A Client-Centered Approach to Supervision

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I welcome this opportunity to update and elaborate upon my earlier statement on supervision (Patterson, 1964). Although that article is still occasionally referred to, it apparently is seldom read by those who make reference to it. At some point, the erroneous statement that my position was that of supervision as therapy entered the literature. The most recent example is in the article by Bernier (1980). Bernier appears to have derived his classification from Brammer and Wassmer (1977). Reference to this source, however, reveals confusion in their attempt to classify the supervision literature in discrete categories. While classifying my approach under the personal-emotional orientation (along with Rogers, Arbuckle, and Altucher), which involves the "supervisor as counselor," they also recognize my concern with the personal skills orientation, along with Ivey, Carkhuff, Truax, and Berenson. One can only conclude after reading Brammer and Wassmer that it is impossible to fit the actual approaches to supervision into any system of nonoverlapping categories. To attempt to do so results in an exercise of confusion and futility.

In this paper I do not pretend to present a model of supervision. Models are essentially hypothetical statements. Here I shall present an actual approach developed and practiced over a period of more than 20 years of supervising practicum students. I do not claim that it represents the client-centered approach, but a client-centered approach. It is, however, quite consistent with Rice's (1980) statement of a client-centered approach, developed entirely independently. It differs from Rice in that it focuses more on the conduct of the process of supervision, while she deals more with the attitudes of the supervisee and the relationship with the client than with the actual supervisory process.

The Context of Supervision

The General Context

Client-centered supervision takes place in the context of a program in which the supervisee is learning to become a client-centered counselor or therapist. The supervisee is thus expected to be thoroughly familiar with the philosophy, theory, and principles of client-centered therapy, and to be committed to becoming a client-centered therapist. This requirement can raise problems in a counselor education program where not all students may be able to make such a commitment. Problems can be resolved, however, in various ways.

First, the program can be identified to prospective students as client-centered in its orientation. A student who desires to become a rational-emotive therapist would not be encouraged to apply for admission. Secondly, a program may provide for more than one approach to counseling or psychotherapy so that the student is not limited to one. No program, however, can include more than a few approaches, so that the student is limited in his or her choices. The student who is not prepared to make a tentative choice prior to entering a program faces an additional problem, perhaps requiring a transfer to another school. Some programs and instructors do appear to offer a so-called eclectic approach, and even offer to allow the student in a practicum or internship to develop his or her own approach. There are a number of reasons, which cannot be gone into here, why I reject this approach.

A characteristic of all therapists—a necessary one, and one related to their effectiveness as therapists—is a belief in the method or approach which they practice. This applies to students in a practicum as well. The comments of Smith, Glass, and Miller (1980) might be relevant here. Discussing their conclusion that other things being equal, different types of psychotherapy are equally effective, they comment:

There is little reason to suspect that eclecticism, a theoretical or practical amalgam of therapeutic techniques that chance and charisma caused to be studied in the middle decades of the twentieth century, will lead to better psychotherapy or the truth about it. Good theories are not mixed from recipes: one part behaviorism, one part humanism; where truth reveals itself, it generally presents a simple, orderly countenance, not a patchwork quilt of scraps. If anything, our findings warn against an eclecticism in practice that fails to differentiate into one type or the other of psychotherapy. One of the paradoxes of psychotherapy (not unrelated to paradoxes about the scientific understanding of human behavior more fundamentally) may be that although all therapies are equally effective, one must choose one to learn and practice. (pp. 184-185)

The supervisor has a commitment to a theory, and the supervisee must have at least a tentative commitment to a theory; it should be obvious that if learning is to occur, they must be committed to the same theory.

There is another solution to this problem which I have proposed. This is based upon the concept that there are some basic common elements in all the major approaches to counseling or psychotherapy. Some of these elements appear to have been identified and to be generally accepted. Eapthic understanding, respect, and genuineness are three of these common elements. These elements appear in perhaps their clearest form in client-centered
therapy. It can be maintained that whatever else a therapist may do, he or she must first respect and understand the client and be honest or genuine in the therapeutic relationship. The student who can accept this position can accept a client-centered supervisor. If, however, a student insists on practicing, for example, rational-emotive therapy, he or she should be referred to the Institute for Rational Emotive Therapy for his or her training. I am sure Albert Ellis would make a similar referral in the case of an applicant who wanted to learn to practice psychoanalysis for example. In any case, the student has, and should have, the choice of a supervisor, if not in a particular program, then by changing programs.

The nature of prepracticum preparation constitutes another aspect of the general context for supervised practice. The student, as indicated above, should have a thorough knowledge and understanding of the approach to counseling or psychotherapy which he or she intends to practice. However, more than a theoretical knowledge is necessary or desirable. There is currently considerable emphasis on skill training with several programs for such training being available. Rice (1980) suggests that "...it seems desirable to have novice therapists first engage in some kind of group training program in which they learn attending behavior, learn to distinguish the internal frame of reference (the client's view of the world) from an external frame of reference (either the therapist's view or some view of external 'reality'), learn to focus on a 'feeling' level, and learn to express in their own words what is heard." How much of this kind of training is necessary is a question. In my view it is greatly overdone in most programs, leading to an overemphasis on techniques as opposed to attitudes. My experience with students in a program in England is relevant here. We (the tutor of the "course" or program and myself) began with a seminar or lecture-discussion session on philosophy and theory, meeting three hours a week, and a prepracticum "laboratory," also meeting three hours a week. Early on, much of the laboratory was taken up with continuing discussion of philosophy and theory. The tutor had prepared materials for using Ivey's program, however, and wished to use them, so we introduced them. After a few sessions the students resisted, characterizing the sessions as "mickey mouse" activity. They felt they were ready to meet with real clients. The sessions did include other activities such as listening to tapes as models, responding to clients' statements on the tapes, rating their responses on Carlhuff scales, role playing, etc. It had been planned to allow the students to work with clients after the second term. But in view of their progress and desires, plans were changed to allow them to start seeing clients in the second term, or after three months of prepracticum. Their performance justified the decision.

As a result of this experience and my experience with students in this country, I have come to the conclusion that the greater the student's understanding and acceptance of the philosophy and theory, the lesser the amount of time that must be spent in so-called skill training. Currently, it appears that the latter is being overemphasized at the expense of the former.

The Immediate Context

While the actual process of supervision to be described later is applicable to supervisees at all levels of experience and training, the particular setting, related to my major experience, is that of the first practicum experience. There are some aspects of supervision at this level that deserve attention.

The supervisor of the beginning practicum student may not know the level of preparation of the student. This is usually the case since the supervisor has not been involved in the basic preparation of the student. My experience in England resulted in a second conclusion, namely that the best way to prepare students for professional practice is to have two instructors who are in basic agreement about philosophy and theory conduct the entire theoretical and practical training of a small group of students (perhaps a dozen).

Lacking this, the practicum supervisor needs to determine the quality of the student's preparation and attempt to remedy any gaps by assigned reading—an inadequate remedy, since reading is not sufficient. Further efforts can be made in the practicum seminar, to be described later. As a minimum, my requirements have been the following: Patterson, *Theories of counseling and psychotherapy* (1980); Combs, Richards, and Richards, *Perceptual psychology* (1975); Rogers, *Client-centered therapy* (1951); Patterson, *Relationship counseling and psychotherapy* (1974). [Earlier, I required Porter, *Introduction to therapeutic counseling* (1950)].

Practicum supervision is individual supervision on a regularly scheduled basis of 1 1/2 hours per week, with additional contacts as needed. Concomitant with the practicum experience, the students being supervised (five to seven in number) meet in two two-hour seminar sessions per week. These seminars are devoted to discussions of philosophy, theory, and practice as well as to professional ethics, special problems such as suicidal clients, psychotic or borderline psychotic clients, brain damaged clients, the minimal brain damage syndrome in children, etc. There is also time devoted to listening to a collection of tapes, some relating to the problem areas listed. With their permission, tapes of students may be used, but for instructional purposes rather than for group supervision.

It should be noted here that the source for clients for practicum students during my period at the University of Illinois was a counseling center operated by the University at an Air Force Base (Patterson, 1966). The students were the staff of the counseling center, and clients were not selected. Students were expected to meet with all clients presenting themselves, including those of all ages with all kinds of problems, including vocational problems and choices.

Admission to the practicum was by decision of the entire staff of the program in a meeting attended by student representatives. The practicum instructors retained veto power for their immediate sections.

Orientation of Supervisees

Students are prepared for the supervisory process in
orientation sessions conducted in two seminar meetings prior to actual work with clients. Orientation covers the following content:

1. Students are not expected to be committed to something called “client-centered therapy.” As noted earlier, they are expected to be committed to acceptance of empathic understanding, respect, and genuineness as necessary conditions for therapeutic change. That these conditions are also sufficient is an hypothesis to be entertained and tested with each client. The writer is convinced on the basis of research evidence and experience that these conditions, with the addition of concreteness or specificity, are sufficient for a wide variety of therapeutic changes in a wide variety of clients. Supervisees are expected to be familiar with the research evidence and to be willing to test the hypothesis with their clients—not, as is often the case, for a brief time of an interview or two, or even less, but for the duration of a number of interviews under supervision. An interesting observation is that many, if not most students, are skeptical at the beginning of the practicum, but as they look back on their experience at the end of the practicum, they realize that they have helped most of their clients without abandoning the hypothesis.

2. The criteria upon which the supervisees are to be supervised and evaluated are made clear to them at the beginning. They are not required to guess what the actual criteria are when a supervisor claims to be an eclectic, to accept “anything that works,” or to allow the student to choose his or her own approach and criteria. The supervisor has criteria, whether he or she admits it or not, and the student has a right to know what they are.

The criteria consist of the achievement of minimal levels (level 3 on the Carkhuff scales) of empathic understanding, respect, genuineness, and specificity of concreteness. The emphasis is on the first and the last, since they can be taught or inculcated more or less directly, while the others are acquired through experience (in the case of respect particularly, experience prior to the practicum) and less directly through modeling by the practicum supervisor. The process of student self-selection and faculty screening for admission to the practicum assures that levels of these conditions, as well as of empathic understanding, are sufficient to assure that clients will not be harmed.

Supervisees are offered two alternatives for evaluation of their achievement of these criteria. They can submit a tape of an interview to be rated by trained raters other than the supervisor, or they can accept the clinical judgment of the supervisor. It is of interest to note that no student has chosen the first alternative.

The supervisor accepts the responsibility of evaluating supervisees as a responsibility to the profession and to future clients of the supervisees. It is recognized that evaluation can be threatening to those being evaluated. The threat seems to be minimized, however, when students know the criteria being used.

In fact, they quickly move into a process of self-evaluation. This is encouraged by the atmosphere of the supervisory sessions, and by the ability of the supervisor to avoid an evaluative attitude during the course of the practicum, reserving it for the end of the period. A formal feedback opportunity is provided for supervisees at the end of the course, but few feel the need for it, since they are aware of their level of achievement. Threat is also reduced by assuring the students that they have been selected because of their current level of functioning and their potential, and are unlikely to receive a failing grade. During a period of more than 20 years only a handful of students have received a failing grade.

3. Supervisees are given three simple, objective, immediate goals or criteria to apply:

a. Keep your mouth shut. You can’t listen to your client if you are talking, and you can’t understand your client if you don’t listen. Allow the client to develop and explore his or her problem in his or her own way, not your way. Important information, feelings, or attitudes will appear when they are relevant to the client. When you begin to understand the client, then will be the time to open your mouth. It is much easier for a beginning therapist to start from a point of talking too little than talking too much. Of course, the counselor may open the first session by an invitation to the client to talk if he or she does not do so spontaneously.

b. Never ask a question. Of course, like all absolute statements, there are exceptions here. The first one is when the beginning therapist doesn’t understand what the client is saying. Even then it is well to allow the client to continue for a time to see if understanding doesn’t develop.

c. Therapy occurs when the therapist responds to the client, rather than when the client is responding to the therapist. The responsibility for the content and sequence of the process is with the client. Since one of the desirable outcomes of therapy is for the client to assume responsibility for himself, the therapy process should give him that responsibility from the beginning.

4. Supervisees are required to tape all interviews for which the client gives consent. Clients are informed that the tapes will be heard by a supervisor.

5. Supervisees are expected to prepare for the supervisory session by:

a. listening to their taped interviews,

b. identifying and making note of sections which they wish to play during supervision, and
c. making notes of questions or problems to be brought up during supervision.

6. Supervisees are encouraged to listen to each other’s tapes in groups of two or three. Actually, very few students do this, perhaps because of time constraints.

The Supervisory Sessions

The supervisory session parallels the therapy session. The supervisor listens, responds to the supervisee, and minimizes questioning. The supervisee is responsible for the control of the session, bringing in tapes for reviewing, locating sections to be heard, and raising questions. The locus of evaluation is placed, as much as possible, on the supervisee. The supervisor, however, has a responsibility to the supervisee’s clients, and should, intervene if it appears that the client is being hurt, or his or her progress is being unduly inhibited. Questioning is usually directed at why the supervisee made a particular response if the supervisor is unable to see how it derives from the client’s statements. Since the supervisor has not, and cannot, hear the complete interviews with all clients, it is often the case that the supervisee’s response is appropriate in the light of the total relationship. Both supervisor and supervisee may listen for long periods with no comments. Occasionally the supervisor may stop the tape, saying something like: “It seemed to me the client was saying … or feeling … I think would have said this …” Seldom does the supervisor indicate that there is only one correct response; never that there is only one best way of phrasing a response. Within the context of implementing the four conditions there are many specific appropriate responses. These responses represent, and allow for, differences in style of language and phrasing among supervisees. There is no insistence upon particular techniques, such as “You feel …” However, occasionally I have suggested that a supervisee begin his or her response with “You feel …” in order to help focus on feelings rather than content.

This lack of concern about content means that the supervision is not devoted to discussion about what the supervisee should talk about, bring up in the therapy session, or direct the client to talk about. She or he is not required to state a specific goal for the next session or, indeed, a goal for the entire therapy process. The goal for every client is the same: to become a more self-actualizing person, in ways desired by or relevant to the particular client. As Rice (1980) notes, “The therapist and the supervisor do not map out content areas that must be dealt with if changes are to take place.”

The client will bring up important or relevant content at the appropriate time and place if the therapist provides the facilitative conditions. There is thus no requirement that the supervisee develop a treatment plan. “The ‘treatment plan’ is simply to establish a therapeutic relationship and, within that relationship, to facilitate the client’s self-directed exploration of inner experience” (Rice, 1980). This is accomplished by the supervisee providing the facilitative conditions at the highest levels of which he or she is capable. This is the supervisee’s objective and plan for each and every interview with his or her clients.

Thus, the supervisory process is concerned with the actual relationship between the supervisee and the client. It is not concerned with the personality or “psychological adjustment” of the supervisee, except or unless this is evident in the relationship with the client in a detrimental manner. Therapists’ hang-ups and blind spots do affect the therapy; all therapists have them. These are more often the result of, or lack of, certain life experiences than of any deep abnormality in the therapist.

Nor is the supervisory process concerned with any so-called psychodynamics of the client, or the identifying, specifying, labeling, or diagnosing of a “problem” or personality defect. The supervisee is not required to “conceptualize the dynamics of the client” or develop hypotheses about “core conflicts” or “primary defenses.” Any such concern treats the client as an object to be studied and dissected; it represents an external, evaluative approach rather than an internal or empathic approach.

To the extent that a “diagnosis” such as that of a psychotic condition or of neurological or physiological factors is necessary, it is best achieved by an approach which allows the client to present, or project, him or herself in an unstructured situation. To be sure, the supervisee is not to be expected to be sensitive to many of the indications of a psychotic disturbance or a neurological condition. Such sensitivity comes only with extensive experience, and it is here that the supervisor must be alert.

The major purpose of supervision is to help the supervisee become a competent counselor or therapist. This does not mean that the supervisor is not concerned about the client. But supervision is not a process of indirectly doing therapy with the client. It does not involve directing the supervisee in what to do or say in his or her next interview with the client. It may, however, include suggestions about what to look for or what to be sensitive to in future interviews. The best way for the supervisor to help the client is to help the supervisee be a better therapist.

A work about the importance of concreteness or specificity should be included. It is my experience that the responses of beginning therapists tend to be quite general. They attempt to respond to or reflect everything a client says in a lengthy statement. Their responses may be summaries in many cases. Such general or summary responses may elicit a client’s agreement—“Yes,” or “That’s right,” etc.—but they do not facilitate more extensive or deeper exploration. Concreteness or specificity in the client’s self-exploration process is an underrated if not ignored or unrecognized element in client progress, and such exploration is discouraged or encouraged by the nature of the therapist’s responses.

It should be apparent that supervision as I have been describing it is not a didactic teaching session. One of the values of a seminar for a group of supervisees is that direct teaching can be restricted to the seminar. To be sure, the restriction is not absolute. Some direct teaching may occur in the supervisory session. But it is best handled in the seminar, particularly since many if not
most of the occasions for direct teaching are of relevance not simply for the particular supervisee being seen, but for the others as well. When such an occasion arises, the supervisor makes a note of it, either with or without mentioning to the supervisee that a particular point or problem will be discussed in the seminar. (If the supervisor makes a written note to him- or herself, the supervisee is informed about it to prevent the possibility of a feeling of evaluation or threat arising.) Where there is only one supervisee, a situation which has been the case for me lately, the supervision may be more didactic in nature.

**Conclusion**

The approach to supervision outlined above relates the conditions of supervision to the conditions of counseling or psychotherapy. Both derive from the same philosophy and theory. No doubt there is a relationship between the conduct of supervision and the approach to therapy in the case of all supervision. The relationship may not be close, however, nor consistent, if it is not recognized. The basic conditions which should be present in both therapy and supervision are empathic understanding respect, genuineness, and concreteness. This does not mean that supervision is counseling or therapy. These are basic conditions in all helping relationships, including teaching. But,

Supervision, while not therapy, should be, like all good human relationships, therapeutic. Supervision is a relationship, which is therapeutic, and in which the student learns. But the learning is not the kind of learning which takes place in the usual classroom. It is more like the learning which takes place in counseling and psychotherapy. It is concerned with the development of sensitivity in the student, of understanding, of therapeutic attitudes rather than techniques, specific responses, diagnostic labeling, or even identifying or naming presumed personality dynamics in the client. (Patterson, 1964, p. 48)

Some may feel that it is undemocratic to require students to accept and engage in a particular approach to counseling or psychotherapy, rather than allowing them to do whatever they feel like doing. This is a misapplication of the concept of democracy. Medical students are not permitted to perform an operation on a patient in any way they wish. To the extent that we know what constitutes effective psychotherapy, to the extent that we have a scientific base for practice, freedom is restricted in the interest of the client. If psychotherapy is at the stage that we can allow students or supervisees to do whatever they feel like doing, then it is not even an art, much less a science, and there would be no justification for attempting to teach it.

**References**


