Supervision Models

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

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

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

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

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

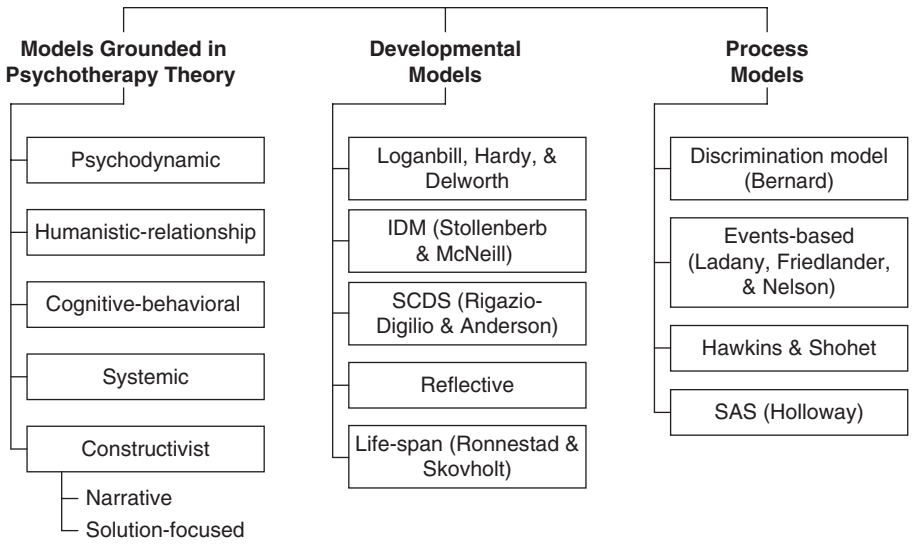

FIGURE 1 Major Categories of Clinical Supervision Models

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

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

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

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

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

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

PSYCHOTHERAPY-BASED MODELS OF SUPERVISION

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

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

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

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

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

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

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

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

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

Psychodynamic Supervision

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Humanistic-Relationship Oriented Supervision

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

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

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

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

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

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

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

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

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

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

Cognitive–Behavioral Supervision

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

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

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

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

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

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

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

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

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

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

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

Systemic Supervision

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

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

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

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

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

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

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

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

Constructivist Approaches

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Exploring exceptions for both supervisees and clients.
4. Developing other possibilities by discussing hypothetical situations with the supervisee as well as considering what meaning is embedded in supervisee's worries about worst case scenarios.
5. Giving feedback and clinical education.
6. Assisting the supervisee in forming the first little step for their upcoming counseling session.
7. Following up in subsequent supervision sessions about changes that occurred for both client and supervisee based on solution-focused techniques and philosophy.

These components are consistent with what others have identified as key SFS approaches, including the importance of focusing on small incremental steps rather than more radical ones.

As with the narrative approach, the supervisor uses a consultant role (e.g., using questions to guide interactions) and gives particular attention to language usage. Presbury et al. (1999) distinguish between *subjunctive language* and *presuppositional language. Subjunctive language* supposes a possibility (e.g., "Can you think of a time when you were able to be assertive with your client?"), whereas *presuppositional language* supposes an actuality (e.g., "Tell me about a time when you were able to be assertive with your client"). Supervisees are less likely to dismiss the latter. As well, in their use of presuppositional language, supervisors convey an assumption of the supervisee's competency.

Presbury et al. (1999) provided some possible examples of questions that a solution-focused supervisor might ask a supervisee. For example, in an effort to direct discussion toward supervisee achievements and competencies, the supervisor might ask, "What aspect of your counseling have you noticed getting better since we last met?" or, "Tell me the best thing you did with your client this week" (p. 151). Should the supervisee focus too heavily on problems that she or he is experiencing with the client, the supervisor might ask, "As you begin to get better at dealing with this situation, how will you know that you have become good enough at it so that you can take it on your own?" and then, later, "What will you be doing differently?" or, "When you get to the point at which you won't need to deal with this issue in supervision any more, how will you know?" (p. 151).

Integrative Supervision

Integrative supervision is used here as it is primarily used in the professional literature, that is, the supervision of integrative therapy (e.g, Boswell, Nelson, Nordberg, McAleavey, & Castonguay, 2010; Foy & Breunlin, 2001; Norcross & Halgin, 1997; Scaturo, 2012; Tennen, 1988). Therefore, it is a psychotherapy-based model, as its primary focus continues to be on the mentoring of the supervisee toward competence in a theoretical context, albeit a flexible theoretical context.

Boswell et al. (2010) suggest that supervisees be mentored to conceptualize a case from a particular theoretical perspective, one that is tailored for the case. If that approach must be adjusted or supplemented as therapy proceeds, it is important that supervision include oversight of the implications of integration of concepts or techniques from another theoretical perspective and the compatibility of such to the original conceptualization. Therefore, a necessity for integrative supervision is the ability and desire to supervise from multiple perspectives as well as a commitment to devote the time necessary to assist supervisees in understanding the constraints and implications of integration. Addressing integrative supervision from a family-therapy perspective, Foy and Breunlin (2001) note, "Therein lies one of the real treasures of integrative work: Each case is uniquely defined by the subtle interaction of the family and the therapist and by the many decisions they address to make therapy successful" (p. 394).

Norcross and Halgin (2005) assert that integrative work is more imaginative and adventurous, but that this can cause perplexity and anxiety as well as satisfaction. They warn that integrative supervisors should be prepared for a wide range of emotions from supervisees, who may become more frustrated that they would be in learning one approach to

therapy. They suggest that a cost–benefit analysis be conducted for each supervisor and supervisee to determine if the gratification of integration outweighs the anxiety it produces, especially for novice supervisees who, as noted by Scaturo (2012), may view adherence to one theoretical approach as a "theoretical life preserver" (p. 190).

In summary, true theoretical integration is far more challenging than technical eclecticism. Therefore, integrative supervisors may need to be prepared to spend more time with their supervisees discussing theory than those who choose to supervise within one theoretical orientation.

Conclusions about Psychotherapy-Based Supervision Models

Supervision clearly found its beginnings within the various schools of therapy theory. Despite the growth of supervision in a variety of directions, any reference to resistance in supervision or reinforcing a supervisee's good work harks clearly back to psychotherapy roots. The primary advantage of leaning toward a psychotherapy-based model in one's supervision is the modeling it provides supervisees who wish to master a particular theoretical approach to therapy. Also, because supervisees "experience" the theory in supervision, their understanding of their clients' reaction to similar interventions increases.

Concerns about using psychotherapy-based supervision include the possible theoretical foreclosure of a supervisee if supervision requires them to commit to one theoretical approach (Bernard, 1992). Also, as noted by Thomas (2010), such supervision may blur the boundary between therapy and supervision, possibly causing confusion for the supervisee about the nature of the supervisory relationship.

DEVELOPMENTAL APPROACHES TO SUPERVISION

Developmental conceptions of supervision are not at all new. In fact, some date to the 1950s and 1960s (e.g., Fleming, 1953; Hogan, 1964). They were moved to center stage, however, in the early 1980s with the work of Stoltenberg (1981) and Loganbill, Hardy, and Delworth (1982). These authors and others (e.g., Blocher, 1983; Littrell, Lee-Bordin, & Lorenz, 1979) struck a resonant chord in the supervision community, which responded enthusiastically.

By 1987, Holloway was able to comment: "[D]evelopmental models of supervision have become the Zeitgeist of supervision thinking and research" (p. 209). That same year, Worthington (1987) performed a literature review that found 16 models of counselor–supervisee development; in a later expansion of this review, Watkins (1995d) identified 6 more. That level of interest could not be sustained, of course. In fact, with few exceptions (e.g., Lambie & Sias, 2009; Young, Lambie, Hutchinson, & Thurston-Dyer, 2011), attention to the topic of developmental models has dropped off considerably since. In part, this has much to do with the quality of extant models; in addition, developmental constructs have been infused into other models of supervision.

Developmental models are not all of the same type. Some draw heavily on psychosocial developmental theory (e.g., Loganbill et al., 1982); others appear to be more Eriksonian by offering discrete, primarily linear stages of development (e.g., Stolenberg, 1981). Stoltenberg and McNeill (2010) include cognitive learning theory, interpersonal influence and social learning, motivation theory, and models of human development, as all contributors of their integrative developmental model (IDM). This list may be adequately comprehensive to appreciate the underpinnings of developmental models of supervision. Said as succinctly as possible, all development models are organized around the needs of the supervisee based on some assessment of his or her status of professional development relative to some standard(s) of performance.

In the following pages, we describe five developmental models: Loganbill et al.'s (1982) model; integrative developmental model (Stoltenberg & McNeill, 2010); systemic cognitive–developmental

supervision model (Rigazio-DiGilio, Daniels, & Ivey, 1997); reflective developmental models; and lifespan developmental models. In addition, we report some of the research on supervisee development that has both informed and supported these models.

The Loganbill, Hardy, and Delworth Model

Holloway (1987) observes that Loganbill et al. (1982) probably were the first to publish a comprehensive model of counselor development. Although there has been scant research follow-up on that model, it is sufficiently unique and important to warrant coverage.

Loganbill et al. chose Chickering's (1969) developmental tasks of youth and redefined them into professional issues for those training to be therapists: competence, emotional awareness, autonomy, professional identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. For each issue, the trainee might be at one of three stages—stagnation, confusion, or integration—or in transition between stages. The stages are as follows:

Stagnation Stage. For more novice supervisees, stagnation is characterized by unawareness of deficiencies or difficulties. The more experienced supervisee, however, is more likely to experience this stage either as stagnation (or "stuckness") or as a blind spot concerning his or her functioning in a particular area. The supervisee at this stage is likely to engage in cognitively simple, black-and-white thinking and to lack insight into his or her impact on the supervisor or client. He or she also may experience counseling as uninteresting or dull.

Supervisees at this stage may exhibit one of two patterns during supervision. In one, the supervisee is especially dependent on the supervisor and idealizes him or her. Alternatively, the supervisee may view the supervisor as somewhat irrelevant, at least with respect to the issue with which the supervisee is dealing. The tone, however, more likely is one of neutrality or unawareness.

Confusion Stage. The onset of the confusion stage can be either gradual or abrupt. Its key characteristics are "instability, disorganization, erratic fluctuations, disturbance, confusion, and conflict," and in which the supervisee "becomes liberated from a rigid belief system and from traditional ways of viewing the self and behaving toward others" (Loganbill et al., 1982, p. 18). This can be troubling, because the supervisee realizes that something is wrong, but does not yet see how it will be resolved.

In this stage, the supervisee recognizes that the answer will not come from the supervisor. The dependency that characterized the earlier stage is replaced by anger or frustration toward the supervisor, who either is withholding or incompetent, depending on the supervisee's particular perception.

Integration Stage. This stage, the "calm after the storm," is characterized by "a new cognitive understanding, flexibility, personal security based on awareness of insecurity and an ongoing continual monitoring of the important issues of supervision" (Loganbill et al., 1982, p. 19). At this stage, the supervisee sees the supervisor in realistic terms, as a person with strengths and weaknesses. The supervisee takes responsibility for what occurs during supervision sessions and has learned to make the best use of the supervisor's time and expertise. His or her expectations are consistent with what is possible from supervision.

The three supervisee stages and their relationships with each other are depicted in Figure 2.

In contrast to other developmental models, which assume a more linear progression across stages, this model assumes that the counselor cycles and recycles through the stages, increasing their levels of integration at each cycle. To explain, Loganbill et al. used the metaphor of changing a tire:

> *One tightens the bolts, one after another, just enough so that the wheel is in place; then the process is repeated. Each bolt is tightened in turn until the wheel is entirely secure. In a similar way, stages of*

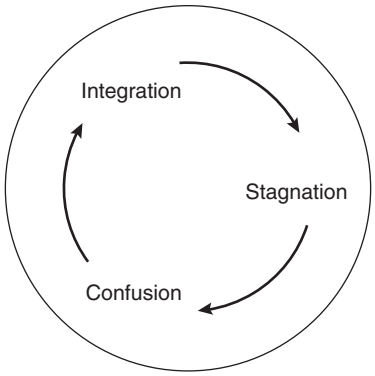

FIGURE 2 The Three (Repeating) Stages of Development (Loganbill et al., 1982)

> *the process can be gone through again and again with each issue receiving increasing thoroughness.* (p. 17)

What makes the model complex is that Loganbill et al. asserted that for any of the eight developmental issues to which the supervisor should be attentive, the supervisee could be at any one of the three stages. The supervisor's role is to assess each supervisee's standing on each of the eight issues and attempt to move the supervisee to the next stage of development. This requires the supervisor to track the supervisee's progress through 24 different positions with respect to the model (8 issues × 3 stages). No one has tested supervisors' ability to do that; our understanding of the limits of working memory (see, e.g., Miyake & Priti, 1999) suggest that it would be difficult. It is more likely that a supervisor will attend more selectively to a few of the eight issues in any given period.

The supervisory interventions that Loganbill et al. (1982) described were adopted by Stoltenberg and McNeill (2010) for their IDM and are described next.

The Integrated Developmental Model

The *integrated developmental model (IDM)* (Stoltenberg, McNeil, & Delworth, 1998; Stoltenberg & McNeill, 2010) is the best known and most widely used stage developmental model of supervision. It has the virtue of being both descriptive with respect to supervisee processes and prescriptive with respect to supervisor interventions.

Stoltenberg's (1981) initial four-stage model was an integration of two others: Hogan's (1964), concerning stages through which supervisees progress; and Harvey, Hunt, and Schroeder's (1961) conceptual level model. Stoltenberg and his collaborators have continued to refine the model (Stoltenberg & Delworth, 1987; Stoltenberg et al., 1998; Stoltenberg & McNeill, 2010). The IDM still has a cognitive basis, but one that is less prominent and relies instead on Anderson's (1996) work on the development of expertise, as well as on others who have conceptualized the development of schemas, rather than assumptions about conceptual level that were used in the original 1981 model.

The IDM describes counselor development as occurring through four stages, each of which is characterized by changes on "three overriding structures that provide markers in assessing professional growth" (Stoltenberg & McNeill, 2010, pp. 23–24):

- *Self–Other Awareness: Cognitive and Affective*—"[W]here the person is in terms of self-preoccupation, awareness of the client's world, and enlightened self-awareness. The cognitive component describes the content of the thought processes characteristic across levels, and the affective component accounts for changes in emotions such as anxiety."
- *Motivation*—"[R]eflects the supervisee's interest, investment, and effort expended in clinical training and practice."
- *Autonomy*—Reflects the degree of independence that the supervisee is manifesting.

Table 1 summarizes the manner in which these three structures are reflected for the four supervisee developmental levels. Supervisors interested in assessing their supervisees' level of functioning on these three structures have available

TABLE 1 Supervisee Characteristics and Supervisor Behavior for Each of the Four IDM-Specified Supervisee Developmental Levels

Level 1. These supervisees have limited training, or at least limited experience in the specific domain in which they are being supervised.

Motivation: Both motivation and anxiety are high; focused on acquiring skills. Want to know the "correct" or "best" approach with clients.

Autonomy: Dependent on supervisor. Needs structure, positive feedback, and little direct confrontation.

Awareness: High self-focus, but with limited self-awareness; apprehensive about evaluation.

Level 2. Supervisees at this level are "making the transition from being highly dependent, imitative, and unaware in responding to a highly structured, supportive, and largely instructional supervisory environment" (p. 64); usually after two to three semesters of practicum.

Motivation: Fluctuating, as the supervisee vacillates between being very confident to unconfident and confused.

Autonomy: Although functioning more independently, he or she experiences conflict between autonomy and dependency, much as an adolescent does. This can manifest as pronounced resistance to the supervisor.

Awareness: Greater ability to focus on and empathize with client. However, balance still is an issue. In this case, the problem can be veering into confusion and enmeshment with the client.

Stoltenberg et al. note that this can be a turbulent stage and "supervision of the Level 2 therapist . . . [requires] considerable skill, flexibility, and perhaps a sense of humor" (p. 87).

Level 3. Supervisees at this level are focusing more on a personalized approach to practice and on using and understanding of "self" in therapy.

Motivation. Consistent; occasional doubts about one's effectiveness will occur, but without being immobilizing.

Autonomy: A solid belief in one's own professional judgment has developed as the supervisee moves into independent practice. Supervision tends to be collegial as differences between supervisor and supervisee expertise diminish.

Awareness: The supervisees return to being self-aware, but with a very different quality than at level 1. Supervisees at this level are able to remain focused on the client while also stepping back to attend to their own personal reactions to the client, and then to use this in decision making about the client.

Level 3i (Integrated). This level occurs as the supervisee reaches level 3 across multiple domains (e.g., treatment, assessment, conceptualization). The supervisee's task is one of integrating across domains. It is characterized by a personalized approach to professional practice across domains and the ability to move easily across them. This supervisee has strong awareness of his or her strengths and weaknesses.

to them the Supervisee Levels Questionnaire–Revised (McNeill, Stoltenberg, & Romans, 1992).

Stoltenberg and McNeill (2010) also specified eight domains of professional functioning in which the supervisee develops:

1. *Intervention skills competence*—confidence and ability to carry out therapeutic interventions
2. *Assessment techniques*—confidence and ability to conduct psychological assessments
3. *Interpersonal assessment*—extends beyond the formal assessment period and includes the use of self in conceptualizing client problems;

its nature varies according to theoretical orientation

4. *Client conceptualization*—diagnosis, but also pertains to the therapist's understanding of how the client's circumstances, history, and characteristics affect his or her functioning
5. *Individual differences*—an understanding of ethnic and cultural influences on individuals
6. *Theoretical orientation*—pertains to the level of complexity and sophistication of the therapist's understanding of theory
7. *Treatment plans and goals*—how the therapist plans to organize his or her efforts in working with clients
8. *Professional ethics*—how professional ethics intertwine with personal ethics

The supervisor interventions adopted for the IDM are those originally described by Loganbill et al. (1982), who in turn had adapted them from the work of Blake and Mouton (1976). Interestingly, Heron (1989) also adapted Blake and Mouton's organization-level interventions to the individual level. The Heron and the Loganbill et al. interventions differ somewhat, but because of the general similarity of their work and because Heron's (1989) six-category system of interventions has been widely adopted in Great Britain (Sloan & Watson, 2001) to conceptualize the work of both therapists and supervisors, we summarize Heron's, which features two broad classifications of interventions, each with three specific interventions.

Facilitative interventions—enable the client (or, in supervision, the supervisee) to retain some control in the relationship. The three specific interventions in this category are:

- *Cathartic*—interventions that elicit affective reactions
- *Catalytic*—open-ended questions intended to encourage self-exploration or problem solving (e.g., Supervisor: "What keeps you from acting on what you are understanding about this client?")
- *Supportive*—interventions that validate the supervisee

Authoritative interventions—provide more relational control to the therapist or supervisor. The three specific interventions in this category are:

- *Prescriptive*—giving advice and making suggestions
- *Informative*—providing information
- *Confronting*—pointing out discrepancies the supervisor observes between or among supervisee (a) feelings, (b) attitudes, and/or (c) behaviors

We should note that Loganbill et al. and Stoltenberg and McNeill do not discuss using the catalytic or informative interventions. Also, they suggest one intervention that is missing from the Heron (1989) model: that of *conceptual interventions,* which help the supervisee link theory to practice. Loganbill et al. suggest that there are two primary ways to do this, depending on the learning style of the supervisee: (a) watch for the supervisee's use of a particular strategy, then help him or her develop a conceptual frame for what was just done; or (b) present the model, then suggest an intervention based on it.

Johnson and Moses (1988) also followed Loganbill et al. (1982) and relied on Chickering's (1969) vectors as the criteria for supervisee development. Rather than the interventions proposed by Loganbill et al. and later revised by Stoltenberg and McNeill, however, Johnson and Moses reduce supervisor input to either *challenge* or *support.* If the supervisor offers too little challenge, the supervisee might slip into stagnation (borrowing from the Loganbill et al. model); with too much challenge and too little support, the supervisee may get discouraged or defensive. The choice between challenge and support is seen by Johnson and Moses as the most critical decision that the supervisor makes. Once this decision is made, Johnson and Moses refer to the Bernard (1979, 1997) schema of roles (i.e., teacher, consultant, and counselor) as being the primary choices for the supervisor to help the supervisee to attain the desired growth. Although Johnson and Moses do not imply that either support or

challenge interventions should constitute the majority of supervisor interventions, McCarthy, Kulakowski, & Kenfield, (1994) found that the most frequent supervisor technique was the offering of support and encouragement, whereas confrontation and the assignment of homework were rarely used. Supervisors, therefore, must reflect on their own work to determine if their avoidance of confrontation is meeting their own needs or that of their supervisees.

Finally, we underscore a part of the IDM that provides an additional anchor for supervisor and supervisee alike. As a way to understand how supervisees develop useful schemata for conducting counseling or therapy, Stoltenberg and McNeill use concepts proposed by Schön (1987). *Knowing-in-action (KIA)* reflects actions that are automatic for the supervisee. When client responses surprise the supervisee, there is a possibility of *reflection-in-action (RIA)*—that is, the supervisee notices what is occurring that is different from other interpersonal interactions or what has occurred with other clients. Between sessions, *reflection-on-action (ROA)* can occur based on RIA and supervisor encouragement—that is, if RIA did not occur in a session, the supervisor can use recordings of the counseling session to stimulate ROA. Through this process, schema are refined and development can occur leading to more complex RIA in session and an expanded repertoire of KIA behaviors. These conceptual tools assist the supervisory dyad both within and across levels.

Systemic Cognitive–Developmental Supervision Model

Rigazio-DiGilio and her colleagues extended the earlier work of Ivey (1986) to develop a model that encourages supervisors to track and intervene with supervisees based on the cognitive style of the supervisee (Rigazio-DiGilio, 1997; Rigazio-DiGilio & Anderson, 1994; Rigazio-DiGilio et al., 1997). Although the *systemic cognitive–developmental supervision (SCDS)* model is referred to as a developmental model using Piagetian terms to describe different types of learners (supervisees), there is no assumption within the model that one type of learner is superior to another. Rather, each of the four cognitive orientations has its advantages and disadvantages for conducting therapy. The task of the supervisor is to identify the primary orientation(s) of each supervisee and to assist each supervisee to become more flexible and to see the world from additional orientations to the one(s) that comes naturally. When supervisees can access all four orientations, they can shift gears when necessary during therapy, thus enabling them to offer assistance that is more likely to be on target. Therefore, although the reader may view other developmental models presented in this section in a vertical fashion, this model is primarily horizontal because supervisees are assisted in expanding their conceptual and experiential capabilities while not forfeiting their original "natural" style. What follows is a description of each cognitive orientation as described by Rigazio-DiGilio (1995). For each orientation, we include the strengths of the supervisee if they are able to use the orientation competently, as well as the deficits if the supervisee is limited or constrained by this orientation.

The first type of orientation described by Rigazio-DiGilio (1995) is the *sensorimotor.* These supervisees are affected emotionally, if not viscerally, by their experiences. Those who are skilled in this orientation can identify feelings easily and process them, permitting them to work through issues of transference and countertransference. If constrained by this orientation, supervisees can be overstimulated by their emotions, and this can interfere with their conceptual skills. They may also rely on "what feels right" as the basis for interventions, rather than solid treatment planning. Rigazio-DiGilio suggests that the supervisor working with the sensorimotor supervisee use a directive style that provides the supervisee with a safe environment to explore sensory data. The goal is to help the supervisee translate an abundance of emotional data into a viable framework for conducting therapy.

The second cognitive style is *concrete,* and these supervisees see the world (and their clients) through a linear, cause–effect lens. The concrete learner can describe the events described by the client, often in the same order as the client presented them. Because of their if–then reasoning ability, concrete thinkers can anticipate patterned behavior of their clients. At the same time, supervisees with a concrete orientation can foreclose regarding their understanding of the client and can have difficulty seeing alternative perspectives. They also have difficulty moving from the specific to the more nuanced in understanding potential directions of counseling or therapy.

Rigazio-DiGilio's (1995) third orientation is the *formal.* These supervisees analyze situations from multiple perspectives and are naturally reflective. They modify their treatment plans easily based on supervisory feedback. They have no difficulty linking a specific session to larger themes in therapy. If the formal orientation is too dominant, however, supervisees have difficulty translating their understanding of client themes to actual practice. They can also underestimate the role of feelings and behavior in counseling. Because they see their analytical abilities as their strength, they may have difficulty when these are challenged.

Finally, Rigazio-DiGilio (1995) describes the *dialectic* orientation as one in which supervisees challenge their own assumptions that inform their case conceptualization. In other words, these supervisees are drawn to think about *how* they think. Because of their tendencies to conceptualize broadly, dialectic thinkers are more likely to consider the broader environment, including historical and cultural contexts. The supervisee with a strong dialectic orientation can become overwhelmed by multiple perspectives, unable to commit to one because competing perspectives appear equally valid (or invalid). Clients may have a difficult time integrating the complex thinking of a dialectic therapist.

In discussing supervision environments, Rigazio-DiGilio and Anderson (1994) suggest that supervisors first match supervisees' orientation and assist them in becoming more competent (i.e., less restrained) with their primary orientation. Once this has been achieved, the supervisor can begin to mismatch orientations to assist supervisees in expanding their competence across orientation. The ultimate goal is for supervisees to be able to move in and out of the four orientations, even though they may continue to be grounded in a particular orientation.

Although the SCDS model has not been widely adopted, it continues to provide an excellent way to assess supervisee's primary way of experiencing and conceptualizing their work. It also provides a developmental model that can be relevant to therapists at any level, especially when they have been "activated" by a client to revert to a safer, primary orientation.

Reflective Developmental Models

Dewey (1933) is credited with the first formal statement about the use of reflection to improve practice. Many others—including, particularly, Schön (1983, 1987)—offer more contemporary statements about reflection, yet all continue to describe it as Dewey originally had. Reflection is a process that begins with a professional practice situation that is somehow upsetting, surprising, or confusing; Holloway (in Neufeldt, Karno, & Nelson, 1996) refers to this as a *trigger event* that sets in motion a critical review of the situation that results in a new and deeper understanding of that situation. It is assumed that the person will implement this new understanding when similar situations arise in the future.

Hinett (2002) observes that those who discussed reflection in professional practice emphasize that, unlike reflections that provide an exact image, reflection in professional practice goes beyond the original to shed light on what might be. In this way, reflection is inherently developmental.

Figure 3 graphically depicts the basic process of reflection as it occurs in supervision. The trigger event can be related to the supervisee's skills, to issues related to his or her personhood

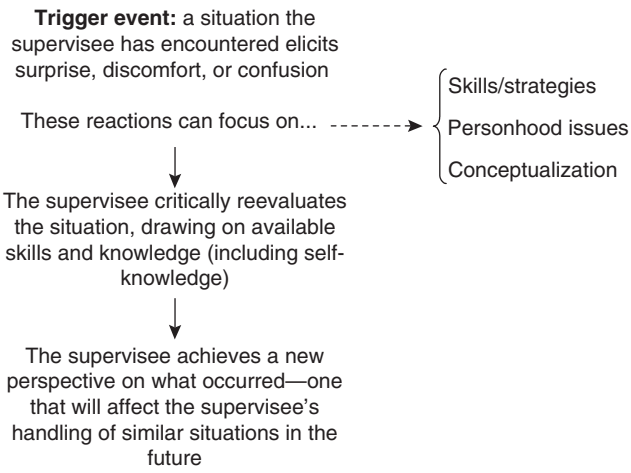

FIGURE 3 The Reflective Process in Supervision

(e.g., countertransference), or to the way the supervisee conceptualizes the client or the therapeutic process. These are the foci of supervision Bernard (1979, 1997) proposes (discussed later). For example, a supervisee might try an intervention with a client that does not work, even though he or she had been sure it would; the supervisee might wonder what there is about a particular client that is so irritating; or, the supervisee might find that what she or he had understood to be going on with the client was simply wrong. Each of these is an example of a trigger event that might set in motion a reflective process that the supervisor would facilitate.

Authors such as Ward and House (1998), Driscoll (2000), Guiffrida (2005), and Frølund and Nielsen (2009) discuss reflective approaches to supervision. The qualitative study by Neufeldt et al. (1996), based on interviews with prominent experts on reflective practice, provides important understandings of the nature of reflection as well. Various interventions and techniques have been developed to assist the supervisor in promoting supervisee reflectivity and are used by a broad swath of supervisors (i.e., not only those who work primarily from a developmental stance).

We close this brief discussion of reflective processes in supervision with three observations. First: We reiterate that it is likely that all supervisors facilitate some level of reflective processes with their supervisees. Second: As supervisors facilitate supervisees' work-related reflections, they are also teaching those supervisees an important skill that they eventually can use on their own. This skill in reflecting on their work—paired with the related ability to self-monitor—becomes an important method of self-supervision (cf. Goodyear, 2006). Once a mental health professional is licensed, he or she typically no longer required to be supervised formally (at least in the United States). It is important, therefore, that she or he be able to self-supervise (see also Dennin & Ellis, 2003).

Our third observation is that reflection should be more than simply "discovery learning" (see, e.g., Kirschner, Sweller, & Clark, 2006). Otherwise, each of us might discover something quite unique, and that discovery might or might not correspond to what others understand to constitute good practice. The supervisee's reflections certainly should involve his or her own internal processes (e.g., confusions, discomforts), but ultimately should be linked to some externally

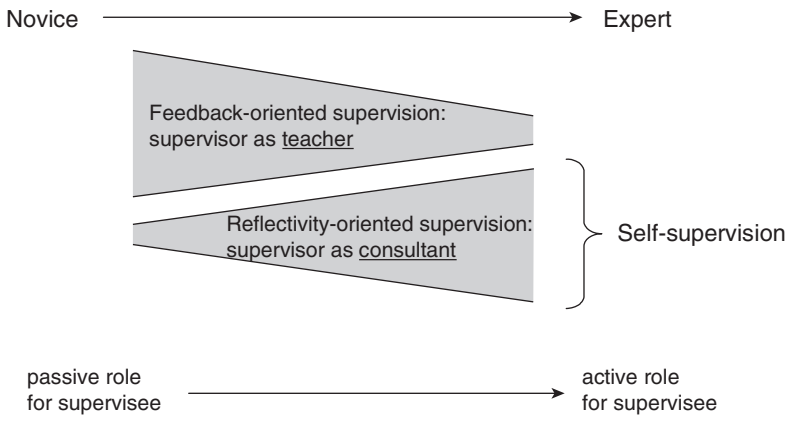

FIGURE 4 A Developmental Conception of the Reflective Process in Supervision

validated understandings of good professional practice as well. Therefore, the supervisee's level of experience affects (a) the extent to which reflection is used as a supervisory process and (b) the quality of the reflections.

Figure 4 suggests how we believe these assumptions translate to practice. It shows, for example, that some level of reflection always is a part of supervision, but that supervision of a more-novice supervisee has a greater teaching component. The intent is to help the supervisee accrue and master the essential practice skills and to develop an appreciation for what constitutes a good or effective skill or way of thinking. Gradually, however, the proportion of time focused on teaching drops as the proportion of time devoted to fostering reflection increases. The ultimate outcome is the ability to use those reflective skills to self-supervise.

The Rønnestad and Skovholt Lifespan Developmental Model

Although most models of counselor development focus primarily on the period of graduate and internship training, professional development no more stops at graduation than does our personal development. The work of Rønnestad and Skovholt (1993, 2003; Skovholt & Rønnestad, 1992b) is therefore important for its articulation of the ways that therapists continue to develop across their professional lifespan.

This model is based on interviews with 100 counselors and therapists who ranged in experience from the first year of graduate school to 40 years beyond graduate school. In their initial analyses of their qualitative data, Rønnestad and Skovholt identify 8 stages of therapist development, each of which might be characterized along a number of dimensions (e.g., style of learning). They also identify 20 themes that are not specifically stage related, but that characterize therapist development across time.

In their later work, Rønnestad and Skovholt (2003) offer a more refined and parsimonious model, based on reinterviews with some therapists, feedback obtained over the previous decade, and their own reanalyses of the data. They collapse the model so that there now are only 6 *phases* (a term that they now believe is more technically accurate than *stages*) of development and 14 themes. Because of the importance of this model, we summarize these phases and then the themes. It is useful to note that the early phases correspond well to stages described by Stoltenberg and McNeill (2010).

Phase 1: The Lay Helper Phase. Novices already have had the experience of helping others

(e.g., as a friend, parent, or colleague). "The lay helper typically identifies the problem quickly, provides strong emotional support, and gives advice based on one's own experience" (Rønnestad & Skovholt, 2003, p. 10). Lay helpers are prone to boundary problems, tend to become overly involved, and express sympathy rather than empathy.

Phase 2: The Beginning Student Phase. Although this is an exciting time for students, they often feel dependent, vulnerable, and anxious, and have fragile self-confidence; therefore, they especially value their supervisors' encouragement and support. Perceived criticism from either their supervisors or their clients can have a severe effect on their self-confidence and morale. They actively search for the "right" way to function, looking for models and expert practitioners to emulate.

Phase 3: The Advanced Student Phase. These students, usually at the advanced practice or internship stage, have the central task of functioning at a basic established, professional level. They feel pressure to "do it right" and therefore have a conservative, cautious, and thorough style (versus one that is relaxed, risk-taking, or spontaneous).

The opportunity to provide supervision to beginning students "can be a powerful source of influence for the advanced student" (Rønnestad & Skovholt, 2003, p. 15), who are able both to see how much they have learned and to consolidate that learning.

Phase 4: The Novice Professional Phase. The years immediately postgraduation can be a heady time, because the person now is free of the demands of graduate school and the constraints of supervision. Still, many find that they are not as well prepared as they had imagined. The new therapist increasingly integrates his or her own personality in treatment. As this occurs, the therapist becomes more at ease. He or she also uses this period to seek compatible work roles and environments.

Phase 5: The Experienced Professional Phase. Counselors and therapists with some years and types of experience have the core developmental task of finding a way to be authentic—specifically, developing a working style that is highly congruent with their own values, interests, and personality. Virtually all have come to understand ways in which the therapeutic relationship is crucial for client change. Their techniques are used in flexible and personalized ways. As well, they have come to understand that it frequently is impossible to have clear answers for the situations that they encounter.

One characteristic of this phase is the ability to calibrate levels of involvement with clients so that they can be fully engaged with the clients, but then can let go afterward. Clients are a valuable source of learning, as is the mentoring many therapists do with more junior professionals. Often they also begin looking outside the profession to areas such as religion or poetry, or even theater or cinema to expand their knowledge of people.

Phase 6: The Senior Professional Phase. These professionals, usually with more than 20 years of experience, typically have developed very individualized and authentic approaches. Despite their felt competence, they generally have become more modest about their own impact on clients. They also tend to have become skeptical that anything really new will be added to the field. Loss is a prominent theme in this phase. This is both anticipatory, as they look toward their own retirements, and current, for "their own professional elders are no longer alive and same age colleagues are generally no longer a strong source of influence" (Rønnestad & Skovholt, 2003, p. 26).

Woskett and Page (2001) observe that it might be possible to think of the first phases as ones that, together, make up a broad *learning* phase, and that the last of the phases might, together, make up a broad *unlearning* phase. Significantly, this latter phase lasts for most of the practitioner's professional life! Most supervision literature focuses on the learning phase, with much less written about the supervision of experienced professionals. The Skovholt and Rønnestad model, however, suggests that the focus of this supervision is less on established models of practice and more on the individualized work of the particular practitioner.

Rønnestad and Skovholt's 14 themes are summarized in Table 2. When the label is not sufficient to fully express its meaning, we add

TABLE 2 Rønnestad and Skovholt's 14 Themes of Therapist–Counselor Development

1. *Professional development involves an increasing higher-order integration of the professional self and the personal self.* Across time, a professional's theoretical perspective and professional roles become increasingly consistent with his or her values, beliefs, and personal life experiences.
2. *The focus of functioning shifts dramatically over time, from internal to external to internal.* During formal training, a person drops an earlier ("lay helper") reliance on an internal and personal epistemology for helping in order to rely on the professionally based knowledge and skills that guide practice. Later, during postdegree experience, professionals gradually regain an internal focus and, with it, a more flexible and confident style.
3. *Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.* A straightforward observation, but its implications for supervision are substantial. It implies, for example, that supervisees should be taught self-reflection and self-supervision (cf. Dennin & Ellis, 2003).
4. *An intense commitment to learn propels the developmental process.* Importantly, Rønnestad and Skovholt found that, for most of their respondents, enthusiasm for professional growth tended not to diminish with time.
5. *The cognitive map changes*. Beginning practitioners rely on external expertise; seasoned practitioners rely on internal expertise. Early on, supervisees seek "received knowledge" of experts and therefore prefer a didactic approach to supervision. They later shift increasingly to developing "constructed knowledge" based on their own experiences and self-reflections.
6. *Professional development is a long, slow, continuous process that also can be erratic*.
7. *Professional development is a lifelong process*.
8. *Many beginning practitioners experience much anxiety in their professional work.* Over time, anxiety is mastered by most.
9. *Clients serve as a major source of influence and serve as primary teachers*.
10. *Personal life influences professional functioning and development throughout the professional life span*.

    Family interactional patterns, sibling and peer relationships, one's own parenting experiences, disability in family members, other crises in the family, personal trauma and so on influenced current practice and more long term development in both positive and adverse ways. (Rønnestad & Skovholt, 2003, p. 34)

11. *Interpersonal sources of influence propel professional development more than "impersonal" sources of influence.* Growth occurs through contact with clients, supervisors, therapists, family and friends, and (later) younger colleagues. Rønnestad and Skovholt found that, when asked to rank the impact of various influences on their professional development, therapists ranked clients first, supervisors second, their own therapists third, and the people in their personal lives fourth.
12. *New members of the field view professional elders and graduate training with strong affective reactions*. It is likely that the power differences magnify these responses, which can range from strongly idealizing to strongly devaluing teachers and supervisors.
13. *Extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability*. Through this process, therapists develop wisdom and integrity.
14. *For the practitioner, there is realignment from Self as hero to Client as hero.* Over time, the client's contributions to the process are better understood and appreciated, and therapists adopt a more realistic and humble appreciation of what they actually contribute to the change process.

    If these "blows to the ego" are processed and integrated into the therapists' self-experience, they may contribute to the paradox of increased sense of confidence and competence while also feeling more humble and less powerful as a therapist. (Rønnestad & Skovholt, 2003, p. 38)

explanatory text. Together with the 6 phases, these themes provide supervisors with an important career cognitive map. Like the other models, this suggests the importance to beginning students of having clear and direct models for practice and supervision that include didactic approaches, but it also adds support for providing a supervision course during graduate training (i.e., as a source of development for the supervisor-in-training) and makes clear how the mentoring of newer professionals is a source of professional development to therapists at phases 5 and 6.

In short, this is a unique and important model. Its applications to supervision, however, are not as direct as is true with some other models. It was developed through a research study of therapist development and therefore remains more descriptive than prescriptive.

The 14 themes vary in their level of implication for supervisors. For example, whereas theme 3, concerning self-reflection, has very important and direct implications for supervisors (who can design interventions to foster the self-reflective process), other themes are more distantly related to supervision. As a final note, it is our impression that the themes could be collapsed in the interest of simplifying. Goodyear, Wertheimer, Cypers, and Rosemond (2003) demonstrate, for example, that it is possible to refine these 14 themes into 6 themes.

Research on Cognitive Development

Thus far, we have presented key developmental models in the supervision literature, yet, there is a body of empirical work that also addresses supervisee development and should be considered as the supervisor implements any of the models we have covered. Some research results may cause the supervisor to modify his or her application of a model; other results confirm the developmental model assumptions. We begin our review with studies concerning the relationship between cognitive complexity and cognitive development, followed by the relationship between experience and development. We end with a discussion of the research that addresses those factors that moderate the relationship between experience and development.

Cognitive Complexity and Cognitive Development. We have ample evidence that trainees with high cognitive complexity are more capable of several of the tasks of counseling, such as increased empathy and less negative bias (Stoppard & Miller, 1985), more sophisticated descriptions of client characteristics (Borders, 1989a), more parsimonious conceptualization of specific counseling situations (Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989), and better ability to stay focused on counseling and less on themselves (Birk & Mahalik, 1996). Because of this, the mental health professions have been invested in determining (or confirming) how cognitive development can be nurtured so that supervisees attain the desired level of conceptual competence by the end of their formal training and be poised for additional development after training.

Simultaneously, the supervision literature has been dominated by developmental assumptions about training and supervision, most of which assume that experience under supervision and cognitive development enjoy a symbiotic relationship. In the following pages, we attempt to answer the following questions: How and to what extent are cognitive complexity and cognitive development related? To what extent does cognitive development occur during training programs? How does it occur? Is supervised experience the most potent training variable for assuring or accelerating cognitive development?

Although it is impossible to isolate these variables entirely, we begin this section with a brief discussion of the relationship between cognitive complexity and cognitive development, and follow with a more elaborate discussion of the role of experience in supervisee development.

As is stated earlier, cognitive complexity has been found to be correlated with competencies that are important to successful counseling. The assumption of the mental health professions has

been that training and supervision stimulate cognitive development among trainees that culminates in increased cognitive complexity by the end of training. In recent years, empirical scrutiny has found that, whereas development does indeed seem to occur as a result of training (e.g., Duys & Hedstrom, 2000), training cannot be described as uniformly robust, nor does it stimulate all aspects of cognitive complexity (Fong, Borders, Ethington, & Pitts, 1997; Granello, 2002; Lovell, 1999; Stein & Lambert, 1995). In fact, to date, there is little to challenge the work of Skovholt and Rønnestad (1992a), who conclude that the majority of cognitive development for mental health practitioners occurs after formal training.

What is unknown at this point is the relationship between baseline cognitive complexity and cognitive development that occurs through training and supervision. In other words, although there is an assumption that higher cognitive complexity at the beginning of training is an advantage, little is known about its lasting advantage throughout training and beyond. Stoltenberg and McNeill (2010) assert that, whereas all trainees begin at level 1 of their developmental model, the speed of transition between levels depends to some extent on the cognitive growth that they have attained in their individual lives.

As Stoltenberg (1981) implies in his earlier work, Granello (2002) speculated that persons of higher cognitive complexity must "re-progress" (p. 292) through earlier stages of development as they conceptualize the intricacies of counseling, but that the learning for trainees of high cognitive complexity may be more accelerated. Although these assumptions make intuitive sense, Lovell (1999) found that the amount of supervised clinical experience accounted for more cognitive development than individual cognitive complexity, although the latter also contributed significantly. Similarly, Granello (2002) found that the bulk of cognitive development occurs between the midpoint and end of training for persons seeking a master's degree in counseling—that is, during the time that the trainee is under supervision. This finding is consistent with the study conducted by Fong et al. (1997). A study that considers counselors over a longer segment of their professional lifespan (Welfare & Borders, 2010b) found that experience in the profession, including postdegree experience and involvement in teaching of counseling, was related to increased cognitive complexity about counseling. Considering these studies together, we may surmise that supervision is critical to stimulate cognitive development, but that persons who are beyond training may indeed be reflecting Rønnestad and Skovholt's lifespan model.

In addition to the obvious benefits of conceptualizing clients in a more complex manner, Ramos-Sánchez et al. (2002) found that higher cognitive developmental levels for supervisees were correlated with stronger working alliances with supervisors and more satisfaction with supervision. Thus, the costs for stalled cognitive development could be significant.

Experience as an Indicator of Developmental Level. The supervisee's level of experience has been one of the more broadly researched areas of counselor development. Although there are a few exceptions (e.g., Friedlander & Snyder, 1983), the great majority of empirical studies suggest that supervisees have different characteristics and different abilities based on the amount of supervised experience that they have accrued (e.g., Borders, 1990; Burke, Goodyear, & Guzzardo, 1998; Cummings, Hallberg, Martin, Slemon, & Hiebert, 1990; Granello, 2002; Ladany, Marotta, & Muse-Burke, 2001; Lovell, 1999; Mallinckrodt & Nelson, 1991; McNeill, Stoltenberg, & Pierce, 1985; McNeill et al., 1992; Murray, Portman, & Maki, 2003; Olk & Friedlander, 1992; Shechtman & Wirzberger, 1999; Swanson & O'Saben, 1993; Tracey, Ellickson, & Sherry, 1989; Tracey, Hays, Malone, & Herman, 1988; Wiley & Ray, 1986; Williams, Judge, Hill, & Hoffman, 1997; Winter & Holloway, 1991). Other reviewers of the empirical literature (Goodyear & Guzzardo,

2000; Holloway, 1992, 1995; Stoltenberg, McNeill, & Crethar, 1994) also identify experience level as an important point of departure for understanding the developmental needs of the supervisee.

Several authors (Ellis & Ladany, 1997; Fong et al., 1997; Granello, 2002) echo Holloway's (1992) earlier caution, however, that there are multiple problems in interpreting the results of most developmental studies, one of these being the lack of longitudinal studies. That is, without tracking the same supervisees over time, it is very difficult to discern whether the significant results of various studies depict true *development* or cohort effects. Yet even without this and other issues fully resolved, there is still ample empirical evidence to support an examination of the supervisee's experience level as one indicator of developmental level.

Researchers examined the relationship between amount of training and supervisee behavior. Looking at the beginning practicum student, Borders (1990) found significant change in supervisee self-reports for self-awareness, dependency–autonomy, and theory–skills acquisition over one semester. McNeill et al. (1985) obtained similar results when they compared beginning trainees to intermediate trainees. Examining prepracticum student growth over a period of one semester, Williams et al. (1997) found that trainees at the end of the semester decreased in anxiety and were better at managing their own transference and countertransference reactions.

Studies that considered larger experience differences have reported inconsistent and more complex results. Cummings et al. (1990) and Martin et al. (1989) found that experienced counselors were more efficient in their conceptualization, using well-established cognitive schemata to conceptualize clients, although novice counselors seemed to require much more specific information about the clients to conceptualize the problem; they were more random in their information seeking, and their ultimate conceptualizations were less sophisticated. Welfare and Borders (2010b) found that counseling experience, supervisory experience, counselor education experience, and advanced degrees all predicated higher cognitive complexity for their sample that included master's level supervisees, doctoral students, practicing counselors, and counseling faculty.

Other researchers have also looked at a broader continuum of experience. Tracey et al. (1988) studied counselor responses across three experience levels: beginning counselors (0 to 1 year of practicum), advanced counselors (graduate students with more than 1 year of practicum), and doctoral counselors (at least 2 years of postdoctoral experience). When supervisee interventions (i.e., dominance, approach–avoidance, focus on affect, immediacy, breadth versus specificity, meeting client demands, verbosity, and confrontation) were compared across groups, doctoral-level counselors were less dominant (yet confronted more), were less verbose, and yielded less to client demands than non-doctoral-level counselors.

Burke et al. (1998) investigated the working alliance of 10 supervisor–supervisee dyads in terms of events that "weakened" and interventions that "repaired" the alliance. Even though all their supervisees had master's degrees in a mental health discipline, experience effects were found in the types of issues that were raised in supervision, as well as in the supervisee's approach to supervision. Less-experienced supervisees (i.e., 1 year or less of postdegree experience) raised issues that revolved around the development of professional skills (e.g., definitions of diagnostic terms, delivery of particular techniques). They also devoted considerable time to a single case, and often did not meet previously established supervision goals. However, more-experienced supervisees were more active in prioritizing the supervision agenda, and also tended to treat their supervisors more as consultants. When issues emerged, they tended to be around differences in theoretical orientation, presentation style, and treatment planning. The Burke et al. (1988) results, therefore, support several assumptions of developmental models of supervision.

Finally, an investigation conducted by Ladany et al. (2001) involved supervisees who were seeking master's degrees in counseling and supervisees seeking doctoral degrees in a mental health discipline. Ladany et al. sought to determine if general experience (i.e., length of time engaged in the practice of counseling) was related to cognitive complexity, or if number of clients seen was a better predictor. Results indicated that experience alone accounted for cognitive complexity around diagnostic and treatment conceptualization. Seeing a greater number of clients over a shorter time span did not produce similar gains in cognitive development. The authors hypothesized that too many clients may discourage the supervisee from reflective activity, or may mean that supervision is less intensive for any particular case, either of which might account for the diminished returns.

A final comment regarding experience is in order before we proceed. Most studies that demonstrate supervisee development over time have confounded experience with training. It is important, therefore, that some researchers have investigated post-training development (e.g., Cummings et al., 1990, Martin et al., 1989; Welfare & Borders, 2010b), as we presently have only modest evidence that experience alone leads to developmental gains. Yet the changes observed within trainees under supervision are promising, and provide evidence that supervision within training is of paramount importance and may serve as a catalyst for lifespan professional development, only to be enhanced by post-degree supervision.

Experience Level and Moderating Variables. We indicated earlier that cognitive complexity interacts with experience; that is, the trainee who has attained high conceptual ability advances more quickly. Winter and Holloway (1991) found that less-experienced trainees were more likely to focus on conceptualization of the client, whereas more-advanced trainees were more likely to focus on personal growth. Trainees with higher conceptual levels were more likely to request a focus on the development of counseling skills and to request feedback, thus indicating less concern about evaluation. Both level of experience and conceptual level (cognitive complexity), therefore, produced significant results in this study.

Swanson and O'Saben (1993) report that supervisees' Myers–Briggs Type Indicator (MBTI) profile, amount of practicum experience (ranging from prepracticum to 15 completed semesters of practicum), and type of program (i.e., counseling psychology, clinical psychology, or counselor education) all produced significant differences in terms of supervisee needs and expectations for supervision. Program membership was the least-dramatic predictor of differences, and level of experience produced the greatest differences. Level of experience differences produced results similar to other experience studies, indicating that supervisees with less experience expected more supervisor involvement, direction, and support.

Finally, whereas Granello (2002) found evidence of cognitive development with experience, she also found that program concentration was a moderating variable. Granello used an instrument that tapped Perry's (1970) model of cognitive development. As expected, beginning counselors-in-training demonstrated dualistic thinking, whereas more-advanced trainees demonstrated multiplistic thinking. (As in Perry's 1981 research, relativistic thinking was not demonstrated.) However, in contrast to students majoring in mental health counseling, rehabilitation counseling, or marriage and family therapy, students majoring in school counseling became *more* dualistic in their thinking over the course of their training, not less. Granello also found that experience in human services prior to the training program, age, or GPA accounted for no differences in cognitive complexity.

Supervision Environment. Much research interest has been shown in the relative importance of matching supervisee developmental level with the appropriate supervisory conditions, typically referred to as the *supervision environment.* The

assumptions regarding the appropriate environment have been based primarily on the work of early counselor development theorists, especially Stoltenberg and his colleagues (Stoltenberg, 1981; Stoltenberg & Delworth, 1987; Stoltenberg & McNeill, 2010). As described earlier in this chapter, the model asserts that during the initial stages of supervision, the supervisee should be offered significant structure, direction, and support to assure movement in a positive direction. As supervisees gain some experience, expertise, and confidence, they are ready to have some of the structure diminished, to be challenged with alternative conceptualizations of the cases that they have been assigned, to be given technical guidance as needed, and to begin to look at personal issues that affect their work. In short, to accommodate the different developmental needs of supervisees, supervisors alter their interventions or the supervision environment.

By and large, research has supported, or partially supported, the supervision environment premises of counselor developmental models (Bear & Kivlighan, 1994; Borders & Usher, 1992; Dodenhoff, 1981; Fisher, 1989; Glidden & Tracey, 1992; Guest & Beutler, 1988; Heppner & Handley, 1982; Heppner & Roehlke, 1984; Holloway & Wampold, 1983; Jacobsen & Tanggaard, 2009; Krause & Allen, 1988; Lazar & Eisikovits, 1997; Miars, Tracey, Ray, Cornfield, O'Farrell, & Gelso, 1983; Murray, Portman, & Maki, 2003; Rabinowitz, Heppner, & Roehlke, 1986; Reising & Daniels, 1983; Stoltenberg, Pierce, & McNeill, 1987; Usher & Borders, 1993; Wetchler, 1989; Wiley & Ray, 1986; Williams et al., 1997; Winter & Holloway, 1991; Worthington & Stern, 1985). The questions that have driven this body of research include: Has the matching of environment to development level of supervisee significantly enhanced supervisee learning, and do supervisees prefer a supervision environment that is developmentally appropriate?

The assumptions underlying these questions have received some support, although there certainly have been mixed results when the literature is examined closely. A study conducted by Ladany, Walker, and Melincoff (2001) produced results that challenged developmental models. As part of their research, Ladany et al. hypothesized that a relatively low level of cognitive complexity, limited experience, and unfamiliarity with a particular type of client would lead supervisees to seek supervision that was more task focused. Instead, they found that all supervisees wanted supervisors to be moderately high on all supervision environments. Ladany et al. concluded that "the theoretical assumption that beginning supervisees need more structure is an overgeneralization or a misguided view based more on clinical lore than on research, which specifically attends to changes in trainees' conceptual understanding of clients" (p. 215). Jacobsen and Tanggaard (2009) found that the subjects in their qualitative study reflected the assumptions of developmental models by and large. However, they also note that major individual differences emerged. Specifically, some novice supervisees found the frustration they encountered when not being offered as much advice and guidance as they wished from their supervisors, and the manner in which they handled that frustration, ended up being among their most memorable learning experiences in supervision. Sumerel and Borders (1996) also found that, contrary to assumptions of developmental models that novice supervisees are reluctant to discuss their personal issues and that supervision should focus on techniques and didactic information, the subjects in their study showed no significant difference when compared to more advanced trainees. These authors concluded that it may not be the supervision environment (intervention) per se that matters, but the style of delivery. Although inexperienced supervisees are expected to find a focus on personal issues to be less helpful, Sumerel and Borders suggest that, when this is done in a manner that is warm, supportive, and instructional, supervisees can benefit. Barrett and Barber (2005), however, argue that the novice supervisee's inability to integrate emotional experience in a way that promotes growth is more to the point. Such integration takes insight and tolerance for ambiguity,

both signs that the counselor has reached a higher level of development.

Despite arguments to the contrary, it seems that moderating variables operate to change the needs of trainees, making them occasionally inconsistent with the assumptions of developmental models. A case in point is an interesting study conducted by Tracey et al. (1989), in which they considered the interaction of level of experience (beginning or advanced counseling psychology doctoral students), reactance potential (an individual's need to resist or comply with imposed structure), supervision structure (low structure or high structure), and content of supervision (crisis or non-crisis) using Brehm's (1966) concept of reactance potential. The authors found that advanced trainees with high reactance (i.e., high need to resist structure) preferred supervision with less structure than did advanced trainees with low reactance. In non-crisis situations, beginning trainees preferred structured supervision, whereas more experienced trainees preferred less structure. However, in crisis situations, *all* trainees preferred structured supervision, regardless of their level of experience or reactance.

This last finding is reinforced by Zarski, Sand-Pringle, Pannell, and Lindon (1995), who note that supervision must be modified based on the severity of individual cases. For supervisees working with difficult or volatile situations (e.g., family violence), more structure may be needed for advanced supervisees until they have attained a necessary level of comfort and competence. Similarly, when Wetchler and Vaughn (1992) surveyed marriage and family therapists at multiple levels, supervisor directiveness was the most frequently identified supervisor skill that therapists thought enhanced their development. This result may indicate that more advanced supervisees take more difficult cases to supervision, thus requiring more direction from the supervisor around these identified cases.

In summary, although supervisors seem to offer different environments when supervisees' developmental differences are pronounced, empirical findings do not as yet support some of the finer distinctions made by developmental theorists. It is difficult to determine if the problem is in the design of particular studies or with the developmental models themselves (Ellis & Ladany, 1997). It is important to recall, however, that development is multifaceted, and the ability to address different levels of competence at any one point in the supervision process is challenging indeed. In addition, we do not know what stage of development might take precedence at any measuring point. It is likely that supervisees master particular aspects of the therapeutic process, thus reflecting more advanced developmental characteristics around these, while still faltering with other aspects of skill development. One group of supervisees, therefore, may represent several levels of development when measured on one variable; if multiple variables are considered, each supervisee may offer a developmental profile in which the supervisee is more advanced on some variables than on others, consistent with development as proposed by Stoltenberg and McNeill (2010). If differing developmental levels require different supervision interventions, each supervisee may need a variety of interventions offered in a discriminating fashion. In short, it is probably best if the supervisor considers both development and environment to be dynamic and fluid, requiring astute observation and flexibility during all levels of training and for post-training supervision as well.

Implications of Research. As noted earlier, although there is still much about developmental models that we do not know, there is a body of research that informs us to some extent. We conclude this section by highlighting some of those findings as well as report the assessment of others regarding research on developmental models.

- *Cognitive complexity matters.* High cognitive complexity (or conceptual level) is an important predictor of success for key counseling tasks, such as offering increased empathy (Deal, 2003; Stoppard & Miller, 1985) and developing accurate

conceptualizations of client situations (Martin et al., 1989). Supervisees with low cognitive complexity need assistance in forming cognitive maps that can be used to assess client issues and in goal setting and strategy selection. Supervision interventions that challenge these supervisees to conceptualize in highly abstract ways will be counterproductive.

Supervisees with high cognitive complexity appear more confident and ask for more feedback to improve counseling skills, and thus seemingly are less concerned about evaluation. It is likely that the process of counseling is more exciting to supervisees with high cognitive complexity because they are able to produce and weigh more options and choose the most appropriate intervention (Gordon, 1990; Holloway & Wampold, 1986).

• *Experience under supervision matters.* Because of the field-specific nature of conceptual level, Stoltenberg (1981) and Blocher (1983) are among those who initially suggested that, at least for novices, experience and conceptual level are highly correlated. Indeed, they suggest that it is possible to predict conceptual level from experience. It is not surprising, then, that much of the development of clinical supervision practice has been informed by this assumption.

Although we have a substantial body of research that supports the claim that supervised experience results in developmental advances for supervisees, the research has its critics (e.g., Ellis & Ladany, 1997). As discussed earlier, the discourse regarding the relative strength of experience to increase the supervisee's competence has become more complicated and more interesting.

• *Experience may be trumped by circumstances.* As discussed earlier, despite the fact that research suggests consistently that the more advanced supervisee wants or requires less structure in supervision, several variables can change this prediction, including a crisis situation (Tracey et al., 1989) or a particularly difficult client population (Zarski et al., 1995). This leads us to the conclusion that supervision of an advanced supervisee is more idiosyncratic than supervision of a novice supervisee. In other words, the novice supervisee most likely needs some structure across his or her client load, whereas the advanced supervisee may benefit from more autonomy with some clients, more structure with others, support with difficult clients, and challenge with those clients who may push the supervisee's personal buttons.

• *Experience level is typically paired with certain developmental characteristics. Supervisors should know these.* With experience, the supervisee should exhibit an increase in: (a) self-awareness of behavior and motivation within counseling sessions, (b) consistency in the execution of counseling interventions, and (c) autonomy (Borders, 1990; McNeill et al., 1992). If these developmental characteristics are not forthcoming, supervisors must ask what might be blocking learning (e.g., cognitive complexity, intrapersonal issues, cultural insensitivity on the part of the supervisor) and to consider this more carefully.

With experience, it is expected that supervisees will develop more sophisticated ways to conceptualize the counseling process and the issues that their clients present, and be less distracted by random specific information (Cummings et al., 1990). Novice supervisees are more rigid and less discriminating in their delivery of therapeutic interventions. An *exaggerated forcefulness* (Tracey et al., 1988) in the delivery of an intervention may indicate that the supervisee is at the front end of a learning curve regarding this intervention. A hallmark of more advanced supervisees is that they are more flexible and less dominant when delivering interventions such as confrontation or addressing cultural differences in counseling.

• *Supervision environment matters.* Supervisee characteristics and developmental agendas must be met with appropriate supervisor interventions in order for growth to occur. Although there are a plethora of supervision techniques to consider, these must be used in ways that are appropriate to the developmental stage of the supervisee. To date, the research supports using experience level as a determinant for supervision

environment, at least initially. At the same time, research has found that it is overly simplistic to view experience level as a sole criterion for intervention.

• *Development only begins during formal training; it doesn't end there.* In their seminal longitudinal study of professional development (Skovholt & Rønnestad, 1992a) and in a more recent reformulation (Rønnestad & Skovholt, 2003), Skovholt and Rønnestad established that development for the mental health professional was a long road, with many intriguing complexities along the way. They also established that most of the development for serious professionals occurred after formal training. Similarly, Granello's study (2002) found that counselor (cognitive) development occurred only in the latter half of training programs. All this underscores the importance of clinical supervision beyond training and the early years in the field.

As a concluding comment about the research focused on developmental models, Stoltenberg et al. (1994) assert: "[E]vidence appears solid for developmental changes across training levels" (p. 419). They also note that, whereas experience alone is a relatively crude measure of "development," it has been used in most studies. For this reason and given that most of this research had focused on a restricted range of experience (e.g., first practicum versus second practicum versus internship), Stoltenberg and colleagues found that "it is remarkable that so many differences have been found among trainees based on this categorization" (p. 419).

Yet Ellis and Ladany (1997), echoing Holloway's (1987) conclusion a decade earlier, characterize their rigorous review of the developmental literature as "disheartening." In particular, they found that methodological problems and failures to eliminate rival hypotheses have so characterized this area of research that "data from these studies are largely uninterpretable" (p. 474).

Probably the safest conclusion at this point is that there is some evidence to support some aspects of stage developmental models. Furthermore, anecdotal reports of untold numbers of supervisors attest to professional development of their supervisees, even if this development does not fall in line with development as it has been conceived. Additional research in this area of supervision is sorely needed.

Conclusions about Developmental Models

Development is endemic to supervision. If supervisors did not believe that supervisee development would occur under supervision, then supervision would be reduced to its gatekeeping function only. Therefore, despite one's primary approach to supervision, all supervisors share some assumptions with those who have focused on supervisee development. The advantage of working primarily from developmental models is that it keeps the supervisor attuned to the different needs of supervisees at different levels in their training. Because developmental models are pantheoretical, the supervisee is not asked to commit to a particular psychotherapy theory too early in the training process.

Potential disadvantages of adhering primarily to developmental models is their relative weakness in describing different learning styles within any stage of development, as well as their relative silence about divergent learning paths. Discussions of supervision environments needed at different levels of experience also give inadequate attention to cultural differences among supervisees.

SUPERVISION PROCESS MODELS

Our final major category of models is supervision process models. These models emerged from an interest in supervision as an educational and relationship process. In fact, although it represents somewhat of an overstatement, one way to describe the three major categories of supervision models is that psychotherapy-based models are primarily centered around passing on one therapy approach, developmental models are centered on the intricacies of the learning process for the supervisee,

whereas supervision process models primarily step back to observe the supervision process itself. These models can be either simple or complex, depending on how much of the process they attempt to describe as well as how many systemic levels. We describe four supervision process models: the discrimination model (Bernard, 1979, 1997); the Ladany, Friedlander, and Nelson (2005) model that focuses on critical events; the Hawkins and Shohet (2000) model; and Holloway's (1995) systems approach to supervision.

The Discrimination Model

Bernard's (1979, 1997) discrimination model (DM) is often considered one of the most accessible models of clinical supervision. It was created in the mid-1970s to assist supervisors-in-training to discriminate among the various choices they had when choosing how to interact with their supervisees. The DM is an eclectic model with the virtues both of parsimony and versatility. It is often the first model novice supervisors encounter.

The DM attends to three separate foci for supervision as well as three supervisor roles:

Foci—Supervisors might focus on any or all of a supervisee's following skills:

- *Intervention*—what the supervisee is doing in the session that is observable by the supervisor, what skill levels are being demonstrated, how well counseling interventions are delivered, and so on
- *Conceptualization*—how the supervisee understands what is occurring in the session, identifies patterns, or chooses interventions, all of which are covert processes
- *Personalization*—how the supervisee interfaces a personal style with counseling at the same time that he or she attempts to keep counseling uncontaminated by personal issues and countertransference responses

Lanning (1986) adds a fourth focus area to the DM, that of *professional issues*. This added focus area is helpful for supervisors when monitoring their supervisees beyond their counseling interactions with clients.

Roles —Once supervisors have made a judgment about their supervisee's abilities within each focus area, they must choose a role or posture to accomplish their supervision goals. These roles change the manner in which the supervisee is approached by the supervisor. These roles include

- *Teacher*—a role assumed when the supervisor believes that the supervisee needs structure and includes instruction, modeling, and giving direct feedback
- *Counselor*—a role assumed when the supervisor wishes to enhance supervisee reflectivity, especially about their internal reality rather than cognitions
- *Consultant*—a more collegial role assumed when the supervisor wishes for supervisees to trust their own insights and feelings about their work, or when the supervisor believes it is important to challenge supervisees to think and act on their own

As a consequence, the supervisor might be responding at any given moment in one of nine different ways (i.e., 3 roles $\times$ 3 foci). Table 3 illustrates how the model might operate in practice. We should note, however, that it is unlikely that the cells of this table are used uniformly. For example, the teacher role for a focus on personalization issues is less likely than the counselor role for personalization issues. However, there are instances when any of the nine choices are the best fit for the supervision task, and supervisors should consider all choices.

The model is *situation specific,* meaning that the supervisor's roles and foci should change not only across sessions, but also *within* a session. Supervisors should attend to each focus as appropriate. The problems arise either when the supervisor attends to one focus at the expense of the supervisee's more salient needs or, in a more-related version, when the supervisor is rigid in a

TABLE 3 Examples of Focus and Role Intersections of Bernard's Discrimination Model

FOCUS OF SUPERVISION	*Teacher*	*Counselor*	*Consultant*
Intervention	Supervisee struggles to exhibit immediacy with clients	Supervisee appears unable to challenge one of her clients	Supervisee is intrigued by the prospect of using music in his counseling with middle-school children
	Supervisor not only models how the supervisee might use immediacy with one of supervisee's clients, but models immediacy in the supervision session	Supervisor asks supervisee to reflect on the fact that she communicates a desire to help her client, but is not doing what is needed for the client to achieve insight and change behavior	Supervisor provides supervisee with the resources for using art forms in child counseling, and offers to help him brainstorm how he might apply what he has learned to his counseling
Conceptualization	Supervisee does not identify the crux of the client's presenting concern	Supervisee assesses a young Black male client at a drug rehab unit as being hostile and resistant	Supervisee shares that he would like to know more about Motivational Interviewing (MI)
	Supervisor requires the supervisee to prepare a transcript of the session and uses it to review client statements, identifying the statements that are directly related to the client's presenting concern and those that are not	Supervisor reflects the supervisee's fears in working with this client as one intervention to help the supervisee understand what is blocking her empathy for her client, and thus making it unlikely that she will understand his behavior within a larger systemic context	Supervisor assists the supervisee in identifying resources and also discusses the possibility of using some of the principles of MI in goal setting for one of his clients
Personalization	Supervisee treats his older female client in a manner that the supervisor finds condescending	Supervisee's desire to avoid making any mistakes leaves her distant and overcontrolling in her counseling sessions	Supervisee shares that she is attracted to one of her clients
	Supervisor reviews videotape of session with supervisee and gives him feedback about one such exchange, pointing out how this is different from his usual demeanor	Supervisor reflects the supervisee's feelings of anxiety and need to be perfect, and asks supervisee to consider how her needs and the behaviors that follow might be affecting her clients	Supervisor offers herself as a sounding board for the supervisee while communicating assurance that the supervisee is handling the issue appropriately and professionally

preference for one particular focus or role. There are many reasons to choose a particular focus or role, but the worst reason is habit or personal preference independent of the supervisee's needs.

Theory and research concerning developmental approaches suggest that supervisors are more likely to use the teaching role with novice supervisees and the consultant role with those who are more advanced. Also, supervisors of beginning supervisees might expect to focus primarily on intervention and conceptual skills, whereas supervisors of more advanced students might expect to spend more of their time focusing on personalization issues.

However, these are general predictions of what a supervisor might do. Bernard (1979, 1997) argues that the effective supervisor is prepared to use all roles and address all foci for supervisees at any level. Still, it is important for supervisors to be aware that too early a focus on personalization may "freeze" one novice supervisee, and too constant a focus on interventions may bore another novice supervisee. The model is only the beginning of truly discriminating supervision.

Russell, Crimmings, and Lent (1984) correctly note that very little research has tested models of supervision that suggest supervisor roles. Their observation remains true today. However, a strength of the DM is that it is among the most researched of these models. A number of studies either explicitly have tested the DM or used it as a way to frame research questions (e.g., Ellis & Dell, 1986; Ellis, Dell, & Good, 1988; Glidden & Tracey, 1992; Goodyear et al., 1984; Goodyear & Robyak, 1982; Lazovsky & Shimoni, 2007; Luke, Ellis, & Bernard, 2011; Stenack & Dye, 1982; Yager, Wilson, Brewer, & Kinnetz, 1989). The model seems generally to have been supported in the various findings of the research to date.

Interestingly, the role of consultant has remained somewhat elusive in these studies. For example, Goodyear et al. (1984) found that a sample of experienced supervisors was able to differentiate among the supervision sessions of four major psychotherapy theorists according to their use of the teacher and counselor roles, but not the consultant role. Similarly, the counselor and teacher roles were validated, but the consultant role was not, in a factor analytic study by Stenack and Dye (1982). In multidimensional scaling studies by Ellis and Dell (1986) and Glidden and Tracey (1992), the teaching and counseling roles were found to anchor opposite ends of a single dimension; the consultant role did not emerge clearly from their data.

This is curious, because the idea of the consultant role for supervisors is intuitively appealing, especially in work with more advanced supervisees. One possible explanation is that the consultant role is "fuzzier" than the others. Although it is frequently endorsed, there is not the common understanding of it that is true of the counselor and teacher roles. In addition, supervisors may indeed find it more difficult than they espouse to remain outside of their *expert* or *therapist* status. Both teacher or counselor postures may be more inherently familiar to supervisors than that of consultant.

Styles versus Roles. Friedlander and Ward (1984) equated supervisory styles with supervisory roles. In fact, their Supervisory Styles Inventory (SSI) measures three styles that correspond roughly to Bernard's three roles (i.e., teacher—task oriented; consultant—attractive; and counselor—interpersonally sensitive). The fairly substantial literature on the SSI therefore reasonably can be understood to have clear implications for the DM as well.

Hart and Nance (2003) offer a framework of supervisory styles that could be understood according to a 2 (high versus low direction) by 2 (high versus low support) framework. That framework, depicted in Table 4, is a potentially useful way to consider supervisory roles. In this framework, there are two variants of the teacher role: although they can be differentiated from one another by their level of support, both are high in direction. In contrast, the other two of the DM's roles are characterized by low direction, although the counselor role has high support and the

TABLE 4 Hart and Nance's Framework for Supervisory Styles

	HIGH SUPPORT	LOW SUPPORT
High Direction	Supportive Teacher	Directive or Expert Teacher
Low Direction	Counselor	Consultant

consultant role low support. Interestingly, these researchers found that supervisors tended to approach supervision with a goal of being high on support but low on direction; their supervisees (fourth-semester master's students), however, approached supervision hoping that their supervisors would be high on support and high on direction. These conflicting agendas may also add some insight into the mixed results regarding the consultant posture within the DM.

In summary, the DM has been adopted widely by supervisors primarily as a tool to consider options within the supervision process. It also provides language to describe supervision that is helpful for novice supervisors and their supervisees alike (Ellis, 2010). Finally, the DM offers supervisors a relatively straightforward way to assess both successful and unsuccessful supervision interactions and identify, if needed, a different focus/role combination for a subsequent supervision session.

Events-Based Supervision Model

Ladany, Friedlander, and Nelson's (2005) Events-Based Model (EBM) is grounded in the premise that most supervision focuses on the "smaller" events in the supervisee's work. They focus on the supervisor's handing of specific events as they occur, drawing on the strategy of task analysis used by some psychotherapy researchers (e.g., Greenberg, 1984). It is because of their focus on task analysis rather than a sole emphasis on the reflective process that we place the model here rather than as a developmental model.

An event has an identifiable beginning, middle, and end. Although it often occurs within a particular session, it might also extend across sessions. In addition, there can be events within events. In all cases, however, an event begins with a *Marker*. This can be the supervisee's overt request for a specific kind of help, or it might be subtler and something the supervisor notices. Markers span all areas of supervisee development, including skill deficits, intrapersonal issues, and issues specific to supervision. Furthermore, Markers may point to more than one issue.

> *Although different Markers suggest similar problems, different problems can manifest themselves with similar Markers. As an example, role conflict . . . can be marked by prolonged silence or missed appointments. These same Markers might also reflect the supervisee's crisis in confidence . . . [T]he Marker phase of the event continues until it is clear to the supervisor precisely what needs addressing* (Ladany et al., 2005, p. 14).

Once the Marker has been assessed, supervision shifts to the *Task Environment,* which might consist of any number of what Ladany et al. (2005) refer to as *interaction sequences.* These are "comprised of various supervisor operations (interventions or strategies) and supervisee performances or reactions" (p. 14). Depending on the situation, these interaction sequences might include, but are not limited to: (a) focus on the supervisory alliance; (b) focus on therapeutic process; (c) exploration of feelings; (d) focus on countertransference; (e) attention to parallel process; (f) focus on self-efficacy; (g) focus on skill; (h) assessment of knowledge; (i) focus on multicultural awareness; and (j) focus on evaluation.

Any given Task Environment is likely to involve the use of multiple interaction sequences. Ladany et al. (2005) gave the example of the Marker as the supervisee reporting feelings of sexual attraction for the client, and then suggest, "The Task Environment proceeds through four stages: (a) exploration of feelings, (b) focus on the supervisory alliance, (c) normalizing experience, and (d) exploration of countertransference" (pp. 16–17).

Although many types of events can become the focus of supervision, Ladany et al. focused on

the seven they believe occur most commonly, devoting one chapter to each: (a) remediating skill difficulties/deficits; (b) heightening multicultural awareness; (c) negotiating role conflicts; (d) working through countertransference; (e) managing sexual attraction; (f) repairing gender-related misunderstandings; and (g) addressing problematic thoughts, feelings, behaviors (e.g., crisis in confidence, vicarious traumatization, impairment).

The progression of the supervisory event depends on such factors as the supervisee's readiness to address the issue, his or her level of development, the supervisor's interventions, and the supervisee's response to them. The end point is the *Resolution,* which Ladany et al. suggest is ideally an increase in one or more of the following: supervisee knowledge, supervisee skills, supervisee self-awareness, or supervisory alliance.

In summary, the Events-Based Model offers rich opportunities for the supervisor to identify supervisee struggles and multifaceted avenues for intervention. Also, it labels many of the particular crises of personalization only alluded to globally in the Discrimination Model. Furthermore, whereas the DM attends only to the supervisor approach in a one-approach-per-incident manner, the EBM does more to explain the multiple steps required to resolve any supervision critical event. This model, then, is particularly helpful when an issue emerges that is derailing the supervisee's development.

The Hawkins and Shohet Model

The orienting metaphor for Hawkins and Shohet (2006) is that of the "good enough" supervisor. The supervisor is there not only to offer support and reassurance, but also to contain the otherwise overwhelming affective responses the supervisee might have. Theirs is a Supervision Process Model that includes not only the supervisory dyad in their schema, but organizational and social contexts as well. Hawkins and Shohet also devote relatively more attention to the focus of supervision than to supervision roles or styles. Although theirs is clearly a supervision process model, much of their description of key supervisory moments reflects a psychodynamic theoretical orientation.

Hawkins and Shohet (2006) developed seven possible supervisory phenomena on which supervisors might focus at any given moment. This, which they describe colorfully as the *seven-eyed model of supervision,* is depicted in Figure 5. They refer to theirs as being a *double-matrix model* that reflects two primary ways that supervisors conduct supervision. The first is to pay attention to the supervisee–client matrix; the second is to attend to this matrix through the supervisee–supervisor matrix using immediacy techniques. These two matrices exist within wider contexts that impinge on and have the power to alter them. The seven eyes, then, are the choices (modes) by which the supervisor navigates the different relationships and perspective within each matrix.

Mode 1: Focus on the client and what and how they present. Attention to the supervisee's narrative about the phenomena of the therapy session, including clients' verbal and nonverbal behaviors; examining how material from one session is related to that of other sessions.

Mode 2: Exploration of the strategies and interventions used by the supervisee. Attention to the supervisee's interventions with clients.

Mode 3: Focusing on the relationship between the client and the supervisee. Attention to the system the supervisee and client create together, rather than on either as an individual.

Mode 4: Focusing on the supervisee. Attention to the internal processes of the supervisee, especially countertransference, and their effects on the counseling.

Mode 5: Focusing on the supervisory relationship. Attention to parallel processes as well as all ways that the supervisor can model what he or she is expecting of the supervisee.

Mode 6: The supervisor focusing on his or her own process. Attention to the supervisor's own countertransference reactions to the supervisee.

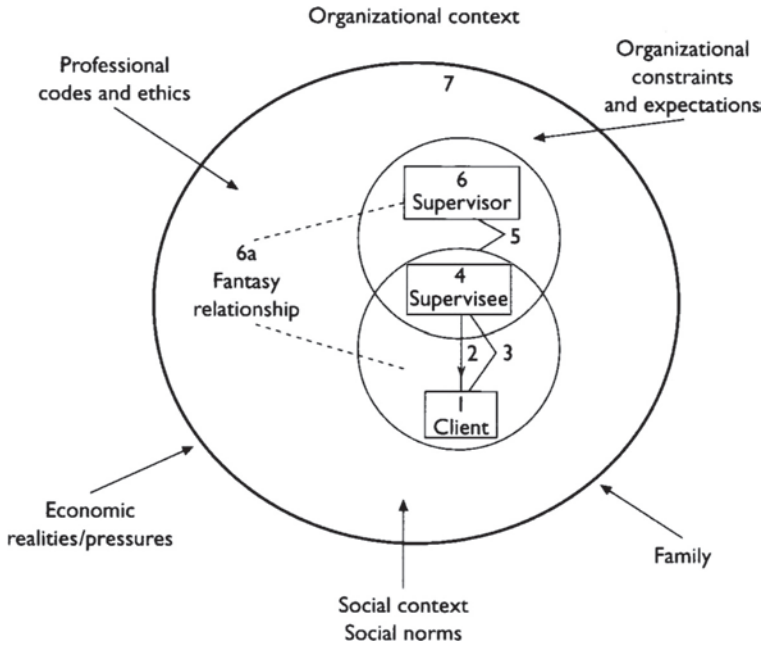

FIGURE 5 Seven-Eyed Model of Supervision

Source: From *Supervision in the Helping Professions, Third Edition,* by P. Hawkins & R. Shohet, 2006. London, UK: McGraw-Hill Education/Open University Press. Reprinted by permission.

Mode 6a: The supervisor–client relationship. Attention to fantasies the supervisor and client have about one another.

Mode 7: Focusing on the wider context. Attention to the professional community of which the supervisor and supervisee are members. This includes the organization in which they work, as well as their profession. Hawkins and Shohet then stipulated that this mode includes considerations of the context of each person in the supervisory system (i.e., client, supervisee, and supervisor) as well as the context of each relationship and that of the supervisee's work in the context of his or her profession and organization of employment or training.

Attention to focus is central to the Hawkins and Shohet model. It is not, however, the only feature of the model. In addition, they introduce five factors that serve as an additional layer to their model: (a) the style or role of the supervisor; (b) the stage of development of the supervisee; (c) the counseling orientation of both the supervisor and supervisee; (d) the supervisor–supervisee contract; and (e) the setting, or what we would call *modality* (e.g., individual, group).

The Hawkins and Shohet model provides a more expansive picture of supervision and their factors include references to both theory and development. The strength of this model is its delineation of seven distinct entry points for the supervisor to consider when conducting supervision.

The Systems Approach to Supervision Model

Like Hawkins and Shohet, Holloway's Systems Approach to Supervision (SAS) model offers a more faceted view of supervision. Unlike Hawkins and Shohet, Holloway does more to weave together her various model elements to portray the systemic reality that each element is related to all others in a cybernetic fashion.

TABLE 5 Functions and Tasks of Holloway's SAS Model

FUNCTIONS	TASKS
1. Advising/instructing	a. Counseling skills
2. Supporting/sharing	b. Case conceptualization
3. Consulting	c. Emotional awareness
4. Modeling	d. Professional role
5. Monitoring/ Evaluating	e. Evaluation

Rather than the 3 (roles) × 3 (foci) matrix proposed by Bernard (1979, 1997), Holloway provided an expanded 5 × 5 matrix of functions (similar to Bernard's roles) and tasks (similar to foci). That is, at any given time, the supervisor may be performing one of the following five functions with one of the following five tasks. As we noted previously regarding Bernard's model, Holloway (1997) commented that "hypothetically a supervisor may engage in any [task] with any [function, but] . . . realistically there probably are some task and function matches that are more likely to occur in supervision" (p. 258). Functions and tasks of the SAS model are listed in Table 5.

Functions and tasks are but two of the seven components of the SAS model. Four of the components are what Holloway terms *contextual factors,* which include not only the three principals in the supervisory relationship (the supervisor, the supervisee, and the client), but the institutional context in which supervision is occurring as well. For the persons involved, these factors can include personal history, cultural dimensions, professional training for the therapist and supervisor, and, for the client, the identified problem. For the institution, *context* includes things like organizational structure and work environment.

The seventh component of the SAS model, the *supervision relationship,* is placed at the core of the model. Thus, Holloway proposes that the relationship is the most important aspect of supervision and it is within the supervisory relationship that all other components are experienced. She also notes that the relationship is affected by three primary elements: (a) the interpersonal structure of the relationship, which includes dimensions such as power differential, attachment issues, attraction, and so forth; (b) where the relationship is situated in developmental terms; and (c) the contract between supervisee and supervisor that stipulates the expectations of each in terms of functions and tasks.

In summary, Holloway's (1995) SAS model offers an intricate view of the supervision process. It not only takes into account a number of key phenomena, it also offers a conceptual map of how these interact to reverberate through the supervisory relationship. As such, the SAS model is an important contribution to the literature.

Conclusions about Supervision Process Models

Supervision process models add more description about the supervision process than do models in the other two principal categories of models. Whether simple or complex, their contribution is, in part, the fact that they can be used within any psychotherapy theory orientation, and are also compatible with developmental models. Process models are also valuable to the supervisor because they counteract stagnation by giving the supervisor a new lens to use in deconstructing supervision.

Although we believe process models are valuable tools, they could be criticized for not placing adequate attention on theory or, for that matter, development. However, these criticisms are only of concern if the supervisor adhered to a supervision process model only.

This discussion of supervision process models completes the triangle of theory, development, and process that most supervisors consult in developing their own supervision approach. As we stated at the outset of this chapter, although most supervisors identify more strongly with one category than the others, it is likely that their supervision is influenced by the other two. It is perhaps for this reason that what we discuss as combined models have been proposed by some authors.

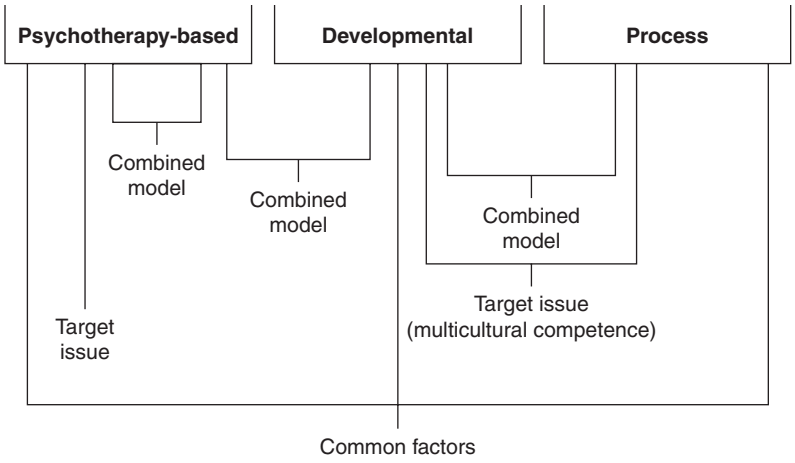

FIGURE 6 Examples of Second-Generation Supervision Models

SECOND-GENERATION MODELS OF SUPERVISION

Because therapy and supervision are so closely linked, developments in psychotherapy theory inevitably will affect supervision models (cf. Milne, 2006). Psychotherapy theory itself is changing. Almost none of the larger-than-life proponents of their own psychotherapy theories are still living. A decade ago, Norcross (Lilienfeld & Norcross, 2003) observed that there is not a new generation of "giants" to replace persons like Rogers, Perls, Bateson, and Haley. Instead, we are in a second or even third generation of psychotherapies, and these tend to be more integrative and evidence-based than the first generation. Norcross concluded that this follows the predictable evolution of a science-practitioner field.

In a similar fashion, the discipline of supervision appears to have settled in with three major categories of supervision models. Those models that have been proposed in more recent years are either models that combine aspects of models from the primary groups or are models with a particular target for supervision. A third second-generation group is made up of those models that attempt to identify common factors that cross all models. Figure 6 depicts the relationship of second-generation models to the original three categories.

Combined Models

Combined models are either relatively simply or highly complex. Pearson (2006) proposes a blending of the Discrimination Model with psychotherapy-based models demonstrating how this would be operationalized for CBT, humanistic, and systems-based supervision. James, Milne, Marie-Blackburn, and Armstrong (2006) suggest a particular emphasis on Vygotsky's (1978) Zone of Proximal Development to enhance CBT supervision, thus blending constructs from psychotherapy-based supervision and developmental supervision. Callaghan (2006) combines behavioral supervision with an interpersonally based approach to form Functional Analytic Supervision, a model that draws primarily from within the psychotherapy-based supervision category. Young, Lambie, and Thurston-Dyer (2011) offer a model that infuses the concepts of reflectivity into Stoltenberg and McNeill's (2010) IDM, thus offering a combined model within the developmental camp.

A more comprehensive combined model is proposed by Aten, Strain, and Gillespie (2008), who were explicit in their belief that psychotherapy-based models are inadequate without the inclusion of constructs from other models of supervision. Their Transtheoretical Model of Clinical Supervision (TMCS) applies knowledge of stages and processes for change from transtheoretical psychotherapy (Prochaska & Norcross, 2007) to clinical supervision. The TMCS includes 10 supervisor-initiated processes of change that include both experiential processes (e.g., assisting supervisees in consciousness-raising) and behavioral processes (e.g., counterconditioning when supervisees need help in thinking, behaving, or feeling differently). By combining elements from various perspectives, Aten et al. hope to offer supervisors a model that meets most—if not all—supervision needs. To this point, they suggest that, because of its complexity, their model can be used to address diversity issues more successfully than others.

Target Issue Models

Another indication that we are well within the second generation of supervision model development is the appearance of models that target a particular supervision issue. Because more-generic models are well established, these newer models can draw from them as needed, yet also apply developments from supervision research or place in the foreground a critical issue for successful supervision.

One target issue model was developed by Ober, Granello, and Henfield (2009) to address multicultural competence among supervisees. Their Synergistic Model for Multicultural Supervision (SMMS) draws from three sources to provide a structure for process and content of supervision. The first of the three is Bloom's Taxonomy (Bloom, Engelhart, Hurst, Hill, & Krathwohl, 1956), a model to promote cognitive development; the second is the Heuristic Model of Nonoppressive Interpersonal Development (HMNID; Ancis & Ladany, 2001), which assists supervisees in learning about multiculturalism and relevant skills in a personally meaningful way; and the Multicultural Counseling Competencies (MCC; Sue, Arredondo, & McDavis, 1992), which provides the model's content. Ober et al. note that although their model was developed to assist supervisors with multicultural supervision, they believe that it is applicable to other areas as well. Whereas these authors espouse a generalization of their model, Field, Chavez-Korell, and Rodriguez (2010) offer an even more targeted developmental model directed at Latina–Latina supervision.

Another model that addresses an important target issue is that of Fitch, Pistole, and Gunn (2010). Their Attachment-Caregiving Model of Supervision (ACMS) stresses the centrality of the relationship to supervision. Specifically, the ACMS describes the normative activation of supervisees' attachment systems and the necessary deactivation in order for supervisees to explore new learning. Within their model, the supervisors provide the necessary safe haven through their responsiveness and flexibility, and later as an anchor and source of guidance for the supervisee once they have arrived at a secure base in the relationship. Fitch et al. assert that their model is additive and designed to be used with other supervision approaches.

Combined models of supervision and target issue models are a predictable development in the evolution of clinical supervision and continue to appear in the professional literature. They enhance our understanding of the primary categories from which they draw, and they have the capacity to spotlight essential components of the supervision process. As such, they represent an important contribution and, we suspect, will be a growing phenomenon.

We end this discussion of second-generation models by considering common-factors models. Authors of these models attempted a different sort of analysis—that of finding themes that cut across all extant models.

Common-Factors Models

Although there is frequent reference to similarities among supervision approaches, there is little

published literature on the topic. Because a common-factors approach is another avenue for working across model categories, we cover the two published contributions here. We also refer the reader to Milne, Aylott, Fitzpatrick, and Ellis (2008), who offer a complex best-evidence synthesis derived from supervision research since the late 1980s to construct a model based on common factors.

Lampropoulos (2003) uses the broad conceptualization of human change encounters to identify common factors in supervision that parallel those in counseling and teaching and, in fact, all human relationships that are hierarchical and where some *deficiency* (i.e., for supervision, lack of mastery of counseling skills) is evident. Lampropoulos proposes the following common factors:

- *The supervision relationship,* which includes facilitative conditions for the supervisee and adjustment of the relationship to attend to the supervisees' needs; establishing a working alliance; and readiness to attend to transference and countertransference issues.
- *Support and relief from tension, anxiety, and distress,* which alerts that, although supervisees are different from each other, all experience some anxiety because of their lack of expertise, which must be woven into a supervision agenda.
- *Instillation of hope and raising of expectations,* which includes not only encouragement, but also setting attainable goals and normalizing developmental challenges that supervisees face.
- *Self-exploration, awareness, and insight,* which Lampropoulos notes is crucial for supervisee development.
- *Theoretical rationale and a ritual,* which simply is a testament that all supervision models include a philosophy or theory and a methodology for implementing the model.
- *Exposure and confrontation of problems,* which points to the inevitability that learning the complex set of skills required for counseling includes rough patches.
- *Acquisition and testing of new learning,* which is, of course, the purpose of all clinical supervision.
- *Mastery of the new knowledge,* which is a final step in order for supervisees to attain self-efficacy as a counselor. This final factor is one that supervisors monitor carefully in light of other factors (e.g., anxiety), and repeat often as new skills and reflective abilities emerge.

Morgan and Sprenkle (2007) conducted a comprehensive review of supervision models in the mental health professional literatures and identified several domains (objectives) that cut across models as well as 48 broad categories of supervision activity. *Domains* include assisting supervisees with the development of clinical skills, acquiring clinical knowledge, learning to function as a professional, personal growth, and achieving some level of autonomy and confidence. Another important domain of supervision models is monitoring and evaluating supervisees. Morgan and Sprenkle identify three constructs that capture the variability of model domains and activities. All three are described as *continua.* The first of these is *emphasis,* with models falling somewhere on a continuum from an *emphasis on clinical competence* (and virtually no emphasis on professional competence) to an *emphasis on professional competence* (with little emphasis on clinical competence). The second construct is *specificity,* with the opposing ends of the continuum being *the idiosyncratic/the particular* and the other end being *nomothetic/general.* The authors describe these extremes as a focus on one supervisee only and his or her clients on one end of the continuum, and the welfare of the profession as a whole on the other. The third construct identified was *relationship,* and the two poles are *collaborative* and *directive.*

Morgan and Sprenkle derived four supervisor roles based on the *specificity* and *emphasis* dimensions of a model: *Coach* (high clinical competence and idiosyncratic emphases); *Mentor* (high professional competence and idiosyncratic emphases); *Teacher* (high clinical competence

and general emphases); and *Administrator* (high professional competence and general emphases). This three-dimensional model offers supervisors a template to assess their own supervision model and appreciate their alternatives.

Evidence-Based Supervision

Evidence-based supervision derives its mandate from evidence-based psychotherapy, which is a call to design therapeutic approaches to reflect research that supports their efficacy. Who, after all, could argue otherwise? When we see our physicians, we want to believe that they are making decisions based on the best available evidence. And the people who seek our services as mental health professionals expect the same.

But matters are not always as straightforward as they might seem. For example, Wampold (2001) vividly illustrates the sometimes-heated controversies that exist with respect to what should count as evidence. As Wampold, Goodheart, and Levant (2007) observe:

> *Evidence can be thought of as inferences that flow from data. These data may be of various types but are derived from observations, in the generic sense of the word (e.g., they may be "observed" by a machine and transformed before being processed by the human brain, or they may be sensory experiences transformed during self-observation). The data become evidence when they are considered with regard to the phenomena being studied, the model used to generate the data, previous knowledge, theory, the methodologies employed, and the human actors.* (pp. 616–617)

As a consequence, the variants of what gets labeled *evidence-based therapy* and *evidence-based supervision* have their advocates and their skeptics (cf., Milne & Reiser, 2012; Osborn & Davis, 2009). For supervision in particular, there is concern that the development of the supervisee may be placed on the back burner if supervision becomes little more than oversight of the extent to which the supervisee is adhering to a specific treatment protocol (see, e.g., Henggeler, Schoenwald, Liao, Letourneau & Edwards, 2008). That said, the focus of authors such as Falender and Shafranske (2007) to identify supervisor competencies may serve as an antidote to such concerns.

Although Milne (2009) argues that evidence-based supervision is a model within which to operate, we choose not to include it as such in our present schema. Instead we argue first that virtually all models of supervision might, hypothetically, be evidence based if adequate research was conducted; therefore, it is not a separate model of supervision. Our second point is that rather than offering us an additional conceptual model, evidence-based supervision as a construct is, instead, an overarching evaluation movement with enormous positive implications for the field if the concerns of its critics are addressed adequately.

CONCLUSION

We cover a great deal of ground in this chapter. Novice supervisors may be as flummoxed considering their choices as counseling and therapy trainees reading their first theories of psychotherapy text. We end this chapter as we began—by claiming that good supervisors incorporate tenets from psychotherapy theory, an awareness of supervisee development, and an appreciation for supervision process in their approach to supervision. Beyond that, we hope this chapter stimulates the reader to investigate distinct models and their offshoots further.

As we conclude this chapter, we also stress that one's model is only the conceptual map for supervision; there is much more that must be addressed in terms of the supervisory relationship, interventions, evaluation plan, ethics, and so forth.