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A COMPETENCY-BASED APPROACH

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A COMPETENCY-BASED APPROACH TO SUPERVISION

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This chapter is coauthored by the supervisor (Nadine J. Kaslow) and the supervisee (Kanika D. Bell), which reflects the partnership that characterizes effective supervisory endeavors. We offer a collaborative, integrative, and competence-based perspective on supervision. The dominant perspective guiding our approach to supervision is a competency-based model (Falender & Shafranske, 2004) that incorporates multiple approaches, most notably developmental (Stoltenberg, McNeill, & Delworth, 1998; Worthington, 1987), process-oriented (Bernard, 1997; Holloway, 1995), attachment theory (Neswald-McCalip, 2001; Pistole & Watkins, 1995), and psychotherapy based. Given that many psychologists (29%–35%; Norcross & Goldfried, 2005) and postdoctoral fellows (79%; Logsdon-Conradsen et al., 2001) self-identify as integrationists, under our approach both the supervisor and the supervisee integrate multiple theoretical orientations: attachment theory, object relations, interpersonal, family systems, existential or humanistic, psychoeducational, and cognitive behavior. We advocate for an integrative model, as we believe it offers a more comprehensive and flexible approach that can be tailored to the unique needs of each individual client. This integrative approach requires that each member of the dyad engage in developing competence and share with the

other member of the team competence in multiple perspectives in case conceptualization and integration. The collaborative-, integrative-, and competency-based approach to supervision keeps at the forefront issues of development, gender, and culture as related to the supervisor, the supervisee, and the clients being served. In addition, transference and countertransference dynamics and interpersonal process issues are focal.

In this chapter, we present our thoughts on a competency-based approach to supervision. We address various supervisory processes areas, including those related to the creation of an effective supervisory alliance and optimal learning environment, the inclusion of developmental considerations, and the ways in which diversity issues impact the process. The strengths and limitations of this perspective from the supervisee's point of view are enumerated, with particular attention paid to the potential for mentoring, the emphasis on empowerment, the safety of the supervisory relationship, and the opportunity to develop competence as a supervisor. Illustrative supervisor–supervisee narratives are presented with regard to the context of supervision, supervision goals and processes, and evaluation and outcomes. We close the chapter recommendations for competency-based approaches to supervision that underscore the collaborative aspect of the supervisory relationship.

DESCRIPTION OF THE SUPERVISION APPROACH

This section provides a description of the supervision approach. We focus on content areas, key supervisory processes, and strengths and limitations of the model.

Content Areas

Given the integrative nature of the competency-based model, interactions between supervisor and supervisee focus on the sociodemographics, history, biological status, behavior, cognition, affect, current interpersonal interactions, transference dynamics, and environmental context of the family, group, or client; how the therapist's personal history and life affect his or her encounters with the client; and the interactional patterns between the therapist and the client, the therapist and supervisor, and the therapist and other professionals working with the client. The supervisor enables the supervisee to gain greater familiarity with an integrative conceptual approach. Various forms of psychotherapy integration may be explored (e.g., common factors, technical eclecticism, theoretical integration, assimilative integration), depending on the particulars of the client (Stricker & Gold, 2003).

Processes

This section focuses on three processes that are key to the competency-based approach to supervision: creating an effective supervisory alliance and an optimal learning environment, considering developmental factors, and attending to individual and cultural diversity. A fourth process, related to evaluation and outcomes, is described in a later section. These processes reflect the major goals of this approach to supervision.

Creating an Effective Supervisory Alliance and an Optimal Learning Environment

Consistent with Winnicott's (1965) work on holding environments (i.e., the caregiver provides a supportive and empathic interpersonal environment that helps the child reduce anxiety, assume age-appropriate autonomy, and develop a meaningful sense of self) that facilitate healthy development and with attachment theory's emphasis on secure attachments for healthy personal and interpersonal functioning (Bowlby, 1988; West & Sheldon-Keller, 1994), this approach to supervision expects the supervisor to possess a range of personal and professional qualities to set the tone for an effective supervisory alliance and create an optimal learning environment. With regard to personal qualities, competency-based supervisors exhibit the capacity to be accepting, collaborative and nonauthoritarian, attentive, empathic and understanding, supportive and warm, encouraging, interpersonally sensitive, socially skilled, dependable, motivated, calm and able to self-regulate, adaptable and flexible, genuine, open-minded, imaginative and creative, self-aware, effective at conflict management, respectful of boundaries, trustworthy, and highly ethical. They demonstrate enumerable working alliance qualities, including the ability to establish an emotional bond that is characterized by support, trust, respect, care, and role clarity; foster collaboration and teamwork; develop an agreement on goals and tasks; acknowledge mistakes and share errors; work through and resolve conflicts; use appropriate self-disclosure; appreciate the dynamics of the supervisory relationship; and convey an understanding of the interpersonal characteristics (including attachment styles) that both parties bring to the relationship. Furthermore, competency-based supervisors are interested in the "person of the therapist," which includes the supervisee's reactions to the client, how one's own personal biases influence one's perceptions and responses, the ways in which one's personal dynamics influence the therapeutic and supervisory relationships, and parallel process phenomenon.

Taking Developmental Factors Into Consideration

The level of development of each party impacts her or his expectations, behavior, and learning. For example, postdoctoral fellows typically benefit most from supervision that acknowledges that they are transitioning to professional

young adulthood and as a result are in the process of creating a more coherent and integrated sense of self separate from authority figures (Kaslow & Deering, 1994; Kaslow, McCarthy, Rogers, & Summerville, 1992). They most appreciate supervisors who engage with them collaboratively, and they value the collaborative relationships they form with their clients and with other care providers (Friedman & Kaslow, 1986).

Attending to Diversity

Supervision conducted in accord with a competency-based model addresses how the diversity characteristics of supervisor and supervisee influence events in supervision, examines the interaction among different forms of diversity, and challenges biases and behaviors indicative of the key "isms" (racism, sexism, heterosexism, ageism). Because both supervision and therapy itself occur within social, historical, political, and economic contexts, both supervisor and supervisee use this knowledge to guide the assessments, interventions, and consultations being performed in the context of supervision. Current guidelines on multiculturalism, sexual orientation, age, and so on (American Psychological Association, 2003, 2004; American Psychological Association, Division 44/ Committee on Lesbian, Gay, & Bisexual Concerns Task Force, 2000) inform the supervision and the clinical work being supervised. Supervisees and supervisors also are evaluated (i.e., they evaluate one another) with regard to their knowledge, skills, and attitudes in working with diverse individuals (Daniel, Roysircar, Abeles, & Boyd, 2004; Pope-Davis & Coleman, 1997).

Strengths and Limitations of the Approach

This section offers both the supervisor's and the supervisee's perspective on strengths and limitations of a collaborative, integrative, and competency-based approach to supervision. The balance of the advantages and challenges of this model need to be considered in its implementation.

Perspective of the Supervisor

This supervisory approach has many positive attributes. A competency-based model provides clarity about the knowledge, skills, and attitudes that need to be acquired through the supervisory process at each developmental stage and in each functional competency (i.e., intervention) domain (Kaslow, 2004; Kaslow et al., 2004; Rodolfa et al., 2005). Attention also is paid to core foundational competencies, such as professionalism, ethics, and individual and cultural diversity. The focus in supervision is not just on building technical competence but also on addressing personal and interpersonal factors (Falender & Shafranske, 2004). The emphasis on an integrative model is intellectually stim-

ulating and allows for flexibility in conceptualization and intervention on the basis of the needs of the particular client and the personal predelictions of both the supervisor and the supervisee. The model places a high value on self-assessment, as well as on both formative and summative feedback, all of which are essential to the growth process (Falender & Shafranske, 2004). The collaborative nature of the approach makes it more rewarding and personally meaningful for both parties. One potential limitation of this approach is that it requires resources in terms of time, commitment, and investment on both the supervisor and the supervisee and the institution in which the supervision occurs. A second potential challenge is that the focus on an integrative model may not be focused enough and there may be tensions in the dyad if one party espouses an integrative orientation and the other has a focused theoretical framework.

Perspective of the Supervisee

From the perspective of the supervisee, a primary strength of the collaborative competency-based approach is its potential for mentoring (Johnson & Huwe, 2003). Supervisees appreciate the empowering balance of autonomy giving, support, and education. Competency-based supervision favorably compares with other models in that there is less overt management and more individualized training. Through attention to personal factors, it provides a safe context to process professional struggles, as well as a secure environment to disclose personal challenges that may impact one's professional life and functioning. Such a supervisory relationship also encourages and supports self-assessment. This might entail reflecting on biases and their impact on clinical encounters; processing countertransference reactions; and attending to interpersonal style and how it influences interactions with peers, colleagues, and clients.

Another key element is the value placed on the potential for developing supervisory skills (Falender et al., 2004). Supervisees find it empowering to be entrusted with the supervision of a more junior colleague and invaluable to have a supervisory relationship that emphasizes their becoming a competent supervisor. One of the hopes of this approach is that the supervisor serves as a role model for effective supervisory processes.

One potential limitation of the approach is that it may be time consuming. In addition, it may not be well-suited to certain theoretical orientations because of the process orientation. Furthermore, it requires a good supervisory relationship because it places demands on the interpersonal relationship.

AN EXAMPLE OF THE APPROACH

Below is an example of the supervision that involved the two authors: the supervisor and the supervisee, who is a postdoctoral fellow. The narra-

tive covers a broad array of topics, including an integrative perspective that is developmentally informed, attention to diversity, contracting, alliance and learning environment, role of mentoring, person of the therapist, self-assessment, assessment of competence, feedback processes, and supervisory competence. These topics are key to the approach to supervision espoused in this chapter. When each topic is addressed in the narrative described below, it is noted in capital letters in parentheses.

Context of the Supervision

The authors work in a university-affiliated, large, urban public hospital that serves a predominantly African American population. The group therapy work supervised was associated with a clinical–research project funded by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, on the assessment and treatment of African American women who were abused, suicidal, and low-income (Grady Nia Project). The supervisor, a Caucasian female, has worked in the setting for 15 years. The supervisee is an African American woman new to the hospital. The interaction highlighted here occurred during the year of her postdoctoral fellowship in psychology.

Supervision Goals and Processes

Goals

There were a variety of goals to this supervisory process. We aimed to engage in a collaborative relationship and use a developmentally informed integrative and competency-based approach to guide our efforts. We were committed to creating a meaningful working alliance that would support a facilitative learning environment. Doing so involved crafting a supervisory contract; bolstering the competence of the supervisee in the domains of intervention and supervision; focusing on the person of the therapist, including emphasizing the value of self-assessment; addressing diversity considerations; assessing the supervisee's competence incorporating both formative and summative feedback; and engaging in mentoring activities to support the supervisee's professional development.

Competency-Based Contracting, Feedback, and Evaluations

At the outset of the supervision, a contract was mutually developed that included the pertinent core domains of competence; activities associated with each competency domain; and expected knowledge, skills, and attitudes to be exhibited at the end of each 6-month period. This contract served as the basis for the supervisee's summative self-assessment at the

6-month and 1-year evaluation points, as well as the supervisor's summative assessment of the trainee at those same times. The supervisee had the opportunity to evaluate the supervisor on these same competency domains, allowing for parallel assessments. Informal, formative feedback in accord with the competency-based contract was offered in an ongoing fashion and often occurred simultaneously with the sharing of self-assessment feedback from each party.

Supervisor: [First meeting.] K, here is a format for a competency-based contract for our supervision. It includes the domains of competence relevant to our work on the Grady Nia Project: service [psychological assessment, intervention, consultation], scholarship and research, supervision that you provide, professional development, and other competencies. I want you to consider over the next week what activities you want to undertake related to each of the domains and what you would like to accomplish over the next 6 months. Next week, we can review your thoughts, complete the contract together, and agree on your roles, responsibilities, and performance expectations. (CONTRACTING)

Supervisee: [Second meeting.] It makes most sense to plan my activities and track my progress taking into account my future career goals. I am interested in both an academic and a clinical career, so I am glad that professional development is something that we can focus on, as I need help figuring out what I want to do next. Given what I am seriously considering, I hope that we can spend time focused on my supervision of others and publishing some research, as well as becoming more skilled in group therapy. I have never had the opportunity before to do ongoing supportive therapy groups or outpatient groups with highly traumatized people with few resources. (CONTRACTING)

Supervisor: It sounds then like our clinical focus should be on group work. Tell me more about what group therapy experiences you have already had, and what was helpful to you in the prior supervision you received on your group work and in your other clinical endeavors. (ALLIANCE AND LEARNING ENVIRONMENT)

Supervisee: My past group therapy work was with children and adolescents. I never did one in a hospital setting or with an audience that wasn't captive. Unfortunately, the supervision for my prior group work wasn't very helpful. Half of it was done by people who did not have much more experience than me clinically or who had different professional backgrounds, and

thus we had dissimilar agendas for the groups. One supervisor micromanaged the group and was punitive in her recommended approach. It would have been more useful if my past supervisors and I had discussed the goals for the group work and the outcomes. Although my group therapy work wasn't well supervised, other supervisors' feedback has been invaluable. This has been from people who shared their own experiences with me and told me about their mistakes, balanced affirming and critiquing my efforts, made me feel appropriately confident, and acknowledged diversity issues. Oh, and I remember, I did have one really excellent group therapy supervisor. His passion was group therapy with adolescents and he was very interested in me personally, and in my developing an identity as a therapist and how I could bring myself into the therapy. (ALLIANCE AND LEARNING ENVIRONMENT)

Supervisor: Thanks for sharing that. I have a better sense of where you are starting in terms of your group therapy work with this population. If at any time the group therapy supervision isn't at the right level for you or isn't helpful enough, let me know. We can always alter our approach. I trust we will need to do so, as the groups are often complex, given the women we serve. (ALLIANCE AND LEARNING ENVIRONMENT)

Given that you are a postdoctoral fellow, I don't feel the need to micromanage your work. However, since this work is unfamiliar to you, I will share my insights with you regarding dealing with abused women, suicidal women, and women who frequently are in crisis and need to be managed primarily in an outpatient setting despite their often serious Axis I and Axis II problems. We can develop some general goals for the group work that can guide your efforts, but usually it is most effective if these goals are developed collaboratively with the groups' members themselves. (DEVELOPMENTAL)

I hope we can freely discuss issues of gender, race, and class on an ongoing fashion. I highly value culturally relevant assessments and interventions. I recall from when you interviewed here that we share this commitment. (DIVERSITY)

As far as the professional development focus of our work, I will do my best to help you sort out what you would like to do after completing your fellowship. We can discuss those issues as often as you would like. I agree that as you become clearer about your career trajectory, we can shift the emphasis of our work together and modify our expectations accordingly. (MENTORING)

I was sorry to hear that a number of your supervision experiences related to group work were unfavorable. Please

let me know if our interactions do not feel positive or help-ful. If this occurs, it is useful to me to hear your suggestions for improving our communication and work together. (ALLIANCE AND LEARNING ENVIRONMENT) I want you to know that if I have concerns about your work, I will share those with you in an ongoing fashion, so there won't be any surprises when the formal feedback comes. I will do my best to give you positive feedback along the way. (ONGOING ASSESSMENT OF COMPETENCE)

Don't hesitate to ask me for the good feedback, and I will provide you concrete examples of how you are progressing within each competency domain. (ONGOING ASSESS-MENT OF COMPETENCE)

Supervisee: [2 months into the supervision.] I feel like I know how to deal with the psychological and emotional needs of the women fairly well. We are establishing strong bonds, where they trust me and enjoy coming to group, and I like doing group. But I struggle with helping them with their basic dep-rivations; they are homeless, jobless, fighting to get their children back, and have serious health problems. I don't know how to assist them in accessing the resources they need. I am frustrated about this. (SELF-ASSESSMENT)

Supervisor: We can talk about how to help the women gain more re-sources than those available to them through the Resource Room and our social worker. But my sense is you know how to do that. I wonder if what might be more useful for you would be to reflect on the feelings their deprivation stirs up in you. (PERSON OF THE THERAPIST)

When I first came here, I felt overwhelmed by what felt like endless needs that could not be met and had rich White person's guilt. (PERSON OF THE THERAPIST, DIVERSITY)

Supervisee: I feel middle-class Black person's guilt. Even though we are of the same race, our lives are different. I don't know anything personally about searching for food on the streets, a real issue for many of these women. (PERSON OF THE THERAPIST, DIVERSITY)

Supervisor: How do you think the women respond to the class differ-ence? How do you think this issue can be addressed best with them? (DIVERSITY)

Supervisee: Interestingly, they are proud of my accomplishments but don't seem to identify with them. They assume White women will be able to achieve what I have achieved. Someone in the group even asked me how my mama reacted to me finishing

the PhD. I try to find ways we are similar and do appropriate self-disclosure. But I am careful about that. There are some ways in which I am similar to the women in the group that I haven't shared. What the women respond to best is my genuine empathy, regardless of whether it comes from experience. (DIVERSITY, PERSON OF THE THERAPIST)

Supervisor: Would it be helpful for us to discuss the things you have considered disclosing but have chosen not to do so? (PERSON OF THE THERAPIST)

Supervisor: [3 months into the supervision.] I have been giving you informal feedback along the way, and you have done the same with me. We both know that the formal evaluation of your performance doesn't occur until the 6-month point. But, as I mentioned when we first started meeting, it is helpful to have more formalized feedback at the midpoint. So, would you like us to do that today, or to have a chance to think about it and focus on the feedback in more depth next week? (FEEDBACK—FORMATIVE)

Supervisee: Let's do it now, but I appreciate your giving me the option.

Supervisor: It would be best if we review each competency domain we had intended to focus upon and consider your strengths, as well as areas for improvement. . . . Now that we've talked about the assessment and consultation aspects of the service contract, let's focus on the intervention part concerning the two groups and the individual therapy you have been doing. What are your intervention strengths? (SELF-ASSESSMENT)

Supervisee: My strongest strengths would be my ability to empathize and just listen. I try to avoid giving too much advice and lecturing the women. They've had enough of that in their lives. I want to communicate that this therapeutic environment is safe, one in which they feel comfortable being honest and expressing themselves. (SELF-ASSESSMENT)

Supervisor: You are gifted at creating a holding environment for the women that is both healing and empowering. I also believe you employ active intervention techniques that are important to the therapeutic work. I am curious about your reflections on additional strategies you use that help the women. (INTEGRATIVE APPROACH)

Supervisee: I do try various interventions, but not in a textbook fashion. I am not sure if my openness to an assortment of techniques and the way I blend interventions associated with different orientations is a strength or a weakness. (INTEGRATIVE APPROACH)

Supervisor: You raise a good point. Would it feel more like a positive attribute if we worked on your developing a better articulated integrated theoretical model? Having such a framework would increase the chance that your interventions felt less piecemeal and more synthesized. This is an optimal stage of your development for you to frame your own model, and I'm willing to guide you in that effort. (INTEGRATIVE APPROACH)

Supervisee: That would be helpful. I have been trying to find a way to piece together intervention techniques that I feel are useful from different schools of thought and, thus, define for myself an integrative orientation. (INTEGRATIVE APPROACH)

Supervisor: Sounds like we agree that this should be a priority area for us over the next several months. At the 6-month point, we can assess your sense of your capacity to formulate such a model and thoughtfully use the model to inform your interventions. You have the theoretical base, clinical acumen, and technical skills to create and utilize such a guiding framework. (ONGOING ASSESSMENT OF·COMPETENCE)

Supervisee: [After reviewing all competency domains.] I like getting this comprehensive feedback at the midpoint. It is more beneficial to my development than waiting until the 6-month period. It gives me a better gauge of where I am, and what I still need to accomplish during the postdoc year. (ONGOING ASSESSMENT OF COMPETENCE)

Supervisee: [4 months into the supervision.] I've noticed something fascinating about the groups. The women speak differently when the other postdoc isn't there. They express more hostility towards Whites and make more comments about racism. They really like her and probably think it would be rude to say those things in front of her. They don't realize that she has worked with this population for a long time and is aware of the devastating effects of prejudice even though she has not experienced it personally. Most African Americans assume that other African Americans have experienced racism; it binds us across class I suppose. Maybe they think that she will misinterpret their anger and take offense. I don't want to talk with her, because the reality is that Black people act differently sometimes when White people aren't around. There is nothing she can do to change that. (DIVERSITY)

Supervisor: [After an examination of the supervisee's reluctance to discuss this with her cotherapist.] I appreciate your reluctance.

However, I think this is a relatively common phenomenon here and definitely worth exploring more with your cotherapist. I encourage you two to dialogue about this. It is important that she know what is going on in the group when she is not there, including things that relate to race, racism, and racially informed transferences. It is essential that you two explore what her interpersonal contributions may be to their perception. Even if you two conclude that there is nothing about her interactions that reflect a problem in cultural competence, I know as a White person working here, that there are always ways in which people can give me feedback that helps me more effectively converse with people very different from me in terms of race and class. Also, I am willing to talk with you two about this together. (DIVERSITY)

Supervisee: I don't think it would be necessary for you to meet with us, because I don't want her to feel she has done something wrong or insensitive. (DIVERSITY)

Supervisor: I realize and recognize that. However, just as you need to be biculturally or triculturally competent working here, so do I and so does she. So if she doesn't hear about this and reflect on how she can increase her cultural sensitivity, we deny her an important learning experience. (DIVERSITY)

Supervisee: I am still uncomfortable, partly about bringing this to a peer. But, I see the relevance, including just telling her we discussed this in group and in supervision. (SELF-ASSESSMENT, DIVERSITY)

Supervisor: I think too that as a postdoc, it is an important developmental issue to have these difficult conversations. How can I help you do so? (DEVELOPMENTAL)

Supervisee: [Next session.] I talked with her this week. She was eager to hear what I had to say; it was something she had thought about. She recognizes the differences between herself and the clientele at the hospital. She thanked me and we decided that when these issues emerge in the future, we will try to talk about them more directly. (DIVERSITY)

Supervisor: This sounds excellent; an important step for both of you. My bet is that not only will each of you grow from this conversation, but your cotherapy relationship will deepen, and your capacity to help the women in the group deal with racial differences and similarities will be enhanced. (DIVERSITY, DEVELOPMENTAL)

Supervisee: [5 months into the supervision.] I'm glad we are meeting today to address group on Friday. I realize that many of the

women we serve have Axis II pathology, and I am comfortable dealing with that. But when a group member is floridly psychotic or in a full manic episode, it can become difficult to manage her and the rest of the group's reactions. Last Friday, X was in some sort of psychotic episode. We were surprised by her presentation because she had never behaved that way in all of the time she has been seen here. Based on her past records, she carries a diagnosis of paranoid schizophrenia, but here she was in a manic episode with psychotic features. She wore several layers of clothing, had makeup smeared on her face, and had no impulse control. She was remarkably paranoid and cursed out other group members. My main concern, other than her safety, was that the rest of the group would misinterpret her erratic behavior as aggression toward them. I got her admitted because she was in no position to go home from group. The group witnessed a fellow member being escorted by security down the hall to the inpatient unit. I debriefed the group after the incident and gave the women a chance to process their feelings. Fortunately, the women understood that this was not X's intentional behavior. They realized she was not trying to hurt their feelings, which was great because X was shouting hurtful things to them. Since Friday, I have gone to the unit to check on X and let her know that we are thinking about her. (INTERVENTION COMPETENCE)

Supervisor: I'm impressed with how you handled the situation. I wonder what impact it had on you. Whenever there is a crisis, it is important to reflect upon what you learned. (DEVELOPMENTAL, SELF-ASSESSMENT, PERSON OF THE THERAPIST)

Supervisee: That's an interesting question, because much of the debriefing I had to do that evening was for a group helper! She cried after group because she was offended and scared by X's behavior. It wasn't X's actions that affected me as much as the group helper's! I had to remember that I am in a supervisory role to the group helpers. She had never seen a psychotic episode like that, so she took X's aggressive language personally. I assured her that although one needs to have somewhat of a thick skin when working with the severely mentally ill, it is common to have feelings about crises. Her reaction made me realize that everyone in the group is emotionally invested, not just the participants. (SUPERVISORY COMPETENCE)

Supervisee: [6-month evaluation.] I need help job hunting. I have realized that psychologists are not sought on Monster.com, nor

are positions posted in obvious places most of the time. My mentors have stressed networking, but I don't really know anyone professionally in Atlanta, as I did not go to school or internship here. (MENTORING)

Supervisor: Let's talk about your expertise and potential positions of interest to you. Now that you have passed the licensing exam, are halfway through the postdoc, and have done a great job, this aspect of your development should be central. (MENTORING)

Supervisee: I like the population here at the hospital. I have always been interested in working with underserved groups. My favorite things are assessments and group therapy with an inpatient or forensic populations. (SELF-ASSESSMENT, MENTORING)

Supervisor: I concur that those are areas of strength for you. It is evident that you like working with the clients here. Let's talk about possibilities and people to connect with in some of these areas. I am willing to contact people on your behalf. Bring your vita to supervision next week and we can revise it for the job market. As we discussed in the postdoc seminar, most people's CV's need to be modified as they transition to the real world. (MENTORING, ONGOING ASSESSMENT OF COMPETENCE)

Supervisee: Our discussion in the seminar was helpful. I learned some basics about what to put in and take off, but I would benefit from individual help. (MENTORING)

Supervisor: Over the week, I will think about people for you to contact. You can get your vita ready. (MENTORING)

Supervisee: [2 weeks later.] I changed my vita and it looks pretty good. I had some difficulty contacting the professionals you directed me to. I'm a bit scared of cold-calling people. I would like to know specifics about how certain people got their jobs and what their duties entail, but I don't know if they would feel comfortable sharing that information. I would appreciate people sharing the nuts-and-bolts stuff. (MENTORING)

Evaluation and Outcomes

In both an ongoing fashion and at discrete and predetermined time points (e.g., every 3 months), the supervisor and supervisee directly assess the positive and problematic aspects of the supervisory relationship and process, supervisory learning environment, and outcomes of the clinical work being supervised. Discussions focus on both parties' comfort with the relationship,

agreement on supervisory objectives and effectiveness in achieving the stated goals, perceptions about each person's openness to feedback and willingness to use this input to make changes, trainee's views about the evaluative process and the supervisor's interpersonal style and professional competence, supervisor and supervisee's views on the extent to which the supervision enhanced the supervisee's professional competence, and a joint assessment of the supervisory impact (Falender & Shafranske, 2004; Lehrman-Waterman & Ladany, 2001). The trainee provides a written evaluation of the supervisor according to the same core competency domains on which he or she is evaluated as a supervisee. On the basis of the joint assessment of the supervisory relationship and process, the parties mutually determine modifications needed to improve the alliance and learning environment. A plan of action is put into place to ensure alterations are made to the satisfaction of both concerned.

Using the contract as a guide, the supervisor, supervisee, and supervisee's supervisee provide feedback on the trainee's functioning in each core competency domain. Feedback includes attention to factual knowledge, clinical skills, judgment, interpersonal attributes (e.g., openness, flexibility, positivity, cooperativeness, willingness to accept and use feedback, awareness of impact on others, ability to deal with conflict, acceptance of personal responsibility, ability to express feelings effectively and appropriately, and awareness of personal strengths and limitations and the need for continuing professional education), capacity to extend clinical skills to new situations and contexts, ethical sensitivity, cultural competence, and development of a primary professional identity as a psychologist (Frame & Stevens-Smith, 1995; Friedman & Kaslow, 1986; Overholser & Fine, 1990; Stigall et al., 1990). Many supervisors who practice from a competency-based framework incorporate standard assessment tools of such constructs as the working alliance and multicultural competence (Bernard & Goodyear, 1998; Falender & Shafranske, 2004). Supervisors recognize the importance of using objective criteria when providing feedback, communicating input clearly and directly, attending to the power dynamics inherent in the supervisory relationship, and ensuring that all feedback is offered in a humane fashion (Cormier & Bernard, 1982; Porter & Vasquez, 1997).

Given that the focus of this approach is on the supervisee's competence, one key element of the evaluation is the assessment of the clinical outcomes of the work being conducted (Ellis & Ladany, 1997; Stein & Lambert, 1995). Such an evaluation must occur in a fashion that is both formative and summative. Attention is paid to the link between the supervisee's clinical knowledge, skills, and attitudes and the progress made by the client with regard to alleviating symptom distress and improving interpersonal relations and social role performance. Audiotapes, videotapes, review of detailed process notes, cotherapy, or live supervision are supervisory methods that facilitate the

assessment of client outcomes and their link to the supervisee's performance. The next section of narrative illustrates various aspects of the assessment of competence in our supervisory work.

Supervisor: [Month 7 (time of the writing of this chapter).] As we have talked about previously, today we will review your self-assessment, my feedback on your performance, and your supervisee's feedback about you. We can review this by competency domain and then use the integrated input to inform our discussion of your goals and activities for the next 6 months. For each domain, let's examine the activities you have completed to date, how you met your goals in this domain, and your areas of strength and ways in which you can improve. We need to talk about how I can help facilitate these improvements. (ONGOING ASSESSMENT OF COMPETENCE)

The following are excerpts from the review for two domains: direct service and supervision provided by the supervisee; there is not space in this chapter to review all other domains—scholarship and research, professional development, other competencies, and involvement in training activities.

Supervisee: [After describing direct service activities completed to date.] I am doing well on the psychodiagnostic assessments, but clearly I need more exposure to projective tests. I would like to get more experience witnessing or participating in forensic evaluations. I am enjoying and doing well with the inpatient groups. Nia groups are going well, but I may have initially underestimated the basic level needs of the women. I can relate to some of their struggles as Black women or depressed persons, but I have often felt powerless when I did not have answers about key things, like how to obtain food, shelter, employment. In terms of consultation, I had the pleasure, thanks to you, of involvement with a local nonprofit organization having problems due to personal disputes between two of its managerial staff members. Unfortunately, one disputant is no longer employed with the organization, but I enjoyed problem solving with the facility's director. I hope to consult more in the future. I didn't realize that problem solving and mediation were strengths of mine. I hope to develop these skills further. (SELF-ASSESSMENT)

Supervisor: You have accomplished a great deal in the direct service domain. I am extremely pleased with your performance. I concur with your assessment of your strengths. As you can see from my evaluation, I would add the following. You are gifted

at forming a strong therapeutic alliance with your clients. Some of our most challenging clients have formed secure attachments to you, are more engaged in treatment than they have ever been, and are improving the quality of their lives. You handle crises in a calm and responsible fashion, do a good job of establishing and monitoring therapeutic goals and applying therapeutic strategies effectively, and have managed terminations professionally. I appreciated your willingness to volunteer to do that consultation. Next time I need assistance with such work, I will invite you. I concur that you have very strong skills in negotiation. These have served you well on the interdisciplinary clinical and research teams on which you work. I really appreciate your sensitivity to diversity considerations in all aspects of the assessment, intervention, and consultation process. You have done an excellent job of raising diversity issues in supervisions, seminars, and team meetings. You have an impeccable sense of professional ethics; that matters a great deal to me. (ONGOING ASSESSMENT OF COMPETENCE, DIVERSITY)

Supervisee: It is good to hear that the evaluation of my strengths is expanding. It is nice to know that at this level of training, I am continuing to improve. I am saying this based on supervisor evaluations over time. It is good to know that I have gained more competence in more areas. (ONGOING ASSESSMENT OF COMPETENCE)

Supervisor: Yes, a longitudinal perspective on one's professional development can be a very gratifying experience. You are right where you should be professionally, and I am confident that you will continue to grow and develop because of your sincere commitment to the learning process and to your own professional growth. (MENTORING)

Supervisee: What do you think about what I named as weaknesses and what would you add? (ONGOING ASSESSMENT OF COMPETENCE)

Supervisor: I think your self-assessment is quite accurate with regards to both your strengths and areas for improvement. Another area that we could potentially focus on more in supervision would be in terms of using empirical data to guide your interventions. Because of our need to focus on addressing the women's day-to-day needs and concerns, as well as your reactions to their plights, we have not taken enough time to consider what the evidence base might add to your conceptualization and intervention armamentarium. (ONGOING ASSESSMENT OF COMPETENCE)

Supervisee: That's true. I think what would be helpful to me would be more conversations about my evolving integrative theoretical perspective and how to ensure that the interventions I conduct reflect this unified approach to psychotherapy and the associated research.(SELF-ASSESSMENT, INTEGRATION)

I really value being a supervisor. I like being in the position to supervise more junior colleagues. It is a great opportunity for me, given that being a supervisor is part of what I want to do professionally. I think it is helpful to the students to have someone supervise them who is close to their level of development. As a supervisor, I am very accessible, which is important given the severity of the pathology and crises of our clients. I tend to my supervisee's personal–professional needs, as well as deal with the client issues. I do a good job helping them to process their feelings regarding their work. (SELF-ASSESSMENT, PERSON OF THERAPIST)

Supervisor: I have been impressed in our weekly conversations about your supervision by your dedication to the process, warm and engaging style as a supervisor, comfort sharing your knowledge with your supervisee, and desire to hone your supervisory skills. As we review the feedback you received from your supervisee, it is obvious that she was impressed by the quality of the supervisory relationship; your knowledge about and sensitivity to both ethical and legal considerations and individual and cultural diversity; and your capacity to effectively impart your knowledge, skills, and attitudes to her regarding interventions and consultations. (ONGOING ASSESSMENT OF COMPETENCE, PERSON OF THE THERAPIST, DIVERSITY)

Supervisee: We got along great; her written and oral feedback to me is consistent with my perception of the relationship. It was challenging to me early on asserting myself as the expert in the room. She asked a lot of questions right off about what she was supposed to do, because she had never worked with individuals with such severe psychiatric disorders before. I want to improve my ability to assess a supervisee's developmental level early on, so I know what they are and are not ready for. (SELF-ASSESSMENT)

Supervisor: That is a good area for us to focus on over the next few months. I don't have any other things I think you need to work on, as you seem developmentally on track for where you should be. You just need more experience, and as you supervise a broader range of individuals, more supervisory challenges will emerge. You have been fortunate that your first

experience has been with such a good trainee. It appears that
each of you have grown a lot. (DEVELOPMENTAL)

CONCLUSION AND RECOMMENDATIONS

Our coauthoring of this chapter reflects the approach to supervision we
recommend, namely a collaborative endeavor with the supervisor guiding the
supervision and the supervisee playing a major role in the coconstruction of
the relationship and the work. Although we believe that all competency-based
approaches to clinical supervision must be collaborative, we recognize that the
form this collaboration will take will depend on a multitude of factors, includ-
ing the developmental stage of both participants, the context in which the
supervision is conducted and in which the work being supervised occurs, the
nature of the work itself, and the degree to which the supervisee's level of com-
petence matches the expected level of competence. As the narrative shows,
effective supervision requires the infusion of diversity considerations into all
aspects of the work (Tummala-Narra, 2004).

The competency-based approach to supervision that is the focus of this
chapter provides a framework for working with trainees who manifest compe-
tence problems. If developmentally informed expectations for knowledge,
skills, and attitudes in each competency domain are clearly articulated but not
met by a supervisee, a competency-based remediation plan must be put into
effect. In addition to remediation activities that are educational in nature,
such a plan may require personal psychotherapy (Elman & Forrest, 2004).
Developing and implementing an appropriate remediation plan requires a
level of supervisory competence; strong institutional and/or collegial support;
and an appreciation of the complexities of the supervisory role as educator,
mentor, and gatekeeper (Forrest, Elman, Gizara, & Vacha-Haase, 1999; Gizara
& Forrest, 2004).

With the shift in the profession of psychology toward viewing super-
vision as a core competency (Falender et al., 2004), more attention needs to
be paid to devising and implementing education and training programs in a
competency-based approach to supervision at the graduate school, internship,
postdoctoral, and continuing professional education levels. For these training
efforts to be most beneficial, the knowledge base about supervision processes
must be expanded and enhanced. For example, common and distinguishing
factors among supervisory approaches need to be articulated. Our field also
would benefit from a richer perspective on supervision methods that reflect
integrative theoretical approaches and the meaningful synthesis of science
and practice (Falender & Shafranske, 2004). Greater delineation of optimal
processes for formative and summative evaluation would be useful (Falender
& Shafranske, 2004). It would be advisable for the profession to identify the

degree and nature of competence expected for supervisees in each core competency domain at each stage of development. Similarly, developmental levels of supervision competence of the supervisor need to be better understood. Furthermore, a consensus needs to be secured regarding when a supervisee's performance is incompetent, that is, when it falls below the acceptable threshold in any of the core competencies. Qualitative and quantitative research methodologies should be used to advance the profession's knowledge about these issues. Unfortunately, there has been a dearth of empirical work conducted on supervision in general and on a competency-based approach to supervision more specifically.

In closing, we hope that our chapter mirrors to some extent the supervisory process—that is, that it combines didactic information with personal sharing. The emphasis on theory integration and competencies is more didactic in nature, whereas the focus on interpersonal processes, transference and countertransference dynamics, the supervisory relationship, and the career development of the supervisee is more personal in nature. We recognize, however, the challenge of presenting narrative, as the reader is not privy to what comes before and after the narrative presented or the affective tone of the interactions. Our conversations are intended as guides to be adapted for each supervisory relationship.

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3

DEVELOPMENTAL APPROACHES TO SUPERVISION

CAL D. STOLTENBERG

Over the years, a considerable amount of research and theorizing about the supervision process, including how trainees change over time, has examined the supervision process as being different from the processes both specifically involved in therapy and those conceived from the perspective of psychotherapy theory (e.g., Loganbill, Hardy, & Delworth, 1982). Generally, in these supervisory theories, an implicit stage theory of therapist development is assumed and supervisory behaviors that are thought to be consistent with the hypothesized level of development of the therapist are specified (Stoltenberg, McNeill, & Crethar, 1994; Worthington, 1987). Focus on therapist change over time from both a quantitative and qualitative perspective serves as the critical difference between developmental and other approaches to supervision (Falender & Shafranske, 2004). Central to a competency-based approach to supervision is the ability to accurately assess the trainee's competence within the context of his or her developmental status and trajectory. The integrated developmental model (IDM) provides a conceptual and empirical approach to development. This chapter briefly overviews the IDM and presents an example that shows how the approach can be implemented. The importance of assessing and intervening at different levels of supervisee development across domains (explained later) is highlighted.

Stoltenberg and Delworth (1987) and, later, Stoltenberg, McNeill, and Delworth (1998) have presented the most comprehensive and detailed model of therapist development and supervision to date, the IDM. The primary basis for this model includes the work of Hogan (1964), Loganbill et al. (1982), and Stoltenberg (1981); theories of human development; and several empirical studies of therapist development (see also Stoltenberg, 1993, 1997, 1998, and Stoltenberg, McNeill, & Crethar, 1995, for expansions of aspects of the IDM). The IDM uses three overriding structures to monitor trainee development through three levels (plus a final integrated level) across various domains of clinical training and practice, thus integrating quantitative and qualitative processes and providing markers to assess development across domains.

The three structures are self and other awareness (with both cognitive and affective components), motivation, and autonomy. These three structures are the developmental markers for change in the therapist-in-training over time across eight domains of professional activity. The *self and other awareness* structure indicates where the trainee is in terms of self-preoccupation, awareness of the client's world, and enlightened self-awareness. The cognitive component includes the content and quality of the thought processes, whereas the affective component accounts for the emotional experience of the trainee moving from anxiety-based uncertainty and lack of confidence (Level 1); through emotional reactions to the client, including empathy (Level 2); and culminating in an awareness of one's personal emotional experience (including an insightful emotional reaction to the client and awareness of countertransference), empathy with the client, and an ability to reflect on the experience (Levels 3 and 3i; see Table 3.1). *Motivation* reflects the trainee's interest, investment, and effort expended in clinical training and practice. The *Autonomy* structure addresses the degree of dependence or independence demonstrated by trainees over time. A particularly important aspect of this approach is the recognition that a trainee is likely to be functioning at different developmental levels for various domains of professional activity.

CONTENT AREAS AND PROCESSES

The domains of professional activity can be conceptualized in varying degrees of specificity. Stoltenberg et al. (1998) offer the following categories: intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics (American Psychological Association [APA] Ethics Code; APA, 2002; see also the APA Web site version at http://www.apa.org/ethics/). Although each could be further reduced to more specific domains, the general categories serve to high-

TABLE 3.1
Developmental Levels and Structures

Level	Motivation	Autonomy	Self and other awareness
1	Motivated	Dependent; need for structure	Cognitive: limited self-awareness; Affective: performance anxiety
2	Fluctuating between high and low; confident and lacking confidence	Dependency–autonomy conflict; assertive vs. compliant	Cognitive: focus on client; understand perspective; Affective: empathy possible, also over-identification
3	Stable; doubts not immobilizing; professional identity is primary focus	Conditional dependency; mostly autonomous	Cognitive: accepting and aware of strengths and weakness of self and client; Affective: aware of own reactions and empathy
3i	Stable across domains; professional identity established	Autonomous across domains	Personalized understanding crosses domains; adjusted with experience and age

Note. From *IDM Supervision: An Integrated Developmental Model for Supervising Counselors and Therapists* (pp. 28–29), by C. D. Stoltenberg, B. W. McNeill, and U. Delworth, 1998, San Francisco: Jossey-Bass. Copyright 1998 by Cal D. Stoltenberg. Reprinted with permission of the author.

light the fact that one must carefully attend to the focal activity in which the trainee is engaging to adequately assess the developmental level at which the trainee is functioning at any given time. *Intervention skills competence* address the trainee's confidence in and competence in carrying out therapeutic interventions. *Assessment techniques* address the trainee's confidence in, and ability to conduct, psychological assessments. *Interpersonal assessment* extends beyond a formal assessment and includes the use of self in conceptualizing a client's interpersonal dynamics. *Client conceptualization* incorporates, but is not limited to, diagnosis. This domain goes beyond an axis diagnosis and involves the therapist's understanding of how the client's characteristics, history, and life circumstances blend to impact adjustment. *Individual differences* includes an understanding of ethnic, racial, gender, and cultural influences on individuals, as well as the idiosyncrasies that form the person's personality. *Theoretical orientation* involves formal theories of psychology and psychotherapy as well as eclectic approaches and personal integration. *Treatment goals and plans* addresses how the therapist conceptualizes and organizes his or her efforts

in working with clients in the psychotherapeutic context. Finally, *professional ethics* addresses how professional ethics and standards of practice are intertwined with personal ethics in the development of the therapist (see Exhibit 3.1).

According to the IDM, the twin processes of assimilation and accommodation induce a trainee's upward movement. Piaget (1970) described *assimilation* as the process of fitting reality into one's current cognitive organization. *Accommodation,* however, was defined as significant adjustments in cognitive organization that result from the demands of reality. Piaget considered assimilation and accommodation to be closely interrelated in every cognitive activity (Miller, 1989). Attempts to assimilate involve minor changes in the individual's cognitive structures as he or she adjusts to new ideas, whereas accommodation involves the formation of new constructs through the loosening of old ones.

Additional models of development provide other ways of viewing the process of therapist development. For example, Anderson's (1985, 1996) model of cognitive development describes changes from novice to expert status that includes more abstract representations in memory of relevant processes and pattern match. In addition, the ability to reason forward from known information, rather than reason backward from a problem statement, constitutes change from novice to expert. Expanding this to the clinical realm, one can see expert therapists engaging in forward thinking, leading to diagnosis and treatment from recognition of patterns displayed by clients with regard to personality characteristics, environmental circumstances, and therapist reactions to the client. Novice therapists are more likely to focus in on specific presenting problems or therapeutic processes and reason backward,

EXHIBIT 3.1
Integrated Development Model Structures and Domains

Overriding structures
- Self and other awareness
- Cognitive
- Affective
- Motivation
- Autonomy

Specific domains
- Intervention skills competence
- Assessment techniques
- Interpersonal assessment
- Client conceptualization
- Individual differences
- Theoretical orientation
- Treatment goals and plans
- Professional ethics

Note. From *Supervising Counselors and Therapists: A Developmental Approach* (p. 36), by C. D. Stoltenberg and U. Delworth, 1987, San Francisco: Jossey-Bass. Copyright 1987 by Cal D. Stoltenberg. Reprinted with permission of the author.

without recognizing broad patterns. Similarly, the concept of "schema development" (Gagné, Yekovich, & Yekovich, 1993) captures processes similar to what is delineated in the IDM regarding therapist development.

Essentially, the IDM suggests assimilation occurs within levels (Level 1, *novice*, through Level 3i, *expert*) and accommodation occurs between levels. In terms of cognitive development, initial formulation of simplistic schemata reflecting one's understanding of clients and the therapeutic process are refined into more encompassing concepts with more broadly associated links to other schemata. For the present case study, I used a practicum rating form for trainees (a rough estimate of developmental level) prior to and after the supervision experience. A rather extensive case conceptualization format provides the supervisor with useful information about the supervisee's clients and, more importantly, forces trainees to collect a broad spectrum of information about their clients, on which to build a conceptualization. Another measure was used, the evaluation of supervision form to evaluate the supervisee's perception of supervision.

Supervisory interventions, as one might expect, should vary according to the developmental level of the trainee (for any given domain). The IDM uses five categories of supervisory interventions to classify supervisor strategies. These are depicted in Table 3.2. Facilitative interventions are appropriate

TABLE 3.2
Supervision Interventions

Intervention strategy	Purposes
Facilitative: nurturing atmosphere; conducive to growth, warmth, liking, respect; conveys trust	Reduces anxiety; allows for reflection and introspection
Confrontive: highlights discrepancies; compares and contrasts emotions, beliefs, and behaviors	Examination and comparison; achieve congruence
Conceptual: theories, principles, substantive content; gives meaning to events, ties together isolated events	Integrate theory and research; analytical thinking
Prescriptive: specific plan of action; direct intervention; prescribes treatment or specific instructions; eliminates certain behaviors	Gives guidance; ensures client welfare; satisfies dependency
Catalytic: promotes change; gets things moving; highlights, defines, articulates, or enhances meaning; processes comments	Stirs things up, promotes reflection and integration

Note. Originally adapted from "Toward a General Theory of Consultation," by R. R. Blake and J. S. Mouton, 1978, *Personnel and Guidance Journal, 56*, p. 330. Copyright 1978 by the American Counseling Association. Adapted with permission. Adaptation for *Supervision Interventions* (handout included in workshop materials), by E. Hardy and C. Loganbill for, 1984, for *Psychological Supervision* (workshop), Iowa City: University Counseling Service, Iowa Memorial Union, University of Iowa. Copyright 1984 by E. Hardy and C. Loganbill. Adapted with permission of the authors.

across levels. For Level 1 trainees, in addition, prescriptive and conceptual interventions are useful. In late Level 1, catalytic interventions can be appropriate. For Level 2, in addition to facilitative interventions, confrontive, conceptual, and catalytic interventions are used regularly. For Level 3, facilitative interventions remain important; confrontive interventions are occasionally used; and conceptual and catalytic remain useful.

STRENGTHS AND LIMITATIONS OF THE APPROACH FROM THE POINT OF VIEW OF THE SUPERVISEE

Entry-level knowledge and skills are expected of the trainees, with higher degrees of each consistent with more advanced levels. Values of the trainee should reflect consistency with the APA Ethics Code (APA, 2002). Reactions to the approach have been consistently positive, with an appreciation for the explicit acknowledgement of variability in knowledge and skills across levels of trainees. Some anxiety on the part of the trainee is expected, and desired, as a motivating influence on the trainee's development (consistent with Piaget's [1970] concept of "disequilibrium"). This can (and should) result in some level of discomfort for the trainee on an ongoing basis so as to stimulate growth (overly comfortable people do not grow). Typically, the process of engaging in learning psychotherapy provides sufficient motivating anxiety that additional stress need not be applied by the supervisor. Common challenges reflect accurate assessment of developmental level for the various domains of professional practice in play during any given supervisory relationship (or any given session). In addition, being flexible in one's ability to respond to the appropriate developmental level for the different domains (often within one session) is challenging. Within the context that I conduct supervision, informal formative evaluation is ongoing, with summative evaluations given at midsemester (oral) and end of the semester (written).

DIVERSITY ISSUES IMPACTING THE SUPERVISORY PROCESS

The supervisor can function most effectively when he or she is aware of the personal and professional values that impact his or her practice. Awareness of one's own cultural background, that of the supervisee, and those of the clients are all important in enabling the creation of an effective supervision environment. Assessing the effects of culture in addition to, and apart from, therapist development is necessary. Gender differences are also important variables to monitor in the supervisory (and therapeutic) relationship.

EXPECTED FUTURE DEVELOPMENTS AND DIRECTIONS

I maintain that this approach is not bound to any one therapeutic orientation, but research has not yet been conducted across all current approaches. The content of supervision, however, will differ by therapeutic orientation, although the process should remain fairly consistent. I expect clinical and research advances to largely fit into the overall framework of this model.

AN EXAMPLE OF THE APPROACH

The following example describes the context in which the supervision occurred, the goals and processes, and the evaluation and outcomes.

Context of the Supervision

The supervision relationship occurred in our Counseling Psychology Clinic, which functions as a community mental health center in a city with a population close to 100,000. The clinic serves a breadth of clientele with diverse cultural backgrounds, ages, and socioeconomic statuses. Clients' presenting problems are typical of community mental health centers with a wide range of chronicity and diagnostic categories and tending to have clients near the lower end of the economic spectrum. Services provided include individual counseling and psychotherapy, family therapy, and marital therapy, in addition to a wide range of assessment services, all with sliding scale fees. Therapists are either master's students in community counseling or school counseling programs, or doctoral students in counseling psychology. Master's students spend their 1st year in the program engaged in practica at the clinic, whereas doctoral students spend a minimum of 2 full years in practica at the clinic (3 full years if they enter with a bachelor's degree but not a master's degree). All supervision of doctoral students is provided on site by faculty in the counseling psychology program. Supervision of master's students is provided by advanced doctoral students as part of a practicum in clinical supervision.

For the present case study, the student supervisee was a 28-year-old single Caucasian man in his 2nd year of the program. He was originally from the Midwest and grew up in a family of limited financial means. He entered with a master's degree in counseling (having had practica in his prior program) and experience working with an adolescent population. His primary theoretical orientation was client centered, although he had experience with cognitive behavioral, relational–cultural, and narrative approaches. During the course of this supervision relationship, lasting over 4 months (one semester), he worked primarily with individual clients, although he also had two married

couples in his caseload. He worked with a cotherapist (female doctoral student, 1 year behind him in the program) when engaging in couples therapy.

I was the supervisor in the case study. I am a married Caucasian man (51 years old at the time of the supervision), and I also grew up in the Midwest in a rural setting, in a blue-collar farm family. I have a PhD in counseling psychology and have been active in clinical supervision for 23 years. I am a professor in the program, as well as the director of training. At the time of this supervision relationship, I was responsible for eight supervisees (seeing them weekly for individual supervision and group supervision or case conference). My therapy orientation is integrative, relying on client-centered, cognitive behavior, and psychodynamic theories to inform my work with clients. As noted earlier, my orientation to supervision is developmental, following the IDM.

Supervision Goals and Processes

The supervisee had completed his 1st full year in the doctoral program, which included two long semesters and the summer session in practicum. I have supervised 2nd-year students in our program for 18 years, occasionally picking up other supervisees with less experience, but usually focusing on this group. Our students go through the program as a cohort, so the trainee had been in practicum for the entire year with the same other seven students. Barring significant experience in counseling, psychotherapy, or assessment prior to entering the program (typically 5 years or fewer as a practicing master's-level therapist), I expect most supervisees in this practicum to be functioning at Level 2 in at least some domains and probably Level 1 in others. Although I had access to prior evaluations of the supervisee completed by other supervisors, I chose to meet with him first before looking over the evaluations so as to approach him with fresh eyes and not be overly influenced by the perceptions of others for our initial meeting.

As is typical for my supervisory sessions, our initial meeting was spent getting to know one another and discussing general training goals for the semester. One of the primary assumptions of the IDM is that therapists personalize their understanding of the therapy process and how they engage in it. As one's personal attributes and characteristics are important influences on one's behavior as a therapist, I find it important to focus considerable attention on getting to know the supervisee. During this session, the supervisee told me things about himself that he saw as important, discussed how he perceived himself as growing through the training process, and shared some expectations for our work together.

> *Supervisee:*   I think I've grown a lot over the past year in my effective-
> ness as a therapist and for sure in my understanding about

how it all works. I've enjoyed being exposed to different ori-
entations, and I think they add to my relationship skills.

Supervisor: So you see yourself as being good at developing facilitative
relationships with your clients? What can I do for you this
semester?

Supervisee: Yes, I think my clients trust me; they come regularly for ses-
sions, and mostly, say I'm helpful. I guess what I'm hoping
will come from this semester is more confidence in my abil-
ities and some help understanding what I can do to move
my clients along more quickly.

After some discussion of my view of counseling and therapy as well as
the supervision process, we went over each of his five current cases, that is,
three individual clients and two couples, as he familiarized me with his con-
ceptualizations of them, his successes, and his frustrations. He was particu-
larly interested in getting input regarding the couples with whom he was
working.

Supervisee: I've had a course in marriage and family therapy, but it was
a pretty broad overview of approaches. I'm not at all confi-
dent in my abilities in this area. For example, I've been
working with this couple for nearly a year. [He hands the
client chart over to me.] As I look at it now, there's really
been no positive change. Their complaints and behavior
are pretty much the same now as when we started.

Supervisor: This couple looks familiar to me; didn't I supervise you and
another student for a session or two near the end of last fall?
[As I peruse the chart I see that, indeed, I signed a couple of
case notes the prior year.]

Supervisee: Yes, we started using the integrative behavioral couples ther-
apy approach [IBCT; Jacobson & Christensen, 1996] under
you, but we kind of moved to a communications approach
and spent a lot of time doing client-centered stuff with each
of them. Actually, they were both referred for individual
counseling, too, but kept coming in for marital therapy.

Supervisor: As I recall, this couple had some real challenging baggage
they were dealing with. Should be interesting to catch up
with where they are now. Think you can bring in your most
recent videotape of a marital session with them next time?

Supervisee: Yes, I was planning on that. I think things are going pretty
well with my other clients, but I'll bring in videos of all of
them, too.

My personal belief is that supervisors supervise in the dark if they do not see videos of their trainees' work with clients or do some direct observation. I think this is true at all levels of training (I know I pick up on things when I view my own videos), but it is most important for the clinical work of those at Levels 1 and 2, according to the IDM. As humans, we have only a certain amount of attention or awareness that we can access at any given time. Thus, trying to pay attention to the client, ourselves, the process, and reflecting on events during the session can tax our memories and ability to focus. If supervisors rely solely on trainees' reactions and memories of their sessions, they are severely limited in their work. Much occurs in any given session beyond the working awareness of most therapists.

In early supervision sessions, I spent considerable time doing initial assessments of the supervisee's status on the three overriding structures delineated in the IDM, primarily for the domains of intervention skills competence, theoretical orientations, client conceptualizations, treatment plans and goals, and interpersonal assessment. Given one's status on these structures, the supervisor can judge the trainee's level of professional development.

Reviewing the supervisee's client charts, discussing his perceptions of the clients and his sessions with them, and viewing videotapes helped me develop an early perspective on his development. In addition, the evaluation from his preceding practicum suggested that he was functioning at the expected level (roughly, a general rating of Level 2 for his work, with strong ratings for relationship skills). For his individual clients, it was clear that he had a good grasp of logical conceptualizations of the clients' personal attributes (including diagnoses), life circumstances, and progress in therapy. He had worked with most of the clients for at least 20 sessions, so we had at least two completed treatment plans (the first done after 5 sessions and then again after each additional 10 sessions) and numerous case notes. I looked for (and found) consistency among written conceptualizations of the clients, their diagnoses, the subsequent treatment plans, progress notes on how treatment was progressing, and in-session behavior (as viewed on videos). This was augmented by the way he described his clients and his work with them.

> *Supervisee:* I'd like to spend some time today looking at videos and discussing my client, Mary. I've been working with her for about a year. She's been coming to the clinic for, I think, around 4 years.
>
> *Supervisor:* Sounds good. Let's take a look. [Supervisee puts in a video, and we begin watching.]
>
> *Supervisee:* This is our most recent session from earlier this week. She's depressed and anxious much of the time. She's had regular problems with suicidal ideation, but she hasn't acted on it. I'm seeing her twice a week now. She says she needs the support.

Supervisor:	What changes have you seen in her over the past year?
Supervisee:	Our relationship has developed really well, I think, over time. She wouldn't open up much for the first few months, but she's pretty good about sharing her thoughts and feelings with me now. I think we have a pretty good relationship.
Supervisor:	She really seems down in this session. And so do you.
Supervisee:	Yeah, she's that way a lot. That's one of the reasons we're meeting twice weekly. She says she gets too depressed and she needs to check in with me more than once a week. [We continue to view the video in silence for a while.]
Supervisor:	What kind of pull do you feel from her during this session?
Supervisee:	Hmmm. I guess I'd say a pull to support her, take care of her. She gets so down, I find myself getting right down there with her.
Supervisor:	How old does she seem to you at this point in the session?
Supervisee:	She's in her early 40s.
Supervisor:	[Laughs.] Thanks, but I didn't ask her age. Forget how old she is, or how old she looks; when you're in the session with her, how old does she seem?
Supervisee:	Hmmm. I guess about 9 or 10. I don't know. She seems really young and dependent.
Supervisor:	And how does that make you feel?
Supervisee:	I guess I usually feel like I need to support her, but sometimes I get frustrated because she just can't seem to get past the depression. And she really doesn't seem to have the energy to do much between sessions.

Our work in this session was primarily within the domains of interpersonal assessment and client conceptualization. The supervisee appeared to me to dealing with Level 2 issues, primarily in the area of self and other awareness. He showed an ability to focus well on the client and he appeared to be experiencing empathy toward her, with a tendency toward, perhaps, overinvolvement. It was clear in his case notes that he understood her feelings of helplessness in her daily life. He was, however, beginning to experience frustration with her lack of movement and her inability (or unwillingness) to work on much between sessions. Supervisory interventions used were primarily facilitative (many of these can be nonverbal), and catalytic (process comments and observations).

I find myself using analogies quite a bit in supervision. One I regularly use is "therapist development and the hole." In this analogy, the Level 1

therapist stands at the edge of a hole, looking down at his or her client. He or she will try to comfort the client in this unfortunate situation, convey sympathy for the predicament, and maybe give some advice on how the client could climb out. The Level 2 trainee differs from Level 1 in that he or she climbs down in the hole with the client (i.e., the trainee feels and expresses empathy). The therapist can now better appreciate the depth of the client's problem or problems, and the client feels understood and not alone. Unfortunately, often neither one knows how to get out. That is a bit like the situation in which the supervisee found himself with this client. He experienced empathy, was able to see her perspective on her life, and was able to communicate that to her. Unfortunately, there they stayed. To remain with the analogy, our goal was to find a way for both of them to climb out (Level 3), using acquired (or developing) knowledge and skills to achieve this goal. At this point, I believe, the supervisee felt he would need to throw the client over his shoulder and carry her out. We spent considerable time over the next few weeks examining ways he could help her find her way to the surface.

Through watching more videotaped sessions and processing what was going on with the client, the trainee, and the process, (through facilitative, confrontive, and catalytic interventions) the supervisee decided that he needed to encourage the client to monitor her daily activities more. She needed to monitor her thoughts, emotions, responses, and outcomes to daily events. He came to believe that the dependency the client had developed on him was slowing her progress, and he noted he had been periodically feeling like a "failed savior." The supervisee felt comfortable in being responsible for decision making about the client, and derived most of his direction in response to observing what was going on in the sessions and reflecting on what he saw, as well as his thoughts and feelings about what he saw. My input remained largely supportive, with some confrontation (pointing out discrepancies among his thoughts, feelings, and actions), making process comments about what went on in the sessions or what he was currently experiencing (i.e., catalytic interventions), and using some conceptual interventions as we discussed how various theories could explain or impact his work with the client.

As we examined the documentation for his couples early in the semester, it became clear that little progress had been made, particularly for the couple he (and two different cotherapists) had worked with for 9 months. The case notes reflected week after week of supportive listening as the partners complained about each other, and attempts at teaching them to communicate more clearly resulted simply in more clear complaints and negativity. On viewing the videotapes, it became evident that the partners were communicating their displeasure with each other quite clearly, but this was not leading to improvement in the relationship.

Supervisee: I really don't think we're helping this couple. Week after week, they come in and complain about each other, and nobody's changing. I haven't had much training in working with couples, just a survey course. I'm feeling pretty lost, and my cotherapist has less experience than me and is looking to me to take the lead. I think I need help.

Supervisor: Let's take a look at the most recent session. Did you bring the video with you?

Supervisee: Yeah. Got it right here. [The supervisee loads the video, and they begin watching.]

Supervisor: What are you trying to do with the couple at this point in the session?

Supervisee: Hell, I don't know. Trying to get them to clarify the complaints they have toward each other. Ends up being a bitch session.

Supervisor: Judging by the case notes, you've had a few of those with this couple, eh?

Supervisee: Yeah, about 9 months of them.

Supervisor: You and your cotherapist look frustrated on the tape.

Supervisee: I know I am. My cotherapist will come in next week for supervision with me, and I think she'll agree we're both pretty frustrated. We referred them both to individual therapy, too, thinking that may help them clarify some of their own issues and help marital therapy.

Supervisor: Has it?

Supervisee: Not that I can tell.

Supervisor: Let me come clean here with some biases of mine. As I read the literature on marital therapy, there's not a lot of evidence that what many therapists do with couples seems to work. Especially if you take the same techniques and orientations you use in individual work and try to make them fit marital therapy. We typically need to introduce more structure when working with couples. Can't let them go ballistic on each other all the time in the sessions. I like to use integrative behavioral couples therapy when I work with couples. It has pretty solid theoretical and empirical support, and it's worked well for me.

Supervisee: Yeah, we started with that but then went a different direction when we switched supervisors. I really need some guidance here. Can I borrow a book or something?

Supervisor:	Sure, got one here. If you like, we can go over parts of this tape again and I can help give you some ideas on what you could do differently.
Supervisee:	That would be great. I hate feeling so lost in these sessions, and we don't seem to be helping this couple much.
Supervisor:	OK, let's review what you know about this couple and start to put it into a framework.

In contrast to the supervisee's work with his individual clients, he admitted to a lack of direction, frustration with not knowing what to do, and concern that the marriage was not improving. In essence, he was acknowledging he was functioning largely at Level 1 here, experiencing cognitive confusion, anxiety, and a desire to depend more on guidance from the supervisor but highly motivated to learn and improve. In this session, I found myself using facilitative interventions to give him support and some conceptual interventions while beginning to move toward prescriptive interventions. There are times, particularly when a trainee is functioning at Level 1, when he or she simply needs input regarding what to do. In my experience, couples therapy is in a number of ways considerably different from what therapists do in individual work. Just focusing on facilitative interventions or, for that matter, confrontive or catalytic interventions at this point would probably serve to mostly frustrate the trainee. Sometimes he or she needs specific input on given theoretical orientations (conceptual interventions) and specific advice on how to implement them (prescriptive interventions).

Over the course of the rest of the semester, we spent considerable time going over videotapes of couples sessions. I continued to rely on facilitative interventions to make the supervisee (and his cotherapist, when she could join us in sessions) less anxious and supported in the process of learning to work with couples. Considerable attention was paid to conceptual and prescriptive interventions, too, as the supervisee was unfamiliar with the IBCT approach, was not married, and had limited couples counseling experience. As his familiarity with the approach increased and his comfort level improved, I was able to back off some on the use of both conceptual and prescriptive interventions and move more toward confrontive and catalytic interventions to allow him to more independently process his thoughts, feelings, and behavior.

Evaluation and Outcomes

By the end of the semester, the supervisee had made significant progress with his clients, particular the individual client, Mary, and the couple described above. Mary was down to one session per week and was completing weekly charts on her daily activities and her thoughts, emotions, adaptive

responses, and perceived outcomes to critical events each week. She reported experiencing less depression most days, and she had become more energized. The supervisee felt good about his work with Mary but believed they had a ways to go before she could function more independently.

The marital therapy experience had, by all accounts, been a success. The couple reported (and demonstrated) more emotional acceptance of each other, and coupling behavior had significantly improved. They suggested toward the end of the semester that they felt they had improved enough to "go it alone." Responses to the Dyadic Adjustment Scale (Spanier, 1976) were consistent with this perspective. The therapeutic relationship terminated with the supervisee noting that he would be available to meet with them on a one-time basis, should they need it, over the next 6 months before his practicum experience ended at the clinic.

My assessment of the supervisee at the end of the semester was communicated to him verbally and in written form with our standard practicum supervisee rating form. Our standard form asks us to rate a number of dimensions on a 5-point scale (1 = *unacceptable* to 5 = *excellent*) for the level of trainee development. I saw him as developing through Level 2 for his individual clients and showing transitions to Level 3. In terms of his work with couples, he had grown immensely, with dramatic increases in confidence and, in my opinion, his ability to conceptualize, develop a treatment plan, and implement it. Given that we often see trainees grow more rapidly in domains that are closely related to others in which they are more advanced, the supervisee's therapy skills with individual clients enabled him to develop more quickly in the arena of marital therapy. With a better understanding of the theoretical basis of the work and a growing familiarity with the different interventions used in the approach, I saw him as solidly functioning in Level 2. For the items in the area of basic communications skills, I rated him 5, or *excellent*, as he demonstrated to me his strong skills set in this area. Similarly, I rated him *excellent* in the areas of single interview management skills and basic planning and treatment program implementation skills. I rated him 4s (*very good*) and 5s (*excellent*) for most items in advanced planning and counseling implementation skills, and in the area of personal characteristics and behaviors affecting professionalism and professional development. I am aware that our faculty supervisors tend to vary the range of ratings they give their supervisees; I probably err on the side of higher ratings, as I believe it is a way to acknowledge the work the supervisees put in to the process and to shape them toward continued growth. Ultimately, however, their performance needs to merit their ratings and verbal feedback. Finally, I recommended the supervisee seek additional experience with clients of different ages and cultural backgrounds than what he experienced in our work together. I also recommended that he continue to develop his skills and understanding of IBCT in working with couples in the future.

The supervisee's evaluation of our supervision experience was communicated to me by him both verbally and in written form. As I was also supervising seven other trainees during this period, I did not know which written evaluation of supervision was completed by him (to encourage the most accurate written evaluations, I require them to be anonymous from the supervisees). I can note, however, that the average ratings of me by supervisees during this period were in the 6 (*quite above average*) to 7 (*very much above average*) on a range from 1 to 7 across the categories of evaluation (i.e., time and effort expended by supervisor, specific input on client management by supervisor, and dimensions of the supervisory relationship). Verbally, the supervisee voiced appreciation for the humor and respect he felt I brought to the process. He noted that he felt he could explore client issues, and issues he had as a therapist, in a safe environment without losing responsibility for his work and without feeling criticized. In the words of the supervisee:

> I felt that I was encouraged to explore thoughts and feelings in my work with clients, and not feel like I was myself the client. Sometimes you'd just sit back, reflect some, and let me struggle. Other times you would propose pretty specific alternatives. I'm not sure how you knew which to do, but I think it really helped me grow.

CONCLUSION AND RECOMMENDATIONS

Supervisors constantly struggle with the balance of optimum service delivery for clients and supervisee training needs. I think the IDM, and the context in which I am able to use it, allows for an appropriate balance. Attending to the domains of clinical practice allows supervisors to be reminded that supervisees do not typically function at only one level of professional development but rather are often functioning at multiple levels for various domains. This is an important process to remember. In addition, monitoring the trainee's progress according to changes in the overriding structures, for each domain, helps the supervisor assess the current status and training needs more accurately.

Unfortunately, there are no adequate pencil-and-paper instruments for conducting an appropriate assessment. The supervisee's behavior with clients and in supervision provides the data from which the supervisor can make these assessments. These ongoing assessments then suggest the degree of structure for supervision and training to be provided by the supervisor (the more developed the trainee, the less structure provided by the supervisor) and types of supervisory interventions that may be used at any given point in the supervisory relationship.

It is important to once again note that this approach to supervision, or any other, cannot be adequately implemented without viewing the process of

therapy (or the process of other domains) directly through videos or observation. This not only allows for working with the therapy process that actually occurred (as opposed to memories or presentations of the process) but also can provide evidence for changes in supervisee behavior that can reflect the success (or lack) of supervision.

We are nearly at the point in setting up our clinic database when we will be able to more fully use therapy process and outcome data to more adequately evaluate the supervision process in our setting. Ultimately, it is our goal to monitor ongoing change in clients as indicated by self-report measures, standardized instruments, and observed behaviors as a function of issues addressed in supervision. Also, using qualitative methodologies to tap into changes in the perspective of supervisees and supervisors over time can add to our clinic supervisors' understanding of the process.

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