, what they were thinking about during the discussion, and whether they wished to discuss anything or found something interesting. After this reflection on a reflection, the session ends, and the team members and clinician may talk some more, privately. The expectation is that this will result in providing many positives for what the clinician has done during the session. In making sense of the use of reflecting teams in triadic supervision, Stinchfield et al. (2007), in reflecting the current directions of Andersen, wrote that, “it is the process, and not the team, that holds therapeutic power and influence” (p. 175). Social construction occurs when novel information that is interjected in conversation provides a difference that is not offered as truth but as a person’s own reflections about what he or she is observing in a way that does

not dictate truth, so much as perhaps an alternative view. The view is close and congruent enough that an alternative reality is visible, and perhaps internalized, thus creating change. As of this writing, there has been only one empirical study of reflecting team use for supervision (Moran, Brownlee, Gallant, Meyers, Farmer, & Taylor, 1995), and the need for more research is obvious due to the many that use and rely on it.

Supervision Configurations

Supervision also has several configurations, from the typical one-on-one, to triadic, group supervision, and peer supervision. The purpose of any supervision configuration is the same, to provide input and feedback to clinicians who are in need or desirous of another perspective on how and what they are doing with their clients. Supervision can be for those in training in a clinical skills class, training of a new or procedural change or during practicum and internship, as well as an ongoing experience at a clinic or practicum situation regarding specific cases or updates of a case load. Most commonly, the supervisor and supervisee(s) discuss procedures, expectations, beliefs, and experiences of their supervision, numbers of meetings, goals, times, and dates. Depending on the model used, contractual agreements taking into account these factors will dictate process and procedure of the supervisory relationship.

An important part of the contract is the use of informed consent, just like in a clinical situation. In several of the formal workshop trainings I have provided, some of the supervisors that are already practicing report that they are still using person-of-the-therapist supervision. Person-of-the-therapist supervision is similar to the sort of supervision psychoanalytic supervision uses, where the supervisee is required to talk about his or her interface/countertransference issues in depth. Supervision becomes more like therapy than it does during clinical supervision. These supervisors should obtain informed consent before they stumble around into their supervisee's psyche. Supervision is not clinical work,

although it comes close at times. If the supervisor and supervisee enter into this sort of supervision, informed consent should be obtained first.

Individual supervision is the typical one-on-one supervision that most think of when addressing what supervision is. This is the version of supervision where Bernard's domains were most helpful to me during my formative years as a supervisor. And I must say that in the early days, her tripartite model—easy to remember and simple to use—included teaching, consultations, and counseling. Much of the early supervision I received, especially from those who had definite psychodynamic leanings, involved a great deal of introspective work. Looking at my own motives in why I did something with one of my clients was seen as relatively important to the movement of my clients in a clinical sense—know thyself, and you can help your clients move to the same spot. Parallelism was important to the work. Even in the early days, the family systems thinking of Murray Bowen (1966, 1974, 1976) suggested that his theory was not one to be learned as a technique, but it had to be practiced on oneself, thus clinicians could not take their clients further than they had gone themselves.

Triadic supervision came about, according to Stinchfield et al. (2007), from the 2001 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards that allow for triadic supervision for students, as well as for individuals. These authors alluded to the significant increase in programs (52% for CACREP programs from 1999 to 2004), as well as in students, as one of the reasons for allowing triadic supervision. I do, however, remember having triadic supervision as far back as 1971, as a means to deal with the time commitment a program in the Illinois Department of Mental Health had with respect to availability of a consulting supervisor. We thought nothing of it in those days; however, we were well aware that our supervision was to be confidential due to the nature of person-of-the-therapist supervision in our psychoanalytically oriented program. My personal experience lately with triadic supervision has also been overwhelmingly positive, as

each member is also encouraged to comment, give opinions, suggestions, and encouragements. The students really like to hear from and give support to each other, as well as feel like others value their contributions to the corporate clinical growth. Stinchfield et al. have a unique version of triadic supervision that includes the use of a reflective process adapted from Andersen (1987) that has excellent potential for use in strengths-based supervision, especially as it is one of the frameworks of strengths-based work.

In this model of triadic supervision, Stinchfield, Hill, and Kleist (2007) pointed out that Andersen has discussed, as one of his ideas about the reflecting practice, that there are both inner and outer dialogues going on all the time, and it is this that makes the practice during supervision so powerful. But first, let us take it step by step to help understand the practice.

First, the authors suggest that the reflecting part of supervision, using the Reflecting Model of Triadic Supervision (RMTS; Stinchfield et al., 2007), should be offered to students, rather than as using it as something that is a usual part of common everyday practice. The invitation and pre-discussion of what RMTS is reflects collegial respect, or as they maintain, presents the opportunity to participate in either RMTS or individual supervision in order to “maintain a sense of safety” (Stinchfield et al., 2007, p. 181). Most likely, if they do choose to participate in RMTS, trainees will pick people whom they know well and trust. It is the authors’ belief that offering choice also cultivates a trusting relationship with the supervisor, thus potentiating their involvement and comfort in the reflecting model. Next, for those who choose to participate in this form of triadic supervision instead of one on one supervision, the two supervisees meet with their supervisor, and every other week one of them present a case situation—in the authors’ setting, the use of videotaped clinical work is used. The supervisor describes the process of RMTS, including an informed consent, and as a usual part of goaling or contracting, the supervisees further agree to this model by either verbal assent or through formal supervisory

contractual process. Then the presenting supervisee proceeds with the formal presentation while the official supervisor and the reflecting supervisee listen. The supervisee presenting the case specifies what they want to show, as well as, perhaps, what they might want the two reflectors to watch for, and what he or she might want to gain from this experience. Then they proceed, and the supervisor and reflecting supervisee listen, and the presenting supervisee and the supervisor may discuss the counseling session. After some time, they shift to the reflecting piece, and the supervisor and reflecting supervisee engage in a reflection of the supervision piece. It is interesting to note that Stinchfield et al. (2007) suggested a 1½-hour time frame and that they also meet with their supervisees every week. At this point of the reflection, the presenting supervisee is not required to speak or comment; only to listen. After the reflection piece of “approximately 10 minutes” the supervisor turns to process the reflection part of RMTS (p. 177). I am intrigued by their use of the “process,” as it seems more modernist than postmodern in its usage. In clinical work or supervision, my usual words to those listening to the reflection are, “So when you heard the team’s reflections, what were your own thoughts, ideas, or feelings? What stood out for you as you listened that you might want to comment on?”

Now, let me get back to the comment I made at the beginning of this reflection of triadic supervision reflecting teams. Andersen (1992b) clearly has set the standard for what goes on during conversations, especially during supervision, with his discussion of inner and outer dialogues or conversations, as he prefers. He makes clear that when people converse, “they are engaged in an “outer” dialog. When they are listening, they are talking to themselves in an “inner” dialogue. Each of the participants is engaged on the same issue from those two different perspectives; talking and listening, the other and inner dialogue respectively” (p. 88). Reflecting on this, and mulling over what Siegel (2007) has taught us about

the brain (see Chapter 4 in this book), our “enslavement” is either taking the conversation in, or filtering it out, depending on the way the language and conversation is constructed and presented, as well as how the receiver’s enslaved view is accepting it. To use Narrative Therapy terms, as clinicians and supervisors we can either work to open space for conversation, or close that space. The structure of the RMTS and reflective work of any kind sets the stage for a release of enslavement and opens us up to understand each other and appreciate what others have said, perhaps not to agree. To deeply understand another point of view, thus to open space for other possibilities, one needs to experience being heard or received. “Pain is created by not being received” (Loegstrup, cited in Andersen, 2001, p. 11). The space for reflection is opened, according to Andersen, because the obligatory rush to answer, that is culturally constructed, especially in some countries and occupations, is changed to allow for longer periods of reflection. Our profession places a high value on responding to a client/supervisee (our inner conversation), in order to be helpful. When this rush to answer is replaced with a rush to pause and listen, inner reflections can be opened for the difference that makes a difference that we discussed earlier (Bateson, 1972). For information to be taken in, and an impact made, means that the reflection piece—the internal conversation—has to have taken place in a way that makes sense to the receiver. The receiver does not have to agree with it in total, or in part, but he or she needs time to reflect and see if it fits and also to have an opportunity to voice his or her own perspective and have that received. The Taos Institute folks argue that meaning is constructed in relationships, and it is by this reflective, recursive manner that our internal conversations are stored, from “our history of relationships—from our early childhoods to our most recent conversations . . . that we determine what is real and valuable for us” (Anderson et al., 2008). It is here that the most important piece

of how to supervise becomes apparent, not only for triadic reflective supervision but for all of supervision. The time to process, reflect, make sense of, and be understood, as well as to acknowledge that supervisors understand too why they have a difference from ours, creates the safe space where new meaning can be constructed. What Andersen said is that “one does not even need a team to alternate talking and listening roles” (1992a, p. 88). People can do that themselves under the right conditions of serious open reflection.

Group supervision or group soup is just what it says, a supervisor or facilitator and a bunch of people that gather to talk about and get ideas of what to do with their clients. I remember in the early days, we used a group soup format to have case staffings, usually with a psychiatrist or clinical psychologist to listen, evoke thoughts from the group, and then pronounce a plan of action with the client. In agency or residential settings, it might also include members of a therapeutic team, such as clinicians of many stripes, such as social workers, activity therapists, dance therapists, aides and or child care workers, psychiatrists, and agency directors or supervisors. From this model, group soup naturally ends up as a training venue to teach models or supervise interns both on site and at the university from which the degree will be granted.

Peer group supervision is just what it says: A group of clinicians gather together and provide support and suggestions with difficult cases. The absence of a designated or assigned supervisor with responsibility and ties to an agency or organization of some kind changes the dynamics of power and hierarchy most supervision configurations have. There is a scarcity of literature on the subject (Kassan, 2010), demonstrating the lack of informal—or should I say unofficial—forms of supervision that occur. Kassan (2010) made the point that peer supervision can become a great source of comfort and help to those in independent practice. Worrall and Fruzzetti (2009) presented an Internet-based training system “designed to help increase the skill with which peer supervisors discriminate more effective

from less effective interventions, allowing them to deliver more effective feedback to their peers or supervisees” (p. 476). Whether it is for training and supervision in Dialectical Behavior Therapy, or simply based on the unique availability of an Internet method, should demonstrate that there are many ways of delivering supervision and that there are many theoretical models for clinicians to use that need supervision from those more fully trained.

Peer group supervision has been written about for the development of school counselors (Wilkerson, 2006), as an adjunct to individual supervision (Akhurst & Kelly, 2006), as a vehicle to collaborate between health workers and mental health workers in the field of infant mental health (Thomasgard, Warfield, & Williams, 2004), with music therapists (Bird, Merrill, Mohan, Summers, & Woodward, 1999), in social work (Hardcastle, 1991), and in counselor education (Benshoff, 1993), showing that it has versatility and usefulness. Although the research on peer supervision follows the usual course of the next new big thing in this field (see a list of research from 1987 to 1997, in Christensen & Kline, 2001), the topic of peer supervision seemed to peter out in the literature after the Christensen and Kline (2001) article was published. Their premise echoes what most group supervision models expect, that “the support for peer group supervision is based on the belief that it offers opportunities for vicarious learning in a supportive group environment.” It is argued that once established, this environment contributes to decreased supervisee anxiety, increased self-efficacy and confidence, and enhanced learning opportunities. Christensen and Kline also postulated that because of the dual factors of being a group, and being a peer-led supervision modality, the issue of hierarchy and dependency that is found in most problem-focused individual supervision, is diminished. In unpacking Christensen and Kline’s research subjects’ qualitative responses, it seems that the same sort of expected outcomes for any group process is evident, meaning that their peer group supervision is no more or less effective than any other

group. Their model also lacks true peer group supervision, as the university supervisors facilitate the group process:

Supervisors supplied initial structure, but as supervisees became more effective in their roles, supervisors served as group process facilitators. From the perspectives of the supervisees, supervisors were most effective when they facilitated feedback, focused on interpersonal dynamics, and intervened to resolve process issues. (Christensen & Kline, 2001, p. 96)

However you slice it, new clinicians value any feedback they can get, including that from peers, who the new clinicians experience as “being highly valuable and important” (Christensen & Kline, 2001, p. 97). One can hope that they feel the same way about their clinical supervisors also.

Peer supervision is an outside-of-formal training and supervision model that allows a clinician to get feedback from his or her peers regarding cases that might be in need of alternative points of view, but they should be differentiated from a “stuck-case clinic” (Quinn, Atkinson, & Hood, 1985), which is a fairly rigorous and formal group supervision model for couple and family therapy.

Training contexts are the last metagroup of clinical supervision I want to address. It must be fairly evident to you at this point that the separate field of supervision has become a force of reckoning in the various fields of mental health clinicians and thus in the literature. Supervision is a method of training and maintaining integrity for the client and the clinician, as well as the organization. Depending on the clinical treatment modality being used for family therapy, individual counseling or therapy, or group counseling/therapy—each treatment modality may have its own worldview, thus its own model of training and supervision. To some extent, they have maintained their own views about clinical practice as well as clinical supervision. In my experience, this also happens between the various guild groups, such as psychology, social work, couple and family, and professional

counseling. That we rarely read each other's literature is a sad commentary on scholarship, but that some refrain from using excellent models of clinical supervision or clinical work limits our ability to be helpful to those we seek to serve. I believe that this is exactly what Jane Speedy (2000) meant when offered her critique of most literature regarding clinical supervision when she said, "It is not a humble or exploratory literature" (p. 428).

Strengths-Based Supervision

The strength of *Strengths-Based Supervision in Clinical Practice* is that it is different and more current than any of the books on supervision I have read and referenced. It is the paradigm shift that needs to happen in the field of clinical supervision to fit with the strengths-based clinical work that is current today. Based on Information Age/Connectivity Age and strengths-based concepts, strengths-based supervision moves away from the "more of the same" mentality that has dominated the supervision field for so long. In reframing the focus of supervision from doing

something *to* supervisees, to collaborating *with* stakeholders, the assumptions of supervision change significantly. Assuming that typical supervision competencies *do* provide needed executive skills, strengths-based supervision provides nine strong basic skills that are typical for any good supervision work and replaces the usual medically modeled deficit and problem remediation focus with the primary four contemporary strengths concepts—Narrative, Solution Focus, and Resiliency means, as well as Positive Psychology—for the operating principles that move the supervision process past mere effectiveness, onward toward excellence. In addition, supervision excellence is assured by using research from social psychology, management, and leadership, all tested and proven concepts that work and should have been a part of clinical supervision from the beginning.

All of these concepts are unpacked in Chapter 4, which looks at how postmodern and social constructionist models inform strengths-based supervision, and in Chapter 5, how Positive Psychology and resilience research adds weight to strengths-based supervision.

2

EXECUTIVE SKILLS OF STRENGTHS-BASED SUPERVISION

The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed.

—Carl Jung (1933, p. 49)

Travel is fatal to prejudice, bigotry, and narrow-mindedness.

—Mark Twain (1869, p. 491)

Most clinical supervision is done by competent and well-heeled supervisors in the trenches who are not attached to academia in any way. This is somewhat contentious to academics, yet the bulk of supervision literature and training is geared toward doctoral students and academics in ivory towers and laboratories. There are far more supervisors without doctoral training (West Russo, 2010), and they deserve our respect, admiration and thanks, rather than the failure of inclusion that occurs in literature intended for doctoral students. There is, it seems, a pejorative favor of doctoral training of supervisors over “in the field” supervisors in the literature’s availability and focus, while in reality there are more of those in the field, and they are doing good solid work. I have nothing but admiration for these folks who provide the bulk of clinical supervision in our world. Thus, the executive skills I present here are aimed at

providing a flavor of the literature on supervision, while at the same time adding up-to-date material past what was originally written. I do so to provide a more current, albeit personal, version in order to round out what many site supervisors never got because they chose to provide quality work in our collective field.

Strengths-based work, yes I will get to it eventually, cannot exist alone, and neither can any form of supervision or clinical work. It is executive skills that provide the groundwork for whatever we do. They are the nuts and bolts of clinical supervision, while resiliency and strengths are the frame through which we must see our supervisees. Several universal concepts from clinical work form the basis of executive skills that help clinical supervisors stay on track regardless of the model they use. This is also a partial review of many of the foundational thoughts of supervision that can inform those of

us who supervise or desire to do so that we just covered. While some experts have suggested that clinicians should work from a strategic frame, while maintaining a structural position (Kottler & Shepard, 2008), I advocate for thinking strengths-based, while adhering to principles that assure quality and ethical work, both clinically and as a supervisor. Each of the executive skills described here is punctuated with actual case material.

Regardless of the model or mode used, clinicians or supervisors, to do their job, must understand and utilize the 10 executive skills: (1) cross-cultural or multicultural competencies, (2) the domains of a supervisor, (3) ethics, (4) developmental stages of a clinician, (5) isomorphs and parallel processes, (6) boundary issues, (7) interpersonal relationship skills, (8) conflict resolution, (9) enhancement of self-efficacy and personal agency, and finally, (10) session management. Each of these areas that I include as a specific executive skill has been researched and written about in great detail, so I will only provide an overview. But I sincerely believe that to be a competent supervisor—even a strengths-based one—these areas need to be understood and continue to be a part of a lifelong learning update that we maintain. Even in the last few years, from when I began the formulation of this book, new and exciting changes have happened in each of these areas.

Over the years, as I provided workshops for new supervisors and those who had no formal training, it was clear to me that the literature compartmentalized a series of skills that were needed to provide adequate supervision. However, although they may all have been situated in edited texts, no one has actually placed them together, and like the executive skills necessary to provide quality clinical work (office rules of conduct, how to start and stop sessions on time, what to do if someone talks too much or too little, etc.), they are the bedrock of quality clinical work and supervision but are rarely taught or written about. An examination of the literature shows that little work has been focused on these “high-level” skills—skills that help clinicians and supervisors pay attention to a

group of guiding principles that help to organize specific events and issues in sessions that lead to smooth and beneficial collaborative work. Executive skills are metaskills, rarely taught in a university setting and from the lack of literature, rarely spoken of or researched, yet seasoned clinicians and supervisors know how to incorporate these in order to run a session smoothly. Especially today, managing the session from entry to exit, from upset to joy, it is useful to know how things work in one’s office during a session. It is important to have a skill set that goes above and beyond one’s model or orientation in clinical supervision. Ironically, the only place I found references to executive skills in counseling was in Chen and Rybak’s book, *Group Leadership Skills* (2003), and in an article on family therapy training by Tomm and Wright (2004). In this chapter, I review what I consider to be the executive skills of a clinical supervisor. Each of the executive skills is punctuated with actual case dialogue. Let us unpack the supervisory executive skills one at a time and understand the synergy they create for competent clinical supervision.

While evidence-based practice may be the current gold standard, statistically proven protocols don’t always work. When they fail, clinicians and supervisors often place blame for the errors and failures on the client, saying the client wasn’t ready or psychologically minded (Hubble, Duncan, & Miller, 1999). Time-bound models do not account for novel or random events that occur in our stakeholders’ lives, so even the best constructed model will not account for a mother’s loss of food stamps, a child’s sudden desire to begin using drugs, or other systemic barriers to smooth sailing treatment. Like a well-trained clinician who has a developed maturity and personal agency and can move with the flow and be flexible when needed, great supervisors are ready to attend to the sudden stops and starts, all the while looking for the supervisee’s strengths and resilience, pointing them out at an appropriate time. Most supervisors have had times when a supervisee experiences a death of a loved one, a romance gone sour, family problems, or a tragedy. These experiences require supervisors to be on their toes and ready to help

their supervisee bring forth his or her natural resilient resources. The supervisor's ability to be flexible is imperative, and our executive skills, if understood, can kick into gear and help smooth out these transitory life events. I have had at least two women give birth and need to be in internship class soon after. Both needed to express their

breast milk for their baby at home, during class, so I left them alone in my office, showed them where the refrigerator was, and started class with the expectation they would join us later. In addition, we videotaped the sessions they missed and sent the tape to them so they would still feel a part of the class.

PERSONAL CARE FOR PERSONAL AGENCY

Jennifer was in her last semester of internship at a program designed to work with women who have experienced sexual abuse at some point in their lives. She had talked several times in supervision about one of her clients, a woman who also had an advanced degree in counseling and who had at times been suicidal. Jen had, according to the agency plan, written a suicide protection contract, but the women had laughed and said, "This is really more for you than it is for me, isn't it?" The woman had no plan at the time, but she had also talked about knowing that at some point in time she would follow through with ending her life.

Then one day, Jen came in looking really stressed and said she had received another client who had been suicidal once before and that this client was always in crisis mode. The wear and tear on this intern was showing, and I asked if she was talking care of herself well enough to have the energy to be present for her clients. Her personal agency was at risk. I asked what were some of the things she used to do that gave her joy and filled her life with energy. The mood in the room changed from hopeless to more hope filled as she discussed how she enjoyed singing in a choir, had not spent any time during her graduate studies doing this, and was waiting until she graduated. Signature strengths when applied can balance the work stressors we all have, and as Jen and I discussed this, we both agreed that the sooner she started this course of action, the more likely it would be that she would continue it as a regular part of her life. The offshoot might possibly be better energy and focus on her clients. I then asked her to describe a time in her sessions when she felt the work she was providing with one of these clients was really profound and solid forward progression. She was able to describe several of these times—she was in the moment—flow—and the clinical work was, in her opinion, the best of the best for client and clinician. As we take care of our supervisees, they will do the same for their clients.

CROSS-CULTURAL AND MULTICULTURAL COMPETENCIES

As I was thinking more about the issue of culture and how it plays into supervision, I chanced to have lunch with my two colleagues and friends,

Drs. Anita Thomas and Sara Schwarzbaum, authors of two fine texts about multiculturalism (Thomas & Schwarzbaum, 2005; Schwarzbaum & Thomas, 2008). So I asked them what they thought would be important to get across to supervisors regarding multiculturalism. Thomas quickly

said, “Talk about it” (A. J. Thomas, personal communication, March 31, 2010). Schwarzbaum agreed. This is good sound advice, but of course, there is more.

Multicultural and cross-cultural thought, including, for instance, the feminist perspective (Nelson, 2006), gender and sexual orientation (Singh & Chun, 2010), cultural (Constantine, 1997; D’Andrea & Daniels, 1997; Dressel, Consoli, Kim, & Atkinson, 2007; Gonzalez, 1997; Inman, 2006; Lassiter, Napolitano, Culbreth, & Ng, 2008; Martinez & Holloway, 1997; Stone, 1997), racial (Butler-Byrd, 2010), and spirituality and religion issues (Puig & Fukuyama, 2008), have become central to the field as we train future generations of clinicians as well as supervisors to work sensitively with all people. Most of the work of cultural sensitivity includes a healthy look at our own epistemological view of who we are and how we learned how to think about and get along with those who are not the same as us. We tend to believe that the way we have been taught to think and believe (social constructions) is not only the right way but that those who are different from us are wrong. Even those with multicultural sensitivity can still carry around messages embedded from years of walking around in a country and culture that continue to institutionalize racist policies and practices. For example, in 2009 a justice of the peace, of all people, refused to marry a couple because they were of different races, while prominent public figures of color continue to be mistaken for each other and parts of our nation are enacting strict and potentially dangerous legislation that effects cultures that might be racially profiled. These actions are the most obvious of concerns, as ever more critical human rights are overlooked as we debate the rights of all people to share in the common good, equally. Those of us who supervise and practice must always be aware of our own worldviews.

Cross-Culturalism and Multiculturalism

There is a distinction between what is meant by cross-culturalism and multiculturalism. Cross-culturalism has to do with the similarities

and differences among discrete cultural groups beyond the constraints of a nation, state, or other structure, while multiculturalism has to do with differences among groups within a larger group such as a nation, or even within the boundaries of a single cultural group. Cross-culturalism would be interested in how blacks who have ancestral roots in Africa are different from Asians or differences of psychologists in the United States from those in Sweden, while multiculturalism might focus on differences and similarities of white Eurocentric males in the United States or compare the Hells Angels from Los Angeles to the Aryan Brotherhood Wonderland Gang from some of our southern states.

For our purposes of supervision in clinical settings, however, as early as 1997 Constantine (1997), as well as D’Andrea and Daniels (1997), suggested that the term multicultural is far more appropriate, because these days the nature of clinical work, thus clinical supervision, is reflective of “multiple cultural factors” (D’Andrea & Daniels, 1997, p. 293). Fong and Lease (1997) made the point that “all supervisors, regardless of racial/ethnic background, need to seek professional development in the knowledge and skills of cross-cultural supervision” (p. 396). Today, we know that to be true, however, as multicultural supervision. Many years later, the field has increased our understanding of multicultural supervision by many folds, making it a rich and growing endeavor that continues to need more professional development training.

Smith (2006) suggested “a core component of the strength-based theory is that culture has a major impact on how people view and evaluate human strengths. All strengths are culturally based” (p. 17). She believed that any time clinicians are involved with counseling where culture is a factor (and almost all are), they should be focusing on cultural strengths rather than on their potential to be victimized due to discrimination, and she noted that strengths-based work has roots in researchers who began to question the relevance of some assumptions of the field, due to their cross-cultural implications.

Furthermore, the implications of a philosophy that adheres to a postmodern and socially

constructed practice have similarities and congruence with those of multiculturalism (D’Andrea, 2000). It moves us away from a universalist perspective to a multiverse, providing opportunities and ways of truth farther past fundamentalism. The standardization of traditional clinical theory and models can be called into question and required to make way for multiple perspectives, due to our understanding of top-down socially constructed beliefs, and this moves us away from holding to any single truth. We are forced to admit and see that our way is only best for us, not for all, and that we may also adopt and rewrite our views over time. So, what does this all mean in regard to multiculturalism embedded in strengths-based supervision? I will give you, the reader, a broad stroke view of the field.

Multiculturalism and Supervision

Earlier in the study of multiculturalism and supervision, Stone (1997) noted a growing problem in a growing field—the literature is slim. Those who are studying this niche of the field disagree on what the focus should be; defining multiculturalism from either an inclusive or exclusive approach uses ambiguous terms such as race, nationality, ethnicity, gender, and so forth, in addition to who should be included in what is called culture. Pointing to a study of biological aspects of ethnicity, the position is made that the boundaries of culture are blurred as there are no discrete boundaries genetically between races (Chapman, 1993, as cited in Stone, 1997). Making an observation that I think is an early precursor to strengths-based thinking, Stone said the following: “One general, unfortunate consequence has been the view of culture as an obstacle to overcome in counseling practice rather than an opportunity to enhance practice” (p. 268). Culture as a strength is centered and put forward, with the caveat and understated notion that multicultural training is cited in the literature for the purposes of training competent clinicians, while we noted earlier that the focus should also be on the training of supervisors.

Throughout the literature, the issue of power and privilege resonate for the supervisor with

respect to issues of gender (Nelson et al., 2006), sexual orientation (Singh & Chun, 2010), and cultural (Constantine, 1997; D’Andrea & Daniels, 1997; Dressel et al., 2007; Gonzalez, 1997; Inman, 2006; Lassiter, 2008; Martinez & Holloway, 1997; Stone, 1997); and supervisor competencies (Dressel et al., 2007; Inman, 2006; Lassiter et al., 2008; Ober, Granello, & Henfield, 2009). The issue of power is a standard part of supervision, one I have tried to deconstruct throughout the section on strengths-based models. Some of the issues of power and privilege that come along with the title of supervision are more likely to be jettisoned, depending on where the supervision is done. The natural consequences of a hierarchical grade-giving occupation as professor *and* clinical supervisor make the problem just that much harder to deal with, yet as we see throughout this book, supervisees want to be treated as competent and collegial members of a team (Heath & Storm, 1983; Heath and Tharp, as cited by Thomas, 1996). Awareness, self-reflection, and open discussion work to maintain open communication and level the hierarchical playing field. Indeed, the importance of self-examination is considered one of the themes that came out of the work of a two-day meeting/discussion of the Supervision and Training Work Group at the 1998 Advancing Together: Centralizing Feminism and Multiculturalism in Counseling Psychology Conference (Nelson et al., 2006). Nelson et al. (2006) also pointed to the ability to contain ambiguity and anxiety as it relates to multiculturalism within supervision, a notion I have experienced quite often while writing this section for this book. “The capacity to make such admissions is related to a supervisor’s ability to acknowledge her or his own limitations in supervision with trainees. Admission of what one does not know is related to the capacity to remain open” (Nelson et al., 2006, p. 116). Regardless of my experience working with urban populations and counseling in multicultural settings for the better part of my 43 years, I have not had sufficient training in a broad understanding of what it means to supervise multiculturally. Sometimes I have felt like a fraud writing a section in which I have experienced but not had formal training. Multicultural competency training was not a required part of my

education when I was in graduate school, and I am the product of a family that didn't think twice about its white power; my beloved father liked only his own kind during an era much different than the one I live in today. We are socially constructed, but that can change through training and self-examination and being open to our own limitations. Thus began a career where my work comprised almost 70% nonwhite clients.

During the writing of this section, I had a supervisory session with a Latino gay man who was stymied in his work with a gay man of South Asian descent. The client presented as depressed and expressed that there is nothing about where he came from to be proud of or like, and that there was no one in this city to whom he relates. Irony: a straight, white 64-year-old male supervisor helping a Latino gay supervisee who is struggling with a situation neither I, nor my supervisee, know very little about. My only hope is that I have recently read several articles for this section, especially Singh and Chun's (2010) *From the Margins to the Center: Moving Towards a Resilience-Based Model of Supervision for Queer People of Color Supervisors* and Field and Chavez-Korell's (2010) *No Hay Rosas Sin Espinas: Conceptualizing Latina-Latina Supervision From a Multicultural Developmental Supervisory Model*; and I have reread Smith's (2006) seminal article on strength-based work. Smith's mantra, again, is that strengths emanate from our culture—work with the cultural strengths and you are working strengths-based, while Singh and Chun advocate for a resiliency model. I feel at home again. My dual cultures of English, which can sometimes be perceived as arrogant and standoffish, are tempered by the knowledge of what my Scottish ancestors had to do to gain their rights for freedom. This is a useful clash, I might rather suspect, but I acknowledge my own limitations. My Celtic epistemology tells me that the universe will provide, while my Scottish Presbyterian epistemology tells me that the Lord will provide if I have been predestined. She (God) did, so we dig for strengths and resiliencies of his client's culture, but we are both unsure of what they are. I start to suggest that he have the young man watch the story of Harvey Milk—what

a mistake; he is white. And I am really glad that there are no roses without thorns—*no hay rosas sin espinas*. So my supervisee goes off to find out about that part of the multicultural situation—his South Asian gay man, coming from a culture where there is no word for gay or homosexual in his language, and he is living in a very multicultural urban city. I am not in Kansas anymore, that's for sure. There is a lot to know when one becomes a multicultural supervisor.

Let us take a look at some suggested skills we need to have and what to do to get there. But before you do that, you should look at the multicultural competencies of the Association for Multicultural Counseling and Development (AMCD), a division of the ACA (Figure 2.1). In addition, both the American Psychological Association (APA; 2002) and the National Association for Social Workers (NASW; 2005) have articulated practice and training stances on multiculturalism.

Dressel et al. (2007), in an attempt to find what successful and unsuccessful multicultural supervisory behaviors might be, conducted a three-round Delphi study with 21 supervisors referred by university training directors, who met the criteria for the study—many years as a supervisor with multicultural experience (number unspecified) and evidence of scholarship in multicultural supervision. The final number of supervisor panel members who stayed with the project to the end was 13. The final results indicated that of the 27 behaviors the respondent group put together for successful multicultural supervision, the most favorably rated behavior was “creating a safe environment for discussion of multicultural issues” (p. 58). The next highest ranked behaviors were those that had to do with supervisors developing their own self-awareness with respect to culture and ethnic identity and communicating respect for their supervisees' ethnicity, ideas about cultural influences in a clinical situation, and openness, empathy, genuineness, and ability to be nonjudgmental (Dressel et al., 2007). Of the 33 behavioral statements the panel decided on, the highest rated behavior to indicate unsuccessful multicultural supervision was a lack of awareness

Figure 2.1 Association for Multicultural Counseling & Development (AMCD) Counseling Competencies

I. Counselor Awareness of Own Cultural Values and Biases

A. Attitudes and Beliefs

1. Culturally skilled counselors believe that cultural self-awareness and sensitivity to one's own cultural heritage is essential.
2. Culturally skilled counselors are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes.
3. Culturally skilled counselors are able to recognize the limits of their multicultural competency and expertise.
4. Culturally skilled counselors recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity, and culture.

B. Knowledge

1. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality/abnormality and the process of counseling.
2. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows individuals to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for white counselors it may mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism as outlined in white identity development models.
3. Culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash with or foster the counseling process with persons of color or others different from themselves based on the A, B, and C, Dimensions, and how to anticipate the impact it may have on others.

C. Skills

1. Culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.
2. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

(Continued)

Figure 2.1 (Continued)

II. Counselor Awareness of Client's Worldview**A. Attitudes and Beliefs**

1. Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.
2. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

B. Knowledge

1. Culturally skilled counselors possess specific knowledge and information about the particular group with which they are working. They are aware of the life experiences, cultural heritage, and historical background of their culturally different clients. This particular competency is strongly linked to the "minority identity development models" available in the literature.
2. Culturally skilled counselors understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices, manifestation of psychological disorders, help seeking behavior, and the appropriateness or inappropriateness of counseling approaches.
3. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness may impact self-esteem and self-concept in the counseling process.

C. Skills

1. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.
2. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (e.g., community events, social and political functions, celebrations, friendships, neighborhood groups, and so forth) so that their perspective of minorities is more than an academic or helping exercise.

III. Culturally Appropriate Intervention Strategies**A. Beliefs and Attitudes**

1. Culturally skilled counselors respect clients' religious and/ or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.

2. Culturally skilled counselors respect indigenous helping practices and helping networks among communities of color.
3. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling (monolingualism may be the culprit).

B. Knowledge

1. Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they may clash with the cultural values of various cultural groups.
2. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.
3. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings while keeping in mind the cultural and linguistic characteristics of the clients.
4. Culturally skilled counselors have knowledge of family structures, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.
5. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.

C. Skills

1. Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping but recognize that helping styles and approaches may be culture bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and modify it.
2. Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a "problem" stems from racism or bias in others (the concept of healthy paranoia) so that clients do not inappropriately personalize problems.
3. Culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.
4. Culturally skilled counselors take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals. A serious problem arises when the linguistic skills of the counselor do not match the language of the client. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor.

(Continued)

Figure 2.1 (Continued)

5. Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of culturally different clients.
6. Culturally skilled counselors should attend to as well as work to eliminate biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions, and they should develop sensitivity to issues of oppression, sexism, heterosexism, elitism, and racism.
7. Culturally skilled counselors take responsibility for educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor's orientation.

Source: Adapted from Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. Alexandria, VA: AMCD.

by a supervisor of his or her own culture or bias. This was followed up in rank order by failing to bring cultural issues into supervisory discussion, being defensive about multicultural issues, and more general behaviors such as not establishing a working alliance or recognizing the hierarchical power differential. What is interesting to me is that many of the statements this panel has set forward are general skills one would expect of any supervisor, and they have limited content connected to multiculturalism specifically. For instance, the highest ranked statement for successful multicultural supervision is to create a safe environment for the discussion of multicultural issues. And although I am at first incredulous that any supervisor would shut down discussion of this sort, I know and have an example of such behavior in a later section discussing boundary issues, where I provide a case example called "Muriel and her Beliefs."

In an interesting study by Inman (2006), it was hypothesized that supervisors who were perceived by their supervisees to have multicultural competencies and by their working alliance or both would have an effect on supervisees' multicultural case conceptualizations. Results of this found that supervisors' multicultural competencies were positively correlated with working alliance and

supervision satisfaction, but they had a negative relationship with supervisees' etiological conceptual abilities regarding multicultural factors. Again, supervisors' knowledge of multiculturalism as perceived by supervisees has a positive effect on working relationships with their supervisees.

Two protocols for the development of multicultural competencies in supervision are worth mentioning. Lassiter et al. (2008) presented a structured peer group supervision (SPGS) model where a supervisee tapes (audio or video) and selects a 10-minute segment to share and has a series of questions, concerns, and areas to focus on, while the peers choose roles they will address, such as nonverbal behavior of either client or supervisee, reactions and possible perceptions of the client, how significant others to the client might react if they were present, multicultural concerns of the case, and so forth. These people then voice their perspectives after the presentation, with the expectation that this will increase hidden concerns or factors of which the supervisee might be unaware.

Ober et al. (2009) proposed a synergistic model (SMMS) combining Bloom's Taxonomy model (Bloom et al., cited in Ober et al., 2009), which promotes cognitive development, with the Heuristic Model of Non-Oppressive Interpersonal

Development (HMNID; Bloom et al., cited in Ober et al., 2009), with process learning and multicultural counseling competencies (Sue et al., cited in Ober et al., 2009). This is a very curricular model, intended for classroom learning, and it is not, in my opinion, practical for applications in group supervision, where the focus is on case conceptualization and strengthening supervisees' skill and personal agency.

During my research for this section, I was enthralled with the manner in which a group of women (Nelson et al., 2006) went about their discussion of multiculturalism. I was also shocked and dismayed at how lengthy, and to my mind, cumbersome and academically oriented, the two models seemed. I have tried to write this book for both those in academics as well as those in agency sites, and I wanted to provide a simple yet easy way to go about training that would benefit their interest and knowledge of multicultural supervision, so I invented and later tested my model with my group supervision class. The procedure used a person-centered group format for the discussion on multiculturalism, facilitated by an outside person. The interns are asked to read five readings, which are referenced in this section, prior to this experience: Nelson et al. (2006), Field and Chavez-Korell (2010), Singh and Chun (2010), Butler-Byrd (2010), and the list of multicultural competencies of the AMCD. After reading these, the supervisor (me) and supervisees (my group supervision class) met for 2½ hours of open discussion facilitated by a skilled group leader. I wish I had done this earlier in the year, because the discussion and openness were wonderful. I would like to include a reflecting team to further facilitate discussion.

Further Discussion on Multicultural Supervision

What strikes me first from all of the literature is that a supervisor's openness to discuss multicultural issues, rather than a supervisee's perception that his or her supervisor is open to these discussions, is most important. Second, what stands out is that the process of imparting

multicultural expectations as part of our supervisor's responsibility begins with us and our own work on our own cultural context and processes and our own openness to explore this during supervision. For me, as a white male supervising in a university that prides itself as the most culturally diverse university in the Midwest, that means I need to attend to my own top-down beliefs about my power and privilege and the fact that as supervisors we have assigned to us, by our supervisees' perceptions, a power and privileged rank that we may not choose but have to accept. Knowing this makes it all the more difficult to deconstruct those perceptions of my supervisees in order to be more in tune as a supervisor who cares about working with and for a multicultural stance. Is being open to discussions and aware of my position in these supervisory relationships enough? Does it matter that I understand and have pride in my own cultural pedigree? It seems important that I am not only willing to immerse myself in understanding other cultures and contribute to an equal footing of all cultures but also that I see them as important to the substance of our growth and resiliency as clinicians who work in a multicultural world. Understanding and promoting multicultural competencies are not only for clinicians but for supervisors as well. If we believe we know it all, we have lost the ability to take risks, be open to the complexity of our supervisory relationships, and "tolerate ambiguity and anxiety related to a lack of certainty" (Nelson et al., 2006, p. 113). In my experience, this is aimed at us all, regardless of our culture, race, gender, or station in life.

FOCUS AREAS AND DOMAINS OF A SUPERVISOR

Janine Bernard (1979, 1997) was the first to actually pinpoint what areas should be attended to when a supervisor begins to work with a clinician. She put forth the idea that there are three areas of focus that supervisors must pay attention to: "process skills, conceptualization skills, and

personalization skills” (1997, p. 310), as well as three spheres of influence which a supervisor makes use of: training, consultation, and counseling. She placed these in a grid so a supervisor can track and situate the supervisory process. Someone having a problem with, say, conceptualization of a counseling situation, can be supervised either by training, consultation or counseling, and so on. Bernard’s work was an effort to provide an easy to understand map that supervisors could conceptualize and use quickly, in order to make interventions. I used this model for quite a long time with success, but lately, I have found its underlying philosophy to be contrary to my views, as it is deficit-based and hierarchically oriented, rather than strengths-based conceptually. I spend more time on this in Chapter 4. But for now, let us look at its parts and what they provide for clinical supervision as an executive skill.

Process Skills

Bernard changed her original version from what she called process skills (1979) to intervention skills (1997), because she believed that the concept of process is not as elegant as the term intervention. What she is talking about, from her reference point I believe, is the observable activities and technical interactions a clinician does while engaged in clinical work. Such things might be when to confront, when to reflect, when to reframe, when to use circular questioning, when to listen, and so forth. This way of working is from a modernist perspective and has a flavor of what Nichols and Schwartz (2001) stated post-modern clinicians avoid, because “too often clients aren’t heard because therapists are doing therapy *to* them rather than *with* them” (p. 205). I have the same dilemma with the term intervention, as it has too many connotations, from planned and orchestrated strategies applied with substance abusing individuals, to the all too frequently used term associated with the military. I think Bernard’s intentions are good, and I would hope that she might agree with my concerns, after

further thought. A better way of thinking about it, I believe, has to do with how clinicians make meaning of and structure their contacts with clients or supervisees during pre-session, intrasession, and post-session. For instance, I might want to ask myself, what do I want to punctuate, what do I want to listen for, ask questions about, and where in the session do I want to see if I can help coconstruct different means or find opportunities to add or expand different meanings in the session? I would also want to think about when I abandon sharing my ideas in favor of my clients. I also might want to ask myself where can I use Positive Psychology ideas or consider how to help the client use narrative reediting, and so forth. So, I agree that supervision as well as clinical work is not just a process of reflecting or being in the here and now but a self-reflective engaged process of human interactions that can change and evolve over the course of a session and the length of clinical involvement.

Conceptualization Skills

Bernard considers this a more subtle part of clinical skills because it has to do with how the clinician (and supervisor) makes meaning of what is going on during a session. She also hooks this up with how to decide what responses to make during the session, so it is in her mind a two-part process. If I am attempting to make assessments of my client’s discourse, of course I am attempting to make meaning of what is meant and where to go with the discourse—in other words, I am in charge of the session and its direction. My druthers again would be to ask the supervisees to be in charge of telling me how *they* are making meaning of what we are doing together and to have *them* evaluate whether what we are doing together is useful (Miller et al., 2007). My conceptual skill, rather than being on evaluation and intervention, will be on asking and refining what we do in the session that can be of more use to the client. My conceptualization skills would be self-reflective as well as interactive, to help define how the session can change to

be more useful. I have heard many discussions that question if supervisees or clients are truthful or fully committed to their own treatment, and in fact I have even experienced those sensations myself. My experience has been that when I believe my client to want something positive out of his or her time with me, it generally happens, and we find a way. Again, the Pygmalion effect as a socially constructed idea is central to this concept. Cooperrider (2000) stated the following:

One of the remarkable things about Pygmalion is that it shows us how essentially modifiable the human self is in relation to the mental projects of others. Indeed, not only do performance levels change, but so do more deeply rooted “stable” self conceptions. (p. 36)

If I believe in my client’s ability and see that person as capable and honest, it has been my experience that it seems to work out. An old tale about hypnotherapist and founder of the strategic model Milton Erickson confirms for me that recursive interactions of how I perceive and act toward others will have an effect on how others may act in return. The tale, one I cannot identify or provide citation for, that has been told to me years ago, goes like this: When asked by someone what he (Erickson) does when he finds a client to be so reprehensible as to make it impossible to work with, he responded as follows: “I form a mental picture of the person and envision him or her as having some genuine desirable traits, and then I act toward him or her as if they are true.” The power of our projections is amazing, as well as verifiable. If I had to decide on one conceptual skill I would want my supervisees to have, it would be an ability to see their clients in a positive light, and somehow that sounds to me like unconditional positive regard.

Personalization Skills

These “skills” are what some believe to be the most important to clinical work, as well as supervision (Luborsky, McLellan, Woody, O’Brien, &

Auerbach, 1985). Bernard said that they are the makeup of who we are: personality, culture, sensitivity, humor, to name a few. How we use ourselves during sessions, make up our personalization skills, and how we make the sessions and work our own, I guess would be another way of looking at it. These skills are also what make up a good deal of feminist clinical ideas (Goodrich, Rampage, Ellman, & Halstead, 1988), so that the person-of-the-clinician (personalization skills) bridges from the technical (techniques and hierarchical stance) to the personal and collaborative. But they can also work to a clinician’s detriment when they undermine a working relationship because of transference or interface issues—personal blind spots caused by top-down personal narratives. Because this component is one of the most critical, when it becomes a focus of supervision, it can be very tricky. Supervisors must continually monitor themselves, reflecting on their known and potential unknown places of vulnerability. The three areas we discussed earlier, what Bernard called skills, fit with the three domains of activities or roles that follow.

Training

Training supervisees is something we all do a time or two or more. Depending on their sophistication, education, and experience, supervisors will find themselves in a spot discussing new techniques or reviewing older but perhaps more appropriate models that might work better with a certain client. This means that the flexibility of a supervisor, with respect to models, should be fairly wide. In these days of evidence-based treatments, or Solution-Focused brief Therapy, there is a tendency to be locked into one method—a one-size-fits-all mentality, that not only violates ethical responsibility but may purposefully avoid techniques that could be used for clients with specific complaints. We discuss more of this in the ethics section.

I have made a conscious effort to make clear that I believe our supervisees are the most

well-trained and well-informed clinicians ever due to the explosion of media and technology. In addition, the efforts in the last few years to increase the competitive edge through training followed by continuing education requirements for licensure have made our clinicians more competitive and better trained than ever before. It is well known that since the mid-1980s there has been over a 275% increase of persons who have trained to be mental health clinicians (Hubble et al., 1999). Those of us who train and teach in universities have felt the impact for our students both for internship placements as well as jobs postgraduation. Those of us who supervise or administer agencies know all too well the competitiveness for jobs and the lack of financial resources to provide clinical services for the clients we serve. It's a highly competitive market, fueling a highly trained clinical surplus. But the point still remains that supervisees are extremely well trained.

Despite this increase of clinical "right stuff," universities have had to cut back on extra elective classes, as course work becomes centralized around guild requirements and students' funds for elective classes past the minimum requirements are usually not available. Add to that the financial crunch put upon agencies where dollars for continued training was routine and now the place where advanced elective training may be collected is during supervision. A supervisor may have a set of skills that is different than what the cadre of Licensed Clinical Professional Counselors, Licensed Clinical Social Workers, clinical psychologists, and so forth, might be provided by a supervisor who has advanced training, or at an agency where a specific model is used, and new clinicians are taken on with the expectation that they will learn those models' skills along the way (B. Atkinson, personal communication, March, 2010; J. Walter, personal communication, October, 2008).

In my internship classes with community and family counselors who are headed out the door soon to begin their clinical life's work, I try to teach them some other strengths-based skills, past the foundational microskills course that is

core to our program, during group supervision. Also, it has been my experience that many programs typically require only one class in family systems, so when the newly trained clinicians hit the market, they might get the additional training during their clinical supervision at their internship site where family therapy is part of the usual treatment routine.

All of this leads me to agree with Bernard, that training can be critical to supervision practices and that supervisors need to know more than a few models and knowledge of the different styles of learning. In my experience, many of our supervisees already have preferred conceptual orientations and approaches to learning. Ed Neukrug (2011) has developed an assessment tool supervisees can take online that will help them and (if they care to share) their supervisor find their preferred clinical conceptual orientation (see <http://www.odu.edu/~eneukrug/therapists/booksurvey.html>). I have used this with my supervisees to help them assess where they are in their development and what they like most from the breadth of the 12 theoretical approaches, as well as the four conceptual beliefs Neukrug has situated in the field of counseling and psychotherapy. After having my group supervision class take the test, I have them discuss what it is about those approaches that they like and don't like. This not only gives us a clue about what they feel comfortable with, but it also provides multiple models that allow for additions and increased readiness to learn different models that they might find useful in the future.

Consultation

Consultation practice has made interesting strides in the past 20-some years since Bernard first wrote her discrimination model of supervision. What has remained constant in the focus and application of consultation skills is that it is a voluntary relationship where a person or persons (the consultant) are in dialogue with a second person or persons (the consultees), regarding a third person or situation, for the purpose of potential change. Consultants are supposed to provide

an assessment of needs and then give suggestions and advice, providing alternatives and objectives that the second person may or may not follow through on. The responsibility for follow-through is always left to the consultee to decide, and over the years consultants have devised a set of operational principles that can influence the follow-through. Block (2000) suggested much of the following: (a) effective decision making should require free and open choice—the consultee (supervisee) always has a choice whether to follow the suggestions of the consultant, (b) implementation requires internal commitment—the consultee and his or her organization needs to be committed to the process of change and believe the process is appropriate, (c) the first goal of consultation is to establish a collaborative relationship and solve problems together *so they stay solved*, (d) change works best when consultees feel the need and understand that the goals and solutions are mostly their ideas, (e) to begin the process means the examination of all data and choice making of commitment, methods, and intended outcome, and (f) collaboration works best, over that of an “expert” role. This is nothing new to most clinicians, as we have recognized for a long time that collaboration—helping clients feel that they own a large part of their changes and helping them experience the solutions as their own—contributes to a successful outcome (Lambert & Bergin, 1994). The last point is the most interesting. Collaboration over “expert” roll fits very well with a strengths-based perspective, such as reflecting teams, narrative, and so forth.

Counseling

This final domain or task Bernard points to is vexing to me. As she intends, counseling is to create a place where supervisors provide an opportunity to reflect on what has happened in their clinical work and to explore the meaning. “Therefore, the supervisor as counselor is more likely to instigate moments for the trainee when things ‘come together,’ when thoughts, behaviors, and personal realities merge to enhance professional development” (Bernard, 1997, p. 312).

This view has an historical basis, and anyone familiar with the way psychoanalysts were trained will be more than accustomed with how this one works. Psychoanalytic training includes going through the process yourself, as part of your clinical work. I remember working with my supervisors, talking about my own family (of origin or nuclear) and how that part of my life was affecting my clinical work. Today, however, ethics dictates that counseling your supervisee might be construed as a dual relationship. I have trained numerous supervisors who blink with distress when I suggest that supervision in this manner could be considered unethical, especially if they have not provided informed consent about their way of supervising and had it agreed upon by their supervisee. If the relationship is voluntary, the client has the right to agree or disagree. If supervisors are working in an agency, they must provide a less “clinical” form of supervision if their supervisee rejects counseling as a part of supervision.

Now there are many times in one’s supervisory life when it is as plain as the nose on the face (given our own top-down constructions) that counseling, either long term or short, would be helpful to the process for a supervisee. Our field has a fair number of impaired clinicians, including those with all the common problems our clients might have, as well as a significant number of clinicians who cross the boundary sexually with their clients. Bringing these issues up to supervisees and providing suggestions for ways they can work things out or even perhaps (and I say this with great trepidation, knowing that there are those out there who love psychic voyeurism) using part of a supervision session to explore how supervisees interface issues might be negatively affecting clinical work. But supervisors need to have a mandate from their supervisees to do so. Supervisors need to explain themselves clearly and make it known that this is a choice the supervisee has. Just as in our own clinical work, it is necessary to provide informed consent, with stipulations that there will be no repercussions if the supervisee says no and suggestions for providing alternative means to work

things out. Even then, supervisees have the right to self-determination, and unless their interface issues are harming clients and it can be documented, they have the right to reject their supervisor's suggestions, without reprisal for following their own path.

The Bernard model leaves us with a short and sweet way of understanding what can and does happen during supervision. Supervisors will consult regarding cases that their supervisees' are

seeing, they will teach new or deeper understanding of clinical skills, and they will find themselves in instances where interface issues (countertransferences) occur, and they may have to do something about that in order for the supervisor to move forward. This last piece can provide difficulties, if we think that the traditional concept of counseling always applies. And maybe there are not any difficulties, if we think of evaluation and counseling from a strengths-based perspective.

KAREN: AN EXAMPLE

Karen was open about her reasons for interning at a domestic violence shelter. She had been beaten many times by her husband before she finally got the courage up to leave him, their children in tow. So, when she began her internship, she ended up talking fairly regularly about the bastards that beat up their wives, and after some time, she began tirades about how gutless were the women who had gone through the program, only to reappear again and again. I spoke with Karen about her anger and asked if she thought maybe seeing one of our free-for-students counselors at the university counseling center would help. She responded fairly angrily that she was fine, but she said she would not speak so blatantly in group supervision in the future. However, her attitude didn't change, only her use of pejorative words, and one day soon after our supervisory "talk," several of her colleagues in group supervision began to take her down for her attitude toward both her clients and their men. She fought back, angrily, and left the class in tears; I followed her out and down the hall, to comfort and talk, leaving the rest of the group members to continue their talk and their regret. Karen didn't want to talk much, especially when I suggested again that she seek help from someone at the center or seriously think about where she is interning and if it is best for her.

Karen slowed down in class with her attitude, didn't participate as much, and told me once she felt as if she didn't belong anywhere. No matter what I suggested, it just didn't seem to help. One day, however, she came to my office smiling and said that she would finish her internship, that she and her site supervisor had also talked, and she had decided that instead of being a domestic violence counselor, she was going to become the agency's marketing and development director, as she had these skills from her past work experience in business. I was relieved, she was overjoyed, and her relationships with her peers began to get a whole lot better. She graduated on time and felt as if she had learned a great deal from her experiences and from the internship. Her distance from the direct services over time gave her perspective, and the last time I saw her, she was doing well.

I do not know why people gravitate to a place where the clinical work is so close to them that interface issues get in the way. Well, that's not true, and as soon as I started to write that last sentence, I knew it was silly. Recovering addicts go into substance abuse counseling treatment, many African American counselors I have supervised want to work with people from their communities, gay and lesbian counselors seek out centers for people with HIV, and I ended up seeing lots of divorcing clients as I went through my own separation and divorce. Unconsciously, or consciously, we work out our own issues and give back to others who are experiencing the same sort of pain we have overcome or in some cases are still going through. Or maybe the universe in its infinite wisdom calls us to this profession as wounded healers. Whatever, rather than being one-up and all knowing, I am glad that I spent time with Karen but let her work it out herself. I'm also pleased that her site supervisor was willing to find her a space that fit where she was at the time, rather than making it a huge pathologizing event. The takeaway for me was that supervisors should never be supervisees' counselors, but they can be an open ear, make suggestions, provide support, and describe their own time when they had to seek counseling for their own interface issues.

ETHICS

One of my favorite colleagues used to start off all her classes on ethics by saying, "Don't sleep with your clients." That was her mantra and a well-intended and needed one at that. The statistics on clinicians of every ilk who still break the sacred and ethical bond is startling. Aside from the fact that every guild from clinical counseling on down to psychiatry has ethical guidelines about dual relationships, and specifically about sexual relationships, it still needs to be said. They are defined as inappropriate; we all know that it is a hierarchical problem, and yet clinicians are human too.

It should be enough that I stress that ethics for supervisors are the same as those for clinicians. It is not by accident that the lawyers in the most famous of all ethical cases for clinicians, the Tarasoff case, sued the supervisor as well as the consulting psychiatrist for not insuring that a clinician followed the duty to warn another person of possible danger, when the clinician had information that might have prevented harm. Supervisors must live with these ethical and legal requirements also, even when they cross another ethical guideline of confidentiality.

As I have noted elsewhere in this book, supervisors have a responsibility to provide informed consent to their supervisees, especially when they are using forms of supervision that might cross other boundaries such as person-of-the-therapist supervision where the supervisor assumes the role of clinician during supervision to help supervisees move past stuck places, or as in early psychodynamic supervision, where it was expected that clinicians learn their craft by being analyzed (Aponte, 1991; Watson, 2005). Early in my career, this was the typical mode of supervision as I was trained by people for the Chicago Institute for Psychoanalysis, but I was never given informed consent back then; my supervisor just plodded on through as a natural course of our supervision. These days, it is a boundary issue and an ethical problem of dual relationship, as well as an issue of informed consent. In my training of clinical supervisors, I have been perplexed that this still goes on as part of business as usual supervision. I have had several supervisors in training who have been taken off guard by the knowledge that they had been crossing the ethical boundary of informed consent as they openly did what I consider to be psychic voyeurism, unnecessarily and unethically. As Hess (2008a) stated, "Sadly, chapters on ethics are necessary because one or both parties does not see the other's interests, values, or being" (p. 522).

An issue of confidentiality and boundary issues under threat in many states (D. Stasis,

executive director, Illinois School Counselors Association, personal communication, February 20, 2010) centers around the issue of school counselors who are expected to “give up” any information that their administrators want to know about students who are in their care. This issue affects not only school counselors but school social workers and school psychologists as well. Legislation has been passed but not without a fight from school administrator associations who feel that all information should be held as non-privileged with regard to their need to know. Again, unless it is a situation of duty to warn of imminent harm, confidentiality is believed by most clinicians to be confidential under the codes and laws of mental health practices.

Finally, every guild has an ethical component that speaks to practicing outside of your boundaries. For instance, the AAMFT’S code of ethics stated the following:

While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience. (AAMFT Code of Ethics, 2001)

Similarly, the ACA’s code of ethics, in addressing boundaries of competency, stated the following: “Prior to offering clinical supervision services, counselors are trained in supervision methods and techniques. Counselors who offer clinical supervision services regularly pursue continuing education activities including both counseling and supervision topics and skills” (see C.2.a., C.2.f., ACA Code of Ethics, 2005, p. 9). All of the guilds, including the APA and the NASW, have codes of conduct related to competency, and this always includes the training and education of supervisory practices. What this means for clinical supervisors is that our guilds mandate competency in clinical supervision, through appropriate training, and in some cases supervision of supervision,

before one can practice the art and skill of clinical supervision. As a part of that training and responsibility, supervisors are bound to their own codes of ethics for all members. Abide by your guild’s ethics and the law of the land where you practice, and as a supervisor you will be an ethical supervisor.

DEVELOPMENTAL STAGES OF COUNSELORS

As Stoltenberg and Delworth (1987) taught us years ago, clinicians go through developmental stages. This developmental process is organic, rather than static. One is never stuck in one stage but may be working at issues in several of our arbitrary descriptions of development. In fact, the transformation of one’s experiences are expected or hoped to be changed into meaningful information. Thus, the emerging clinician is seen as moving toward a goal or end state through the incorporation of new more meaningful information (Stoltenberg & Delworth, 1987). Growth is organic, ever changing. I would add that these stages are isomorphic to the process supervisors go through also. In addition, as I have said elsewhere, most supervisory research and literature are intended for academics, but they are also a useful way of understanding any supervisory relationship or context—be that of new supervisees and/or supervisors beginning new relationships or learning new skill levels. I will try to synthesize Stoltenberg and Delworth’s work here with an attempt to stay within the spirit of that work. As they pointed out, there have been discussions prior to their early work (Blocher, 1983; Hogan, 1964; Hunt, 1971; Littrell, Lee-Borden, & Lorenz, 1979; Ralph, 1980; Stoltenberg, 1981; Yogev, 1982), and several since their work began (Rønnestad & Skovholt, 1993, 2003; Skovholt & Rønnestad, 1992, 1995), but Stoltenberg and Delworth’s ideas remain an important way of viewing the clinician’s progress and development (Stoltenberg & Delworth, 1987). To reiterate, their stages follow.

Level 1: The Beginning of the Journey

During this beginning stage, clinicians are usually very dependent on their supervisors, and they may imitate them a great deal. They can lack self-awareness, think about their cases and clinical work categorically, and show the world, unbeknownst to themselves, that they have limited experience (Stoltenberg & Delworth, 1987). Graduate student supervisees can quote little known facts about Carl Rogers, Aaron Beck, or Steve deShazar, depending on the guild with which they are associated, while supervisees in agencies can tell interesting stories about their supervisors and how cleverly they were able to help them. They are using role models as a way to learn socially about their field and practice.

Supervisees at this stage have high motivation to do well, and their anxiety can be channeled into hard work—almost overdoing their clinical responsibilities. They are also focused on skill acquisition, building up a grand library of half-read books on every form of counseling known to man. They are highly dependent on supervision, so supervisors can use this to their advantage by providing a supervision environment that provides well-defined structure, thus keeping the new clinicians' anxiety low. By providing positive feedback regarding counselors' abilities and focusing on specifics rather than on the supervisee, you can ease them into a good working alliance and begin to build their confidence. It is also at this stage that criticism of their work is taken very personally and can hinder the relationship. As in any relationship that will be of great importance to both parties, care must be taken to move slowly, and the use of positive connotations and relationship building is essential to future contacts (Stoltenberg & Delworth, 1987). Kind words about their ongoing fund of techniques or how well they did with difficult cases will go a long way to an ongoing bank account of a positive working relationship. I remember a supervisor who told me, "You helped me to believe in myself, even when the cases were very difficult, and when I was not

doing my best—you still believed in me, and that helped me to keep on going. You saw my strengths when no one else including me could see them."

Level 2: Trials and Tribulations

The second stage can be challenging, both for the supervisor as well as the supervisee. Much akin to an adolescent stage, Level 2 supervisees show a fluctuating motivation, great striving for independence, and more self-assertive, less imitative behavior and the typical dependency/autonomy conflict that goes with most middle growth stages. Stoltenberg and Delworth (1987) conceptualized this stage as one of confusion, and rightfully so.

As can be true with adolescences, during this stage a supervisee's various skills, strengths, and weaknesses are becoming more evident. But also, now that supervisees know that this is a job they can do—they are over the frightfulness of sitting with someone who has problems and conversing—they begin to have an awareness that this is not a job for the faint of heart, that there is more to this profession than using good counseling skills and technique, and that not all cases respond as hoped for, even with good skill level usage. Many of the supervisees with whom I have worked had the largest collection of technique books on the widest variety of models known to mankind, all with the first two chapters dog-eared, highlighted, and underlined, as they searched for the silver bullet that would fix all their clients. They often tend to mix methods, such as solution focused therapy and cognitive behavioral work. Or they think that all family therapists use genograms or ask for narrative stories.

They begin to see how certain professional ethics like boundaries relates to the work and that some of their case load may have severe and traumatic, even toxic horrific situations that illuminate the limitations of counseling process with certain clients. These factors can lead one to "take home" the situations, as they work out how best to deal with situations they have not known

before. At the same time, supervisors are also inclined to increase their supervisees' autonomy, while noting that they may not actively seek opinions or the advice of their supervisor, if not altogether resist discussion of cases. This is a wrongheaded, albeit natural protection device that occurs so that they do not look foolish or incompetent to the supervisees who they have been trying to imitate.

Strategies that most often work during this time are to provide a highly autonomous supervisory situation, with little structure. As with clients who present with similar profiles, allowing them to go it alone not only gives them the autonomy they wish for but also the flexibility to work out problems for themselves. Other strategies include providing supervisees with a good blend of client types, so that they see a broad variety of clients where difficulty is not generalized to the entire field but can be seen as case specific. Providing a supportive environment that is consultative, where generalizations can focus on theory and its application can be useful. I always ask supervisees to provide me with several alternative views of clients as a way of broadening their repertoire of theory and technique. I am displeased with the notion that one model of counseling should fit well for everyone. And though I am not fond of eclecticism, I do think that understanding more than one way of working with people increases the chances for success.

Another means to being helpful with supervisees is to use your relationship. Many new supervisees are fearful of developing a strong relationship clinically, thinking that they might lose their "objectivity." My experience is the opposite. Those supervisees who have positive, caring relationships with me have almost always been willing to listen to my suggestions, as well as be up front about why my ideas will not work with certain cases or situations. In fact, most supervisors at one time or another will be their own worst critic. This is the sort of give and take you develop with both adolescents as well as supervisees during this stage.

I remember with fondness one of my last doctoral supervisors of my own supervision, focusing

and building on our relationship, with little care toward "professional boundaries." Instead he was always interested and mentoring me as if we already had a collegial relationship. While it presented some of its own issues, it also served to increase my feelings of competency and professionalism, as we worked together in several other venues including publishing, attending, and presenting at conferences. Interns especially like to hear the stories of my own trials and failures, as it seems to make me more human to them. Collegial mentoring supervisory relationships have to be real, I believe. One of my classes with advanced doctoral group counselors took me on and all but tore me apart because of a serious mistake I had made. In the efforts to repair the situation, one of them said, "I just don't understand; most of the students here think the world of you—put you up on a pedestal as someone to really learn from, and here you did such a stupid thing" (it wasn't that stupid). My reply was that I didn't like being put on a pedestal, because the fall is always hard. But being real with supervisees is what they like the most from us—the reason that they look up to us, and yet that very act that can make us a great model can also be the one thing that works to keep us out of reach. This closeness of relationship carried over to the relationships I had with my clients and my own supervisees, and they too experienced a change in their relationships with the clients they were seeing. It is isomorphic. This movement away from a purely clinical view of clients (supervisees) to a more human attention of focus on relationship, both with client and during supervision, was a wonderful change from earlier days when we were always analyzing interactions from a purely clinical perspective. This posture or position helps supervisees begin the process of differentiation from their supervisor, and supervisees will find that they are ready and can be less inclined to take the supervisor's word as final, without first critically evaluating supervisors' suggestions as applied to clients. Their own trials and tribulations need to be critically evaluated by their own hand and supported within a collegial relationship, rather than at the foot of some almighty all-knowing supervisor. Again, the metaphor of

adolescence is appropriate, as good enough parents allow their offspring to try out new ideas, support autonomy, while at the same time providing a background of operating principles of adult behavior.

Supervisees generally know what they should be doing, even when difficult cases present themselves. The skilled supervisor supports their supervisees' decisions, while at the same time holding up professional competency as a model for them to judge their own work. Supervisors should work with the idea of attraction, rather than submission. As Heath and Storm (1983) have said elsewhere, supervisees will work better if they believe that their supervisor has something to offer them that is helpful, rather than criticism.

In a later chapter I provide a case example of a supervision session I had with one of my supervisees. She began her session by telling me what a hard, horrible day she had been through and ended with a story of a mother and teenage daughter that used horrible obscenities toward each other. But there will surely be worse human tragedies that our supervisees will be a witness to: sexual abuse of children, rape and physical abuse, potentially dangerous clients, and substance abuse of every kind. If our firefighters and police officers see the horrible, seamy physical events of life, then surely clinicians in our field see the same as remnants of the same in relational, interpersonal, and psychological troubles. To work with our supervisees as if this were merely a clinical event and miss seeing the trauma or providing empathy and support, supervisors miss the point, in my estimation.

I have made the analogy that this second stage is like that of an adolescent, where basic skills are evident, but their knowledge of their own abilities has not been refined. Like a new teenage driver, they can drive most competently but have not refined the skills and maturity that need to go with it to become sophisticated and mature behind the wheel. This takes several years, perhaps a dent or two in their parents' car, as well as a speeding ticket or two, perhaps. Sometimes overconfident, sometimes underconfident, but also unwilling to share these feelings

or thoughts for fear they will look foolish, or worse yet, not ready to take their place in the adult world, this stage takes life lessons that have to happen on their own. Parents, or in our case clinical supervisors, cannot hold their hands forever but should stand ready and open to discuss and even bring up issues to discuss in a way that also depersonalizes the situation, so that the new clinician is not humiliated. Pointing out their strengths is always a good place to start these discussions.

Level 3: Challenge and Growth

The third stage of development is one where their personal sense of counselor identity and self-confidence begins to shine. Whatever the clinician's guild may be, they begin to feel membership. Because their motivation to continue learning and doing this work is more stable, they feel more comfortable in talking about both their struggles as well as their strengths. Their autonomy is not threatened by their supervisor, and they seek the supervisor out to discuss cases as consultation and their own self- and other awareness is heightened. Having moved through the first two levels successfully and now unencumbered from the fear of not measuring up that they encountered in the first level, and confronted with the realities of how difficult and responsible this job can be as in the second level, a second-order shift has occurred. They have moved up from going through the motions and can now fully participate in clinical work with all its trials and tribulations, knowing that they are well prepared and supported (Stoltenberg & Delworth, 1987).

At this point, supervisees are able to be with their clients, and most are not drawn into the various traps that may be a part of the work. Aware of transferences and countertransferences, and hopefully, having begun to deal with some of their own interface issues, they are able to pull back from the relationships and evaluate what has to be done for good clinical work to occur, as well as understand where they stand relationally with their clients. They do not have their ego

invested in their clients' process, most often, and can tell pithy stories about their own mistakes, laughing about how such and such client evaded them or how they missed important pieces of their clients' lives. One of our biggest problems is how serious we can take ourselves and our work, while at other times feeling like a fraud. One of my doctoral mentors once told me that all of the good clinicians will feel like imposters at many times during their lives. Our pitiful hour or two a week, as important as it is, has a hard time competing with the rest of their lives or the cacophony of competing suggestions, world-views, and family of origin operating principles. And at this level, they hopefully recognize that their clients' growth, change, or wellness really depends on the clients and that although as a clinician they may be a help giver, the journey is not theirs to travel but can sometimes be a support system, sometimes a guide, and sometimes a mirror to their clients as they do the walking. But the journey always rests with their clients: their choices, their moves, their life.

Generally aware of their own strengths and weaknesses, Level 3 clinicians can think of individual differences of their clients. It is during this third stage, with good supervision and mentoring, a new or new to a model changed clinician begins to understand the ethics involved and to assimilate the professional perspective of such a change. Energy has been freed up from the first two levels, and these higher level aspects of clinical work, albeit most important, become integrated.

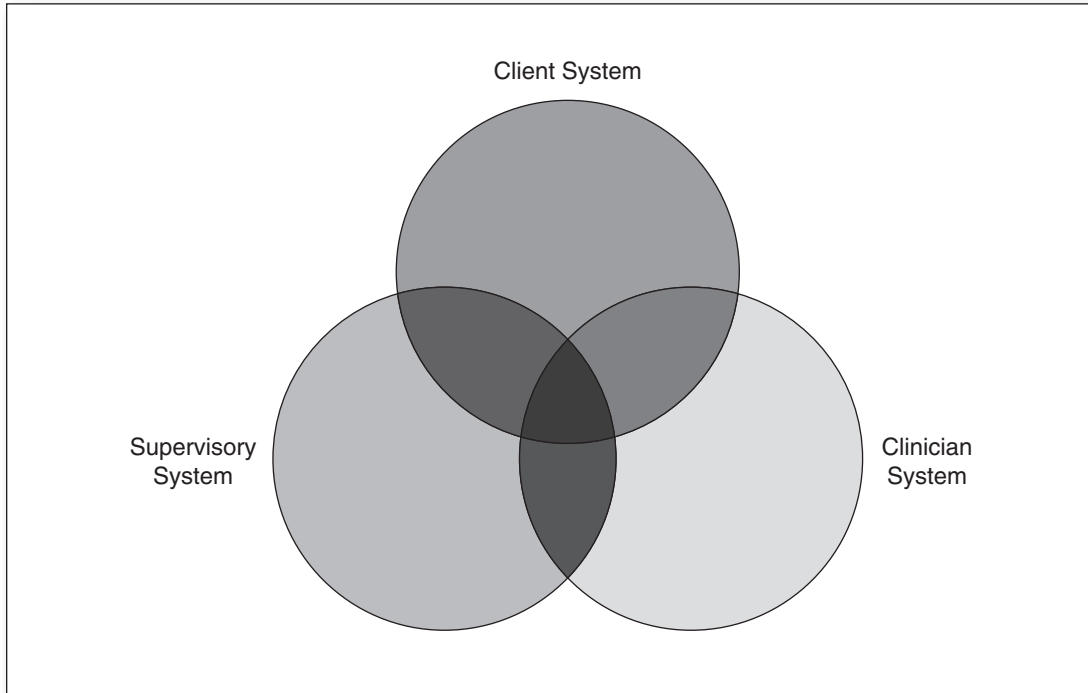
Again, Delworth and Stoltenberg (1987) have provided the beginnings of what is helpful in the supervisory environment during Level 3. Remembering that they have named this final level one of challenges and growth, it seems natural that supervision should both acknowledge the supervisees' strengths as well as those areas where they may still have some dependency on their supervisor for more support and/or consultation around specific areas that affect their clinical life. Most often, as with previous stages, case accountability needs to be provided, but within the context of support and growth, rather than as a check and balance that may be present during the previous levels.

Supervisees may be beyond formal, regular supervision, but they may seek help with specific cases. There is a need for supervision to advance past a single theoretical framework, broadening the supervisee's repertoire. Focus should be on integration of all aspects of the counselor (Delworth & Stoltenberg, 1987).

Equipped with the understanding of the developmental process of counselors, both newly trained, as well as those retrained in a new framework or model, clinical supervisors need a tool to increase clinicians' competencies. It is at this level that basic executive skill comes into play. Clinicians need to believe in their skill levels as well as their ability to work toward proficiency and competence.

ISOMORPHS AND PARALLEL PROCESSES IN SUPERVISION

The word comes from Iso—meaning same, and morph—meaning structure. Any two systems that are connected are said to have isomorphic properties when there is similarity between the two. Isomorphy refers to the part of two or more structures that have a correspondence. As there is an interconnection between all systems that are interrelated, this correspondence has the potential of influence (see Figure 2.2). I assume that all systems in relationship will have this correspondence and thus will be open to the potentiality of influence, when recognized. Conceiving of a client system, be it individual, family, or group, the interconnectedness of those systems with their own systems are also affected by the connection to a counselor, as there is an interconnection between the supervisor and the counselor they have been asked to help. A change in one part of the system will create a change in the corresponding parts. This is basic systems principles at work. A stuck client system—group, family, or client—can create (not cause, but contribute to the creation of) a stuckness between the client and counselor, which will then affect or potentiate a stuckness within the corresponding counselor or supervisor system. They are nested systems, with a correspondence.

Figure 2.2 Isomorphic Structure

The more commonly understood concept of parallel process is often cited in the literature (McNeil & Worthen, 1989; Williams, 1997). Originally referring to a part of transference and countertransference of psychoanalytic treatment, early analytic supervisors noted that what was happening in supervision between supervisor and supervisee was also happening in the transference relationship between the therapist and client (Morrissey & Tribe, 2001; Sumerel & ERIC Clearinghouse on Counseling and Student Services, 1994). Parallel process represents something that can be worked through or an issue that needs addressing, while an isomorph epitomizes patterns of interrelated systems that remain similar in form, despite a context change. The roots of these two phenomena are similar to the two models from which they come. Parallel process concepts in clinical work were first

recognized in conjunction with psychoanalytic models (Heuer, 2009; Rodriguez, Cabaniss, Arbuckle, & Oquendo, 2008; Sumerel 1994), while isomorphs are most often associated with the training and supervision of family therapists (Liddle, Breunlin, & Schwartz, 1988b; Liddle & Saba, 1983; Liddle & Saba, 1985). As Sumerel (1994) suggested, “The concept of parallel process has its origin in the psychoanalytic concepts of transference and counter transference. The transference occurs when the counselor recreates the presenting problem and emotions of the therapeutic relationship within the supervisory relationship” (pp. 1–2). Morrissey and Tribe (2001) described parallel process to be “the unconscious replication of the therapeutic relationship in the supervisory situation” (p. 103). Much of the literature regarding parallel process suggests that the cause is related to the anxiety of

the supervisee, regarding the supervisee's work with a client who is similar through projection identification, as the client projects his or her own feelings onto the clinician and the clinician projects them onto the supervisee. But there are multiple views of what parallel process is and the causative nature of this action or event (Morrissey & Tribe, 2001). In any case, the concept of parallel process runs parallel to the models from which it comes, being seen as intrapsychic, linear, reductionistic, and from a problem-focused model.

Liddle and Saba (1983) introduced the concept of isomorphs in the training and supervision of family therapy, staying true to a systemic frame work, rather than a more linear model that might be associated with analytic or other models of counseling and therapy. Believing that isomorphs are a valuable tool for trainees of family therapy, White and Russell (1997) suggested that the concept crosses all forms of clinical work despite their theoretical model. Noting that contexts being replicated at multiple systems overlays, regardless of their dissimilarity, are not conceived of as linear or work in only one direction because the rules of the larger system seem to constrain and provide principles for how they should behave. Isomorphs are common culture to mathematicians and physicists and also stem from general systems theory, providing a fuller,

more complete view of what happens between a client system, up through a client/clinician system, and through, perhaps, to a client/clinician/supervisor system where it may, "not existing with a reductionistic certainty, but as showing tendencies to exist. Such an analogy allows context replication and mirroring of sequences to be thought of in other than the familiar domino-effect, cause-and-effect ways" (Liddle & Saba, 1983, p. 10). Oh, these systems folk! You gotta love 'em.

White and Russell (1997) made the point that the concept of isomorphs is a standard part of understanding supervision within the field of marriage and family therapy, and yet, there is a lack of clarity with regard to its usage and meaning. They noted that there are four different phenomena identified and discussed in the literature: (a) identification of repetitive or similar patterns, (b) translations of therapeutic models and principles into supervision, (c) acknowledgment that the structure and process of therapy and supervision are identical, and (d) isomorphism as an interventive stance. In their treatment of isomorphs, Bernard and Goodyear (2004) suggested that "the supervisor who is aware of this process will watch for dynamics in supervision that reflect the initial assessment that the supervisor has made about what is transpiring in therapy" (p. 141).

ISOMORPHS IN PRACTICE—AN EXAMPLE

Mary had a 13-year-old son, Tony, the identified client who was referred to our therapeutic day school for severe acting out behavior, running away from home whenever mom confronted him, and on at least one occasion, pulling a jack knife out to threaten her. Mary would then try to console him and end up giving in to his demands. When she tried to step up to the plate with some parental authority, he would become more abusive and confront her with her inadequacies as a parent and woman.

Mary had divorced her husband Bill 3 years previously, because of Bill's verbal and occasional physical abuse to her, and although there was still contact between the boy and his dad, Mary was adamant that she did not want him in family sessions. However, whenever Tony became abusive toward Mary, her first response was almost always to call Bill for help.

As was typical of our program, both son and mother were required to have counseling sessions—both together, as well as separately. The resulting feelings of defeat, anger, and resentment toward her ex-husband Bill and her powerlessness with son Tony were almost always the subject of discussion during Mary's "parent consultation" session with her therapist Joan. Joan's attempts to get Mary to both back off from calling in Bill's help, as well as to "reward" Tony's misbehavior with more placating and lack of consequences, was repeatedly met without interest, and Mary stated that she didn't know what else to do.

Corresponding with these issues, Joan's supervision with me became almost identical, process-wise, to what was happening in other parts of the system. She repeatedly expressed exasperation and a sense of defeat in her sessions with Mary, as well as when they had family therapy. In her individual sessions with Tony, he was polite, and almost too sweet, while in their family sessions, he would rule the roost. The more that this happened, the more Joan hung around my office asking for help. Parallel process describes the experience to some extent, but understanding it as an isomorph gives one the knowledge that the dilemma can be changed. As soon as I recognized the pattern, I stopped being so willing to give up suggestions and began asking Joan to brainstorm ways she herself could get out of her own pickle. This led to a different sort of work between Mary and Joan, which was similar to the work between Joan and I; it enabled Mary to begin acting differently in her relationship with Tony. Once again, Tony predictably acted out and pulled a knife on his mom. This time, rather than backing down to the seriousness, Mary called the police. This is a responsible and appropriate act to the potential violence, and it underlines the seriousness of Tony's actions. Counseling could now once again be back on track, and it dealt with Mary's feelings, as well as her responses to setting better limits and consequences that matched Tony's actions. Mary could be commended for her parenting response to a very serious situation. In addition, Joan could be commended for her work with this system.

By knowing about and being aware of isomorphic properties in relationships, supervisors may discern when this aspect is jeopardizing progress and how to move away from the pull that is common to all parts of the system involved. For our purposes, with regard to strengths-based supervision, I am strangely interested in how both parallel and isomorphic processes can be viewed through a similar lens, darkly. Friedlander, Siegel, and Brenock (1989) said similar things about parallel process when they noted that a new supervisee, who is having a difficult time with a client that seems helpless, may also act in a similar fashion by becoming "helplessly dependent on the supervisor's advice.

If the supervisor resists responding to the trainee's self-effacement and instead helps the trainee to take more control, the trainee may adopt a similar strategy in the next session with the client" (p. 149). It sounds the same, doesn't it? Well, perhaps someone more knowledgeable about both concepts could straighten me out, but here is my take with respect to strengths-based supervision. Like the concepts of resiliency, the issue seems to be one of attitude. Family systems folk went a long way out to provide a concept that did not replicate parallel process, a concept from the grandmother of all problem-focused thought. Liddle and all his colleagues were set on using an idea that did not pathologize their

supervisees, by recognizing that there were similarities among clients, supervisees, and supervisors when they were in cahoots with each other. They were normal events that supervisors could use to produce learning for their supervisees in a manner that might help make the learning become their own, rather than something they learned at the feet of their master practitioners.

BOUNDARY ISSUES IN CLINICAL SUPERVISION

The worrisome issue of boundaries is a holdover from clinical work; however, research has demonstrated that at the graduate level of training, severe boundaries are not as helpful as a professional collegial relationship. There are different parameters and factors at work when training and supervising that necessitate a second, perhaps less stringent look at boundaries between supervisee and supervisor, than would be held to between a clinician and a client. Aside from some of the more serious boundaries, such as those that are sexual, there are differences between clinical and professional boundaries. This section explores some of these.

As Herlihy and Corey (1997) pointed out, there is a diversity of opinions on the topic of dual or multiple relationships in counseling supervision, leading one to believe that there are many ways and reasons that boundaries may be bridged and very few that present a hard and firm boundary that should never be crossed. Sexuality and issues of unequal power differentials between supervisor and supervisee are some of the issues that have strong agreement as to their problem potential, as well as being unethical. Ironically, the issue of conflict within the supervisory relationship points to three issues beyond inappropriate sexual contact or harassment. Nelson and Friedlander (2001) studied conflictual supervisory relationships from the supervisee's point of view and found that the issue of availability was bidirectional, in that supervisors who were seen as distant and remote, as well as those who seemed overly friendly or too familiar, were found to be of concern (Nelson & Friedlander, 2001). Nelson and Friedlander as well

as Moskowitz and Rupert (1983) found that conflicts can also be problematic around the issue of the type of counseling model being used, although Nelson and Friedlander pointed out that these issues are lower on the concern scales and can usually be worked out. The conflicts that can arise from a more senior clinician being supervised by a rather new and less clinically experienced supervisor, however, can be more problematic than a supervisor who requires a specific model being required. These issues of conflict are also breaches of boundaries, because they entail relationship issues that can be very personal.

According to Gutheil and Gabbard (1993), boundary issues can be viewed as being harmful or not harmful. Areas such as time, money, gifts, services, self-disclosure, and physical contact, when shared in a counseling or supervision relationship, may be considered items where breach of boundary exist but may not be seen as overly harmful. Sexual misconduct and other areas where power differentials are evident are in a harmful category. The issue of boundaries can be a difficult and important concept within the supervision relationship. Problems with boundaries usually come from novice, unsure or unclear supervisors, and sometimes with impaired clinicians. A review of the literature found that the majority of writing and research in the area of boundaries for our profession focused on the area of inappropriate dual relationships, mostly regarding sexual misconduct or abuse (Clipson, 2005; Evans & Hearn, 1997; Glossoff, Corey, & Herlihy, 1996; Lamb, Catanzaro, & Moorman, 2004; Lamb, Catanzaro, & Moorman, 2008; Moleski & Kiselica, 2005; Pearson, & Piazza, 1997; Rinella, & Gerstein, 1994; Robinson, 2006; Shavit, 2005a; Shavit, 2005b). These are the sort of boundary issues that when crossed, give a bad name to all professions. We have ethical standards as well as legal and professional consequences for those who stray. But sometimes, especially in the venue of supervision, they are based on a prejudicial view of the one in the supervisor seat. The literature on conflict in supervisory relationships references two specific issues reflected in boundary problems, other than sexual, as detrimental to the process of supervision. One is how close or distant the

supervisor seems to be as perceived by the supervisee, and the other is forcing a model on to a supervisee that is counter to what he or she has already learned and is comfortable with

(Moskowitz & Rupert, 1983; Nelson & Friedlander, 2001) without a prior contract and updated discussions). Two case vignettes will demonstrate how this can get out of hand.

MARIE AND STRENGTHS-FORCED SUPERVISION: AN EXAMPLE

Marie and Jake were interns at the same internship site, with the same clinical supervisor. The clinical supervisor of the site was a well-known strengths-based clinician, and both students were eager to intern with this site and their supervisor, Kate. Both the site and the supervisor had a good reputation in the state and locally, and both interns were given ample opportunity to learn and practice strengths-based clinical work from this master practitioner/supervisor. Somewhere in the middle of the clinical experience Jake became unhappy with his supervision. He would present cases to Kate and then almost slyly say, "So Kate, you keep telling me that I should only work on the presenting problem and work from a strengths-based position, but the records have indicated that this client has had a severe substance abuse problem in the past. I think we should be talking about relapse prevention strategies. What do you think?"

When Jake would talk with me about his site supervision, I could tell that he was having trouble. My usual default modus operandi is to listen carefully to see if there is a serious risk and then default to their site supervisor's thinking, unless it was way off base. Sites "own" their clients, their methodology, and their risks. Universities do not have privileged positions with agency sites, above and beyond any contractual agreement. I began to believe this after being a site supervisor for many years, when a brand new PsyD university supervisor with limited family counseling experience attempted to change the methodology our agency was using, expecting the students to work outside of our agency's established family protocol. Even experienced and savvy university supervisors can never have all of the information in front of them to make snap clinical judgments when they are only armchair supervising.

I encouraged Jake to explore his own motivations and worldviews that informed this case, and I commented on how hard it is to learn a new model that can seem to be at cross-purposes with an old model we know well. He agreed, and for a short time, his case presentations with me were again on track, but not for long. The same challenging situation came back several times, and he commented that the strengths-based model was too restrictive and did not take into account many of the elements of counseling he had learned in his counseling skills class—a modified person-centered model. "Besides," he said, "she is really pushy about learning all of the skill sets and won't let me see clients without her being present. All my fellow interns and classmates are seeing clients alone by now, including Marie. She seems to be Kate's pet pupil."

A discussion on the phone with the site supervisor indicated that this was only partially true, that Marie was seeing a woman alone that they had seen together for a time. Also, Kate said that Marie had, in her opinion, learned some of the basic tenets of strengths-based

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clinical work well enough that she thought the case would be better off with only one clinician in the room, with videotaped supervision. She was well aware of the dynamics of her two interns and her own relationships with them, and she really believed that Jake was coming along fine, albeit a bit slower than Marie. She agreed that it may seem unfair to Jake, that Marie had “her own case” to work with, but that Jake was slated to get a case of his own soon.

At our university, clinical experience is a year long, over three semesters, and many normal life events occur during that time, including, on rare occasions, switching clinical sites. So, I told Jake that if he was really unhappy and wanted to switch sites, we could look into it. He decided that maybe he would stay and learn something after all. He also stated that he wanted to go back to working with the substance abuse community

when he finished and I wondered if some of what he would continue to learn might rub off and will be useful in his future clinical work.

In retrospect, I think that the turning point was when I offered up my support to Jake in the form of an option to find another site. Rather than feeling as if the strengths-based model was forced on him, it once again became his choice.

MURIEL AND HER BELIEFS—AN EXAMPLE

Muriel was a nonpracticing, cultural Jew, and her internship supervisor Mike was an evangelical Christian. One day one of Muriel’s clients was talking about an argument she had had with a colleague regarding her religious beliefs, especially creation versus evolution . . . being more on the evolutionist side. Muriel listened and validated her client’s right to believe what she wanted, while Mike watched from behind a one-way mirror. When Muriel went for her consultation break to discuss the case, Mike was clearly upset and pursued Muriel with questions regarding her own views of creation versus evolution. Muriel was very clear with Mike, to her credit, that this was out of bounds for their supervision discussion, but Mike persisted, wanting to know specifically what she believed. Muriel finished the case, somewhat upset, and later, she made her point with Mike that this was uncomfortable territory for her because of their differences in religion. The next day, he persisted again, and again she made it clear that she did not want to discuss this issue, but she remained worried that this interchange could change the dynamics of their clinical relationship. Muriel went to the site’s clinical director and was later changed to a different site supervisor.

I was very proud of Muriel for sticking to her guns, using her voice, and risking a problem by going over Mike’s head. The issue of Muriel’s beliefs is not an issue to be challenged, but perhaps Mike’s views and insinuations should be a subject of his own supervision with his immediate supervisor. To this agency’s credit, Mike’s supervisor did spend some time with him regarding this issue, and he later apologized for his inappropriate boundary breach.

The point to these stories, of course, is that some boundary issues should be clear and out of bounds for supervision. There are simply issues and places that supervisors should not go with their supervisees; for instance, differences in religious beliefs are clearly inappropriate for discussion, especially when pursued in such a hostile manner. If the issue was one of clinical concern, then the issue is in bounds for discussion, but in Muriel's case, the supervisor had no right to pursue her because of his own issues. And even if there was a shade of difference, the fact that Muriel said she was uncomfortable in discussing the issue should have been enough. The other case could be perceived as crossing over into a conflictual place if a supervisor had not made it clear and provided informed consent in regard to training and supervision with a specific model. If a supervisee begins to feel pushed into a direction he or she clearly does not understand or agree with clinically, the supervisor has a responsibility to discuss the meta-issue and stop pushing the model until that issue is cleared up and a forward direction agreed upon between supervisor and supervisee. Clear expectations, using and encouraging "voice," and good feedback will establish an open collegial boundary with good expectations of both participants and "soft influence," thus avoiding pitfalls.

Interestingly, some areas of boundary crossing can be viewed as useful to both parties. For instance, a qualitative investigation of patterns of interaction in clinical supervision found that the process of supervision appears to have much to do with the nature of the relationship, and that openness between supervisor and supervisee can be relationship-focused *and* multihierarchical (Keller, Protinsky, Lichtman, & Allen, 1996). During this research, Keller et al. (1996) discovered that discussing supervision processes (transparency and metacommunications) between supervisee and supervisor increased the level of trust and collegiality between students and supervisors. It was found that supervision can be enhanced by increasing vulnerability on both sides of the relationship and collegiality, without harm to boundaries. It may be that seasoned

ethical supervisors do not worry much about the boundary issues and focus on relationship building in the process. Ethical supervisors may not have to worry about rigid boundaries and thus can spend time forming long-lasting, interesting, and ethical collegial relationships. I, for one, found myself in the lucky situation of having three very competent and well-known supervisors in different situations during my doctoral program. These very generous educators gave their time and talents to help me develop supervisory skills, as well as writing and publishing skills, that I would never have gotten if they had not reached out and developed personal relationships with me.

In agencies, the issue of hierarchy and boundaries are very different than they are in the university setting. Setting us straighter on the appropriateness of boundary issues between our supervisees and ourselves, White and Russell (1997) suggested an alternative, more realistic collegial position, as they pointed out that the more rigid boundaries of therapy are not the same as those supervisors might have with supervisees. Using their training with burgeoning marriage and family therapy students, they made the point that our socialization (social constructs) have taught us to believe that personal and more intimate relationships with clients are regarded as off bounds. While this may be true for our clients, it might often not be true with our supervisees, as this relationship involves creating future colleagues (Ryder & Hepworth, as cited by White & Russell, 1997). "We expect to meet them at future conferences, publish with them, refer clients to them, and so forth" (White & Russell, 1997, p. 330). I believe this to be true, and maybe even more so in agency supervision; at least this has been my experience both personally, as well as with colleagues from agencies where they publish together and also spend time together outside of work, publish and even go to festive conferences away and outside of work. So, supervision relationships do and can cross boundaries, but what seems to keep them from crossing that chasm to the dark side? Lamb et al. (2004) studied the issue of multiple relationships with psychologists and found that their values of

ethics and morals were most often indicated as what helps them from moving outside the boundaries; however, this does not always hold true with supervisees.

I have experienced firsthand in several settings how boundaries can blur and be both beneficial as well as problematic. It is important to remember that boundaries are not real, concrete “things,” but they exist in our minds, formulated and socially constructed by what we have learned from those who teach us, as well as past and current situations. Each circumstance is different and constructed as people come together and utilize their own construct of where they want to go with each relationship. The caution is to be aware that hierarchy can be powerful and abused on both sides. If it feels wrong, check it out with others, and talk about it openly. If you cannot do that, or feel uncomfortable doing so, ask someone else about it, and get good council. The power differential can be a true double bind, where there are mixed messages and one of the parties is uncomfortable with talking about it for fear of reprisal. If that is the case, get out of the relationship and go to someone at a higher level that you trust to talk it out. I do not want to give the impression that all dual relationships are bad. Due to the culture or the whereabouts of the supervision site, the context will change.

When I was a brand new professor, I went to lunch with a site supervisor and our shared student, toward the end of her internship experience to celebrate the end of her term. I intended to pay my own way, but I was stopped by the site supervisor when I went for my wallet and told that our student would be offended if I did not accept her gracious gift. She was Vietnamese and was very proud to “pay back” her two supervisors with a lunch for the time and interest we had given her. So, I got a great Vietnamese lunch and learned about wonderful French coffee that I still love to this day.

The newest issue to come up regarding boundaries is about the ubiquitous social networking sites on the Internet. The CEST-Net, an electronic mailing list for counselor educators, has had a very active debate in regard to the potential

for problems with being “friends” with students or supervisees on these sites. Immature and risky young people can say and post things that perhaps should not be seen anywhere, but they are fearless and sometimes do not understand the risks. Posted information is seen by some as a dual relationship, especially if that information is being shared with supervisees or supervisors.

During this debate, someone mentioned that they hated Facebook and would like to have it disbanded, but she had never been on the site to see for herself. Media changes so quickly. According to a YouTube video from “Did you Know,” there are 200 million registered MySpace users and 31 billion searches on Google every month (see http://www.youtube.com/watch#!v=PHmWZ96_Gos&feature=related), and the video concludes that we live in exponential times, ever expanding our knowledge and the electronic social media we use. Supervisors and educators cannot hide from this, but we can be careful and set out our own parameters, as it has not been set for us as of yet. During this electronic mailing list debate, a woman spoke against all of the cautious writers to say the following:

I have seen the “establishment” rebel against computers, video tape, white board instead of chalk, computer based training, going from disks to USB drives, etc.

Well, it is media, plainly. That is all. The telephone probably started similar discussions.

By the way, if you are relying on a “chain of command” type respect from students, then you probably do not have it now—fear is a bad motivator. Respect is from being professional in your dealings and knowing what you are talking about. If you are honest, you do not have to have two personas.

I had 250 people that used to work for me. Most called me by my first name or nickname, only strangers used my rank. They also generated more output than any other similar organization in the USAF. I never doubted their respect. They did what needed to be done because I asked them to, even when going to war. Their efforts went well beyond what I expected. These sterile “I am the

leader” theories that gave birth to some of these “boundary” discussions are what they seem to be—authoritarian and antiquated. One earns respect. (Fisk, 2009)

There is something about what Lt. Col. Fisk said that rings simple truth for me beyond our attempts to regulate behavior of clinicians and supervisors. If we act professionally and yet are human within the context of our professional regulations, we can extend the professional relationships to become clear and further refined beyond their constraints. I am reminded that Thomas found several of Heath and Tharp’s (1991) points of the supervisory process to be what clinicians want most: a relationship based on mutual respect and a supervision process that becomes a human experience (Heath & Tharp, cited in Thomas, 1996). I do not think it is overkill to point out that White and Russell (1997) suggested a realistic collegial position, where there are less than usual ridged boundaries found in therapy, because we might bloody well be meeting former students at conferences and even publishing with them (White & Russell, 1997). Finally, again I present the words of someone who has been at the top of a hierarchical relationship and who seems to know better: “These sterile ‘I am the leader’ theories that gave birth to some of these ‘boundary’ discussions are what they seem to be—authoritarian and antiquated. One earns respect” (Fisk, 2009).

INTERPERSONAL RELATIONSHIP SKILLS

Important to what supervisors and clinicians do is how we relate to one another. If not for our interpersonal relationship skills in forming and maintaining relationships, we would have nothing. Sometimes called people skills, they include such things as using active listening and reflections and watching how you say things to people—for example, being too gruff, too soft, and so forth—they are the basis of how we relate to one another in everyday life as well as our professional life. Interpersonal skills can also

include such things as how you carry yourself and interact with people. Do you appear confident and yet empathic and caring? Are your words congruent with your facial gestures and body posture? Those who studied communications theory and used it as a model of clinical work (Watzlawick, Beavin, & Jackson, 1969) suggested that all behavior is communication. For example, if my daughter Zoe were to come in our house after school, throw her books on the table, and run up to her room shutting the door quickly without saying hello, I am being told something. How I begin to decode that message will depend on our previous socially constructed meaning making of such or similar behavior. Also, communication is broken down into patterns of what is called report and command or digital and analog processes. Researchers postulated that all communication has both a report (general content) and a command (do something about what I am saying). Nichols, in explaining these phenomena, described it thus: “The report (or content) of a message conveys information, whereas the command is a statement about the relationship. For example, the statement, ‘Mommy, Sandy hit me’ conveys information but also implies a command—Do something about it” (Nichols, 2009, p. 111).

An interesting study by Klein (2009) looked at, among other qualities, what has typically been called the Big Five (see Digman, 1990) of broad domains of personality, in regard to finding the existence of antecedents for higher levels of learning and using interpersonal skills. The results of these analyses provided evidence for the existence of meaningful antecedents of interpersonal skills. The Big Five has been one of the most empirically researched and comprehensive models in human sciences and also one of the most debated. The five factors are Openness, Conscientiousness, Extraversion, Agreeableness, and Neuroticism, not necessarily in that order. These factors can be rated on a continuum, from those who show high to low, and perhaps the antithesis of the named trait. For instance, one can measure high on the agreeableness trait or at the opposite end that would be high as disagreeableness. Each of these

factors also has constituent traits that cluster around the other factors. Briefly, I describe the factors and their traits:

- Openness as a factor includes an appreciation for the arts, adventure, imagination, curiosity, and experience—largely, this factor usually is considered to differentiate between people who are down to earth and those who might be more imaginative.
- Conscientiousness as a factor includes self-disciplined individuals versus those who tend to be more spontaneous.
- Extraversion as a factor includes people who are engaged in life, have lots of positive energy, and enjoy being with people, while introverts can lack social involvement, even though they also may be active and energetic.
- Agreeableness as a trait includes those who are compassionate and caring, tending to be more optimistic and cooperative, rather than suspicious and oppositional.
- Neuroticism as a factor tends to include people who have more negative emotions than positive, potentially being more angry, anxious, or depressed, while at the other end of the continuum includes people who are more relaxed, are most often calm, and do not get rattled as much.

Of interest to those in the training and development field are the findings that two of the personality dimensions, Openness and Extraversion, are related to performance outcome in training programs (Barrick & Mount, 1991). Jang, Livesley, and Vernon (1996) concluded their work noting that the factors of the Big Five have about equal portions of being hereditary and learned, meaning that having good interpersonal skills can be either learned or improved through training; but also we know that they have a big impact on outcomes and openness to change. Interpersonal skills are an indication of how supervisors can influence outcomes because of the way they interact with their supervisees in relationships that are open, engaging, and optimistic. Supervisors who show genuine concern and are open to different experiences rather than being one dimensional seem to engage relationships

more than those who are closed off and have negative views and attitudes toward novelty with their supervisees.

Relationships can be fragile, and yet they are extremely important. We are creatures that are made to relate with one another, and we need to be in relationships to survive. Relationships are the building blocks of our interconnection and human behavior, depending on our interrelationships to work, play, cohabit, cocreate, and nurture our young. Relationships are built on trust and mutual respect. Good relationships are the meat and potatoes of good working clinical relationships. Guidelines for good relationships include being respectful of each other. Name calling and sarcasm, or providing hurtful and harmful feedback, can damage relationships. Showing respect for others as human beings can increase the currency with which relationships depend. When discussing a problem, keep the problem the problem, and do not blame or use language that can be construed as adding fuel to a complicated situation. Do not personalize the discussion, but stay focused on the issues, and use basic “I” statements when in disagreement.

During any conversation there is a tendency to drift from the subject being discussed, to other subjects that one might be reminded of from the conversation. Goal-oriented conversations should, however, have a point. Staying on subject is a great way of making sure conversations progress, and it is the supervisor’s task to do so in a careful and courteous way.

Make it a habit to use reflective, active listening, so you can really understand each other. We all have a basic need to be understood and feel that what we say is important, and our opinions are valued. This means that you should try to see others’ points of view, and let them know you understand, even if you don’t agree. And above all, accept each other with positive regard; basic attending skills make excellent relationship skills.

When we take interpersonal skills into the consulting room, other dimensions and behaviors can also be helpful. If someone is rambling on, it may be appropriate to say quietly and respectfully,

“Can I jump in here please?” But then, after saying what is on your mind, remember to again get back to the person you are discussing with, regarding where you left off. Even restating what you heard the person saying before you interrupted will show that person respect as well as interest. Many of these skills are also useful in conflict resolution, as we shall see.

Conflict Resolution: A Beginning

Not an afterthought, conflict resolution skills are an extremely important part of supervision not usually taught as typical supervision skills. Several authors have researched and discussed the need for conflict resolution skills by supervisors, and have demonstrated that conflicts in supervision sessions are that it is one of the most detrimental factors for new clinicians in how they behave and solidify clinical learning (Korinek & Kimball, 2003; Moskowitz & Rupert, 1983; Nelson & Friedlander, 2001). Issues are discussed, typical critical points in clinical supervision are raised, and suggestions for resolving them are presented.

The research and discussion of conflict and conflict resolution skills in clinical supervision is scarce but entirely needed (Jackson, Junior, & Mahoney, 2007). During a review of the clinical supervision literature, I found that there are very few that mention conflict resolution skills, and yet those who have done supervision for any length of time know that there is a need (Moskowitz & Rupert, 1983). Those who have studied and researched conflict within the supervision process have imparted us with an incredible amount of useful data; all that points to the need for better training in conflict resolution. Over and again issues of conflict during supervision seem to cluster around central issues. The anxiety of the supervisee seems to be central to conflictual situations during supervision. The hierarchical relationship positions the relationship in such a way that the supervisee is subordinate to the supervisor. The very nature of the hierarchy places the supervisee at a lower power level, which leads to either obedience or

insubordination whenever a conflict or disagreement occurs. Conflict resolution assumes a few basic ideas—simple to understand, easy to practice, harder to use in the heated moment unless you have trained and worked at using them. According to conflict resolution theory, conflicts arise when someone becomes uncomfortable with how a current relationship or situation is working. For conflict resolution to become effective, one of the participants needs to at least acknowledge that there is a problem or conflict and speak up with the hope of resolving the current conditions. Next, all parties involved need to be receptive to the idea of resolution. Conflict arises when there are differences in the way two or more people see the situation and/or because they have different value systems or objectives. Polarization of positions creates a tension building up to the point where someone finally says something, and it is acknowledged by all parties. At this point, especially within situations where a perceived hierarchy occurs, the parties will either begin to work toward a solution or insist that the problem is not real, or worse yet, assume that the person who brings up the conflict is the cause.

Dealing with conflict in a supervision relationship, or in any relationship, has two methods or negative outcome reductions. The first is prevention; the second is intervention. As with most mental health concerns, it is less costly emotionally to provide prevention strategies, thus avoiding the problem, than it is to head into intervention strategies after the fact. We look at interventions first, because they also provide us with a series of behaviors that can be useful preventatively.

As we apply conflict resolution to clinical supervision, we must be reminded that (a) the quality of the relationship is seen as essential to positive outcomes in supervision, and (b) the hallmark of successful supervision is the resolution of conflict that occurs naturally because of the power imbalance between supervisor and supervisee (Holloway, 1995; Worthen & McNeil, 1996)—it is a natural component of

supervision and almost any hierarchical relationship. While people battle over opposing positions and solutions—“Do it my way!” “No, that’s no good! Do it my way!”—the conflict is a power struggle. What is needed is to change the agenda in the conversation?. One must adopt a win–win attitude that says, “I want to win and I want you to win too.” The challenge then is how to have this happen.

A Synthesis of Basic Strategies

Let us look at some generic thoughts about conflict resolution strategies and apply them to the supervisory relationship. To begin with, the challenge of adopting a win–win approach decidedly suggests that to be effective, one must change his or her view of a supervisee from an opponent to that of a partner in the conflictual relationship. Both supervisor and supervisee want something out of this relationship. This is consistent to my premise that those with whom we work are truly costakeholders in the process. If a supervisor can remove his or her ego from this process and focus on resolving the conflict rather than being right, a shift in attitude for both will take place that can alter the dialogue that will follow; in fact, dialogue really becomes possible. But, as creatures of habit, we most often find that our default behavior is to defend ourselves when we feel attacked. So, it takes forethought and practice, but in the end, it is well worth it.

Next, research suggests that talking about each other’s needs can significantly change the direction of outcome to a win–win position. Attempting to find what is fair for both parties and working slowly to reach that point in discussion is key. As in Bowenian systems therapy (Bowen, 1978), the secret to most productive change is to remain engaged while maintaining a nonreactive attitude to statements that may enflame. Remembering that all situations can be seen as either problems or as opportunities reframes the supervisor’s intentions and provides a context for the win–win situation all parties hope for, while looking for a creative response

to the conflict can be a turning point in changing problems into possibilities.

The use of empathy for the supervisee’s position can lessen the potential emotional reactivity that will lead to conflict, so good interpersonal skills, active listening, and a building of rapport and openness on both sides can go a long way to defusing conflict and producing solutions. Rather than focusing on personalities and traits that may be irritating, focusing on data—information on both parts in order to get a clear nonemotional picture of what the problem is on both sides—will help. For instance, a supervisor might say the following: “One of the components of supervision is that we have goals that we both agree with. What are you wanting from our time together?” This might be followed up with this: “I understand that you have had lots of experience in CBT, and now you are at an agency where we use Solution-Focused Therapy. I would like to see you succeed in learning the model in addition to your skills in CBT. I believe it might be useful to you in the long run, not that you will have to be chained to it forever. Does that sound reasonable to you? What do you think we might do together to help you in that direction, because I want you to be successful here in your time with us.”

In the scenario I just provided, I was appropriately assertive in speaking about what my goals for this supervisor are in regard to some expectations, and I used “I” statements. The essence of being appropriately assertive is being able to state your case without arousing the defenses of the other person, giving credit for the other person’s skills, saying how it is for you rather than what he or she should or should not do. Your “I” statement is not about being polite; it is not necessarily soft, but it also is not rude. It is about being up front without being reactive. Managing how you are feeling while you begin the process of de-escalating the conflict is very important.

Once the process is moving past the initial conflictual emotions, look for options. Make it explicit that you both have outcomes you desire, and make those outcomes explicit. You might want to suggest that both parties take some

time to take a break and write a list of desirable outcomes—of potentials—so that you can both look at your lists and see where there are commonalities. Looking for common ground makes for a universal position and says we both have some things we want from meeting together that can be agreed upon.

Coleman and Deutsch (2006) suggested two rather out of the box creative components of conflict resolution. One is that after making some decisions regarding outcome, each party takes a break and is so quick to complete a contractual agreement. What is the rationale behind this thinking? They suggested the following: “Research has shown that humans tend to be poor decision makers because they often choose the first acceptable solution to a problem that emerges, even if it is far from being the best that could be developed” (p. 407). They believed that creative tension and not giving in to the first solution can make for longer lasting satisfaction for both parties, because of the engagement and creativity that comes from exploring all the possibilities. Why settle for the first outcome when others that are better might come along (Coleman & Deutsch, 2006)? In addition, they also suggested moving the venue of discussion from one location to another to get perspective and to try to see some humor without being disrespectful, to help both parties move past the seriousness of the situation as “disputants often approach their problems grimly” (p. 408).

During the problem-solving stage of conflict resolution it is useful to break out outcomes and solutions into smaller parts that are easily accomplished. It is also useful to make problems into solvable behaviors that can be tried out first before committing to complete change. Finally, find a location that is common ground, rather than meeting in an office of one of the parties (The Carroll-Keller Group, n.d.). There is too much psychological baggage imbued with an office where the conflict may have begun or where the power of the hierarchical relationship looms overhead.

By taking a broader perspective you may be confronted with the enormity of the difficulties.

Identify what you can do to affect a particular problem, even if it is only a small step in the right direction. One step forward changes the dynamics and new possibilities can open up.

Preventing Conflict

Several ideas I have used successfully come to mind that have prevented potential conflicts in supervision. The first is a concept that is close to what Russian psychologist and educational specialist Lev Vygotsky (1987) suggested, called *scaffolding*. Scaffolding is a teaching pedagogy that includes helping to prop up new learning by providing support, so that the student will succeed rather than fail. There have been many times when I have had students with experience in other similar fields, such as music therapy, or substance abuse counseling, where they have some great skills that could be expanded some. Usually they have a concreteness in their view of the professional relationship and are more like what we discussed in the first stage of development (Stoltenberg & Delworth, 1987) where they hold on to concepts as if they are absolutely true, wanting to show their supervisor that they know something. Later in this book I will tell the story of a student who was a music therapist who had left a doctoral program because one of her professors had told her she needed to abandon all of her previous experience and ideas if she was to succeed. I embraced her previous experience instead and encouraged her to learn even more and complementary techniques so she could be an even better music therapist, as well as a licensed counselor. I utilized her skills to encourage new learning. I know I routed potential conflict right out the door that day.

Next, I have discovered that by naming potential problems now and by dialoguing about them, we collaboratively create potential possibilities and solutions ahead of time. I find it far better to head off problems that I see coming than to deal with them later. Conflicts and differences need not be a problem, if supervisors anticipate, use forethought and creativity to change them into opportunities.

MARY JANE AND CONFLICT—AN EXAMPLE

Mary Jane was the director of clinical experience at a large mental health agency, and she was having difficulty with her boss Paul, as many people have had before her. Paul, a rather newly hired CEO, had been experienced by staff as someone who was dictatorial, ran a top-down hierarchical organization, and “bullied” people into submitting when he wanted his way. Mary Jane was just like her boss; she didn’t give an inch but she was also on the board of directors, and so she had some leverage. Paul demanded a face-to-face meeting in his office to settle their conflict, and she had put him off saying she wanted to think about their situation and her options. She asked me to consult to see if there might be a way of leveling the playing field. We talked about options, and she wanted to go after him, invoking the support of friends on the board of directors, to give Paul his walking papers. I suggested that they were not about to run him out of town, but she might gain some leverage by doing three simple acts. First, she needed to stop being so reactive to what Paul did, and think logically. Next she needed to prepare for any meeting, and bring along an advocate so that Paul’s usual bullying would either be corroborated by another or would not happen. And finally, she needed to have the meeting on neutral grounds, rather than in Paul’s office. As a good consultant, I talked with her about this, attempted to get a commitment from her to follow through on my suggestions, and let her go to work on this plan. She was able to complete two of the three, but Paul was adamant about meeting in his office. The meeting terms were negotiated and she met with a list of complaints, which included conditions for other workers; she also requested that he stop his bullying behavior or she would bring it to the board of directors. All conditions were documented, because her advocate was present, and Mary Jane felt satisfied. Although she did not get everything she asked for, the meeting was productive, and the organization began to run better.

Promoting Counselor Self-Efficacy and Personal Agency: A Core Executive Skill

An individual’s beliefs about their ability to carry out behaviors, and their beliefs about the connections between their efforts and the results of those behaviors to affect motivation, behaviors, and the persistence of effort, are called self-efficacy (Bandura, 1977b). Self-efficacy is the belief in one’s capability to organize and execute the sources of action required to manage perspective situations (e.g., “I know I can do it”; Bandura, 1986). Personal agency is the ability to originate and direct actions for a specific purpose

(e.g., “I have the skills and knowledge to set a goal, begin working toward that goal, and complete a task”). Personal agency is directly linked to the person’s belief in his or her ability (self-efficacy). Personal agency is characterized by a number of core features, including intentionality, forethought, self regulation, and self-reflectiveness about one’s capabilities, quality of functioning, and the meaning and purpose of one’s life pursuits.

Counseling self-efficacy (CSE) and the personal agency that goes with it are key to both basic and strengths-based clinical supervision principles (Daniels & Larson, 2001). But where does it come from? How do counselors obtain or

learn to have agency? They gain agency every time they have a mastery experience in the field. Watching new counselors realize that they can make it through a session with a new client and noticing that they don't stall, or that they ask the right questions and noticing that their client smiles when they are leaving—that is a mastery experience. Each time puts more experience in their bank. Clinicians gain agency when they watch their supervisor actually do a live clinical session and know that they can replicate a technique or skill they watched, again adding to their bank. As supervisors encourage their supervisees, they are persuaded to try new things or take stock in how far they have come.

To have personal agency is to intentionally make things happen through one's actions. The core features of agency enable people to play a role in their own self-development, adaptation, and self-renewal with changing times. Personal agency comes from several sources: mastery experiences, vicarious experiences, verbal persuasion, and personal psychological states. As supervisees try out their new learning, they receive internal (and perhaps external) feedback of their successes, adding to their fund of agency regarding a specific task (mastery experiences). Vicarious experiences as well as verbal persuasions from their supervisor can increase their agency; as they are asked questions regarding their own views of their behavior—meaning-making questions—supervisees begin to internalize their successes. According to their own internal psychological state, supervisees will include these skills as their own, value them, and evaluate them. Some supervisees have a greater capacity to look at their own skill levels and learn with optimism, while others do not learn self-efficacy and may need more time to begin changing their internal views. It is useful to see these psychological traits as learned, rather than as personality traits. Optimism has been shown to be a learned phenomenon (Seligman, 1996).

In my experience, CSE is cocreated by, and includes the use, of strength-based clinical values, supervisory forethought, and finding and using one's own voice (Covey, 2004). Others have also

included intentionality (a representation of a future course of action to be performed), forethought (setting goals, creating a course of action likely to produce desired outcomes, while avoiding detrimental ones), self-reactivity (in order to self-motivate, and give shape to the course of action), and self-reflectiveness (Larson, & Daniels, 1998). This becomes perceived self-efficacy, and it can influence whether people think pessimistically or optimistically—and are self-enhancing or self-hindering. None of the components of agency are more central than the belief in one's capability to exercise a measure of control over his or her own functioning and environmental events. To be efficacious, counselors must orchestrate and continuously improvise multiple subskills to manage ever-changing circumstances in the session. It is one's *perceived* self-efficacy and personal agency that allows one to make judgments of how well one can execute the actions and make corrections to shape the future. The use of agency questioning has been used in both Solution-Focused Therapy as well as Narrative Therapy. Questions that ask people for their input into their own positive processes help them to interpret and restory their events in a way that illuminates their own successes in some endeavor, in this case success in a clinical session. Questions such as "How do you think you were able to do that?" or "Given your struggles to achieve a more successful outcome with that client, in what part of the discussion (with the client) did you find you were playing a more useful role with your client, and how were you able to do that?" play an important role in helping clinicians see their growth and successes during a part of their own development, when they might be prone to look in the other direction.

Several behavioral components are important to following through with one's personal agency: people must have forethought; their behavior must have directionality and intentionality; they must be able to self-regulate their actions, rather than be cast to random thoughts and feelings; and finally, they must be self-reflective, using evaluative feedback, correcting their efforts back toward their goals should they error. What determines

forethought's direction, however, are the personal standards and values of the agent. This is a circular process and an evolving process. According to Bandura (2001), people check on their actions through what he called performance comparisons with one's own goals and standards, all of which are imbedded in our personal value system or what he believed to be our "moral agency." Self-efficacy is far easier to explain than it is to teach rationally. One can, I believe, facilitate the building of someone else's self-efficacy through modeling, giving praise, and positively punctuating when someone is on track by our discussions, but for the actual learning, the self-feedback must come from and be internalized by the person living the experience of growing self-efficacy.

This personal feedback process, which others call second-order cybernetics (Bateson, 1979), or the newer term top-down metacognition (Siegel, 2007), is the internal guidance system that keeps us on track but that is always inputting new, novel information, thus learning. The interesting part of this concept, now proven through brain research, is that it filters out "negative" information (information that doesn't fit with what one already "knows" to be true or believe) and only attaches meaning and interest in change (learning) when presented in a way that allows for adaptation. In other words, we attempt to maintain what we already believe to be true, while canceling out what we believe to be false, even when presented with evidence to the contrary. Learning is homeodynamic.

Thoughts on Self-Efficacy and Personal Agency

In my opinion, one of the most important components of supervision is the continued imparting of our belief in our supervisees and the development of their own agency. It is my opinion that supervision—as in clinical work—should be agentic in all we do. I believe it is the crux of strengths-based work. Agency helps us to have voice, morality, and a sense of self as a

basic creator of our personal and professional lives and our ability to produce quality work; at the same time we learn from our mistakes without being overly upset by them. Agency is recognizing that we can create our own way, not as something perfect, but with excellence—with elegance. As Michael J. Fox has said, "I am careful not to confuse excellence with perfection. Excellence, I can reach for; perfection is God's business" (Fox, n.d.). Personal agency also means knowing how to pick one's self up and move on, learning from our efforts, so we might adapt and be resilient. This is the most critical piece of supervision we can provide—to our supervisees, our clients, ourselves, and to others.

Session Management

Many of the clinical mechanics are the same for both clinicians and supervisors. When and how do you start a session? Do you contract for goal-oriented outcomes or do you just open the session up to listen and talk? How do you terminate supervisory contact? Do you do it when they retire or graduate or never? What happens when your supervisee is cranky or angry? How do you de-escalate the process, and how do you bring the session and the relationship back to a working productive venue? Session management includes those behaviors and processes that we all do and mostly do well. My take on it is that we as supervisors should consider what we do from the beginning of a contact—opening moves with first-time supervisees—to the ending. I also think we should not only model these for our supervisees, we should ask them to consider how they want to run their sessions with their own clients and help them develop their own operating principles for session management. After all, it is not our session, but they may pick up the fact that we trust them but want them to consider how to have a session that has forethought and alternatives for potential problematic situations. I want my supervisees to have back doors of escape (sometimes literally) and a thought-out plan for session management that will provide comfort and structure for both

them as well as their clients. I cannot tell them how to do it, but I can have a discussion about how I have done specific things that work for me. So, I end this chapter here and suggest that you outline potential sessions' management from beginning to end, right now.

THE RELATIONSHIP BETWEEN
SUPERVISOR AND SUPERVISEE—
PERSONAL AND PROFESSIONAL

Reflections

The novice as well as a seasoned supervisor needs to hone his or her executive skills, which I laid out earlier. Without them, supervisors will

float in the flotsam of the events, conflicts, and processes that occur while helping supervisees work in their area of expertise. In clinical work, this means that developing executive skills are as necessary for clinicians as they are for supervisors—the processes are isomorphic.

It is the executive skills that transcend the models, clinical beliefs, and dilemmas that clients come with. Seeing one's supervisee—co-see or stakeholder—as the main person the supervisor is responsible for places the supervisor in a position to be most helpful to the supervisee's growth and development, rather than as a super astute manager of someone else's cases. These executive skills allow the clinical supervisor to move ahead with what Covey (2004) believes is a change from effectiveness to excellence.

