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PSYCHOTHERAPY-BASED APPROACHES TO SUPERVISION

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For the novice clinician, the task of learning how to conduct psychotherapy is both personally and professionally challenging. Trainees, who may be quite competent at teasing out psychological complexity in the classroom or in case conference, may find themselves adrift in the therapy room. Seemingly straightforward clinical interventions are found to be less so in actual practice, and interpersonal skills, which may have served trainees well in their personal lives, may be strained in their attempts to develop an effective therapeutic relationship. By its very nature, psychotherapy is a complex interpersonal process that requires the clinician to incorporate theory and evidence-based practices in a systematic, yet flexible, manner to enhance client collaboration and to promote understanding and cognitive and behavior change. The training process is further complicated by the multiple, and often competing, approaches that may be taken in treatment.

Psychotherapy-based supervision orders the learning process by providing a coherent approach to therapy in which knowledge, theory, and technique derived from a specific orientation inform the conduct of treatment and provide a clear focus for supervision. Further, techniques used in therapy may be tailored and used as learning strategies in supervision, for instance, attending to dreams in psychodynamic supervision or assigning homework in cognitive therapy

supervision, providing the trainee with a direct experience of the use of the intervention. In addition to providing an organizing heuristic for training, psychotherapy-based supervision provides a foundation on which specific competence can be developed in treatment protocols, which have demonstrated efficacy for particular psychiatric conditions. While being mindful that contemporary psychotherapy practice increasingly appears to be integrative in nature, training aimed at ensuring preprofessional competence is enhanced, in our view, through psychotherapy-based supervision in which a foundation of skills can be obtained. In the following sections, we present three models of psychotherapy-based supervision, which illustrate learning approaches that intentionally provide a correspondence between theory and practice in supervised treatment and in supervision.

SUPERVISION IN COGNITIVE THERAPY¹

Cognitive therapy is a form of psychotherapy that is based on a cognitive conceptualization of the client. Clients' difficulties, including both emotional and behavioral reactions, are understood in terms of their perceptions of situations, which are influenced by their basic understandings of themselves, others, and their worlds. In addition to offering an evidence-based approach, cognitive therapy aims to achieve its therapeutic objectives in a time-efficient manner; thus there is an emphasis in sessions on actively identifying key problems and cognitions and teaching clients skills to solve problems, modify dysfunctional thinking, reduce distress, and increase functional behavior. To accomplish these objectives, therapists intentionally structure sessions, collaboratively set agendas, focus on problem solving, and suggest between-sessions assignments. Therapists and clients operate as a team, and therapists directly elicit feedback at the end of sessions.

Challenges in Cognitive Therapy Supervision

There are several challenging aspects of conducting cognitive therapy effectively; these aspects make supervising challenging as well. First, basic counseling skills are critical. Therapists must demonstrate appropriate empathy, caring, regard, and very important, accurate understanding. What is appropriate and helpful to one client, though, may be unhelpful to another, because clients (especially those with personality disorders) vary both in their desire for closeness with their therapist (Safran & Muran, 2000) and in their preferred interpersonal styles.

¹Judith S. Beck contributed the section "Supervision in Cognitive Therapy."

Second, therapists must learn the cognitive conceptualization for each of the Axis I and Axis II disorders and how to use this theory-based understanding to formulate general treatment plans, because key cognitions, and the approach to modify them, differ from disorder to disorder (Padesky, 1996). When clients are depressed, for example, effective treatment focuses on their negative ideas about themselves, their worlds, and their futures (among other things). When clients have panic disorder, though, therapists need to focus on clients' catastrophic misinterpretations of bodily or mental sensations. Understanding the general formulation and treatment for a given disorder is often insufficient, because many times clients present with comorbid conditions or complex problems. Therapists must also learn how to quickly conceptualize the individual client within therapy sessions and to use this conceptualization to develop a plan that will not only help the client feel better by the end of the session but also prepare him or her to have a better week (Beck, 2004). This requires both a sophisticated application of cognitive principles and the ability to readily apply them in the here and now of the psychotherapy session.

What also makes cognitive therapy supervision challenging is the importance of conceptualizing and planning at two levels. Supervisors have to not only conceptualize clients' difficulties and how to ameliorate them but also conceptualize therapists' difficulties and how to approach and teach the therapist (Liese & Alford, 1998). Supervisors first determine the client's most important problems, cognitions, and behaviors to address. Then they identify the skills (conceptual and technical) that the therapist must use for the treatment to be optimally effective. Finally, they conceptualize the therapist's difficulties and develop a plan for remediation. To accomplish these tasks, supervisors must engage in an ongoing assessment of the therapist's competencies as well as developing a supervision plan that considers how best to instruct, taking into consideration the therapist's level of experience and expertise, attitudes toward supervision and toward the supervisor, attitudes about their clients, preferences, personality styles, and previous (and perhaps concurrent) experiences in supervision (Newman & Beck, in press).

Features Common to Both Cognitive Therapy and Cognitive Therapy Supervision

Cognitive therapy supervision shares some commonalities with cognitive therapy treatment, including the following:

- developing the relationship;
- planning the session on the basis of one's conceptualization;
- structuring the session;
- collaboratively setting homework, including the practice of standard cognitive therapy tools; and

- using techniques within the session such as direct instruction, guided discovery, role play; and
- responding to automatic thoughts or beliefs, and composing coping cards.

These techniques and practices are described subsequently.

Supervisors, like therapists, need to develop a sound relationship with supervisees (Newman, 1998). Doing so serves a dual purpose. It allows the supervisee to feel safe and to trust the supervisor, which usually leads to a good, collaborative relationship. And it allows the supervisor to model basic interpersonal skills: positive regard, empathy, and accurate understanding. As in therapy, supervisors seek to create a balance between (a) eliciting and reinforcing adaptive behavior and positive experiences and (b) correcting maladaptive thinking and/or behavior. Also, they seek to have the supervisory relationship be viewed as collaborative teamwork: supervisors and supervisees working together to achieve goals.

Another common feature is planning the session on the basis of one's conceptualization. Therapists need to conceptualize the client and supervisors need to conceptualize both the client and the therapist's conduct of the therapy session. To develop accurate conceptualizations, therapists are asked to present clients' diagnoses, demographic information, presenting problems, clear descriptions of their current functioning, and history (developmental, family, social, educational, vocational, medical, and psychiatric). As therapists collect additional data, their supervisors help them conceptualize clients according to the cognitive model. Supervisors often teach therapists to use the Cognitive Conceptualization Diagram (see Figure 4.1), to aid them in quickly identifying clients' key problems, cognitions, and coping strategies. This worksheet allows therapists to learn how to plan treatment in and across sessions (Beck, 2006).

A third common feature involves the structure of the supervision session, which parallels the structure of a therapy session, as seen in Exhibit 4.1 (Liese & Beck, 1997). First, the supervisor does a check-in with the supervisee, to reestablish their alliance, for example, "How are you? How was your week?" This is similar to doing a mood check with clients, in which clients are asked to rate their moods and make a comparison with previous weeks. Second, the supervisor sets an initial agenda with the supervisee, for example, "So, if it's okay, we'll review what you did for homework and I'll give you feedback on the session I listened to. Is there anything else you want to put on the agenda?" Supervisees often have questions about their readings, diagnostic criteria, other clients, cognitive therapy concepts and techniques, and how cognitive therapy conceptualizations and interventions compare with those from other psychotherapeutic modalities. Therapists set agendas with clients, too, although usually with a more specific question, for example, "What problem or problems do you most want my help in solving today?"

Next, the supervisor makes a bridge between sessions, reviewing what the therapist did for homework and what was learned from it. The supervisor also

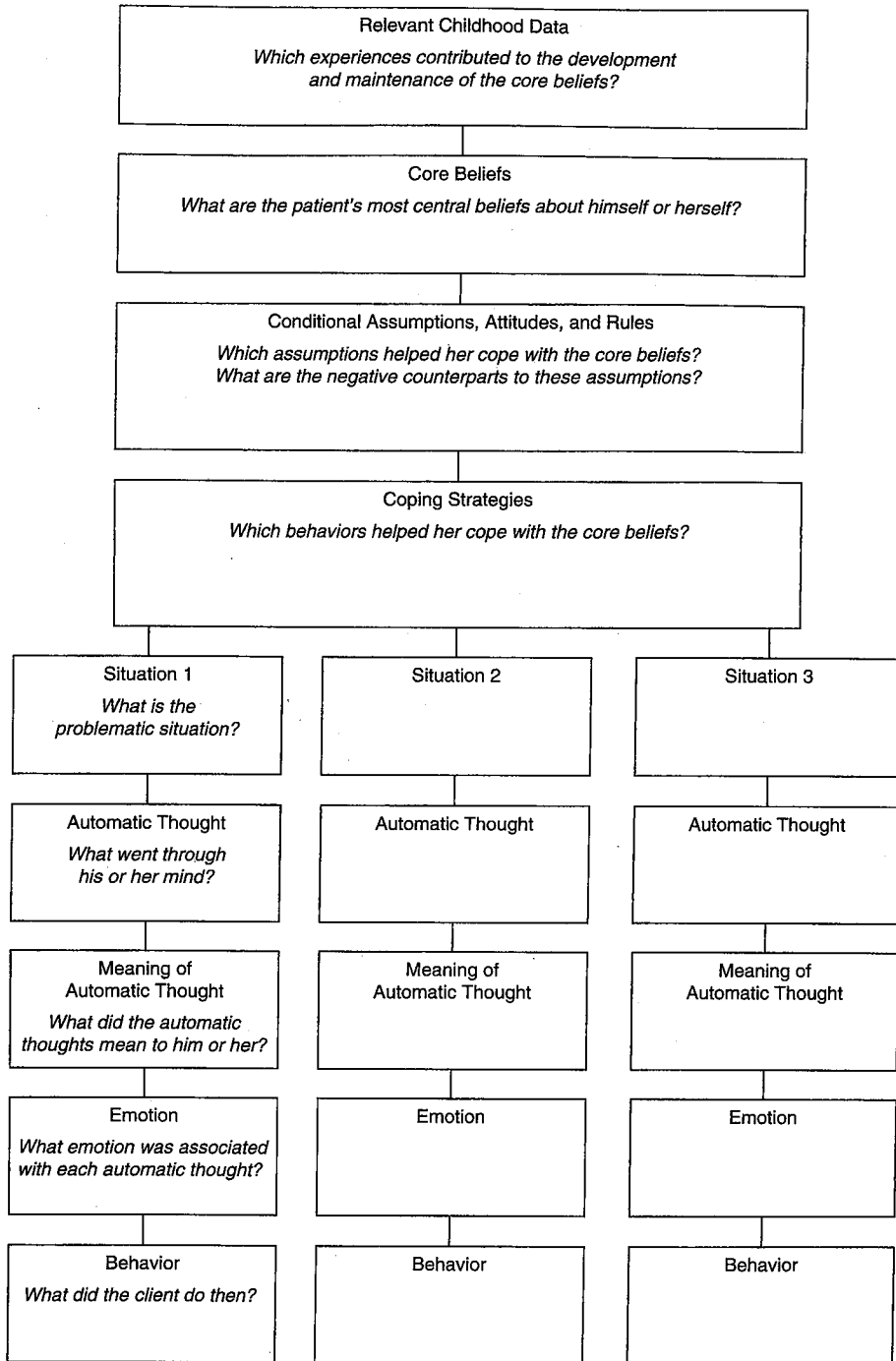


Figure 4.1. Cognitive Conceptualization Diagram. From *Cognitive Therapy Worksheet Packet* (p. 3), by J. S. Beck, 2006. Bala Cynwyd, PA: Beck Institute for Cognitive Therapy and Research. Copyright 2006 by J. S. Beck. Reprinted with permission of the author.

EXHIBIT 4.1
Comparison of Therapy Session Structure With Supervision
Session Structure

Structure of therapy session	Structure of supervision session
1. Mood check	1. Check-in
2. Set agenda	2. Set agenda
3. Bridge	3. Bridge
4. Prioritize agenda	4. Prioritize agenda
5. Discuss problems	5. Discuss case(s), problems, etc.
6. Homework	6. Homework
7. Summary	7. Summary
8. Feedback	8. Feedback

Note. From *Handbook of Psychotherapy Supervision* (p. 121), by C. E. Watkins, Jr. (Ed.), 1997, New York: Wiley. Copyright 1997 by Wiley. Adapted with permission.

finds out if there is anything else the supervisee feels is important to mention, for instance, if the therapist had any contact with the client between sessions. This bridge is similar to a therapy bridge in which the therapist asks the client about homework, about important events (positive and negative) that happened between sessions, and whether there is anything the therapist should know that might arise before their next session.

Then, the supervisor asks the therapist to prioritize the agenda and select an initial topic or problem to discuss. (Usually, it is feedback on the therapy tape the supervisor has reviewed.) They discuss the session, and the supervisor provides concrete feedback and teaches the therapist needed skills. The supervisor checks on the therapist's understanding; then they collaboratively set a relevant homework assignment. A beginning supervisee, for example, may not be familiar with helping clients make a decision by recording and assessing the importance of advantages and disadvantages. The supervisor might describe the process verbally and/or role play the technique with the supervisee. A natural homework assignment would be to read more about the technique, to apply it to a decision the therapist needs to make, and to implement it when appropriate with a client. Selecting a problem, doing problem solving, teaching skills, eliciting the client's understanding, and collaboratively devising a follow-up homework assignment are typical occurrences in therapy sessions as well.

Assigning supervisees to use the same basic cognitive therapy tools as their clients serves several purposes (Beck, 1995). Using worksheets such as Dysfunctional Thought Records (Beck, 2006) to respond to their client-related (or supervisor-related) dysfunctional thinking can help supervisees reduce anxiety or frustration with clients (and supervisors). Using cognitive therapy techniques can also help them better understand how to explain such techniques to clients. In addition, therapists often gain insight

into the importance of motivating clients to do their homework assignments. If they themselves have difficulty completing their supervision homework, they begin to see how difficult it is for their clients. When therapists read consumer-oriented cognitive therapy material (prior to suggesting that their clients read it), they often learn important conceptual and treatment issues, strategies, and interventions. Finally, many standard cognitive therapy techniques, such as activity monitoring and scheduling, can help therapists do better self-care.

A final commonality between cognitive therapy treatment and supervision is the use of standard techniques within the session. At various times, the supervisor may use direct instruction ("Here's how to do activity scheduling with a client"), guided discovery ("How do you think your client might answer the following: 'If I start to get overwhelmed with negative emotion, then [what bad thing might happen]?'"), role play ("How about if you play yourself, and I'll play your client, so you can practice teaching me about the cognitive model?"), responding to automatic thoughts or beliefs ("What's the evidence that you'll actually do harm to your client? Is there evidence on the other side, that at worst, you just won't help him very much at the next session?"), and composing coping cards ("When I get anxious before my next therapy session, remind myself that I shouldn't be able to cure the client during the session but that I can probably reestablish a nice relationship and do some problem solving with him.").

Features Unique to Supervision

In cognitive therapy supervision, supervisors listen to therapy tapes in their entirety. This practice is important because therapists are often unable to accurately pinpoint, and therefore report, problems (Liese & Beck, 1997). Difficulties in any given session may be related to one or more of a host of factors: a problem in establishing or maintaining a sufficiently strong therapeutic alliance, in collecting important data, in conceptualizing the client, in developing a coherent strategy, in structuring the session (which often includes skillful and gentle interrupting), in setting an agenda, in focusing on problem solving, in eliciting or effectively helping clients respond to key cognitions, in checking on client understanding and agreement, in reviewing or collaboratively setting homework assignments, and/or in eliciting and appropriately responding to clients' feedback.

Difficulties may also arise from factors external to a specific therapy session. Clients may require more treatment or a higher level of treatment than they are receiving; they may not be receiving or consistently taking appropriate medication; they may have an undiagnosed organic problem, and/or their environment may be too deleterious for them to progress (Beck, 2005). It is difficult, if not impossible in some cases, for supervisors to offer effective guidance if they cannot assess the data directly from therapy tapes.

When listening to tapes, supervisors ask themselves the following questions to help them plan their supervision sessions:

- What seem to be the client's most important problems, cognitions, emotions, and behaviors?
- What other data is necessary to conceptualize the client and formulate an overall treatment plan and strategy for the following session?
- What did the supervisee do well?
- What were the supervisee's weaknesses (conceptual, interpersonal, behavioral)?
- What does the supervisee need to learn in terms of diagnostic considerations, conceptual ideas, strategies and techniques?

Supervisors often use the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980), as a guide when listening to therapy tapes. The CTRS enables supervisors to identify strengths and weaknesses of the therapy session and highlight problems. This scale, used in major research studies and by the Academy of Cognitive Therapy to assess competence, contains 11 items:

- agenda,
- feedback,
- understanding,
- interpersonal effectiveness,
- collaboration,
- pacing and efficient use of time,
- guided discovery,
- focusing on key cognitions or behaviors,
- strategy for change,
- application of cognitive and behavioral techniques, and
- homework.

Although the CTRS was developed as an evaluative tool, it can also be used as an important supervisory tool, allowing supervisors to conceptualize therapists' difficulties, specify problems, and plan supervision. Supervisors can also teach therapists to review their own tapes, use the scale, and discuss their ratings at the next supervision session. In this way, therapists themselves can become more proficient at assessing their performance and identifying the areas in which they need improvement.

AN EXAMPLE OF THE APPROACH

Emily was a postdoctoral fellow with minimal therapy experience. The client she presented in our first supervision was a severely depressed 57-year-old married African American woman, Joan. During the initial supervision session,

we discussed administrative details, reviewed the cognitive model and basic principles of cognitive therapy, established Emily's goals for supervision, and delineated my role as a supervisor and her role as a supervisee. She then presented Joan's case, and we developed an initial cognitive conceptualization, based on the data Emily had collected. Emily's homework assignment was to review several chapters in a basic cognitive therapy text (Beck, 2005) and to read a coping card we had collaboratively devised in session to address Joan's anxious thoughts about being a poor therapist.

When listening to the tape of Emily's next session with Joan, I found that Emily was quite passive. She primarily listened to the client and occasionally provided empathy and some reflection and support. The content of the session was quite conversational in nature, dealing with some of the client's current and past experiences (some of which were problematic, some of which were not), and especially her difficulties with her alcoholic husband.

In deciding how to supervise Emily at the next session, I first asked myself, "What are the most important things for her to do in the next session?" Specifically,

- Does she need to change anything to strengthen the therapeutic alliance?
- What data does she need to obtain from the client?
- What does she need to learn conceptually?
- What does she need to learn about structure?
- What techniques does she need to learn?

I also had to take into consideration the strength of our supervisory relationship and the level of Emily's anxiety in deciding how to approach her.

In our next supervision session, I did a general check-in with Emily. Then we set a broad agenda: a (quick) review of our previous supervision session and Emily's homework, my feedback on her tape, and a few specific questions Emily had about cognitive therapy. Emily had found reading the chapters and reviewing her coping card helpful, and we reviewed the cognitive model in terms of Emily's anxious cognitions about doing cognitive therapy.

In providing feedback about the tape, I first assured Emily that there were things she had done well in the session, for instance, she had a nice manner with the client, demonstrated accurate reflection, and used empathy well. I then listed the most important things I wanted to spend time on during our supervision session (i.e., getting the big picture about Joan, structuring the session, and focusing on problem solving) and elicited her agreement. It is important to note that had I found a problem with the therapeutic relationship, I would have addressed this difficulty first and foremost, because a problematic alliance may lead to a client's leaving treatment prematurely or failing to engage sufficiently in treatment (described briefly below). In this case, Emily seemed to have a reasonable alliance with the client, so we discussed the client's major problems.

Emily identified some difficulties she had gleaned from her first two sessions with the client: problematic relationships with her husband and grown son, general loneliness, and lack of pleasure. Given that Joan was severely depressed and had not spoken about engaging in any activities outside of the house, I hypothesized that an important initial goal in treatment might be to help the client become behaviorally activated. Emily had not realized it, but she was lacking crucial information about the client's daily activities. Through questioning, I helped her understand that it was probably more important initially to ensure that the client was behaviorally activated than it was to spend time trying to improve a very long-standing marital problem that the client was unlikely to make much headway with in the coming week. We then discussed a technique for obtaining the data Emily needed about the client's daily schedule. We role played how Emily could ask the client to describe a typical day, from the time she woke up in the morning until the time she fell asleep at night, and how to use this data to guide the client in setting goals.

Next, we role played how Emily could set an agenda and obtain the client's consent to add the topic of increasing mastery and pleasure activities, if as we suspected, Joan's days were unstructured and largely unproductive. When I again elicited Emily's feedback, I recognized that she needed help responding to her dysfunctional ideas about interrupting the client (see transcript below). We then discussed how Emily could help the client commit to scheduling some activities in the coming week. I also suggested that Emily do some additional reading on setting agendas, on behavioral activation, and on setting and reviewing homework with clients. We concluded the session with my asking Emily to summarize what she thought was most important for her to remember or reflect on in the coming week and asked her for feedback.

The following transcript illustrates how I helped Emily respond to concerns she had about interrupting the client to set an agenda. I initially framed her concerns in terms of the cognitive model and then used standard techniques to help Emily evaluate and respond to her automatic thoughts. I then reviewed this process of evaluation, comparing it with the process Emily will use to help her client evaluate her thoughts.

Supervisor: Okay, let's come out of role play [about interrupting to set an agenda]. What did you think of that?

Supervisee: [Hesitantly.] Well, it sounded pretty good. . . .

Supervisor: But?

Supervisee: I don't know. I guess it makes me feel kind of uncomfortable.

Supervisor: [Emphasizing the cognitive model.] So if you're feeling uncomfortable, we know you must have had some automatic thoughts. What were you thinking as we did the role play?

Supervisee: I'm afraid the patient won't react well if I interrupt her.

Supervisor: Okay, is it okay if we evaluate that thought?

Supervisee: Sure.

Supervisor: Now, this is the kind of questioning you'll use with Joan sometimes. First, is there any evidence that Joan won't react well if you interrupt her?

Supervisee: I'm not sure.

Supervisor: Well, does she seem prickly to you? Easily offended?

Supervisee: [Thinking.] No, I don't think so.

Supervisor: Any evidence on the other side—that she might react okay?

Supervisee: [Thinking.] I guess I don't really know one way or the other.

Supervisor: Well, I guess the worst that could happen is that she could get annoyed, and then you could just say, "I'm sorry," and let her continue talking.

Supervisee: Yeah.

Supervisor: What's the best that could happen?

Supervisee: Well, that she wouldn't mind.

Supervisor: In fact, maybe the best is that she'd be grateful you're directing the session more and helping her with her problems.

Supervisee: Yeah.

Supervisor: What do you think the most realistic outcome is?

Supervisee: I don't know. I guess maybe she'd be surprised, but maybe not annoyed.

Supervisor: What's the effect of believing that she's not going to react well?

Supervisee: I guess it makes me feel uncomfortable about interrupting.

Supervisor: And what could be the effect of changing your thinking about this?

Supervisee: I guess I could try it more easily.

Supervisor: Which might then really benefit the patient.

Supervisee: Yeah.

Supervisor: So what do you want to do?

Supervisee: I'll try it. I guess there's nothing really to lose.

Supervisor: [Coming out of role play.] Okay, good! Now, can we review what we just did? Because this is what you'll often do with clients. You reported feeling uncomfortable, so I asked you

what was going through your mind, and you told me your automatic thoughts. I then asked you if it was okay to evaluate your thought, and when you agreed, I just asked you a standard list of questions to help you see the situation differently. [Pauses.] And how do you feel now?

Supervisee: Better. Not so uncomfortable.

Supervisor: Good. Now I'm going to show you how you can record what we just did on a Dysfunctional Thought Record. You see that the first few boxes are just the cognitive model. The questions I asked you are printed here at the bottom. Sometimes they all seem to apply; sometimes just one or two seem to apply. But they're designed so patients can really analyze how realistic and useful their thoughts are, instead of just telling themselves, "Oh, maybe this isn't true," or just responding superficially to them.

Supervisee: Uh-huh.

Supervisor: In chapter 8 [of *Cognitive Therapy: Basics and Beyond*], you'll read more about this kind of Socratic questioning. But Emily, it's important to realize that the Dysfunctional Thought Record isn't appropriate for all clients. If you read the chapter, though, I think you'll get a better idea about what Socratic questioning is like.

Supervisee: Okay.

Supervisor: So, how about for homework if you read chapter 8 and do a Dysfunctional Thought Record on this thought: "Joan won't react well if I interrupt her"?

Supervisee: Sure.

Supervisor: And if you're feeling anxious or uncomfortable about anything else having to do with Joan or therapy or supervision, you could do another Dysfunctional Thought Record. The more you do yourself, the better you'll get at them and the better you'll be able to help your clients with them.

This kind of discussion served a dual purpose. First, it addressed the supervisee's concerns and made it much more likely that she would follow through with her supervisor's suggestion at the next therapy session. Second, it reinforced the cognitive model and demonstrated to her that identifying, evaluating, and responding to automatic thoughts can help one feel better and behave more functionally. Having experienced a change in affect herself, the therapist deepened not only her understanding of, but also her appreciation for, the Socratic questioning process.

Conclusion

Supervision in cognitive psychotherapy shares with other psychotherapy-based approaches the task of helping trainees to integrate theory into clinical practice and to apply theory-based knowledge and techniques in the clinical setting. Cognitive psychotherapy supervision is distinctive in that many of the foundational principles and techniques used in psychotherapy are directly implemented in supervisory practice. Although not intended to produce therapeutic benefits to the supervisee, attention is placed on supervisee attributions and beliefs, the effects of such beliefs on psychotherapy practice, behavioral techniques to reduce anxiety and to enhance skill development, directed and structured activities during supervision sessions, and the use of between-sessions assignments to facilitate learning and skill development. Supervisors must necessarily possess interpersonal strengths and be highly trained and experienced in the clinical application of cognitive behavior psychology as well as in the implementation of a cognitive approach to learning and skill development. Such an approach is consistent with an evidence-based orientation in professional practice.

PSYCHODYNAMICALLY ORIENTED SUPERVISION²

The relational psychodynamic model of supervision, which I present, draws on relational psychoanalytic clinical theory (Aron, 1996; Hoffman, 1998; Mitchell, 1997; Pizer, 1998) about the centrality of relationships in structuring the mind. In the relational psychodynamic literature on supervision (Berman, 2000; Frawley-O'Dea, 2003; Frawley-O'Dea & Sarnat, 2000), client, therapist, and supervisor are viewed as cocreators of two reciprocally influential relationships, the clinical relationship and the supervisory relationship. Exploration of the supervisory relationship, as it relates to the clinical relationship, is considered essential to the tasks of supervision. This model is especially well suited to address unsymbolized affective states that arise within clinical relationships—states that supervisory models that rely primarily on symbolic communication between supervisee and supervisor tend to neglect. When disturbing states of mind are transmitted from client to supervisee, they are often subsequently enacted with the supervisor rather than verbally described to him or her. By attending to the supervisee's countertransference experience and to the supervisory relationship, such states become accessible for processing.

Relational psychodynamic supervision shares many commonalities with the treatment approach it is based on, and it is also intended to teach. The

²Joan A. Sarnat contributed the section "Psychodynamically Oriented Supervision."

medium of instruction thus becomes the message. For example, in both the relational psychodynamic therapeutic and supervisory situations:

- The helper is interested in the “regressive experiences” (Sarnat, 1998) and the transferences and resistances of the person being helped as these interact with his or her own;
- The helper cultivates a state of reverie (Ogden, 2006), which leads to the reception of, and eventual translation of, nonverbal states into verbal understanding; and
- The helper emphasizes the here-and-now experience as a vehicle for psychological growth.

At the same time, the supervisor is not constrained to functioning only as a model for the therapist. He or she also fulfills the more usual supervisory functions, both didactic and mentoring, that are distinct from the relational psychodynamic therapeutic role.

Exploration of therapist countertransference plays an important part in this kind of supervision, and the teach–treat boundary is defined in a way that is meant to provide a safe and spacious container for that important work. The supervisor makes himself or herself available for exploration of supervisee unconscious material and regressive experiences insofar as these may relate to the supervised treatment (Sarnat, 1998) while also making it clear that the supervisee is free to set limits on the extent and depth of that exploration. The supervisee who is in treatment may of course elect to analyze her countertransference response with her therapist. Nonetheless, this model asserts, the impact of the therapist’s psychology on his or her work with his or her client may be helpfully addressed by the supervisor. The commitment of the relational supervisor to also explore his or her own dynamics as they impact the work protects the supervisee from becoming the container for supervisor anxiety and defense, and it mitigates supervisee shame³ (Sarnat, 1992). Throughout supervision, the supervisor also upholds the teach–treat boundary by indenturing all analytic exploration to the *supervisory task*, which is defined as facilitating the supervisee’s clinical development by helping him or her to help his or her client (Frawley-O’Dea & Sarnat, 2000).

Although mutuality characterizes this kind of supervisory relationship, it is simultaneously understood to be an asymmetrical one in which the supervisor has greater power and must take responsibility for that power. Further asymmetries of the relationship include the fact that the supervisor carries primary legal responsibility for case management (in practicum and internship settings), for establishing the frame and tending to the boundaries of the super-

³This point distinguishes the relational supervisory model from the ground-breaking, yet now dated, model of supervision created by Ekstein and Wallerstein (1972).

visory situation, and for assessing and adapting to the supervisee's learning needs. The following vignette illustrates this approach.

AN EXAMPLE OF THE APPROACH

Andrea, a doctoral intern at a publicly funded mental health clinic, was in her 6th month of a once-weekly psychodynamic psychotherapy with Doug, a depressed and financially troubled professional in his 50s, with a history of disturbed early relationships and multiple abandonments. Doug had never truly mourned his wife, who had died a number of years before. As a result of work done in the initial phase of treatment, Doug was able to start a new romantic relationship and his depression abated. Andrea felt the therapy was going well and obviously liked Doug. Andrea had initially told Doug that she would be available to work with him for the 11-month training year.

Andrea was a trainee in her 20s who had been in her own treatment for several years. She was very interested in psychoanalytically oriented treatment and was just beginning with a new supervisor, Carol, who was a psychoanalyst. Carol would be taking over the supervision of her work with Doug.

In their first supervisory hour, Carol asked Andrea about her experience of presenting her work with Doug to her previous supervisor.

Supervisee: Actually, the truth is I almost never presented Doug to my previous supervisor.

Supervisor: Why was that?

Supervisee: My previous supervisor didn't seem to get how Doug and I were working together, and her supervisory comments just seemed off to me.

Supervisor: Can you tell me any more about what was unhelpful?

Supervisee: [With discomfort.] Now that I think about it, I guess the problem was that right at the beginning of our work, my supervisor commented that I was doing "supportive" psychotherapy with Doug rather than "exploratory" psychotherapy. I guess I heard that comment as a total devaluing of my work with Doug and felt a need to protect our relationship from her judgments. I also started feeling really critical of myself for not doing "real therapy" with him, so I just didn't talk about my work with Doug any more.

Supervisor: And it sounds like you didn't discuss your feelings about all this with your supervisor either.

Supervisee: No, it just didn't occur to me. In fact I'm not sure I even articulated any of this to myself until you asked.

All of this puzzled Carol, because she knew and respected Andrea's previous supervisor and had trouble imagining her devaluing Andrea's work. She wondered what else might have been going on between Andrea, Doug, and her previous supervisor. Perhaps Andrea was feeling a need to protect her work with Doug from intrusion because of something she was unconsciously responding to in Doug. Carol also made a mental note to be on the lookout for the possibility that her own comments might cause Andrea to feel narcissistically wounded. Andrea kept her own counsel about all of this and simply turned to inquiring about the clinical relationship. After Andrea summarized Doug's history, Carol asked about Andrea's experience of their therapeutic relationship.

Supervisee: Most of the time, I find our hours to be unproblematic and enjoyable. We laugh and joke together a lot. I especially enjoy him since I see him immediately after a really difficult client—someone who I always feel I need to get a lot of supervisory help with. But there is actually something going on for me now with Doug that I would like your take on. I recently invited Doug to continue in treatment for an additional year, since finding out that that will be possible for me. I thought he would jump at the idea, but he seems to have a lot of misgivings about it. He said that he didn't feel that continuing would be "necessary" for him, although until now he hasn't said a word about wanting to end treatment.

Carol was intrigued. This was hardly a typical therapeutic relationship, and Carol's first take was to wonder if something was being avoided by both client and therapist. Because Andrea had understood from Carol's description of Doug's history that separation and loss were major issues for him, she was not surprised to hear that setting an ending date would stir up conflict for him. She continued to listen.

Supervisee: So, the question of our termination date is still unresolved, and I'd really like your help in thinking about how to handle this with Doug. I should probably also mention that Doug has been canceling some of his hours.

Supervisor: Really? I wonder if he is reacting to your invitation to continue. Tell me some more about what's been going on.

Supervisee: Actually it was just before I told Doug that we had the option to continue treatment that he cancelled three sessions in a row. Before each appointment, he would call and leave a message for me to call him back, and then he always explained why he couldn't make his appointment and assured me that he planned to return the following week. And then he did in fact come back. He did the same thing

again, canceling three more times, just recently. It was the same pattern. He'd call before each cancellation and leave a message about the cancellation and ask me to call him back.

Andrea appeared surprisingly unconcerned about the cancellations, although Carol found herself reacting with great concern. The disparity in their reactions grabbed Carol's attention. But for the moment Carol said nothing, hoping to learn more about its meaning and how it illuminated what was going on unconsciously between Andrea and Doug.

When in this first supervisory session Carol started to intervene, she did so carefully, wary of spooking Andrea as her previous supervisor apparently had. In part because she had a positive impression of Andrea, she started from the assumption that Andrea must have good reason for her approach to Doug, even though Andrea could not articulate her rationale for working with him in this way. Carol imagined that Andrea was trying to mitigate some anxiety that had been evoked in Doug by the therapeutic relationship. Carol wanted to help Andrea to put into words what she was responding to in Doug so that she might think more clearly about why she was adopting this particular therapeutic stance and could then make more conscious choices about it.

Supervisor: I'm interested that you find yourself taking this approach with Doug, which is different from how you are working with other patients. What do you know about how and why you do it?

Supervisee: It is funny isn't it? I'm really not sure why I am this way with him, but maybe I'm picking up on some sensitivity in him. I guess I've adapted automatically, without really thinking about it.

Supervisor: Your mutual enjoyment of humor seems to be serving an important function. But I'm puzzled by your seeming lack of anxiety about these cancellations. How do you understand it?

Supervisee: It's because I'm sure he'll be back next hour, just like the last time. This just seems to be his way.

Supervisor: I wonder if you could be intuitively adapting yourself to Doug's anxiety about being close to you, allowing him to titrate how much contact he has with you—As if you had a sense that you need to tolerate his distancing without overreacting to it and maintain the connection with him as he moves away.

Supervisee: Huh! I hadn't thought about it that way, but it makes sense.

Although Carol here refrained from making any specific suggestions to Andrea about how she might intervene differently with Doug if anxiety about closeness

were indeed the issue, sensing that such intervention might feel intrusive to Andrea, Carol hoped that their conversation might free Andrea to think about and speak more directly to Doug about what was going on between them. In any case, Carol felt satisfied with her attempt to join Andrea in her efforts to treat Doug, and she felt that she and Andrea were beginning to establish a supervisory alliance around the case so that Andrea would feel comfortable about continuing to present Doug to her.

In the following supervisory hour, Andrea did indeed again present Doug. However, Andrea also mentioned that Doug had canceled for a fourth consecutive week, and she again showed a surprising lack of curiosity or concern about what this might mean or how to address the situation. This alarmed Carol, and she felt that she had misjudged Andrea's ability to make use of their conversation in the previous supervisory hour.

Now Carol found herself abruptly shifting her attention from understanding Andrea's view of Doug to understanding the defensive meanings of Andrea's apparent indifference to Doug's withdrawal. Why was Andrea continuing to show such reluctance to intervene or even think about what was going on? Carol also began to feel distressed as it dawned on her that she had failed in the previous session to fully appreciate the degree of Andrea's defensiveness and that this failure had caused her to neglect Doug's therapeutic needs. All concern for Andrea's vulnerability to narcissistic injury and potential for feeling criticized forgotten, Carol now, with a good deal of intensity, confronted Andrea's seeming indifference to Doug's disappearance.

Supervisor: It's hard for me to understand why you don't feel more concerned about why Doug isn't showing up. This is a real problem in the therapy, and you seem almost not to care.

The atmosphere in the supervisory hour became suddenly tense. Feeling under attack, Andrea froze—she seemed unable to articulate her thoughts. Carol quickly realized how unhelpful her tone had been and tried to back off. She spoke to Andrea more gently.

Supervisor: Let's try to think about why you might be responding in this way.

Supervisee: [With reluctance and discomfort.] Well . . . I'm not really sure. [Pauses.] Actually, it makes me think about the trouble I have standing up for myself in certain intimate relationships. If that's what's going on here, maybe it means that I withdrew because confronting Doug makes me uncomfortable.

Carol was heartened that Andrea was able to begin to reflect on how her own psychology intersected with Doug's, but she was also worried about how making

this disclosure felt to Andrea, coming so early in their supervisory relationship, and under duress. Had Carol caused Andrea to feel exposed and shamed, as well as criticized, and would she now want to avoid discussing further her work with Doug? With these thoughts in mind, Carol felt it best not to inquire further into Andrea's reaction. It seemed more important to help Andrea to feel in control of what she disclosed, and where and when she disclosed it. Carol tried to take pressure off.

Supervisor: Something important does seem to have been activated in you in your relationship with Doug. It's certainly something to think about, and you might want to explore what's going on further at some point in the future, either in your own treatment or, insofar as it relates to your work with Doug, here in supervision. But for now we've done enough.

Andrea nodded. The time was up, and Andrea looked shaken when she rose and left the office. Carol remained uneasy about what had taken place and found herself mulling it over during the following week. In the next supervisory hour, Andrea started.

Supervisee: After our supervision, I decided to call Doug. I told him that I thought something more than "work pressures" were motivating his absences, and that he needed to come in so that we could talk about it. And he did actually show up for his next hour.

Carol was, of course, pleased to hear of this change in Andrea's approach to Doug, and Doug's responsiveness to it, and Andrea seemed pleased with herself as well. Before beginning her presentation of the hour, however, Andrea said she would like to talk some more about what had happened the previous week. Andrea's awareness of Carol's relational approach to the supervision enabled her to make this request. Carol welcomed the opportunity to talk about what had happened, although she also felt anxious about what Andrea would say to her.

Supervisor: I think that's a good idea. I know that last time was hard for you.

Supervisee: [Tearfully.] It was so painful to see how my own anxieties were affecting my work with Doug, and seeing it really undermined my confidence in myself as a therapist. I had a few very dark days. I know you were right, but what you said to me left me feeling overwhelmed and overexposed.

Carol felt a pang of guilt as she remembered the tone of her confrontation of Andrea, despite her intention to move carefully. Carol tried to reassure Andrea.

Supervisor: I can imagine how hard that interchange was for you. Keep in mind that it takes many years to become a skilled therapist, and all of us have our difficulties that come up in the process, me included. Willingness to face those issues, painful as the process can be, is what distinguishes those therapists who become highly skillful from those who do not. I feel great respect for therapists who are willing and able to reflect upon their own psychologies on behalf of their work with their patients.

Supervisee: Thanks for saying that. I've been thinking a lot about my trouble standing up for myself in certain relationships. It limits me in so many ways.

Andrea seemed to be inviting further self-exploration. Carol did not, however, feel it would be useful to pick up this bid in the current context. She sensed that to do so would be to collude with Andrea in viewing herself as the only person in the room who struggled with anxiety and defense. She was also aware that Andrea needed help with her tendency to avoid confrontation. Carol therefore returned to the issue between them.

Supervisor: I wonder if you have anything more specific that you would like to say about our interaction last time?

Supervisee: Not really. It was hard but really useful. If you had asked me right after our last meeting, I might have had some feedback for you, but I really don't anymore, now that I've had time to process it.

Carol knew that Andrea had special reason to be cautious in this relationship in which Carol had so much more power than she did, and so she persisted.

Supervisor: What do you think you would have said if we had spoken immediately after the session?

Supervisee: [With some hesitation.] I guess that it got a little too personal and intense. And I didn't understand why you suddenly had such a strong reaction when the previous week you didn't take issue at all with what I was doing with Doug.

Carol was impressed that Andrea was able to be so forthright in her feedback and so on target. And her question—really, a reproach, carefully couched—rang true to her, fitting in with her own thoughts about what had been stirred up in her at that moment. Having already given the matter some thought during the intervening week, Carol felt prepared to say something about her own motives. Carol also hoped to make clear to Andrea that she was not the only one struggling with anxiety and defense.

Supervisor: When I realized that I had been misreading the situation between you and Doug and that he was not receiving the therapeutic help he needed, I became alarmed. I think my discomfort caused me to act toward you in a way that got that discomfort out of me and, unfortunately, put it into you. The issue isn't so much the accuracy of my take on what was going on, but the particular way that I communicated it to you. I'm guessing that the feelings were too hot for me to tolerate in that moment, and so I passed the hot potato to you. . . . A classic example of a failure of containment, and a resulting projective identification.

Andrea was relieved to hear Carol's acknowledgement of her own participation in evoking the painful feelings that had overwhelmed her in the previous hour. She was also intrigued by Carol's reconstruction of her defensive process. Being taken over by the warded off feelings of another—that is, receiving a pathological projective identification—was a phenomenon that Andrea had read about and understood intellectually but had never been able to pinpoint in her own experience. She wondered whether the concept might help her to understand and tolerate her uncomfortable reactions to Doug rather than needing to avoid them. She started feeling more optimistic about both the therapeutic and supervisory work. Andrea now felt ready to present her latest hour with Doug, and the material reflected her optimism.

Supervisee: Doug opened the session by telling me that the anniversary of his wife's death had recently passed. He said that he realized that he had needed to keep to himself, avoiding spending time with even his closest friends during this difficult period. He just felt more comfortable getting through the anniversary on his own. I didn't say too much back to him, although I felt genuinely touched by his ability to confide this to me. I just said, "Maybe that's why you needed to stay away from me too." I know that was a pretty lame interpretation and that I was still avoiding addressing the intensity of the transference-countertransference situation. I just couldn't figure out what else to say.

Supervisor: Actually I think your comment was an excellent light-touch transference interpretation. Your tone reflected your sensitivity to Doug's dread of experiencing too-intimate contact, all the while supplying the crucial link to the transference that he could not make himself. I think that your interpretation may help Doug to bear the feelings that have been causing him to cancel his hours. But it will take time for the two of you to work through his resistance to feeling more with you. In fact I think that helping Doug develop the capacity to

remain in contact at moments when he most needs help could be seen as the central goal for the therapy.

Supervisee: That way of seeing the goal for therapy makes sense to me. I realize that I haven't been so clear about what we were trying to do till now. I think that I can help him with that, if we keep talking about all this in supervision.

This supervisory crisis was cocreated by the psychologies of each member of the supervisory triad, interacting with one another via the parallel process.⁴ As the client, Doug was of course expected to introduce his psychological problems into the situation—in this vignette, his maladaptive defenses against feelings of loss and separation. But Doug was not the only member of the supervisory triad who was struggling with anxiety and defense. Andrea, perhaps because of her own overlapping area of vulnerability, downplayed the cycle of withdrawal and counterwithdrawal that had developed between herself and her client. She also may have unconsciously invited her supervisor to take on the role of critic, which she was trying to evade within herself. Carol, despite her best intentions, fell into that role, in part because of the unconscious invitation from Andrea to do so but also out of her need to defend against her own feelings of guilt, shame, and anxiety about her neglect of the client's therapeutic needs. Through her sudden confrontation, Carol evacuated those feelings into Andrea. Andrea, because of her own psychology, her vulnerability as a beginning therapist, and her lower status position as supervisee, found herself a defenseless and momentarily traumatized recipient of the projected affects.

Defensive processes, unconscious conflicts, and disruptive enactments are human inevitabilities. As psychotherapists, we expect that our clients will bring their difficulties to therapy, and we acknowledge that we have blind spots too, which require self-reflection and, sometimes, consultation. When we take the role of supervisor, however, we often ignore the reality that we continue to grapple with the same difficulties. This is so even if we have the benefit of more experience, more training, and more personal therapy, as well as an apparent position of objectivity outside the transference-countertransference field of the therapy. In fact, the transference-countertransference field often parallels into the supervisory relationship, and even an experienced and well-analyzed supervisor's vulnerabilities sometimes render him or her unable to contain his or her supervisory countertransference reactions at critical junctures in the

⁴In a relational model of psychodynamic supervision, parallel process is viewed as a quite ubiquitous phenomenon rather than a rare and problematic event. As this example illustrates, paying attention to the manner in which emotional states are routinely passed from person to person can lead to useful illumination of the intersubjective processes within the supervisory triad, to the benefit of client and therapist (Frawley-O'Dea & Sarnat, 2000).

supervisory process. At such moments, the supervisee, as the more vulnerable member of the supervisory couple, can be put at risk, and is dependent on the supervisor to take responsibility for his or her own contribution to difficulties.

A relational supervisor will try to think through his or her conscious participation after it has occurred, and if necessary, will seek consultative help. Having addressed his or her own reactions, he or she may then decide to process the experience with the supervisee. Having taken responsibility for his or her own participation in the unfolding of events within the supervisory triad, he or she can then address the issue in whatever way makes sense within that particular supervisory relationship. It is the supervisor's job to do so in a way that neither overburdens the supervisee with inappropriate supervisor disclosure nor distracts the dyad from the supervisory task of helping the therapist grow professionally and helping the client. In this example, the supervisor's processing of a supervisory conflict helped her supervisee to overcome her anxiety about confronting someone who had hurt her, and it contributed to her supervisee's understanding of defensive processes—all in the here and now. The relational supervisor thus models the clinical theory she is trying to teach, and does so in a manner that respects the teach–treat boundary. She thus addresses tensions in the supervisory relationship that can inhibit teaching and learning and demonstrates in real time how to work through enactments within a helping relationship. For the relational supervisor, these are all core interpersonal and professional competencies.

SUPERVISION IN FAMILY THERAPY⁵

Family therapy is a form of psychotherapy based on a family systems conceptualization. Attention to the process of the family and therapist–family interaction; repetitive interaction patterns; stories that families tell that maintain the presenting problem, strengths and resources as opposed to pathology; and the parallel process or isomorphism of supervision and therapy are all significant components. Increasingly, specific competencies are being described for family treatment (Berman et al., 2006; Heru, 2004). For example, Kaslow, Celano, and Stanton (2005) presented a competency-based approach to family systems that includes consultation with the multiple systems that influence the family: self-awareness and family-of-origin awareness, accurate self-assessment, evidence-based practices, and individual and cultural diversity consideration. Contemporary practice draws on diverse theoretical orientations to provide a means to understand the multiple forces that influence the functioning of the

⁵Veronica Barenstein contributed the section "Supervision in Family Therapy."

family system and to direct clinical interventions. Supervision places particular attention on the trainee and supervisor as active agents and members of the system in which they are intervening, as well as integrating systems theory and contributions from other psychological approaches in practice.

The approach taken in the supervision process discussed in this chapter draws on a combination of a structural family therapy foundation (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Lee, & Simon, 1996) and an awareness of ecosystemic, cultural, and gender issues and narrative techniques. Significant components of the structural approach include attention to the process of the family and therapist-family interaction, repetitive interaction patterns, stories that families tell that maintain the presenting problem, strengths and resources as opposed to pathology, and the parallel process or isomorphism of supervision and therapy. The focus is experiential, on the here and now of the therapy and the supervision experiences, and on the self of the therapist who uses him- or herself to impact interactions. Supervision places particular attention on the trainee and supervisor as active agents and members of the system in which they are intervening (Colapinto, 1988). It directs supervisees' attention to process and designs creative interventions to obtain structural change, countering the family system's striving for homeostasis. The strength-focused stance entails a search for unused resources in both the family and the therapist. As noted here and throughout the supervision process, attention is drawn to dynamics within the family system, within the family-therapist interaction, and within the supervisee-supervisor dyad. The perspective that multiple systems of influence operate at all times on individuals and relationships is made explicit in examining the dynamics affecting the systems involved implicitly in the treatment.

In family systems formulations, presenting problems are maintained by dysfunctional and rigid family interaction patterns or family structure. Structural family therapy posits that change occurs at the structural level in families as they expand their behavioral repertoires in response to therapist intervention and direction. Changes lead to behavioral and internal emotional recalibration in individual family members and to a resolution of the presenting problem. Challenged to try novel ways of interacting in sessions that do not fit with the stories they hold about themselves, they struggle to integrate and make sense of these new experiences (e.g., a mother who sees herself as incompetent successfully setting limits on her children in session). The therapist's role is to create contexts in which people can try new behaviors as the therapist cognitively frames these to assist their integration into existing family stories, precipitating change. The role of the supervisor is to work on multiple levels, ensuring adequate treatment to the client, and performing in parallel interventions with the therapist and the group therapy supervision group. Trainees, just as clients, are encouraged to try new behaviors and to construct new or evolving stories reflecting their development as clinicians.

The therapist is an active participant in the system with a range of styles, intensity levels, and emotional distances corresponding to individual and cultural family factors. The therapist and family cocreate the therapy context. Developmental issues for the supervisee include the intensity of level of focus on the clinical process and the role of the self of the therapist. Early on in the supervision, a major focus of the exploration of the supervisees' intervention choices is on uncovering constraints on the supervisees' behavior in the session and on their views of the family. These constraints stem from the past experiences supervisees bring into the therapeutic and supervisory encounters: personal (e.g., their role in their family of origin), professional (e.g., their previous training), and cultural (e.g., pressures associated with gender roles, age, or economic status).

Supervisees' past experience, individual and cultural factors, and how these might constrain the therapist's behavior in the session or views of the family are primary foci at the onset, as well as recognition that family-of-origin and life experience factors play a major role (Storm, McDowell, & Long, 2003). Particular emphasis is placed on the diverse cultures in which the family, therapist, supervisor, and setting are situated and the cultural pressures associated with gender, religion, ethnicity, age, economic status, and so on, each of which affect and delimit experiences within the system, including the process of therapy.

Supervision of family therapy shares the same objectives as that of other orientations—ensuring high standards of care for clients, balanced with training in the application of theory in practice—and uses similar formats for supervision, individual, and group consultation. Hallmarks in training are live supervision; review of videotapes; providing feedback through telephone or in vivo to the trainee therapist during the session (Liddle, Becker, & Diamond, 1997); developmental thinking (Liddle, 1988); and in structurally informed training, structural mapping and cotherapy live consultations in session by the supervisor.

AN EXAMPLE OF THE APPROACH

The following narrative example is drawn from the third author's group supervision of psychology interns within a training clinic at a public state university hospital. The group consisted of four psychology interns and a psychiatry fellow observer (Danielle, Eileen, Kim, Marian, & Victor); all had some clinical experience, having worked previously with families from a cognitive behavior therapy or psychoeducational approach, but were beginners with this modality.

Clinical supervision began after several didactic seminars on theory and after analysis of videotapes from family therapy masters and the supervisor, intended to create an atmosphere of collaboration and trust. In this process, the supervisor models risk taking and discusses effective interventions as well as those that were not entirely successful and how that is useful to the therapy

process. To allow for the integration of didactic and experiential aspects of learning, the supervision format included presession discussion (including viewing videos from the previous session), live supervision, and a brief postsession debriefing.

The following excerpts were taken from the supervision of one of the interns' first and second sessions with a divorced mother and her two children (10-year-old son, Rob, and 14-year-old daughter, Kate). The family presented for treatment, as Rob had been labeled emotionally disturbed and conduct disordered at school and Kate was recently diagnosed as depressed. The parents divorced 10 years ago and, after years of joint custody during which the children lived with their father, the mother received full custody 2 years ago, reportedly because of the father's neglect.

Presession Supervision

Early in the year, an important supervisor task is to normalize the expected feelings of inadequacy that supervisees' experience as they are immersed in a new modality. In addition to normalizing them, another way to counter them is to simultaneously highlight and bring to the supervisees' awareness the clinical competencies they possess as well as those areas for improvement. This is often a parallel process to normalizing the overwhelmed families coming for treatment and the search for strengths that is part of the early stages of therapy. From the beginning, the supervisor tries to get the group to slow down and redirects the focus to pay attention to process in both the session and in their own interactions, as a clue to the effectiveness of their interventions.

Victor: I thought you engaged the children well, the first time, and got them talking.

Kim: Yes, initially I worried that they'd feel you were on the mother's side.

Supervisee: It's funny, but I guess, subjectively, I felt this physical sense of being stuck. Even now, thinking about what more I could have done in the session, it feels difficult! And . . .

Marian: [Jumping in.] I think it's really interesting though, because that probably reflects how the family feels. I wonder what might happen if you shared that feeling of "stuckness." Let me know if this is not appropriate for this model. But, if you are having that feeling of sitting with them and feeling stuck and not knowing what to do, chances are they are too. It may be an interesting joining thing to do to normalize it. Like saying, "I understand how you feel stuck. I'm even feeling that way right now." Would that render you helpless, or is it a kind of mirroring . . .

Kim: What about taking them back to a point in time when they were not stuck?

Supervisee: Yes, I tried that. Partly, I was thinking, maybe it was because it was the first session, and I don't have experience working with families in this model. With the didactics, I thought, "It looks so natural!" but it was different being in the room. I felt like I was watching for so many things and was slightly overwhelmed by all the different dynamics, and that was a new feeling. I felt that I was trying too many different things at once.

Supervisor: Yes, it's a lot at the same time. Part of the initial reaction is often not feeling competent enough . . . and like all you learned in the past few years has suddenly disappeared! It's a part of the process. But everything has *not* gone out the window, because we saw it through the mirror—it was there! Somehow, through the overload, the first feedback from your colleagues was that you were able to connect, and that's quite impressive. [The supervisor normalizes Danielle's feelings and highlights her strengths.]

Supervisor: OK. Let's rewind. I want to go back to what Marian was saying. Danielle [Supervisee] said, "I felt stuck," and you said, "Well, could you use that to normalize?" and Kim said, "And could we then do this . . . ?" Those are all perfectly good possible interventions with the family, but do you think your comments were useful? How do you know? [The supervisor intervention redirects the focus on the process and on the effects of the clinical interventions.]

Marian: I don't know . . . I'm not sure . . .

Supervisor: How come?

Marian: Danielle didn't really respond to my comment . . . and then she went on with what she was saying anyway. . . . Oh! I guess it wasn't really helpful! It didn't register!

Supervisor: What step was missing here?

Marian: [Without missing a beat.] Asking what she's stuck about?

Supervisor: Right!

Marian: [Smiling.] I *assumed* what she was stuck about. [It is important that supervision assist supervisees to identify their assumptions.]

Supervisor: Right, so there was a disconnect, and this is parallel to what we see in the family. So, processwise, attempting to help Danielle, what position did you take with her?

- Kim:* We were trying to problem solve for her too fast, without asking questions. We should be more solution focused.
- Supervisor:* So you may have been trained to believe that you need to solve people's problems. What is the implicit message of that intervention for Danielle?
- Kim:* That . . . we need to give her the solution?
- Marian:* That she can't do it?
- Supervisor:* Yes, it puts you in the position of the expert and the implicit message is that she doesn't have the resources to develop her own solutions. In this model, a balance is created between being the expert in helping people get unstuck and creating a context where they can experiment with their own alternatives. How do we help them access resources themselves?

In this brief excerpt, a triple parallel process was identified: What happened in the family constellation (with the mother making assumptions regarding the children that kept her stuck) was mirrored by the therapist and again within the supervision group process. The systems perspective informed awareness of a potential shared dynamic and initiated a process of collaboration within the group. The supervision shifts from pre-session discussion to a review of the videotape to observe the family and therapy process that may have gone unnoticed.

Videotape Review in Supervision

- Supervisor:* Do you have something in particular you want us to watch?
- Supervisee:* No, just stuckness. Anywhere. [Danielle fast-forwarded to an interaction between Mother and children.]
- Mother:* I just want us to get along. . . . He [pointing to Rob] was not doing well in school, and I was told he was developing a serious behavior problem. . . . He even threw rocks at some windows with a slingshot.
- Rob:* [Angrily.] You don't know anything! That's not true . . . Why do you have to tell everyone our business?
- Mother:* [Impatient.] That's what we are here for. [She proceeds describing more bad behavior as Rob begins to cry quietly. Mother makes no attempt to engage or comfort her son. Danielle hands him the tissues and generally validates his feelings.]

- Supervisee:* It sounds like these were some really painful times. [To Rob.] I know it's hard to talk to someone new about all this.
- Mother:* This is not the family I wanted! [Danielle visibly reacts to this comment, sitting up in her chair.]
- Rob:* [Wiping away his tears.] You think you are a saint! You think that it's all Daddy's fault . . . but it isn't!
- Kate:* Yes, Dad is not like that! You don't know. . . . We lived with him for all those years, you didn't.
- Mother:* Well, he obviously couldn't handle it! There was that meeting about Rob's problems that he walked out of, which started this whole change in custody.
- Supervisee:* What was different when you lived with your dad? [Here the supervisor notices that the supervisee seeks to return to familiar territory and to lower the intensity in the session by returning to family story content instead of intervening at the here-and-now relational level and possibly increasing the emotional intensity in the session, and decides that it is a useful segment to explore with the group.]
- Supervisor:* [Stopping the tape.] What did you see?
- Supervisee:* It was so hard. We were all thinking that mom was not paying attention to the children's feelings. The children are very angry with her. But I get the sense that they really do want her to hear them. Rob got mad at Mom for telling everybody his business.
- Supervisor:* So, the children are upset, and Mom seems to not respond to that at an emotional level. She keeps talking. [The supervisor deliberately punctuates the interaction process. It takes time for trainees to learn to consistently not get caught up in the content and it is a prerequisite for structurally informed therapy.]
- Marian:* And Rob was tearful throughout the session—that's not expected for a 10-year-old male.
- Supervisee:* Right!
- Supervisor:* What was the feeling for you in the room with that family? [The video brings immediacy and can be effectively used to jog the supervisee's affective state memory of the experience to lead to a richer supervision.]
- Supervisee:* By the end of the session, it felt like we were connecting, though for them it was hard. I'd like to work with them. I felt a big pull of Mom needing help. With her, I felt like I

needed to baby or take care of her because she seemed very fragile, even though Rob was crying and Kate was off to the side at times.

Supervisor: What about Mom seemed fragile?

Supervisee: Mom? I worried that she would derail us or that I needed to keep her from saying something hurtful to the children.

Marian: I sensed the same thing. I felt her distance from them was palpable.

Kim: She kept talking of "sacrifice" and was almost resentful about how they were ruining her life.

Supervisor: She seemed at the end of her rope, overwhelmed, dealing with stress, but it's interesting that she would seem "fragile" to you, but what I'm hearing is you all want to protect her kids from her more than protect her . . . or to protect her from ruining the family? [Beginning therapists trained in an individual modality first often position themselves in a protective stance as the children's therapist rather than the family's. Family therapy supervisors need to bring this bias to supervisees' awareness early on as they begin to practice this modality, because it constrains their ability to choose how they want to position themselves guided by their therapeutic goals.]

Supervisee: She's can't seem to experience or listen to the children as they express feelings, what it was like for them.

Supervisor: First, it's great that in the midst of a busy session, you still were able to register your reaction to the Mother. That awareness is the first step to having a greater choice in your interventions. Let's explore it. What happens to you as a therapist when you have a sense that someone in the room is fragile? [Again, in a process parallel to that of therapy, the supervisor uses a technique with Danielle often used with families to help them expand their potentialities, which includes supporting her existing skills and challenging her to expand her range of interventions. In addition, this segment began the exploration of the iatrogenic effects of having a pathology-focused lens.]

Supervisee: You back off . . .

Supervisor: What would you have done if you hadn't backed off?

Supervisee: I don't know. Maybe commented on the situation? That her son was crying and she didn't seem to notice?

Supervisor: Great! It doesn't matter so much which specific intervention you would have used but that in some way you would

have used the process in the moment. So, your reaction to the mother as “fragile” kept you from challenging her. If you are viewing her as fragile and lacking in internal resources, what is your expectation of what will happen if you challenge her to do something different?

Supervisee: That she won't be able to do it?!

Supervisor: So it's hard to challenge if you don't believe people have resources. . . . The reality is that they may not be able to access those resources immediately. . . . But, if you intervene from where you believe they are, resources are more likely to emerge, and this gives you a direction to follow. . . . What would you then be curious about?

Eileen: Why they weren't able to use them?

Supervisor: Right! You can then be curious with them about how come they are not able to do whatever it is that is missing in the interaction in the moment. What could you then say to this mother?

Supervisee: “Your son is crying. Can you talk to him about it?”

Supervisor: So, you would be challenging her to do something different, and communicating your expectation that she has this in her. So, if she can't, you can be genuinely curious. Think of your other therapeutic experiences: Is this feeling specific to this family or this mother? Or do you tend to find yourself feeling very protective of all your patients or of parents in families you see? [This is a prompt to assess the contributions of the system and the therapist as the supervisor begins the work on the therapist's self-awareness and use of self in session.] Did you notice what you did instead?

Supervisee: I felt stuck. . . . And then I tried to comfort the son?

Supervisor: Yes. You protected the son instead of exploring the mother's difficulty and possible ability to do so herself. You said before that you felt you were “doing everything” and, after watching, I agree that you may be *overworking*, doing too much for the patient. The question is: How can you help them access resources themselves?

[The supervisor prompts Danielle to observe her reaction and use it as information about the family system itself, which can also keep her from being inducted into the system.] You can also use your reaction to mother to hypothesize about the family dynamics. Ask yourself, what would it be like for the children if they feel that this parent is fragile?

Supervisee: Scary.

Eileen: That the parent's needs come before their needs.

Supervisor: Scary! So, would you share your feelings?

Supervisee: So then, the problem becomes the children's behavior!

Supervisor: So now Rob and his mother have something that is "not feelings" to be engaged about.

The videotape review adds to the group's understanding of the emotional tenor and inter- and intrapersonal dynamics in the family session, as well as brings a quality of immediacy that prompts exploration and enhances the supervision process. The supervision content includes consideration of process dynamics; personal reactions of the supervisee in the immediacy of the supervision session (as well as in the therapy session); and support, encouragement, and challenge to expand her clinical interventions, all while keeping in mind the systemic factors that inhibit new learning.

Structural Mapping in Case Conceptualization and Treatment Planning

Structural mapping is a pictorial or graphic method for capturing family interaction patterns. Hierarchies are spatially represented, and lines and symbols are used to represent boundary types, subsystems, and coalitions and to place emphasis on the main variables at play in defining a family's present structure in contrast to the intergenerational and historical focus of genograms (Minuchin, 1974). Steps to develop in supervision include the abilities to translate observations to a meaningful representation of interaction patterns; to identify and to discuss changes to the patterns that would make the family be more functional (i.e., boundaries strengthened and hierarchies realigned); and to brainstorm possible interventions within the family system (e.g., having the mother open up conversations with the children). Intervention effectiveness can be assessed by family map shifts. The use of structural mapping provides a unique approach to understand systems, consider foci for intervention strategies, and track change. Early in the year, supervision sessions start with an analysis of the family process and joint development of a family map within a descriptive case presentation that focuses on content and history. Later, with experience, trainees begin case presentations with a family map to provide context to discuss the presenting problems, treatment progress, interventions, goals, and questions that entail process and family structure.

Supervisor: What is the main story in this family? Why did they come in?

Supervisee: The children have problems. . . . Rob is a problem child who doesn't respond to limits or care about consequences.

Marian: And, according to Mom, it's Dad's fault.

Supervisor: So, we know that they have a story that they'll bring into therapy, but that that story is well rehearsed, and it maintains the problem. It's hard to introduce novelty through it, so we need to see what is invisible. What do you know about them beyond what they told you?

Kim: What we saw?

Supervisor: Yes.

Marian: That the children are angry?

Supervisor: And what happens when they get angry? [This intervention intends to facilitate exploration of the interactional process; eliciting behaviors and not asking why's or feelings at this point.]

Supervisee: Mom did not hear them.

Eileen: And Kate got angry too.

Marian: Rob protected his sister.

Supervisor: How can we translate their usual ways of relating to representation on a map? We need a picture and hypotheses that we can test in the next session. Let's formulate some structural hypotheses, or we can be inducted into the system and the family story and have the same blind spots as the family. Who's in control in this family? What are the boundaries like?

Supervisee: Rob seems to set the tone for the family with his facial expressions and his anger.

Marian: But Mom was able to get them here for the appointment!

Supervisee: She didn't have control over Rob's misbehavior and she argued with them once here.

Supervisor: So, how would you represent that?

Supervisee: Rob on top? Kate also up there . . . Mother below or at same level . . .

Eileen: Rob and Kate team up against Mom.

Supervisor: They seem to have developed a strong coalition that doesn't let Mom in at times . . . a rigid boundary. So, mainly, what we see in the map is a hierarchy reversal. Rob has the most power, doesn't obey rules, and dictates interactions in the family. Mother positions herself at the sibling level, while complaining about her life to them and not being parental. Rob and Kate have a coalition against Mother and remain caught in the conflict between their parents. The children have learned to be protective of each other, so listening to

their mother feels like a betrayal of their father. These behaviors have been adaptive and have worked for them at some point. What goal of therapy flows from that map?

Supervisee: To flip the hierarchy back? To make the boundaries less rigid?

Supervisor: Yes, reversing the hierarchy, helping Mother regain leadership while the children have an age-appropriate voice and permeable boundaries. How do you challenge Mother to be parental when she begins to act as a sibling?

Eileen: Just reflecting back, "It seems that none of you like the current situation."

Supervisor: And how do you envision that they would respond?

Eileen: They'd feel validated?

Supervisor: OK, that can be useful. It can be part of the joining technique, normalizing how tough it is for them now. But you need something more specifically connected to the process observations from the map, to introduce novelty. Something geared towards activating Mother or towards blocking the coalition between the siblings.

Supervisee: Maybe by asking that Mother comfort the son if he cries. . . .

Supervisor: Great! For the coalition between the siblings, address that and activate Mom at the same time by asking Mom to block the son from interrupting when she is talking with her daughter and vice versa. [Throughout the supervision, role plays of these interventions, an experiential training tool, can be helpful to solidify the trainees' skills in this approach.]

Supervisor: The map can help us challenge the family story. The story is that the son is in control; he has no limits and supposedly doesn't care about anything. Yet, in the map, we see how close he is with his sister, how tuned in, caring, and protective of her when she is upset. And how reactive he is to Mom. This is the beginning of challenging the story. We could challenge Mom to be curious about how this sensitive, caring boy, who's embarrassed by the retelling of his behavior, did those things. Are you ready?

Supervisee: What if I ask her to comfort the children or talk to them and she can't?

Supervisor: Whenever you ask people to do anything in session, you have to be prepared for them not to be able or willing to do it, and to work with that. [As the supervisor deals with the possibility that the trainee is not ready to do this intervention,

brainstorming alternatives is an effective method to help allay trainees' anxieties regarding attempting challenging interventions.] What questions could you ask?

Supervisee: Find out why she couldn't?

Supervisor: Yes. Then you can explore that and it may give you material to normalize it if it helps (e.g., Mother's own fear of rejection) . . . and to continue creating a new story about how they get stuck.

Structural mapping provides a procedure that makes manifest the dynamics of particular interest in systems-based therapy and can be used during all phases of treatment as well as throughout trainee development. Use of such a tool provides clarity and reinforces particular modes of observation and understanding.

Live One-Way Mirror Supervision

Live supervision simultaneously situates the supervisor in the here and now of treatment and of supervision. In live supervision, the supervisor is afforded a unique and direct role in ensuring an effective course of treatment and training. The supervisor may actively challenge trainees to expand their repertoire during the session, in areas agreed on (e.g., to not overly dilute their challenging interventions or to step back from a central role mediating interactions between the mother and children, which maintains the status quo by signaling to mother that the therapists do not think she can do this). In addition, the supervisor helps the team behind the one-way mirror to work on conceptualization, to identify opportunities for intervention, and to develop interventions in the immediacy of the session. Early in the training year, comments and interventions are more directive (e.g., "tell Mother . . ."); later in the year, the phoned-in supervisory comments may be more open (e.g., "get Mother to interact with the kids about this"), leaving more to the supervisee to develop his or her own style and sense of efficacy. Supervisees have a normal initial ambivalent reaction to live interventions or consults. They feel both relief at receiving needed suggestions and implied criticism of their efforts. Acknowledging and normalizing this, repeatedly, early on enhances collaboration and encourages reception of this learning activity.

[At the second session, after an initial report by the family on how their week went, Mother complained that Rob was still getting angry easily and frequently. The supervisor uses a phone intervention to her supervisee.]

Supervisor: [Phone intervention to supervisee.] Danielle, create an enactment to open up the possibility of a different interaction

and to see the family's response. . . . Danielle, support Mom's concern and ask her to find out from her son what he's angry about. If she tells you that she already knows why, have her check in with her son.

To be consistent with the goal of shifting the family hierarchy and challenging the mother to be parental instead of part of a pouting sibling threesome, the therapist was directed to activate the mother to take the lead in this interaction. In this way, the therapist neither does the mother's job by taking her place in a dialogue with her son nor places the responsibility on the child by asking him to initiate the feedback to the mother. In this sense, the live supervision and the therapy mirror each other, with the mother being challenged by the therapist only to stretch and step out of her comfort zone, as the supervisor challenges the therapist to do the same in challenging the mother directly.

Supervisee: [To mother.] I can understand your concern. Can you find out from your son why he's so angry?

Mother: I know why he's angry. He used to get his own way when he lived with Dad and he thinks that it's all my fault that things have changed. He doesn't like my rules.

Supervisee: Can you find out from Rob if that's it and talk about it?

Mother: [Turning to her son.] So, it's that, isn't it?

Son: No! It's that when we tell you something you don't hear us, and you make faces as if *you* are angry.

Mother: [To supervisee.] The problem is that they resent that they now have to live with me and he doesn't get to see his father. [While Mother continues to talk about this, Rob starts tapping with his foot noisily on the leg of the chair, while looking up at the ceiling, demonstrating the underlying disconnect at the process level, like the previous session. Noticing that the therapist does not address this clear interaction in which the mother did not hear the child, and the child started to act out his anger, the supervisor calls in again.]

Supervisor: Ask Mom, "What just happened?" Tell her, "Please tell Rob what just happened to you when he spoke that you could not respond to what he said? What did you feel? So that the two of you can talk about it and Kate will listen." [Here I was helping Danielle to remain in the here and now, with the family's experience in the room, while maintaining the intensity by directing them to interact with each other instead of through her.] [Danielle repeated this intervention verbatim. With a couple of starts and stops, the mother

was able to express that when the children start to tell her how they feel, she feels blamed and it is difficult for her to listen.]

Through the use of live supervision, the training process was brought into the immediacy of the consulting room, supervisor recommendations were implemented and novel interventions were used that led to new competencies both in the supervisee and in the family. The treatment team went on to work collaboratively with the family on creating a space for the dialogue to develop (without being cut short when the intensity increased), for Mother and Rob to be able to hear each other, and for the three of them to begin to have a different experience of their connection.

Postsession Discussion

The postsession may allow for full discussion but often provides just a few minutes between sessions to highlight the main processes observed and to identify points for future discussion. Supervisors may need to clarify or challenge the therapist's emergent (yet, at times, repetitive) story of the supervision therapy session, so that the experience is not unwittingly shaped to fit into their old story and self-appraisal. Supervisees, not unlike clients (or anyone else), may be resistant to incorporate new information into existing self- and other-schemas, which would shake up existing intra- and interpersonal systems. Trainees, especially at the beginning of the year, tend to highlight their own weaknesses and insecurities, so it is important to reframe and to highlight their strengths and the progress they are making (as illustrated in the following excerpt).

Supervisor: How are you? What's your reaction after that session?

Supervisee: Better. I was glad you called! At the beginning, I was getting a bit overwhelmed again, like last time. . . . When you called in and pushed me to keep insisting that they talk to each other, and they did. . . . I felt like I was able to have a bit more distance and breathing room to observe a bit while they interacted. So I could think about my next move. . . . I didn't feel so stuck or overwhelmed. . . . Well, not all of the time. . . .

Supervisor: And so it seems that although you initially felt overwhelmed, you found yourself better able to think in the session. I was also impressed by how seamlessly you integrated the supervisory feedback while maintaining your own style and your connection with the family, and to feel not as stuck as you did early in your work with this family. . . .

Although this example is truncated and did not allow for a full explication of the approach as practiced over the course of a training relationship or case, it does illustrate the fundamental perspective used in structurally informed supervision in family systems. Unique to this approach, emphasis is placed on working with therapists to position them effectively within the system, which at a process level, determines the impact of their interventions. Further, attention is directed to isomorphism for members of the family with each other, therapists with the family, trainees with their colleagues, and supervisors with their supervisees, which provides the key to understanding the ensuing process and its reflection of dynamics influencing the multiple systems involved in treatment and in training.

OPPORTUNITIES AND CHALLENGES IN PSYCHOTHERAPY-BASED APPROACHES TO SUPERVISION

Psychotherapy-based approaches provide opportunities for the development of competence in a specific therapeutic modality. Through the consistent application of theory and technique in the interrelated contexts of therapy and supervision, trainees are socialized into and learn to apply the orientation's clinical theories (causes and solutions to psychological difficulties), modes of observation, and clinical practices. Such immersion sets the stage for supervisees to advance their knowledge of, and competence in, the specific therapeutic approach, as well as to learn the nuances of clinical application. For effective psychotherapy-based supervision, supervisors must possess expertise in the therapeutic approach and the setting must provide opportunities to work with clients for whom the treatment protocol is appropriate. Supervisors should counter beliefs reflecting Pollyannaish, uncritical, or blind advocacy for the modality and should encourage critical thinking and measured flexibility in the application of the theoretical approach.

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