

Personal Philosophy of Supervision

A Paper

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By

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Philosophy of Supervision

Systems Thinking and Concepts

My philosophy of supervision and therapeutic approach with clients share much in common. Both approaches have been highly influenced by several theoretical approaches including strategic therapy, MRI brief therapy, rational emotive behavioral therapy (REBT), and the communications approach, and both use a developmental framework to organize assessment and intervention. I actively listen to clients and supervisees in order to understand the presenting problem, the digital and analog content; then, I strive to recognize and understand the ongoing interactional relationship patterns of *how* the content is being communicated (Watzlawick, Beavin, & Jackson, 1967). The pattern and process of communication contains the command-level message, the message about the relationship. By understanding the nature of relationships and identifying irrational thoughts and behaviors that may be present in the client or supervisee, I can highlight ineffective interactional patterns and help model effective patterns. Clients, therapists, and supervisors have a recursive “ongoing mutual influence and shared responsibility” (Becvar & Becvar, 1999, p. 27) as transacting members of the therapeutic process. The most important influence on the effectiveness therapy is the therapeutic relationship. Likewise, the relationship of supervisor and supervisee plays an important role in the purpose of supervision (Roberts, 2000).

Purpose and Goals of Supervision

Supervision seems to have a two-fold purpose: ensuring client welfare and fostering the supervisee’s professional development through an intense, interpersonally-focused, one-to-one, evaluative relationship between supervisor and supervisee (Loganbill, Hardy, & Dellworth, 1982; Mead, 2000). Evaluation plays a key role in supervision, combining a subjective component, the supervisor’s thoughts and insights on the supervisee, with the objective standards outlined in the codes of ethics for counselors and supervisors. Evaluation of both supervisee and supervisor offers a concrete measure of the quality and effectiveness of the supervisory process. I discuss the evaluation component of supervision from the very beginning (Allanach, 2009; Campbell, 2000). Having an expectation of evaluation helps create and maintain a relationship conducive to reaching the goal of supervision.

My goal for supervision is to provide mentoring, teaching, coaching, and administrative leadership to counselors at diverse developmental levels (Morgan & Sprenkle, 2007). As supervisees express thoughts, feelings, and behaviors that seem on the surface to be incongruent with their usual expressions, I view such expressions as an indication the supervisee is transitioning from one developmental stage to the next (Lee & Everett, 2004). The task for me during these transition phases involves patience, nurturing, and support.

Supervisory Roles and Relationships

I strive to create and maintain a favorable context for supervision by promoting open and honest dialogue about the relationship between client, supervisee, and supervisor. In the therapeutic relationship, I model behaviors with the client that I hope will carry over into the client’s other relationships. In isomorphic fashion, I also provide patterns of relating with my supervisees that will travel through to the supervisee-client relationship (Yingling, 2000). Just as with clients, I avoid dual relationships with supervisees as much as possible in order to protect

the supervisee from harm; yet, avoiding any and all dual relationships can be an impossible task (Peterson, 2001). I have to move between being coach, mentor, teacher, and administrator, depending on the content dimensions of supervision (Morgan & Sprenkle, 2007).

As a supervisor, one of the administrative roles I carry out is as a gatekeeper for the profession (Russell et al., 2007). Thus, I am required to monitor supervisees' progress towards professional goals in order to protect them from harming clients or themselves. I explain this role to supervisees at the beginning of the supervisory relationship, along with provisions for remediation in order to help the supervisee meet professional standards of practice.

Context of Supervisor: Personal and Professional Experiences that Affect Supervision

I evaluate the development of supervisees on a personal and professional level, and I take the same care to evaluate my personal and professional development as a supervisor. My personal experiences, positive and negative, in being supervised greatly influence the way I supervise. I am vulnerable to the same parallel processes at work on all participants in therapeutic and supervisory relationships. For example, one of my supervisors required me to bring in videotape of my work with clients that could be reviewed in individual or group supervision. I remember the nervousness, defensiveness, and excitement I experienced as I received feedback from my supervisor and peers. As a result, I believe I am more sensitive to the feelings of my supervisees as they bring videotape in for critique.

I have to maintain constant awareness of the isomorphic processes at work in order to promote those that are effective and derail those that are undesired. My personal and professional developmental level at any given time exerts a profound effect on my ability to be in the moment with my supervisees. Therefore, I am committed to personal and professional development and taking good care of myself as a supervisor (Allanach, 2009). I try to remain aware that the same types of biopsychosocial influences that often constrain clients as they seek growth (Breunlin, 1999) also affect my supervisees and me as a supervisor. In addition, normative isomorphic forces from the MFT profession, such as accreditation standards, codes of ethics, and licensing requirements, affect supervisors, therapists, and clients (Weir, 2009). Consequently, I must be willing to self-assess and change in order to grow personally and professionally.

Theory of Change/Therapy as Integrated into Supervision

In therapy and supervision, change occurs at two levels. The initial goal of therapy and supervision is to promote change within the system, or first order change (Watzlawick, Weakland, & Fisch, 1974), a task that require assisting clients or supervisees in identifying and solving the presented problems. Second-order change occurs when there is a change of the system, a "change of change" (Watzlawick, Weakland, & Fisch, 1974, p.11). The *content* becomes secondary to the *process*, and both must be considered in context in order to provide a *new* system in which a solution to the presenting problem can become a possibility (Becvar & Becvar, 2003, Watzlawick, Weakland, & Fisch, 1974).

In therapy and in supervision, the content of the session calls for interventions that lead to logical resolutions to the presented content (Becvar & Becvar, 2003). It is *how* the content is processed that gives meaning; therefore, real change demands attention of the therapist or supervisor to the context of the relationship interactions (Becvar & Becvar, 2003; Watzlawick, Weakland, & Fisch, 1974). I use a metaphor to describe the process of change that

conceptualizes core beliefs, thoughts, behaviors, and feelings as being four balloons, interconnected by rubber tubes. When one balloon is squeezed, the air is forced out and the other balloons expand. This metaphor highlights the interconnectedness of these characteristics of humans. Core beliefs or world view, thoughts, feelings, and behaviors affect and are affected by one another, often becoming unbalanced. When the system becomes unable to find homeostasis, first order change rebalances the balloons. Once the system is balanced, then second order change can happen by replacing any faulty core beliefs with more effective ones. The process of examining core beliefs or world view uses REBT to highlight irrational emotive behaviors (IRBs), challenge IRBs, and replace them with rational options.

While the process works effectively with supervisees as well as clients, the focus on supervisees is on their world views of clients and the therapeutic relationship. I find it important to consider the developmental stage of the supervisee personally and professionally throughout the supervision process in order to promote growth within each stage and transition to the next on several levels.

Supervision Model

I use a developmental model of supervision (Loganbill, Hardy, & Dellworth, 1982) as a map for the supervision process. The model addresses eight supervisory issues: competence, emotional awareness, autonomy, theoretical identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. I use three stages to describe the developmental level of supervisees for the eight issues: stagnation, confusion, and integration. A supervisee can be in one of these three stages in regards to how they are functioning in each of the eight areas; therefore, I must use assessment and evaluation constantly in order to facilitate the supervisee's growth in each of the eight areas, both within and across the three developmental stages. I can determine the stage by the supervisee's "attitudes and perspectives toward the world, the self, and the supervisor" (Loganbill, Hardy, & Dellworth, 1982p. 17).

The first stage, stagnation, is characterized by unawareness (Loganbill, Hardy, & Dellworth, 1982). New supervisees may be naively unaware of any deficiencies, and more seasoned supervisees may simply be stuck. The supervisee may view the world with dichotomous thinking and have rigid, narrow thought patterns. A low self-concept and strong dependency upon the supervisor may exist, or the supervisees may believe they are "functioning perfectly well" (Loganbill, Hardy, & Dellworth, 1982, p. 18), viewing the supervisor as being unnecessary. In the confusion stage, supervisees are undecided as to whether they are good therapists, are still dependent on the supervisor, but are less prone to either/or thinking. When supervisees reach the integration stage, they have developed new realistic views of their strengths and weaknesses, a sense of direction and future, and a more reasonable view of the supervisor.

Context of Therapist and Therapy

It is important for me to consider the biological, psychological, and sociological influences at work in therapeutic and supervisory relationships. Internal and external factors work in recursive fashion to create the context for relationships. One important factor at work in supervision is the distribution of power in the supervisory relationship. I strive to be aware of how my presence as a member of the majority culture affects my ability to see clients and supervisees clearly, and it affects how clearly they can see me. Race, gender, ethnicity, sexual orientation, spirituality, and a host of other cultural factors affect core beliefs, thinking, behavior,

and feelings within all the transacting members of the supervisory process. I believe in the importance of respecting and hearing all the voices in supervision (Lee & Everett, 2004).

Process of Supervision: Structure, Modalities, Methods, and Interventions

Loganbill, Hardy, and Dellworth (1982) provided four primary functions of supervision: monitoring client welfare, enhancing supervisee growth within developmental stages, promoting supervisee transition from stage to stage, and evaluating the supervisee. These primary functions provide a map in assessing the current developmental stage of the supervisee, choosing the most appropriate modality for supervision, and selecting the proper supervisory interventions. In reality, it is difficult to assess where a supervisee falls on the developmental continuum; however, the model provides a way of organizing my work with supervisees on an ongoing basis.

I use a variety of modalities for supervision including, individual, triadic, and group supervision. I prefer individual and triadic supervision and try to pair supervisees according to developmental levels in order to promote growth between stages (Loganbill, Hardy, & Dellworth, 1982). Within each of these modalities, I have supervisees present cases by self-report, video and audio, and I am planning on beginning live supervision using reflecting teams (Silverthorn, et al., 2009; Yingling, 2000). Although I have used self-report case presentation most frequently, I prefer video or live supervision because supervisees are not usually aware of their blindspots and tend to report the favorable aspects of cases (Bernard & Goodyear, 2004).

Without seeing the supervisee in action via video, audio, or live supervision, I am susceptible to stagnation (Bernard & Goodyear, 2004), becoming ineffective in helping the supervisee become aware of strengths, difficulties, and growth opportunities. Therefore, I require all supervisees to provide video or audio recordings of their work with clients for use in group and individual supervision on an ongoing basis. The supervisee writes up a case conceptualization using a standardized form (Gehart, 2010, p. 42-46) and presents the case. I provide supervisees with feedback on their case conceptualizations using a rubric (Gehart, 2010, p.47-52). I always want to see or hear the beginning and ending of the session, but ask the supervisee to provide another segment 10 to 15 minutes in length.

In group supervision, I begin by asking the supervisees what strengths they see in the case presentation. I have them provide evidence from the case that supports their feedback. Using common factors found in group therapy (Yalom & Leszcz, 2005), I encourage professional peer relationships among supervisees and encourage the formation of a “supervision family” relationship. Using many of the same interventions in supervision as in therapy, though with different outcomes expected, encourages patterns of interaction within the supervision group to be transmitted isomorphically into therapist/client relationships and on to clients’ other relationships. For example, I use circular questioning to get clients and supervisees to articulate the meaning they bring to the situation. Some interventions must be different due to the relationship. For example, I teach supervisees the three-stage developmental supervision model I use and often have them self-assess for each of the eight core supervisory issues. Discussion often moves from the *content* to the *process*, and I have supervisees consider how they are thinking, feeling, and behaving in the moment. I then have them look for similarities in the current interactional pattern with how they are interacting with the client. As supervisees consult their personal genograms, they are often able to identify how their own family-of-origin experiences are playing out isomorphically in the supervisory process and in the therapy office. I

strive to adhere to ethical guidelines for supervisors and not cross the boundary from supervision to therapy with my supervisees, a process sometimes difficult to navigate without guidance.

Ethical and Legal Issues in Supervision

In carrying out the functions of supervision, “ethical decision making is often more complex than clinical ethical decision making” (Storm et al., 2001, p.231) due to the supervisor’s responsibility to clients, supervisees, the profession, and the community as outlined in the American Association for Marriage and Family Therapy’s Code of Ethics (AAMFT, 2001). Such codes provide guidelines on ethical matters, but supervisors should adopt and practice an ethical decision making model in order to meet the spirit of the ethical guidelines (Zygmond & Boorhem, 1989). I use Kitchener’s model as described by Zygmond and Boorhem (1989). I am also finding it helpful to incorporate best practices offered in peer-reviewed research articles to address issues such as the difference between therapy and supervision (Storm et al., 2001) and when multiple relationships may actually be beneficial for supervisees (Storm et al., 2001). Part of my decision making process involves consulting supervision for myself when faced with difficult ethical issues. The same is true for legal issues that may arise out of my responsibility for my supervisees and their interactions with clients.

The best cure is often prevention, and I take full advantage of supervision and legal resources as needed. By setting up the supervisory relationship with a signed written disclosure agreement at the beginning of supervision, a document containing the nature of the supervisory relationship with expectations and remedies for supervisor and supervisees, many legal and ethical dilemmas can be avoided. Confidentiality, dual relationships, and standards of due care guide both therapy and supervision; however, navigating these and other ethical responsibilities takes an extra measure of preparation and follow up for supervisors.

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