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# Defining and Understanding Clinical Supervision *A Functional Approach*

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## Introduction

### Definition of clinical supervision

In this book, we use the term "supervision" synonymously with "clinical supervision" and "psychotherapy supervision." However, what is meant by these terms requires some consideration, as there has been a wide range of practices across the mental health professions (e.g., "management" supervision, clinical "case" supervision), with the use of correspondingly different definitions. There are also differences of emphasis internationally. A popular definition in the United States regards supervision as

> . . . an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients, she, he, or they see, and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (Bernard & Goodyear 2014)

In the United Kingdom, supervision has been defined within the National Health Service (NHS) as "A formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex situations" (Department of Health, 1993, p. 1). However, prior reviews suggest that these definitions of supervision are problematic (e.g., Hansebo & Kihlgren, 2004; Lyth, 2000). For example, the popular Bernard and Goodyear (2014) definition does not specify the nature of the "intervention." Additionally, surveys

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indicate that practitioners are unclear over the nature and purposes of supervision (e.g., Lister & Crisp, 2005).

To develop an improved, empirical definition of clinical supervision, a systematic review of 24 empirical studies was reported by Milne (2007). The first part of that review was "logical," clarifying the criteria for such an improved definition. This indicates that a definition needs to state the precise, essential meaning of a word or a concept in a way that makes it distinct (*COED*, 2004), the "precision" criterion. This requires comparisons and examples to distinguish related concepts (e.g., therapy, coaching, or consultancy). Second, a sound definition also needs "specification," namely a detailed description of the elements that make up the concept of supervision (*COED*, 2004). The next task is to operationalize the key relationships in supervision, so that appropriate forms of measurement are indicated, and so that we know what it means to manipulate supervision with fidelity (e.g., to prepare a manual or guideline). The fourth and final logical condition for an empirical definition of supervision is that it has research support: it is corroborated by the available evidence. Milne then applied these logical criteria to the available definitions, building on Bernard and Goodyear, to offer a definition that synthesized those available: "The formal provision, by approved supervisors, of a relationship-based education and training that is work-focussed and which manages, supports, develops and evaluates the work of colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching, and collaborative goal-setting. The objectives of supervision are "normative" (e.g., case management and quality control issues), "restorative" (e.g., encouraging emotional experiencing and processing, to aid coping and recovery), and "formative" (e.g., maintaining and facilitating the supervisees' competence, capability, and general effectiveness). These objectives could be measured by current instruments (e.g., Teachers' PETS; Milne, James, Keegan, & Dudley, 2002)." This definition was then tested through a systematic review, to assess whether it was consistent with and supported by the findings of the most relevant supervision research (a sample of 24 studies). Overall, the systematic review indicated that the definition was valid. We have shared this definition with the contributors to this handbook, with the aim of working from a clear and shared definition.

## Functions of Psychotherapy Supervision

Milne's (2007) definition identified three broad objectives of supervision: normative, restorative, and formative. This follows Proctor (1988) and is consistent with the one used by the NHS in the United Kingdom (Department of Health, 1993). Bernard and Goodyear's (2014) definition also identifies three purposes of supervision, two of which overlap with the normative (i.e., monitoring the quality of professional services and serving as a gatekeeper) and one with the formative objective (i.e., enhancing professional functioning). As will be indicated shortly, there are additional functions that supervision can serve, although the terms that are used by different authors can obscure the distinctions that they make. To provide a more complete specification of what supervision can achieve and to clarify how these functions relate,

we distinguish between what supervisors do (i.e., the methods or techniques that they use, such as the different approaches to teaching), the functions that these methods serve (e.g., normative, formative, and restorative), and the outcomes or goals that normally result (i.e., competencies, capability, a sense of professional identity, and the obtaining of a professional qualification or award). Figure 1.1 provides a graphic display of those distinctions. It indicates that the ultimate purpose of all this integrated activity is safe and effective psychotherapy.

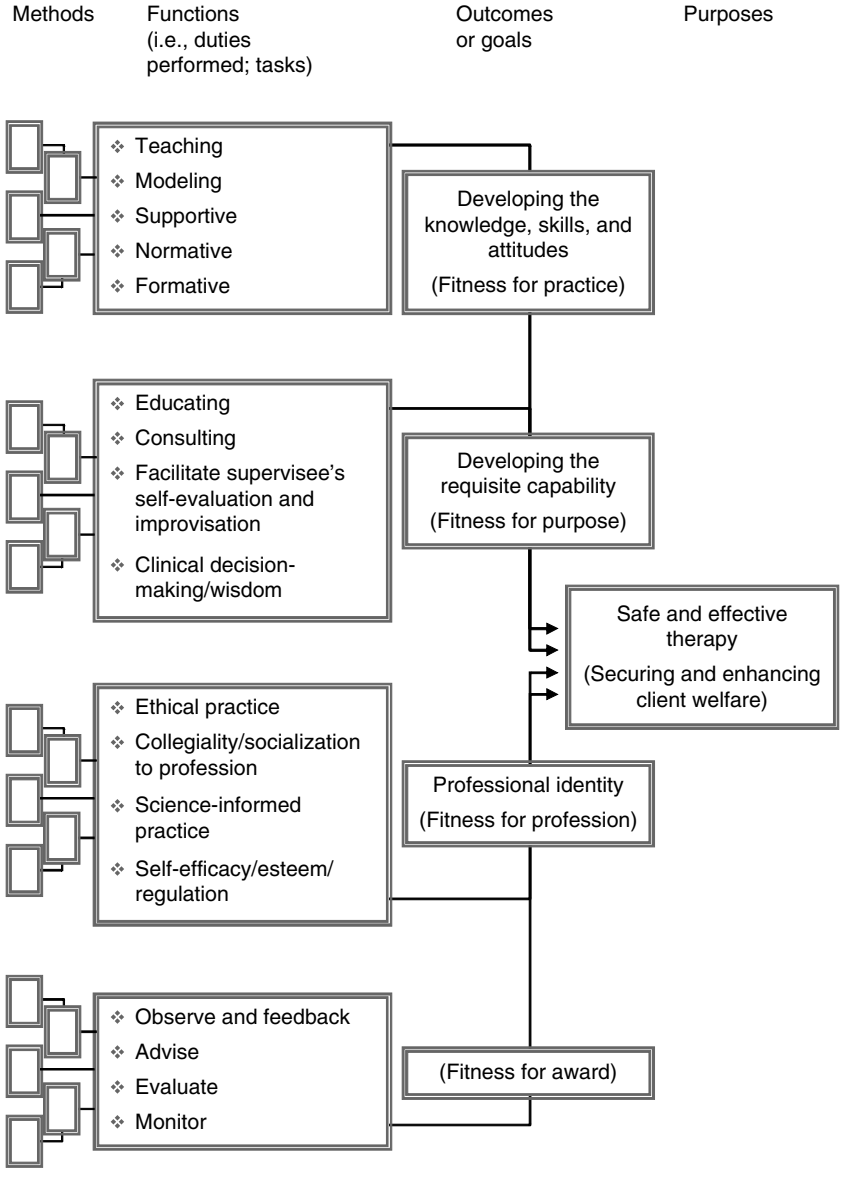


**Figure 1.1** How the different functions of supervision combine to foster safe and effective clinical practice. *Source:* Milne (2009). Reproduced with permission of Wiley.

## Developing competent therapists

Perhaps the best-recognized function of supervision is to enable supervisees to become competent as psychotherapists. It also appears to be supervision's key contribution: "Supervision has been identified as perhaps the most important mechanism for developing competencies in therapists in training" (Callahan, Almstrom, Swift, Borja, & Heath, 2009, p. 72), something that has been recognized by others previously (Falender & Shafranske, 2004; Holloway & Poulin, 1995; Watkins, 1997a). This endorsement also comes from both parties: a UK survey suggested that supervision was the main influence on clinical practice, as perceived by supervisors and their supervisees (Lucock, Hall, & Noble, 2006). As indicated by Figure 1.1, supervisors utilize interventions such as teaching and modeling to assist supervisees in becoming competent therapists, but it is also noted there that supervisors need to provide a supportive environment (Ladany & Inman, 2012; Russell & Petrie, 1994; Watkins & Scaturo, 2013), one that acknowledges the requirements for competent practice (e.g., recognizing any service standards that apply, such as those that specify how clinical reports should be completed).

## Developing capable therapists

Of course, it has also been recognized that no amount of expert supervision prepares novice therapists for their whole careers. This is why there are systems of continuing professional development (Golding & Gray, 2006; Grant & Schofield, 2007). But one of the vital building blocks that a supervisor can help to cultivate during initial professional training is the capacity for future development. A term that is used in the United Kingdom to capture the distinction between such current and future competence is "capability." This refers to those problem-solving, creative features of a rounded practitioner (Fraser & Greenhalgh, 2001). In pursuing this function, Figure 1.1 notes that a supervisor may emphasize education rather than training so as to facilitate career-fostering qualities such as critical thinking and self-evaluation.

## Creating a professional identity

Alongside competence and capability, the supervisee needs to develop an ethical approach (Thomas, 2010) and so the supervisor will encourage suitable reflection (and similar methods, such as guided reading) to foster cultural competence, related awareness of sound practice, and therapist identity development (cf. Leszcz, 2011; Watkins, 2012b). Linked to ethical awareness is socialization to the supervisee's profession, as in developing collegial attitudes and practices, and in highlighting distinctive features of one's own profession. This is captured in Figure 1.1 as the third broad goal of supervision, one that is concerned with enabling practitioners to fulfill the expectations (purpose) of their own profession. To illustrate, a capable clinical psychologist has research skills in order to work as a scientist-practitioner, drawing on research competencies to tackle clinical problems. Over time and once internalized, these should afford the novice therapist with a means of self-monitoring and self-regulation. In such ways, supervision enhances clinical accountability (Milne

& Reiser, 2012; Watkins, 2012c) and can afford an accepted defense against litigation (Thomas, 2010).

## Enabling supervisees to obtain their qualifications

Since we have been emphasizing the novice supervisee, it is appropriate to add that a key function of supervision is to assist supervisees who are in initial professional training to secure the necessary qualifications to continue their careers. This implies that supervisors will use methods that support systematic observation of their supervisees, so that corrective feedback (formative evaluation) can be provided during the process of supervision, but also so that formal (summative) evaluation can be carried out at the close, as in recommending a grade or an action. In turn, this may lead to advice to address a failure to demonstrate competence, and related methods that support suitable monitoring arrangements. A case in point is a supervisee who has not yet demonstrated the correct application of particular therapeutic skills, who lacks the necessary treatment fidelity. Within England's innovative program, Improving Access to Psychological Therapies (IAPT; Department of Health, 2008), "supervision is a key activity which has a number of functions, not least to ensure that workers deliver treatments which replicate . . . the procedures developed in those trials that underpin the evidence-base: treatment fidelity" (Richards & Whyte, 2008, p. 102). Once supervisees can demonstrate the necessary fidelity, then supervisors are normally empowered (by the university that grants the degrees) to recommend that supervisees pass that element of their training.

## Safe and effective therapy (clinical benefits)

The aforementioned four supervisory objectives or functions can be viewed as providing the necessary conditions for supervision's overriding purpose, which is to promote safe and effective clinical practice (Falender & Shafranske, 2004; Kilminster, Cottrell, Grant, & Jolly, 2007). In being effective, supervision should improve the outcomes for clients (Holloway & Neufeldt, 1995; Krasner, Howard, & Brown, 1998; Lichtenberg, 2007) – the long-standing "acid test" of supervision (e.g., Ellis & Ladany, 1997; Lambert & Arnold, 1987). Due to complex causal relationships and associated methodological challenges (Wampold & Holloway, 1997), that supervision–client outcome link has been minimally studied (Hill & Knox, 2013; Watkins, 2011). But those few outcome studies that do exist suggest that supervision can indeed contribute to client gains (e.g., Bambling, King, Raue, Schweitzer, & Lambert, 2006; Callahan et al., 2009; Wrape, Callahan, Ruggero, & Watkins, in press).

## Context

While in Figure 1.1 we have depicted the supervisee as nested within supervision, it is also appropriate to think of the supervisor in turn as nested within a wider system, one with very similar parameters. For instance, the supervisor should also be competent, capable, and ethical. This begs the question of whether suitable arrangements are in place to support and develop the supervisor. For instance, do patients provide

feedback on the supervisees, their therapists (e.g., client satisfaction data)? Do supervisees provide feedback on their supervisors (e.g., fidelity to the training programs specification for supervision)? Are supervisors supported by training and other forms of continuing professional development? How is the overall system managed? In relation to the final question, the supervision system normally includes relevant policy guidance, whether from professional bodies (who approve training programs for therapists, issue practice guidelines, etc.), public governance (national or state legislation, funding, etc.), or other sources. For instance, the UK government has increasingly supported supervisor development (e.g., Department of Health, 1998), with "dramatic changes," such as the IAPT initiative (Turpin, 2012, p. 24).

In summary, we realize that we have not done justice to all the functions that can be served by supervision (e.g., during the post-qualification period, through improving the recruitment and retention of therapists, raising job satisfaction, or aiding workload management), but it is clear that supervision serves several vital functions, ones that have increasingly received recognition within research, as well as through some professional bodies and government policies. We next ask how supervision has developed latterly, selecting the competencies movement as our example.

## Developments in Clinical Supervision

As an educative process, clinical supervision is designed to foster the development and enhancement of therapeutic competence in supervisees. But what are the specific supervision competencies that make achieving that objective increasingly likely? What are the specific supervision competencies that guide and provide direction for the entirety of the supervision process? While those questions have always been of supervisory concern, the matter of competencies has received unparalleled attention in the supervision arena over the last approximate 15-year period. Substantive supervision competency initiatives have emerged from Australia, the United Kingdom, and the United States (see Falender & Shafranske, 2004, 2012b; Falender et al., 2004; O'Donovan, Slattery, Kavanagh, & Dooley, 2008; Psychology Board of Australia, 2013; A. Roth & Pilling, 2008; Turpin & Wheeler, 2011). In each of those efforts, a host of core competencies – deemed *sine qua non* to the effective practice of clinical supervision – has been identified and explicated. Although those initiatives continue to evolve, they seemingly provide a useful blueprint for competency considerations in other countries as well (e.g., Bang & Park, 2009). Indeed, the international zeitgeist within the supervision field has become dominated by the competency-based training of supervisors (Holloway, 2012), and all indications suggest that that trend will continue its ascendance in the decades ahead.

But with all of this attention being directed toward competencies, what do we mean specifically by the more focused term of "competency" and the broader term of "competence"? Professional competence can be defined as being qualified, knowledgeable, and able to act in a consistently appropriate and effective manner – reflecting critical thinking, judgment, and decision making – that is in accordance with standards, guidelines, and ethics of the particular profession being practiced (Rodolfa et al., 2005). It involves, to use the often quoted words of Epstein and Hundert (2002), "the habitual and judicious use of communication, knowledge . . .

[and] technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" (p. 226). In Figure 1.1, competence is synonymous with "capability."

The more focused term, competency, could be defined as "the combination of skills, abilities, and knowledge needed to perform a specific task" (U.S. Department of Education, National Center for Education Statistics, 2002, p. 7). This supervisory goal – the development of the requisite knowledge, skills, and attitudes for clinical practice – is also noted within Figure 1.1. Across supervision competency frameworks developed thus far, skills, knowledge, and values have been repeatedly accentuated as being the core, requisite components of competencies, and it is their amalgamation and integration that then bring competencies to life. For example, where the competency of "establish effective supervision alliance" is concerned, some of the skills and knowledge that would be needed to make that reality include understanding what an alliance is, having understanding about what is involved in its formation and repair, possessing the interpersonal skills to develop and maintain such an alliance, and being able to effectively implement those alliance-fostering skills during supervision (Falender & Shafranske, 2004; Watkins, 2013b, 2013c). A competency, then, first entails the necessary bundling of the required knowledge, skills, and values, and once that particular set has been satisfactorily integrated, only then does realization of the competency begin to occur within the practice setting, guided by a value base.

## On contemporary competency frameworks

Let us look more specifically at the three supervision competency frameworks developed thus far and consider the primary guidance that we can accordingly extract from each of them (see Watkins, 2012a).

1. *The North American approach* In 2002, the Association of Psychology Postdoctoral and Internship Centers Competencies Conference, in conjunction with 34 professional groups or associations, sponsored the Competencies Conference in Scottsdale, Arizona. Professionals were included from the United States, Canada, and Mexico. The primary purposes of the conference were to identify core psychology practice competencies, formulate competency models for guiding future training, and develop means by which competencies could be assessed and evaluated (Kaslow et al., 2004). Some of the principal contributions to either emerge from that conference or that have since been stimulated by its deliberations include the following: the proposal of the cube model of competency development in professional psychology (Rodolfa et al., 2005); adaptation of that model to clinical supervision (Bernard & Goodyear, 2014); identification of competency benchmarks across different developmental levels (American Psychological Association, 2011, 2012; Fouad et al., 2009); fashioning of an assessment toolkit for competency evaluation purposes (Kaslow et al., 2009); and engagement in continuing efforts to revise, refine, and render the culture of competence increasingly practical and user-friendly (e.g., Association of State and Provincial Psychology Board's competency-based practice framework; Hatcher et al., 2013; Rodolfa et al., 2013; Schaffer, Rodolfa, Hatcher, & Fouad, 2013).

At the 2002 Competencies Conference, its supervision work group (composed of both academicians and practitioners with supervision expertise) was specifically charged with identifying the core components of competence in supervision, the most critical educational and training experiences that facilitate development of supervision competence, and various strategies for assessing supervision competence (Falender et al., 2004). The supervision work group developed a supervision competencies framework that (a) utilized three variables – knowledge, skills, and values – in understanding and defining the various competencies of supervision; (b) was guided by an appreciation of developmental and diversity considerations; and (c) embraced the view that being and becoming a competent supervisor was a lifelong process that required ongoing reflection, self-assessment, practice, and education. Some of the knowledge, skills and values competencies that their expert consensus work group identified as important included knowledge of models and research on supervision, awareness, and knowledge of diversity in all of its forms, relationship skills, commitment to lifelong learning and professional growth, and commitment to knowing one's own limitations (Falender et al., 2004). This assembly of competencies was considered to provide a somewhat comprehensive framework or blueprint that could then be used accordingly to guide and inform the supervision process; that continues to be the case today (Falender & Shafranske, 2007, 2012a, 2012b; Fouad et al., 2009).

2. *The UK approach* In the United Kingdom's IAPT program, the construct of competencies has also been and continues to be central to the defining of supervision practice (A. Roth & Pilling, 2008; Turpin, 2012; Turpin & Wheeler, 2011). The IAPT initiative, which began in 2006, is designed to offer approved interventions for individuals suffering from depression and anxiety. Shortly after the program's initiation and in an attempt to increase the probability of competent therapeutic practice being provided, attention understandably turned to the importance of delivering competent supervisory services, and a group of experts was subsequently convened to identify the competencies that were deemed necessary for the provision of effective supervisory functioning.

   Based on that expert reference group's deliberations, four sets of supervisor competencies were identified and elaborated on: generic supervision competencies, specific supervision competencies, specific models/contexts, and metacompetencies. Those competencies were designed primarily with the practicing professional in mind. Some of the IAPT generic supervision competencies include ability to enable ethical practice; ability to foster competence in working with difference; ability to form and maintain a supervisory alliance; and ability for supervisor to reflect (and act) on limitations in own knowledge and experience (A. Roth & Pilling, 2008). The overall group of IAPT competencies shares much in common with, and nicely corresponds with, the earlier work of Falender et al. (2004). Like the US supervision competence framework, the IAPT supervision competence framework provides a somewhat comprehensive blueprint that can be used to guide and inform the supervision process (A. Roth & Pilling, 2008). Furthermore, as of this writing, more specific competency frameworks that give focus to particular forms of treatment supervision (e.g., cognitive-

behavioral, psychodynamic) have been developed and detailed (http://ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm).

3. *The Australian approach* In Australia, a competency-based system to guide supervisory practice and evaluation has also been recently established. While mandatory supervisor training programs have been in place in Queensland, Tasmania, and New South Wales, the Psychology Board of Australia has worked to establish a national system for the training of clinical supervisors and has now successfully done so; that work builds on, and is informed by, the earlier supervision competence frameworks that have emerged from the United States and United Kingdom (Gonsalvez & Milne, 2010; O'Donovan et al., 2008; Psychology Board of Australia, 2013). Thus, a competency-based approach to supervision – "which includes an explicit framework and method of supervision practice, and a consistent evaluative and outcome approach to supervision training" (Psychology Board of Australia, 2011, p. 5) – has been vigorously advocated, pursued, and now achieved.

The board has identified seven competencies that supervisors must demonstrate: Knowledge and understanding of the profession, knowledge of and skills in effective supervision practices, knowledge of and ability to develop and manage the supervisory alliance, ability to assess the psychological competencies of the supervisee, capacity to evaluate supervisory process, awareness and attention to diversity, and ability to address the legal and ethical considerations related to professional practice (Psychology Board of Australia, 2013). More detailed specification of what is involved in each particular competency has been clearly provided by Australia's Psychology Board (see *Guidelines for Supervisors and Supervisor Training Providers*). Like its predecessors, the Australian supervision competence framework provides a nice blueprint that informs supervisory conceptualization and conduct, and the supervision process ideally should be conducted with those competencies foremost in mind.

## On consistency across frameworks

In surveying these three frameworks, what might be their binding similarities of which we should take note? What consistencies in supervision competencies are in evidence from Australia, the United Kingdom, the United States, and perhaps even beyond? In considering how those competency blueprints might apply to the treatment/supervision situation in other countries (cf. Atieno Okech & Kimemia, 2012; Bang & Park, 2009; Malikiosi-Loizos & Ivey, 2012; Palmer, Palmer, & Payne-Borden, 2012; Richards, Zivave, Govere, Mphande, & Dupwa, 2012; Stupart, Rehfuss, & Parks-Savage, 2010; Vera, 2011), six fundamental areas of supervision competency appear to be identifiable across cultures and countries: (a) knowledge about and understanding of supervision models, methods, and intervention; (b) knowledge about and skill in attending to matters of ethical, legal, and professional concern; (c) knowledge about and skill in managing supervision relationship processes; (d) knowledge about and skill in conducting supervisory assessment and evaluation; (e) knowledge about and skill in fostering attention to difference and diversity; and (f) openness to and utilization of a self-reflective, self-assessment stance in supervision (Watkins, 2013a). While not necessarily exhaustive, those six areas of

focus appear (to at least some degree) to be universally important for supervisory practice wherever it may be conducted. The crucial, differentiating variable within this international mix, however, would seemingly be the ways in which those areas of focus are particularized and indigenized across cultures (cf. Moir-Bussy & Sun, 2008). That indigenization will be informatively communicated and displayed in the many instructive chapters that follow. We have wished to provide a forum here where (a) the richness and beauty of supervision's international diversity could be accentuated and appreciated, and (b) cultural incommensurability (Kozuki & Kennedy, 2004) – the inappropriate, indiscriminate, and ethnocentric application of a culture-bound way of thinking to other cultures – would be avoided. In our view, the contributors to this handbook have indeed fulfilled these wishes.

## What Can We Expect of an "International" Handbook?

Bernard and Goodyear (2009) have stated, "Clinical supervision is of interest to mental health professionals in a number of countries. . .. supervision research is becoming increasingly global" (p. 300). Despite this, we lack a book that takes a truly global perspective. To illustrate, the 52 contributors to the *Handbook of Psychotherapy Supervision* (Watkins, 1997b) were all based in North America, as were the 48 contributors to *Psychotherapy Supervision* (Hess, Hess, & Hess, 2008). The handbook by Cutcliffe, Hyrkas, and Fowler (2011) adopts a similarly narrow perspective, restricted this time by profession (nursing). Therefore, in the present handbook one of our goals is to give voice to the increasingly international, multidisciplinary nature of clinical supervision. But what does it mean to take an international perspective, and what is the rationale?

### Mutual awareness

At one level, an international perspective means acknowledging that the national context matters by giving researchers from around the globe a chance to present their perspectives, concerns, and related work. As a result of this internationalization effort (van de Vijver, 2013), we hope to offer a more culturally informed, inclusive, and globally applicable account of supervision. This effort facilitates dialogue and surely aids the dissemination of research and practice between countries, fostering the exchange of ideas between a worldwide cast of authors (and readers). This is surely a readily achievable but nonetheless valuable goal, because it better acknowledges what is deemed important within supervision research and practice in different national contexts, helping to raise awareness and deepen our understanding (through accessing multiple, culturally diverse perspectives: Nilsson & Wang, 2008).

In this sense, we hope that the handbook will be a bit like a "cultural immersion experience," allowing readers and contributors to become more aware of the diversity of research and practice across countries (Wood & Atkins, 2006). Benefits to such heightened awareness include recognition of our respective cultural biases, such as the dominant Western value of "individualism" (i.e., stressing autonomy and competition) in contrast to the kind of "collectivist" value base (i.e., stressing interdependency and collaboration) associated more commonly with Asia and Africa (Brislin,

2000). In practical terms, this means that Western interventions, such as cognitive-behavioral therapy (CBT) supervision, may be relatively unacceptable or ineffective in some other cultures, due (for instance) to locating problems within the individual instead of the system. A further example of international diversity is the status accorded to people within a hierarchy: by comparison with Western cultures, in Asian cultures a person in authority (like a supervisor) might be accorded greater respect and authority, and expected to provide more protection and guidance. Reiser and Milne (2012) cite an example:

> In initial meetings, discussions with an Asian American immigrant trainee included a review of cultural differences and her sense of willingness to accept challenges in supervision versus the level of support she felt she needed. She also noted that her cultural heritage involved high levels of respect for elders and teachers; and a sense that it might be impolite to ask questions, reveal private emotions (might be viewed as weakness) or unnecessarily 'bother' her supervisors. The trainee and the supervisor noted how this cultural predisposition might prevent the student from fully participating in supervision and feeling free to disclose difficult emotions associated with being in supervision-normative experiences as a therapist in training. (p. 14)

On this awareness-raising rationale, we are delighted to have recruited a truly international cast of authors, including those from many countries that have perhaps been overlooked in previous handbooks. Consolidating this "awareness-raising" aim, one of our contributors, Professor Tsui (Chapter 10), will explore international perspectives explicitly, giving attention to how variables such as personal characteristics (e.g., race and religion), social roles, and contextual factors (cultural and political) influence supervision.

## Providing assistance

In addition, we think that an international perspective means assisting researchers in other countries through promoting collegial interaction, cooperation, and collaboration, to pool resources. For instance, supervision researchers in Australia (e.g., Gonsalvez & Milne, 2010) have drawn on British guidelines on clinical supervision (A. Roth & Pilling, 2008). As a result of such assistance, we are in a position to consider the global implications arising from research in one particular country. A case in point is supervisor training, something close to our hearts (see Chapter 8).

## Mutual development

A final major way we see an international perspective paying dividends is through mutual development. In this sense, if this book is truly international we would hope to see authors from around the globe drawing on it to trade supervisory practices and exchange research findings in ways that help to strengthen the discipline. This might include drawing on concepts or techniques that help to accelerate progress, or which highlight unwise options or empirical blind alleys. Fostering such collaboration is our most ambitious goal because of obstacles such as the inherent cross-cultural challenges: just as there are challenges in working in a culturally competent

way in a clinical or supervisory capacity, so there are challenges in doing so between culturally divergent systems or states. That is, the individual differences that rightly interest us in our one-to-one work are mirrored by "international differences." In both instances we surely need cultural competence: the ability to work effectively with people with distinctive qualities, including their country, ethnicity and culture. Few would question that "culture matters in psychotherapy and supervision" (Lopez, 1997, p. 586), and we hope to illuminate some of the important ways that it also matters internationally, so as to help researchers to address these obstacles.

In summary, we believe that the rationale for "an international perspective" is to promote mutual awareness-raising, mutual help, and mutual development. The intellectual origins of supervision are truly international, drawing initially on European philosophy, alongside Russian physiology and neuropsychology. Although the field has developed most rapidly within the United States, supervision has progressed differently in the rest of the world, representing different things to different people at different times (for an illustration from psychology, see Baker, 2012). The cross-cultural emphasis in the international handbook is intended to make research and its applications more globally accessible, acceptable, and effective while valuing diversity in understandings, perspectives, and methods.

## Conclusion

Supervision is now recognized as essential to high-quality clinical practice and to the development of mental health clinicians, a status that appears to be shared internationally. "From Sweden to Slovenia, from north Texas to Northumberland, supervision has. . . become or is fast becoming an increasingly internationalized, globalized, and (ideally) indigenized area of practice and inquiry . . ." (Watkins, 2012a, p. 301). In some countries, it has progressed from relying on the opinions of a few enthusiastic experts to a situation where governments, professional bodies, and others now firmly acknowledge the necessity of supervision. Therefore, now is a very good time to try and to ensure its continued development. We believe that this development is likely to be accelerated through continued collaboration between experts, as per the illustration of the consensus over the supervision competencies. Further, we hope that the international dimension within this volume will contribute direction and collegiality to the collaborative effort.

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