A Transtheoretical Model of Clinical Supervision

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The purpose of this article is to introduce a transtheoretical model of clinical supervision for professional psychology. The various stages and processes of change inherent in the transtheoretical psychotherapy model (Prochaska & DiClemente, 1982, 1984, 1986; Prochaska & Norcross, 2007) are assessed and applied to clinical supervision. Specifically, relevant literature is examined; supervisee stages of change (SSC) and supervisor processes of change (SPC) are introduced and discussed; and existent models of supervision are contextually compared to the proposed transtheoretical model. Strategies and recommendations for implementing and researching a transtheoretical approach to clinical supervision are also provided.

Keywords: clinical supervision, transtheoretical model, professional psychology education, professional psychology training

Prochaska and DiClemente (1982, 1984, 1986) examined the most popular systems of psychotherapy and found that several commonalities existed among them. However, they were not able to find one system of therapy that provided sufficient answers to all of the challenges therapists regularly encounter. Prochaska and Norcross (2007) stated, "Depending on one's theoretical orientation, psychotherapy can be conceptualized as interpersonal persuasion, health care, psychosocial education, professionally coached self-change, behavioral technology, a form of reparenting, the purchase of friendship, a contemporary variant of shamanism, and many others" (pp. 3). In response to the lack of a comprehensive psychotherapy theory, the transtheoretical psychotherapy model

was developed (Prochaska & DiClemente, 1982, 1984, 1986; Prochaska & Norcross, 2007). The result was an empirically supported (e.g., Bowles, 2006; Park et al., 2003) approach to psychotherapy that has widespread appeal to clinicians.

Having been modified only slightly over the past 25 years, the transtheoretical model has proven to be an effective tool for understanding the dynamics of change (Levesque, Gelles, & Velicer, 2000). Using this model, researchers interested in human growth and development have maintained that rather than a static occurrence, change is an ongoing process. According to Brogan, Prochaska, and Prochaska (1999), this type of change is both temporal and dynamic, meaning people are able to move boundlessly from stage to stage and often do so in a cyclical manner. Consequently, clients move through a series of stages on their way to achieving goals that facilitate growth and development (Levesque, Cummins, Prochaska, & Prochaska, 2006).

While the transtheoretical model of psychotherapy has not resolved all conceptual issues and conflicts that exist among the various theories from which it draws (DiClemente, 2007), research does suggest that the processes and stages associated with this model are far-reaching in terms of their applicability and utility. Though not an exhaustive list, the transtheoretical model has been found to be effective in aiding in the treatment of substance abuse (Velasquez, von Sternberg, Dodrill, Kan, & Parsons, 2005), pathological gambling (Petry, 2005), nicotine addiction (Prochaska, DiClemente, Velicer, & Rossi, 1993), and obesity (Logue et al., 2005). Additionally, the significance of this model is evidenced by contributions from researchers seeking to better understand and address issues such as domestic/intimate partner violence (Eckhardt, Babcock, & Homack, 2004; Shurman & Rodriquez, 2006), safe-sex practices (Redding & Rossi, 1999), and stuttering (Floyd, Zebrowski, & Flamme, 2007). Finally, the tenets associated with the transtheoretical model have proven to be valuable in terms of

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assessing and facilitating change at agency and organizational levels (Levesque et al., 2001; Prochaska, 2000).

Given the transtheoretical model's broad utility and empirical support, it is the authors' contention that this model can be successfully applied to the process of clinical supervision. Heretofore, neither the relationship between the stages of change or the processes of change has been empirically investigated at the supervisory level. Thus, the purpose of this article is to introduce a transtheoretical model of clinical supervision (TMCS). The stages and processes of change explicated by Prochaska and DiClemente (1982, 1984, 1986), and Prochaska and Norcross (2007), for use in psychotherapy, are discussed and modified to facilitate a comprehensive understanding of, and novel approach to, the application of clinical supervision.

Clinical Supervision and the Transtheoretical Model

Assumptions

Nine principle assumptions provide the bedrock for the TMCS. First, no one supervision model can account for or capture the complexities of the supervisory process (Gilbert & Evans, 2001). Therefore, a clinical supervision model of this nature may provide a template for supervisors that informs their understanding of the needs of their supervisees and aids in the selection and integration of supervision modalities to help meet those needs. Second, supervisors should expect supervisees to enter into and move through clinical supervision with varying degrees of apprehension and motivation and fears of performing incompetently. Third, the TMCS can be used to facilitate supervisees' holistic professional growth and development or be used to target and address deficient or problematic behaviors. Fourth, supervisees' openness and ability to grow and change will vary across skill sets and behaviors. It is possible for supervisees to be operating at more than one stage of change simultaneously. Fifth, supervisors will be the most efficacious when they are able to accurately assess supervisees' needs across the stages of change and then aptly employ corresponding processes of change. Sixth, using the TMCS, supervisors and supervisees will operate with increasing intricacy as each gains experience in their respective roles and the supervisory alliance is strengthened. Seventh, the TMCS differs from other psychotherapy-based models of supervision because it promotes the inclusion of other supervision constructs, modalities, and interventions. Eighth, supervisors using the TMCS may be uniquely suited to address diversity issues because they have the tools to assess the need for and the flexibility to integrate multicultural (Constantine, 2001; Falender & Shafranske, 2004), feminist (Prouty, 2001), gay and lesbian affirmative (Halpert & Pfaller, 2001), and religious and spiritual (Aten & Hernandez, 2004) approaches to supervision. Finally, the utility of this model may be limited by supervisors' level of experience and abilities. More experienced supervisors will likely be able to develop more complex, integrative, and personalized approaches to supervision, whereas novice supervisors may struggle to successfully use the model offered as a means of conceptualizing clinical supervision.

Supervisee Stages of Change

The TMCS consists of six supervisee stages of change (SSC), which are used to conceptualize supervisees' general developmen-

tal status and acquisition of specific skill sets. The SSC provide supervisors with a means for understanding how supervisees move or develop through the supervisory process on both macro- (i.e., overall professional growth and development) and microlevels (i.e., ability to apply specific skills and interventions). While some supervisees' development will be linear, for most, growth and evolution will occur in nonlinear formations. Prochaska, Norcross, and DiClemente (1994) suggested that clients typically go through what they referred to as a "spiral model of change" (p. 47). Therefore, supervisors might similarly expect supervisees to cycle in and out of the stages several times before realizing stable change. Following is an overview of the six SSC.[1]

Precontemplation Stage

In the precontemplation stage, supervisees are either largely unaware of the possibilities for change, not focused on change, believe change is not possible, or resistant to the very idea of change. Still, though supervisees may be unaware of their need for change, others in the supervisees' environment (e.g., supervisors, instructors) may be cognizant of potential growth areas. Stoltenberg, McNeil, and Delworth (1998) reported that resistance among supervisees varies according to level of development functioning, with neophyte supervisees being less aware of how to change and more resistant to the prospect of change. Like precontemplative clients, precontemplative supervisees who are not ready to change might react defensively when the possibility or need for change is addressed in supervision (Prochaska & DiClemente, 1984). Conversely, supervisees may readily accept suggestions for change once supervisors establish rapport and present realistic alternatives or options for growth.

Contemplation Stage

Based on his work with problem drinkers, Baldwin (1991) concluded that when operating in the contemplation stage, clients are typically "thinking but not doing" (p. 39). The same may pertain to supervisees, who, while in this stage, have a sense that change is needed, but are not sure how to change or are not committed to changing. Common among supervisees at this stage is deliberation and stagnation resulting from increased awareness about what it means to function in a professional role or perform as a competent clinician. Consistent with clients in the contemplation stage, for supervisees, the prospects of change can evoke ambivalence, apprehension, distress, and anxiety (Turnbull, 2000). Important to note is that contemplative supervisees may remain in this stage for a prolonged period of time. While it is common for supervisees to fear this type of dialectic, supervisors should be aware of, and prepared to address acute anxiety, which has been found to impede supervisees' growth and developmental functioning during this stage (Friedlander, Keller, Peca-Baher, & Olk, 1986). Supervisors need to recognize that supervisees in this stage are in the midst of serious deliberation regarding what it will mean to change, the pros and cons associated with change, and the effort and energy that change will require (Prochaska, DiClemente, & Norcross, 1992).

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[1] Contact the principle author for clinical vignettes of the supervisee stages of change.

Preparation Stage

Unlike supervisees in the previous two stages, those in the preparation stage are aware of areas in need of growth and intend to change. Supervisees' resolve may be evidenced in small behavioral changes that antecede more pronounced action. Similar to clients in psychotherapy, this stage for supervisees will likely be short lived (Turnbull, 2000), and forward movement to the action stage, or regression to the contemplative stage, will likely occur in a relatively short period. Supervisees having successfully negotiated the ambivalence, apprehension, distress, and anxiety typically associated with the contemplative stage, might feel compelled to rush into action. Although eagerness to achieve growth may engender positive feelings in supervisees and their supervisors, Kern (2005) asserted that people too often move from contemplation to action only to "fall flat on their faces" (Stage Three: Preparation/ Determination, para. 3) because they have not established the necessary clinical foundation. Consequently, collaborative goal setting between the supervisors and supervisees, which results in small behavioral changes, improves the likelihood that supervisees' will advance to the action stage and ultimately achieve their goals (Lehrman-Waterman & Ladany, 2001).

Action Stage

Supervisees in the action stage encounter struggles and distress similar to those experienced by supervisees in the contemplation stage (e.g., anxiety resulting from an incongruence between supervisees' increased awareness and their readiness to change). The difference, however, is that the anxiety experienced by supervisees in the action stage results from the application and implementation of new knowledge, skills, and treatment interventions. Supervisors can expect supervisees to begin making commitments to professional development, and executing concerted behavioral strategies to affect client growth. Vespia, Heckman-Stone, and Delworth (2002) reported that supervisees' desire for growth and willingness to assume greater responsibility (e.g., increasing one's independence and autonomy) signified increased professional competency. Although supervisees have not reached their desired level of change at this stage, a greater commitment to change is present, which, if fostered by supervisors, can promote further growth. While seemingly obvious, it is not uncommon for supervisors to overestimate supervisees' level of competence, and withdraw at the first signs of growth and integration. To avoid these types of pitfalls Pearson (2004) urged supervisors' to maintain accessibility to supervisees' at all developmental stages, in spite of perceived growth.

Maintenance Stage

Supervisees in the maintenance stage purposefully strive for and make a conscious effort to sustain achieved areas of change. Along with being capable of supporting their own personal growth, supervisees in this stage will likely experience less developmental setbacks. However, supervisors should know that continued success requires long-term adjustment to the acute changes made in previous stages (Perz, DiClemente, & Carbonari, 1996). Supervisors' primary goal during the maintenance stage is to help supervisees maintain positive momentum, unite developmental changes, and promote continued growth. Prochaska et al. (1994) pointed out that if consolidation does not occur, the risk of regressing and returning to a precontemplative or contemplative state is increased. Thus, supervisors should not interpret maintenance to mean that supervisees seek only to preserve growth in a particular area; rather, the goal is to build off of positive changes that have been made in order to prevent regression.

Termination Stage

During the termination stage, supervisees have achieved increased competency in a particular area, obtained a new skill set, corrected problematic behavior, or progressed to a new developmental stage. According to Guillot, Kilpatrick, Herbert, and Hollander (2004), termination is reached when a particular area of change has become automatic and, therefore, does not require ongoing conscious attention. This stage provides supervisors and supervisees with an opportunity to assess the gains made in supervision, identify areas still in need of growth, and discuss the supervisory relationship. Nevertheless, there are always areas of professional development that require attention. Termination, as it applies to the TMCS, is not meant to imply that supervision is over or no longer necessary. Rather than ending the relationship in a classical sense, termination in this model denotes a transition during which supervisors and supervisees assess supervision goals and refocus on more pressing or advanced areas of professional development. To help supervisors accurately identify supervisees' in the termination stage, the following adaptation of Turnbull's (2000) psychotherapy criteria are offered. One, supervisees assume a more solidified professional identity. Two, supervisees' implement skills in question more naturally and appropriately. Three, supervisees grow more confident in their ability to utilize skills. Last, supervisees' utilization of skills produces more therapeutic benefits. Once satisfactory change or growth is achieved supervisors will likely need to modify or shift their respective roles (e.g., educational, supportive, collaborative). All the same, they should remember that supervisees still require regular support and encouragement to maintain and build upon their achieved growth (Nelson & Friedlander, 2001; Pearson, 2004).

Supervisor Processes of Change

The 10 supervisor processes of change (SPC) described in this section consist of a series of interventions that can be used to facilitate supervisees' movement from one SSC to the next. As with the transtheoretical psychotherapy model, the SPC have been categorized as either experiential or behavioral. Freyer et al. (2006) reported that the experiential processes are most effective at the start of treatment, while the behavioral processes are best used as therapy advances. The five experiential processes are (a) consciousness raising, (b) dramatic relief, (c) self-reevaluation, (d) environmental reevaluation, and (e) self-liberation. The five behavioral processes are: (a) stimulus control, (b) counterconditioning, (c) contingency management, (d) social liberation, and (e) helping relationships.

Experiential Processes

Consciousness raising. The focus of consciousness raising is on helping supervisees gain awareness of the intricate dynamics

associated with psychotherapy and clinical practice. Supervisors seek to raise supervisees' level of consciousness in effort to increase familiarity and knowledge. Socratic questioning, a method by which supervisors ask deliberate questions to help supervisees clarify meaning or identify alternative actions (Overholser, 1991), can help them conceptualize and interact with their clients in a more intentional and skilled manner. In addition to instilling new information, Holloway (1995) suggested that in order to maximize awareness supervisors should consider supervisees' cognitive styles, and ". . . negotiate a personal way of using a structure of power and involvement that accommodates the trainee's progression of learning" (p. 42). Likewise, Rigazio-DiGilio, Daniels, and Ivey (1997) wrote that the ways in which supervisors present information is often just as important as the way it was provided.

Dramatic relief. Sometimes referred to as catharsis, dramatic relief is a process whereby observing emotional scenes in the clinical environment evokes emotions for supervisees. Prochaska and DiClemente (1992) reported, "Dramatic relief provides clients with helpful affective experiences, which can raise emotions related to problem behaviors" (p. 150). Dramatic relief processes allow supervisors to create experiences for their supervisees that recapitulate supervisee-client interactions within the context of the supervisory relationship. As a result of having to attend to existent parallel processes with one's supervisor, supervisees learn how to initiate and more intimately engage in the therapeutic process (Mothersole, 1999).

Self-reevaluation. Self-reevaluation pertains to an affective and cognitive assessment of supervisees' self-image, which occur with or without the presence of maladaptive or disruptive behaviors. Not surprisingly, self-evaluations become more accurate as supervisees gain experience (McNeill, Stoltenberg, & Romans, 1992). Consequently, supervisors should help supervisees consider how both the short- and long-term affects change may have on themselves, their clients, and the supervisory relationship. Related to this is that supervisees' self-efficacy is linked to their ability to develop accurate self-evaluations, with higher levels of self-efficacy associated with more accurate perceptions (Daniels & Larson, 2001). Though Steward, Breland, and Neil (2001) asserted that supervisees' self-evaluations are enhanced by positive encouragement, they also cautioned that novice supervisees with overly supportive supervisors developed less accurate self-evaluations because they are not sufficiently challenged or motivated to mature.

Environmental reevaluation. When environmental events occur that prompt supervisees to consider some form of self-change, environmental reevaluation is enacted. In a therapeutic context, clients reevaluate the effects of their behavior on their environment. In a supervisory context, supervisors help supervisees reevaluate how their behaviors (positive or problematic) have affected or are affecting their clients, themselves, and their supervisor. Having supervisees evaluate their own actions or performance, using client satisfaction surveys, perspective shifting, and giving constructive feedback are ways supervisors can use environmental reevaluation.

Self-liberation. Similar to consciousness raising, self-liberation involves supervisees attaining greater self-awareness. This process, however, stipulates that supervisees increase the degree to which they assume responsibility for their choices and actions. To promote such growth, supervisors can encourage supervisees to engage in self-awareness activities (e.g., completing a genogram or therapist self-care inventory), provide precise and direct feedback (e.g., discussing one's strengths and limitations), or help critically evaluate existent options (e.g., Socratic questioning; Goodyear & Nelson, 1997; Neufeldt, Karno, & Nelson, 1996).

Behavioral Processes

Stimulus control. The process of stimulus control involves avoiding or mitigating stimuli believed to impede growth or elicit problem behaviors resulting from supervisees' ongoing adaptation to supervision and the supervisory relationship. Shame, for example, is a stimulus that supervisees are susceptible to, and one that often evokes feelings of incompetence or failure. Consequently, supervisors need to continuously monitor for shame, because, according to Yourman (2003), in an effort to avoid feeling embarrassed or incompetent supervisees may withhold important information. As with shame or other stimuli that may hinder supervisees' development, supervisors should be aware that ongoing amendments to the supervisory environment are likely necessary to meet the ever-changing needs of their supervisees (Chagon & Russell, 1995; Stoltenberg et al., 1998).

Counterconditioning. The process of counterconditioning helps supervisees consider and develop alternative ways of behaving, thinking, feeling, and interacting with their clients. Counterconditioning interventions, such as watching videotaped sessions, provide supervisees with opportunities to witness and receive feedback about how they are interacting with clients, solicit feedback, and discuss the contents of their sessions. Furthermore, supervisors are able to point out or model alternative supervisee actions, challenge supervisees, and help supervisees' process their experiences with psychotherapy or supervision (Kagan & Kagan, 1997).

Contingency management. This process is based on the principles of reinforcement, with supervisees learning to reward themselves and how to be rewarded by others for making positive changes. For supervisees, positive reinforcements may increase the likelihood of continued growth and development. Barrett and Barber (2005) asserted that because supervisees, especially neophytes, begin to lose motivation and confidence if they are not given adequate guidance, structure, and praise, supervisors should provide ongoing positive support while simultaneously attending to clinical and professional growth. Building on the work of French and Raven (1959), Holloway (1995) proposed that supervisees attribute various forms of power to supervisors. According to Evans (1998), if supervisors use their power appropriately, supervisees will be more inclined to internalize and integrate feedback. Conversely, supervisees who only receive negative feedback will likely lack self-efficacy and be less receptive to the change process.

Social liberation. The process of social liberation occurs when social opportunities or alternatives become more readily available and accessible to supervisees. Social liberation largely pertains to supervisees' socialization as professionals. Expanding the frame of supervision to include opportunities for discussion about professional development (e.g., the role of clinicians in various work environments, client billing, insurance, licensure) and experiences that occur outside of supervision (e.g., case conferences, peer supervision, professional seminars) can be used to demonstrate that supervisors are vested in supervisees overall growth. Social liberation interventions can extend directly from the supervisor-supervisee relationship. In

fact, Greig (1998) found that supervisees reported that supervision mentoring relationships had more influence on their professional development than academic preparation.

Helping relationships. Finally, change can be fostered through the establishment of positive supervisor-supervisee relationships. That is, bonds based on trust, acceptance, openness, and compassion need to be formed. Similar to clients in psychotherapy, supervisees benefit from supervisory relationships that provide containment: "holding-environments" (Winnicott, 1960, p. 47) can make supervisees feel secure and empowered to work toward growth-oriented goals or positive behavioral modifications. Related to this is that supervisors should be purposeful in communicating their expectations, evaluative criteria, roles, boundaries, and duties with supervisees (Pearson, 2004). Factors such as these are to be considered when attempting to build relationships with supervisees, because, as Vespia et al. (2002) noted, "Such preparation could assist in the identification and negotiation of power differences and in the exploration of world views and expectations about supervisory processes and relationships" (p. 57).

A Contextual Comparison

According to Bernard and Goodyear (2004), most models of clinical supervision can be organized into four primary categories: (a) developmental models, (b) social roles models, (c) psychotherapy-based models, and (d) integrative models. Though comparisons in this section occur categorically, specific models will be identified to highlight similarities and differences.

Developmental Models

Developmental models (e.g., Loganbill, Hardy, & Delworth, 1982; Ronnestad & Skovholt, 2003; Stoltenberg et al., 1998) are used to conceptualize supervision as a continual process rather than as a means to an end. Developmental models typically posit that supervisees' progress through a series of stages toward greater professional proficiency. For instance, in reference to the Integrated Developmental Model (IDM), Stoltenberg et al., 1998, suggested that supervisees develop across four stages: level 1 (inexperienced supervisee), level 2 (seeks greater autonomy but motivation fluctuates), level 3 (motivation and skills become more solidified), and level 3i (mastery of numerous therapeutic skills through a personal approach to therapy). Similar to developmental models, the TMCS's SSC may provide supervisees with developmental steps to move through on their way to actualizing desired behaviors (Prochaska et al., 1992).

Most developmental models define change in broad conceptual terms. The TMCS, however, is unique in that it would appear to allow for change to be conceptualized at both broad macrolevels (e.g., reduce panic attacks) and microlevels of change (e.g., learn to identify panic attack triggers). Additionally, several developmental models (Watkins, 1993) outline various guidelines for creating supervisory environments that promote supervisee growth (e.g., creating a safe structured environment for a novice supervisee). Here too, interventions are typically conceptualized at a broad macrolevel perspective. The TMCS is novel in that it could offer interventions through the processes of change that can attend to both macro- and microlevel issues. Likewise, in comparison to developmental models, the TMCS seems to give more detailed attention

to recognizing peoples' openness to changing specific thoughts, feelings, and actions. The TMCS, when compared to developmental models, may also be uniquely suited for addressing maladaptive behaviors and impairment (e.g., Carey, Purnine, & Maisto, 2001).

Social Roles Models

Considering the change process, the TMCS would appear to also overlap with a number of social roles models (Bernard, 1979, 1997; Carroll, 1996; Holloway, 1995, 1997; Williams, 1995), most of which afford supervisors the flexibility needed to match interventions with specific supervisees' contextual needs. For example, in the Discrimination Model, Bernard outlined three focus areas of supervision (i.e., intervention, conceptualization, personalization) and three supervisor roles (i.e., teacher, counselor, and consultant). Social roles models instruct supervisors to first identify supervisees' particular needs and then select a role to operate from that will attend to those needs: such approaches typically allow supervisors to move between focus areas or roles as needed. Though behavioral change is central to both the TMCS and social roles models, the TMCS recognizes the potential influence that emotions, environmental factors, and cognitions have on actions (Norcross & Prochaska, 1986; Prochaska, Velicer, DiClemente, & Fava, 1988). To effectively respond to the potential influences these factors have on supervisees' and help them progress toward desired goals, supervisors using the TMCS are encouraged to integrate unique interventions derived from the SPC (e.g., consciousness raising). On the whole, the TMCS is more technique oriented than social roles models, which have historically been more focused on evoking change and growth via the supervisor-supervisee relationship.

Similar to the application of social roles models, the SPC may allow interventions to be matched with the "here and now" needs of supervisees. Another commonality is that they increase training and supervisory options for supervisors. Nevertheless, the ways in which these interventions are delivered differ. The direct and explicit nature of social roles models aid supervisors in narrowing the supervisory process to the fewest possible scenarios needed for delivering effective interventions. Arguably, the TMCS provides more targeted interventions because of the greater specificity offered by the SPC, which are more comprehensive than most used in social roles models. For instance, the Discrimination Model (Bernard, 1979) focuses primarily on training interventions, Holloway's Systems Approach (Holloway, 1995, 1997) focuses primarily on monitoring interventions, and the Hawkins and Shohet Model (Hawkins & Shohet, 2006) focuses primarily on process and content interventions. The TMCS on the other hand, offers interventions drawn from the SPC for each of these foci.

Psychotherapy-Based Models

Researchers have suggested that most supervisors report utilizing a psychotherapy-based approach to clinical supervision (Bernard & Goodyear, 2004). This may not be surprising, considering the practice of clinical supervision grew out of the psychoanalytic movement, which placed great emphasis on helping counselors-in-training gain insight and increased self-awareness (Frawley-O'Dea & Sarnat, 2001). Without question, psychotherapy-based supervision models provide supervisors with a sense of familiarity, as it allows them to extend their primary theoretical orientation to

the supervisory process. Nevertheless, these models have received criticism for painting a narrow picture of the complexities and phenomenon of supervision.

Comparatively, a shared strength of psychotherapy-based supervision models and the TMCS is that they often have a theoretical base that is more evolved than other supervision models. For example, most psychotherapy-based models attend to topics like human nature, worldviews, client symptomology, and the etiology of psychosocial problems. While beneficial, this also means that interpretations of the supervisory experience are typically limited to one particular approach or perspective, such as psychodynamic or cognitive–behavioral. Unlike most psychotherapy-based approaches, the TMCS encourages a wide range of interpretations through the integration of diverse theoretical perspectives. An additional strength of both psychotherapy-based models and the TMCS is that they offer greater insight into the therapeutic process; a potential downfall, however, is that supervisors who use these approaches may be inclined to view supervisees from a clinical or treatment perspective rather than a training perspective.

Integrative Models

Gilbert and Evans (2001) noted that ". . . many supervisors will either be supervising psychotherapists who regard themselves as integrative (i.e., eclectic), or will be called on to supervise across theoretical orientations . . ." (p. 85). Similarly, Bernard and Goodyear (2004) wrote, "Most supervisors eventually develop their own unique integrationist perspectives . . . In short, we believe that to develop an integrationist perspective probably is inevitable" (p. 100). Integrative models of supervision allow supervisors to draw from a wide range of techniques and applications. These integrative models also facilitate the use of diverse supervision concepts and strategies. For example, Norcross and Halgin (1997) presented a series of principles that promote a combination of techniques that allow supervisors to respond to supervisee and client needs.

Though technically a psychotherapy-based model, the TMCS most closely resembles integrative approaches to supervision because of its emphasis on incorporating multiple interventions and approaches (i.e., the TMCS allows for the development of individualized and tailored practices) and its pragmatic approach to intervening. Further, like integrative approaches, the TMCS extends beyond its roots in psychotherapy and provides a seemingly natural relationship with other supervision models and interventions. Whereas most integrative models are driven largely by principle (e.g., supervisee overall development), the TMCS appears to have stronger theoretical scaffoldings and consequently may provide a more sound theoretical foundation for bridging multiple systems of intervention.

Implications

Overall, we believe a TMCS will contribute to the supervision literature and supervision practice in a number of ways. The TMCS could provide clinical supervisors with a dynamic and integrated way of conceptualizing and intervening in supervision. Specifically, the TMCS is different from other supervision models in that it provides supervisors with a theoretical lens for viewing supervisee growth and change from multiple perspectives. Supervisors who use the TMCS may then be equally equipped to address

the broad developmental needs and specific "here-and-now" skill needs of supervisees by simultaneously utilizing the SSC and SPC. The SSC also offer insight into understanding supervisees' openness to change along with targeted stage-matched interventions via the SPC. Similarly, the TMCS might allow supervisors and supervisees to develop both macro- and microlevel goals. For example, a macrogoal for supervision may be to help a supervisee become competent at administering cognitive assessments. Before this goal can be reached, however, the supervisor needs to ensure that other microcompetencies (e.g., rapport building skills, effective interviewing skills) are in place that will position the supervisee to accomplish this new task. In contrast to most supervision models, a TMCS might be uniquely suited to address maladaptive behaviors and impairment. The diverse SPC offered to supervisors may present an increased selection of techniques and interventions for attending to supervisees' needs and behaviors. Additionally, the TMCS appears to lend yet another pathway to integrative supervision. Though the model proposed is derived from a well-known approach to psychotherapy (Prochaska & DiClemente, 1982, 1984, 1986; Prochaska & Norcross, 2007), we assert that the TMCS is best categorized as integrative because it may give supervisors the opportunity to draw from and utilize multiple supervision models for intervening while also applying insights from the vast body of research on the transtheoretical model.

As noted above, a unique feature of this model is that it provides supervisors with a conceptual framework for understanding how supervisees grow and develop as clinicians. While some supervisees will advance across the SSC in linear order, for most, change will likely occur in a cyclical and fluid manner. Likewise, it may take supervisees numerous attempts to change existing behaviors or integrate a new skill or set of skills. Readers should gain the sagacity that supervisees are to be conceptualized at multiple SSC simultaneously, as their level of openness to change may vary across behaviors; a supervisee may demonstrate excellent assessment abilities and be in need of increased awareness to diversity issues. It should also be noted that environmental and circumstantial situations may cause supervisees to regress to less effective behaviors or slow their developmental or professional growth. For example, one of the authors was supervising students in Southern Mississippi when Hurricane Katrina struck the Gulf Coast. Undoubtedly, this had a drastic effect on his supervisees, a few of whom reported feeling as if they had to "relearn" skills and behaviors (e.g., self-care, basic attending behaviors) they previously believed they had mastered.

The TMCS might also provide supervisors with stage-matched processes of change that can be used to identify supervisees' readiness, and ability to change. That is, the SSC provide supervisors with a conceptual framework for recognizing how open supervisees are to changing a particular belief or behavior. To facilitate the desired growth and maturation of supervisees, various SPC, in tandem with the SSC, offer purposeful ways to intervene in the supervisory process Together, the SSC and SPC may provide supervisors with the flexibility needed to target specific supervisee behaviors at both macro- and microlevels. Therefore, supervisors can focus on specific supervisee behaviors that they believe facilitate supervisees' change or growth. For example, after identifying the appropriate SSC for a supervisee who is resistant to video taping their counseling sessions, their supervisors

would select and administer the SPC (e.g., consciousness raising) believed to best modify this type of maladaptive behavior.

Supervisors who use the TMCS should be cognizant of making informed stage-process decisions. For example, Prochaska and Norcross (2001) asserted that client stages of change provide proscriptive as well as prescriptive information that can guide clinicians' approach to interventions. For this reason, supervisors are cautioned to avoid stage-process mismatches. Prochaska and Norcross cite two potential mismatches: one, implementing change processes most appropriate for individuals in the contemplation stage—consciousness raising and self-reevaluation—during the actions stage; and two, relying on change processes most appropriate for the action stage—reinforcement management, stimulus control, and counterconditioning—while an individual is attempting to negotiate the stage of precontemplation or contemplation. With regard to the latter mismatch, it would be considered premature to implement action-oriented processes if supervisees are not aware that change is needed, or supervisees are aware but not committed to taking action. Such supervisees would most likely first benefit from processes that facilitate awareness (i.e., consciousness raising, dramatic relief, environmental reevaluation). Thus, it is important for supervisors to appropriately assess the SSC before selecting an SPC.

Conclusion

The transtheoretical model's (Prochaska & DiClemente, 1982, 1984, 1986; Prochaska & Norcross, 2007) well-researched stages and process of change for psychotherapy are extrapolated to clinical supervision throughout this paper. Although the TMCS provides a seemingly natural and practical approach to supervision, readers need to be apprised of potential limitations and recommendations for future research. As previously noted, little has been written about the transtheoretical model's applicability to clinical supervision. The content and major claims herein are largely based on research supporting the psychotherapy model, and the authors' anecdotal supervisory experiences. Thus, a major limitation of the proposed TMCS is the lack of empirical evidence to substantiate its application at the supervisory level. Being that this is a budding model of supervision, of major benefit would be research to clarify whether or not existent research on the transtheoretical model of psychotherapy is applicable to the TMCS.

Another limitation of this model is that instruments designed to assess supervisees' SSC have yet to be developed. Measures and evaluative tools are needed to assess supervisees' behavior and motivation in order to provide a more empirical and standardized method of categorizing supervisees across the SSC. Related to this is that empirical research is needed for researchers to identify which SPC are most useful for moving supervisees from a specific SSC to another. Further investigation that includes the development of measures and assessment instruments would help supervisors select and match SPC with appropriate interventions. The information gained from instruments that evaluate the stages in which supervisees are operating for each skill could help supervisors apply techniques and interventions with greater exactitude. The authors offer these recommendations in anticipation that they will ultimately lead other researchers to pursue a more refined and sophisticated TMCS.

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