

3 Models of Clinical Supervision: Current Approaches within an Historical Context

What follows is a brief history of clinical supervision. It is not all-inclusive, but touches on the developmental highlights. The models discussed are still in use today.

3.1 *Psychoanalytic Foundations of Clinical Supervision*

Psychoanalysis as a discipline was founded by Sigmund Freud towards end of the 19th century. From the beginning of his working life, Freud was discussing his ideas and practices with others and they with him, although the terms clinical consultation and clinical supervision had not yet been adopted. As far back as 1902, he was involved as teacher, mentor and observer in the work of young doctors practising to become psychoanalysts. This early type of supervision was didactic in form and the work centred on the patients' dynamic processes.

Other helping professions began to develop their own supervision practices at this time and it is difficult to know who influenced whom, or precisely in what order events unfolded. Social workers in the U.S. were introducing supervision as a "supportive and reflective space" (Carroll, 2007, p. 34) and other types of welfare workers were picking up these ideas at, or around the same time.

No matter which discipline or what form of clinical supervision one practices, psychoanalytic concepts have brought much richness to clinical supervision in all its phases. Freud's psychodynamic ideas of parallel process and creating a working alliance are foundational across models of clinical supervision, having "informed the work of supervisors of all orientations" (Bernard & Goodyear, 2009 p. 81). It is believed that Max Eitingon of the Berlin Institute of Psychoanalysis first made supervision a formal requirement for psychoanalytic trainees in the 1920s, just as mandatory standards for both coursework and observational treatment of patients were established by the International Psychoanalytic Society (Carroll 2007; Bernard & Goodyear, 2009).

The two schools of thought on clinical supervision that competed for dominance in the 1930s were the Budapest School and the Viennese School. The former held the concept of clinical supervision as a "continuation of the supervisee's personal analysis" (Bernard & Goodyear, 2009, p. 82) which meant having the same analyst (supervisor) performing dual roles as both therapist and supervisor. In therapy, the focus would be on the analysand's (supervisee's) transference issues in relation to the analyst; in supervision, the focus would be on the analysand's countertransference issues in relation to his or her own clients. The latter school held the idea that the analysand's transference and countertransference issues were both to be processed in therapy, so that supervision was retained as a teaching forum.

A psychodynamic model which emerged later on, in the 1970s, had a wide resonance for many practitioners both inside and outside psychoanalytic circles. This work marks the beginning of the supervisee as the centre and focus of the supervision process. Ekstein and Wallerstein conceptualised clinical supervision as both "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” (Bernard & Goodyear, 2009, p. 82). Thus, the focus was on teaching rather than providing therapy, with the aim being for the supervisee to understand the overt and covert dynamics between supervisor and supervisee; to learn how to resolve difficulties which arose, and to develop the skills necessary to help his or her clients in the same fashion.

In the past decade, two psychodynamic therapists and supervisors, Mary Gail Frawley-O’Dea and Joan E. Sarnat, introduced a fresh psychodynamic supervision model in their book *The Supervisory Relationship: A Contemporary Psychodynamic Approach* (O’Dea, M.G. and Sarnat, J.E. , 2001, New York: Guilford Press), which suggested a new philosophical and practical position for the supervisor in relation to the supervisee. Previously viewed as an objective expert with a mastery of theory and technique, the supervisor in this model is afforded space to act less the dispassionate expert and more an active participant in the unfolding process of supervision. Thus, his or her authority “resides in the supervisor-supervisee relational processes” (Bernard & Goodyear, 2009, p. 82), rather than in the absolute, immutable position of the all-knowing superior. In such a relationship, both parties acknowledge a mutual influence and the supervisory stance shifts effectively from that of outside, reflective observer to informed and purposefully influential insider.

Points to remember about psychodynamic supervision:

- Process and relationship oriented, with a focus on intrapsychic phenomena and interpersonal processes, in order to develop insight and provide containment
- Close parallels between therapy and supervision

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).

3.2 Clinical Supervision Based on Counselling Models

In the 1940s - 1950s, there was another shift in the delivery of clinical supervision. The new models which emerged were based upon and tightly bound to the counselling theories and interventions of the practising supervisor.

3.2.1 Person-Centred Supervision

Carl Rogers, the founder of a humanistic, person-centred model of therapeutic practice, did not differentiate greatly between therapy and supervision, but simply shifted his role during sessions depending upon what his supervisees required at the time - personal therapy, or professional supervision. As with the psychodynamic models, the person-centred model, to be effective, relied upon a strong and trusting relationship between supervisor and supervisee.

Rogers was among the first to use electronically recorded interviews and clinical transcripts in supervision (Bernard & Goodyear, 2009, p. 83), rather than relying only on the self-report of those he supervised. Carl Rogers’ influence on both therapy and clinical supervision practices has been profound. Though Rogers’ approach is less focused upon today in the

U.S., it is still widely taught in the UK and many of the skills learnt by new practitioners world-wide can be traced back to him.

Points to remember about person-centred supervision:

- Process and relationship focused, with genuineness, warmth and empathy being imperative relational traits
- Exploration of self, both personally and in the context of the work, is essential to the process, with movement towards differentiation and self-actualization the goal of both therapy and supervision
- Encompasses both teaching and therapy:

“I think my major goal is to help the therapist to grow in self-confidence and to grow in the understanding of himself or herself, and to grow in the therapeutic process...Supervision for me becomes a modified form of the therapeutic interview” (Rogers, cited in Bernard & Goodyear, 2009, p. 83).

3.2.2 Cognitive-Behavioural Supervision

Cognitive-Behavioural Supervision, like the various models of therapy related to it, emerged in the 1960s. It was a far cry from what had come before, in that the focus shifted dramatically away from the relationship and dynamic processes existing between supervisor and supervisee (or therapist and client) to the development of practice skills. Becoming an effective therapist, like becoming an effective person, involved mastering specific tasks and learning to think in ways which were beneficial to the personal or professional self, whilst taking actions to extinguish (in CBT terms) unhelpful thinking and behaviours that create problems. Thus, success as a therapist depended upon one’s ability to learn the work and to do it well, rather than on a good fit between therapist and client.

The tasks assigned to supervisees in clinical supervision would mimic that offered to clients in therapy, such as imagery exercises and role playing. As with cognitive behavioural therapy, this type of clinical supervision would hold that it is the intervention which counts, and specific interventions lead to specific outcomes, if followed precisely and faithfully. Assessment and close monitoring of supervisees was routine, as it was considered essential to the work that they both understood and properly utilised the theory and practice of the therapy, as expressed in the treatment manuals.

CBT in its current form, or forms, is more variable and open to influence than fifty years ago. For instance, more attention is now paid to relationship than in the past, and ideas from Eastern philosophy have been incorporated into the work by some practitioners (e.g., mindfulness, meditation). Similarly, these ideas tend also to be incorporated into clinical supervision and training in CBT work.

Points to remember about cognitive behavioural supervision:

- Instructional and skills-based (or strategy-based), with focus on achieving technical mastery, e.g., how to challenge negative automatic thoughts

- Explicit and specific goals and processes followed, e.g., negotiating agendas at the beginning of each session
- Use of behavioural strategies with supervisee, e.g., role play and visual imagery

3.2.3 Family Therapy (Systemic) Supervision

Family Therapy (Systemic) Supervision theory and practice has been documented since the 1960s, with family therapists taking the unique step of making therapy a highly interactive and involved team effort, by observing their colleagues' clinical work with families and engaging with them and the client family as part of the treatment team.

Although family therapy had been emerging for several decades, it broke through as a formal discipline with its own clear set of ideas in the 1950s, as a direct result of the work of an anthropologist named Gregory Bateson, and his colleagues at the Palo Alto Institute. Findings from The Bateson Project created a paradigmatic shift in the field of family therapy and refocused the energies of its practitioners. Family therapists began to understand the family as an interactive system; to pay close attention to communications between family members; to view causality as circular rather than linear and to believe that change could start with any member of a family, thereby impacting the whole.

These ideas influenced the way in which family therapy clinical supervisors approached their work with supervisees, as supervisees were themselves understood to be part of an interlocking group of systems, all of which affected how they performed their work (e.g., family of origin; interaction with the client's family system and the supervisory system).

There were several models of family therapy and it was considered essential that clinical supervision be consistent with the model of therapy that the supervisee was learning to practice. Despite differences in opinion regarding how problems emerged and what might help to solve them, all models held in common the role of the therapist as "active, directive and collaborative" (Liddle et al., cited in Bernard & Goodyear, 2009). This was also the case with clinical supervision, in which supervisors were highly engaged with their supervisees.

It was then and is now common practice for clinical supervisors to observe the work of their supervisees. Sometimes this was (and is) done live, as in training programs, with the supervisor offering interventive suggestions via phone through a one-way mirror to the supervisee during sessions. This is a unique contribution of family therapy to the practice of clinical supervision that is called simply "live supervision." More common is for supervisees to present recorded sessions of their work with clients and/or to offer written transcripts of sessions, which are then reviewed and discussed in clinical supervision sessions.

Another unique contribution of family therapy to clinical supervision is the reflecting team, a therapeutic model introduced by Norwegian family therapist Tom Andersen in 1985. A reflecting team is a group of therapists who observe a colleague conducting a family session, then have an open conversation with one another, observed by the colleague and client family, about what they noticed in the session. This is done respectfully and thoughtfully, with great care and consideration taken in relation to the possible impact of their observations. The idea is to generate fresh possibilities for the clients and to offer multiple perspectives and a sense of hopefulness.

In the same way, a reflecting team can observe a family session facilitated by a supervisee, focusing their reflective comments on what they noticed in the supervisee's work. This is common practice in training programs, where a group of supervisees might act as a reflecting team, under the guidance of a clinical supervisor.

Points to remember about systemic supervision:

- Focus on relational approach to understanding of and intervention in presenting problems
- Makes explicit connections between people and the wider social context
- Greater use of direct observation and live supervision (compared to other supervision models)
- Supervisor's role is that of director or consultant
- Focus on the supervisee's position within the broader system
- Principles and techniques used in therapy are congruent with those used in supervision and may be applied to supervisee, e.g., strategic interventions, family of origin exploration

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).

3.3 Developmental and Social Role Model Approaches to Clinical Supervision

Developmental and social role model approaches to clinical supervision have been in use since the 1950s, but began to gain great popularity during the 1970s and 80s.

Developmental models

There are many models of clinical supervision that can be defined as developmental, which can be further categorised into three types: stage developmental models; process developmental models and life-span developmental models. These focus on the developmental stages of the supervisee in relation to the clinical supervision process. Clinical supervisors are also understood to go through developmental stages as they hone their talents and skills in their work with supervisees.

Stage developmental models describe supervisees moving through progressive stages in their professional maturity and within the supervisory relationship. The beginning counsellor is seen as highly motivated, but with only limited awareness and quite dependent on the supervisor. Over time and through experience gained, the counsellor becomes more consistently motivated, more fully aware, but less self-conscious, and more autonomous. An example of a stage developmental model is The Integrated Developmental Model (IDM) developed by Cal Stoltenberg, Brian W. McNeill and Ursula Delworth.

Process developmental models are those which focus on processes in the supervisee's work which "occur within a fairly limited, discrete period" (Bernard & Goodyear, 2009, p. 92).

Examples include:

- *Reflective models of practice* - models which encourage the use of reflection to improve practice, by focusing on an experience in a counsellor's professional practice which is having an emotional or intellectual impact that requires deeper understanding. Originally based on the concepts of John Dewey in the 1930s, these models continue to be developed and widely used today.
- *The Loganbill, Hardy and Delworth model* - a counsellor development model based on processes which are "continually changing and recursive" (Bernard & Goodyear, 2009, p. 94) and expressed by characteristic attitudes towards the work, the self and the supervisor. A key difference in this model is that it dismisses ideas of linear progression through stages in favour of continual cycling through "with increasing...levels of integration at each cycle" (Bernard & Goodyear, 2009, p. 94).
- *Event-based supervision* - a task focused model in which the supervisor and supervisee focus on analysing how the supervisee has managed particular discrete events in his or her work. Supervisee and supervisor decide where to focus their attentions by either a direct request of the supervisee, or by the supervisor picking up on subtler, or less direct, cues.

Task-focused developmental models of clinical supervision, such as Michael Carroll's, break down supervision into a series of manageable tasks. In Carroll's integrative model (which is also a version of social role model), he suggests the following seven central tasks of clinical supervision: creating the learning relationship, teaching, counselling, monitoring (e.g., attending to professional ethical issues), evaluation, consultation and administration.

Lifespan developmental models, such as The Ronnestad and Skovholt Model, focus on the development of counsellors across the lifespan, rather than just the few years when they are new to their work. This six-stage model begins with "The Lay Helper Phase" and ends with "The Senior Professional Phase" (Bernard & Goodyear, 2009, p. 98), and is unique in articulating the differing needs in clinical supervision for counsellors at each stage of their professional lives.

Social models

Social role model approaches to clinical supervision focus on the roles, tasks, foci and functions of clinical supervision. Two examples are Hawkins and Shohet's "Seven-eyed Model," (originally called the "Double Matrix Model") and Holloway's "Systems Approach to Supervision (SAS)."

The "Seven-Eyed Model" (Hawkins and Shohet) recognises that the clinical supervisor employs different roles or styles at different times, but also concedes that the role or style, is likely to be most influenced by the particular focus of the work at the time. This is a process model, which stresses attending to the processes that occur during supervision and within the supervisory and therapy relationships. Hawkins & Shohet coined the term the "good enough" supervisor, alluding to the object-relations idea of the "good enough" mother (i.e. one does not have to be perfect, or get everything right). They believe that a

primary and consistent role of the supervisor is that of providing containment for the supervisee.

The “Seven-Eyed Model” of supervision is called such because it recommends seven areas of focus for exploration in supervision: (1) content of therapy session; (2) supervisee’s strategies and interventions with clients; (3) the therapy relationship; (4) the therapist’s processes (e.g., countertransference or subjective experience); (5) the supervisory relationship (e.g., parallel process); (6) the supervisor’s own processes (e.g., countertransference response to the supervisee and to the supervisor-client relationship), and (7) the wider context (e.g., organisational and professional influences).

Holloway’s “Systems Approach to Supervision Model” is integrative and comprehensive, taking into account a number of factors which impact upon supervision. Holloway recommends that five systemic influences and relationships be considered: (1) the supervisory relationship (phase, contract and structure); (2) the characteristics of the supervisor; (3) the characteristics of the institution in which supervision occurs; (4) the characteristics of the client, and (5) the characteristics of the supervisee.

Holloway then offers a task and function matrix for conceptualising the supervision process, in which the five functions are: monitoring/evaluating, instructing/advising, modelling, consulting/exploring, and supporting/sharing. The five tasks of the matrix are: counselling skills, case conceptualisation, professional role, emotional awareness and self-evaluation. The matrix provides twenty-five task-function combinations. The tasks and functions together are said to equal process, and all are conceptualised to be built around the “body” of supervision, the relationship.

Points to remember about developmental and social role model approaches to clinical supervision:

- Historically, a point of transition when the focus of supervision shifted from the person of the worker to the work itself
- Conceptualise clinical supervision as related to, but separate from, counselling, and as a unique process requiring its own practice principles, knowledge base, and skill set
- Focus on the tasks, roles and behaviours in clinical supervision

References for this section: Bernard & Goodyear (2009); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).

3.4 Postmodern Approaches to Clinical Supervision

Postmodern approaches (a.k.a. Social Constructionist or Post-Structural models) to therapy and clinical supervision have been emerging since the 1980s and include narrative therapy models, solution-focused models and feminist-influenced models. The therapeutic models built upon postmodernist ideals began to have a heavy influence on the practice of therapy in general and on family therapy, specifically, in the 1990s, which inevitably changed the practice of clinical supervision for those involved. This was considered to represent a major paradigm shift in the practice of systemic therapies in particular.

The philosophical perspective of postmodernists, in their various disciplines, is that:

“Reality and truth are contextual and exist as creations of the observer...grounded in their social interactions and informed by their verbal behaviour” (Philp, Guy, & Lowe, cited in Bernard & Goodyear, 2009, p. 86).

Thus, there is no objective, observable reality or one truth, but multiple realities and truths based on a wide range of human experience and interpretation, expressed predominantly through language - itself a tool with which we construct our worlds.

Anyone practising narrative, solution-focused, or any other type of therapy underpinned by a postmodern world view, would give a strong emphasis to language and would understand the power implicit in words. Practitioners of these models attempt to understand the client's world as the client understands it and do not assume a shared reality or truth between themselves and others. Since knowledge is not held as absolute, open and reflective questions which maintain a stance of curiosity in relation to the client is a hallmark of the work. These traits would be apparent in clinical supervisors as well as therapists.

Although there are significant differences in the various models of clinical work and supervision which fall under the umbrella of postmodernism, they have some shared qualities which are distinctive to them. Firstly, the role of the clinical supervisor is more consultative than supervisory, with the relationship being valued as a collaboration and dialogue being guided by questions rather than answers. There are some clinical supervisors working from these modalities, in fact, who refer to themselves as consultants and their supervisees as colleagues, no matter the difference in their levels of experience.

This leads to the second distinctive feature of these models, which is that there tends to be a very conscious effort to avoid emphasising hierarchical differences between supervisor and supervisee and in fact, to minimise those differences in status as much as possible. Thirdly, there tends to be a strong focus on the strengths and successes of the supervisee, with a view to building upon those, rather than close analysis of perceived failures or faults.

Special mention should be made here of Johnella Bird, from The Family Therapy Centre in Auckland, New Zealand, who has emphasises the use of relational language and what she calls “prismatic dialogue” in evoking directly the voices of all the participants (including the client) in counselling and supervision. To this end, a thirty to forty minute long prismatic interview (that is, one in which the counsellor is invited to consider aspects of the situation from the position of client) is audio-taped, and the tape taken back to the client for comment and reflection. According to Bird (2006) counsellors:

“...experience a sense of movement as they engage in prismatic dialogue. Invariably this movement produces awareness of new possibilities for therapeutic directions and conversations. I believe one of the principal tasks of super-vision is to liberate the mind in order to foster the counsellor's sense of creativity.”

(p.4)

Points to remember about postmodern models of supervision:

- Focus on subjective experience
- Multiple truths are understood in relation to context
- Strong emphasis on language and its relationship to power (e.g., the dominant discourse)
- Supervisor's role is that of consultant
- Effort to subvert hierarchy, with striving towards equality between supervisee and supervisor
- Focus on the supervisee's strengths
- The client's perspective is included directly where possible

References for this section: Bernard & Goodyear (2009); Bird (2006); The Bouverie Centre (Moloney, Vivekananda & Weir, 2007); Carroll (2007).