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# A COMPETENCY-BASED APPROACH TO COUPLE AND FAMILY THERAPY SUPERVISION

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*The competency-based movement continues to guide professional psychology. This has been highlighted through the establishment of essential foundational and functional competencies. The current paper focuses on the intervention competency domain and delineates its relevance within the field of couple and family therapy (CFT). We begin by providing an overview of 8 essential components of CFT: developing a systemic formulation, forging a systemic therapeutic alliance, understanding family-of-origin issues, reframing, managing negative interactions, building cohesion/intimacy/communication, restructuring/parenting, and understanding and applying evidence-based CFT models. We then provide a brief illustration of foundational and functional competencies essential to CFT. We conclude by addressing the CFT competency within an integrative approach to supervision and provide a case illustration that depicts this process. The relevance of establishing unique, evidence-based, theory-specific competency components is highlighted.*

*Keywords:* competencies, couple and family therapy, supervision

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The current zeitgeist in professional psychology is competency based (Kaslow, 2004). Many recent efforts have led to this shift to a culture of competence and its assessment, including the identification of the key foundational and functional competencies and their essential components in the competencies cube and the Benchmarks document (Fouad et al., 2009; Kaslow et al., 2009; Roberts, Borden, Christiansen, & Lopez, 2005; Rodolfa et al., 2005). The competencies cube, which emerged from the Competencies Conference, pictorially depicts the foundational and functional competencies and their intersections, taking developmental phase of professional development into account (Kaslow, 2004; Rodolfa et al., 2005). The Benchmarks document further refines the core foundational and functional competencies across three levels of professional development (readiness for practicum, readiness for internship, readiness for entry to practice), and for each professional developmental level, provides the essential components that comprise these competencies, as well as behavioral indicators that operationally define the essential components (Fouad et al., in press). Intervention, which includes psychotherapy at its core, is one of the functional competencies highlighted in the competencies cube and Benchmarks document. Although essential components have been delineated for this competency in the Benchmarks document, we must ascertain the essential components of the intervention competency unique to each theoretical orientation, as well as ways in which various foundational and functional competencies are linked to this competency and how these linkages may be unique depending on the theoretical frame and associated modality(ies).

This article focuses on the essential components and associated foundational and functional competencies for intervention/psychotherapy from a systemic perspective, also known as cou-

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ple and family therapy[1] (CFT), and addresses these competencies in the supervisory process. The term *CFT* is used to capture the intervention/psychotherapy functional competency.[2] CFT is distinct from other types of therapy; the focus is on interactions among family members in their relational contexts. Although traditionally practiced with more than one person, it can be used with a single individual; the epistemological framework defines the systemic nature of the treatment. CFT is associated with family psychology, which brings a systemic focus to psychological science and the competencies associated with psychology (Nutt & Stanton, 2008).

There has been interest in defining competencies for family psychology (Nutt & Stanton, 2008) and articulating a competencies-based approach to family psychology training (Kaslow, Celano, & Stanton, 2005). Attention has been given to the competencies required for psychiatry residents who work with families (Berman et al., 2006). The most ambitious proposal of CFT competencies, developed for American Association for Marriage and Family Therapy (AAMFT), is organized by six domains: admission to treatment; clinical assessment and diagnosis; treatment planning and case management; therapeutic interventions; legal issues, ethics, and standards; and research and program evaluation (Nelson, 2007). These efforts guide our articulation of the essential components of CFT and their integration with foundational/functional competencies.

## Essential Components of CFT

Identifying the essential components of CFT is challenging for several reasons. First, CFT requires the practitioner to consider multiple-systemic influences and their interrelationships and to address multiple domains consistent with a given theoretical model, while balancing diverse perspectives of family members and responding to them in ways to sustain their engagement in treatment. Second, there is no unified theory of healthy couples/family functioning or therapy. Third, there is no evidence for the differential effectiveness of various intervention models, causing some to propose that "common factors" across models account for the efficacy of CFT (Sprenkle & Blow, 2004). Fourth, there is a lack of adequate research on specific change mechanisms (Heatherington, Friedlander, & Greenberg, 2005), despite data supporting the efficacy and effectiveness of CFT for a variety of disorders (Carr, 2009a, 2009b). As a result, selection of competencies in CFT has been based on consensus of expert opinion (Nelson et al., 2007). This literature would be strengthened by integrating research on change processes and evidence-based models in CFT. The next section proposes eight essential components of CFT. These components differ from the extensive list proposed for AAMFT (Nelson et al., 2007) in that they address intervention only, are evidence based, and are specific to CFT, with the exception of the last component, which is relevant to all therapy modalities.

### *Developing a Systemic Formulation*

The gateway to all CFTs is a systemic (relational) formulation of the presenting problem of an individual, couple, or family (Nutt & Stanton, 2008; Sprenkle & Blow, 2004). Systemic formulation, a conceptualization of a symptom or problem in terms of recursive family processes and patterns, is common to all evidence-based CFT models. It may be developed at the onset of CFT or during the course of individual therapy, such as at a therapeutic impasse. The guiding question answered by the systemic formulation is: "What relationship processes contribute to or maintain the symptom, or constrain symptom resolution?" A systemic conceptualization supports CFT therapists in being cognizant of the whole system when engaging with only part of the system. Systemic formulations may attend to: relationship patterns in the present and in prior generations, family developmental context, power dynamics, belonging/intimacy, meaning of symptoms within the family's sociocultural context and history, family routines and rituals, and family strengths. Specific elements vary based on age of the index patient, presenting problem, and CFT school. To develop a systemic formulation,

[1] We recognize that not all CFT approaches are systemically oriented; our focus here is on CFT models grounded in systemic theory or principles.

[2] According to the literature on competencies in professional psychology (e.g., Kaslow, 2004), the proper term is *intervention*, of which therapy is only a part. However, because our focus is on psychotherapy and because the term *therapy* is more commonly used in the family psychology literature than the term intervention, we use the term therapy in this article.

the therapist assesses the couple/family using circular questions, genogram assessments, enactments, sculpting, and/or questions about family rituals (McGoldrick, Gerson, & Petry, 2008; Nutt & Stanton, 2008). The systemic therapist recognizes those presenting problems for which family assessment and treatment are warranted and is attuned to family strengths and resources.

*Forging a Systemic Therapeutic Alliance*

The expanded therapeutic alliance (allying with each member individually, with various subsystems, and with the whole family) is a common factor unique to CFT (Sprenkle & Blow, 2004). Therapeutic alliance is the quality and strength of the collaborative relationship between family members and therapist, and includes a shared commitment to the goals of therapy in the context of a positive emotional bond (Friedlander, Escudero, & Heatherington, 2006). Alliances between each family member and the therapist, between a therapist and a subsystem, within the family, and within the treatment team reciprocally influence one another. Developing an alliance is more complex in CFT than in individual therapy because members present with differing personalities, developmental needs, and clinical issues; members often have competing perspectives on the problem; interactions between the therapist and any one member affect interactions between or among the others; and alliance development is more complex in the case of cotherapy. In couples therapy, the concept of balance/neutrality is key to a successful alliance (Weeks & Treat, 2001). Evidence-based techniques for developing a therapeutic alliance differ according to the treatment model, presenting problem, and developmental stage of the index patient. Such techniques include "joining" behaviors (empathic attunement, validation), goal setting, rekindling commitments to the relationship(s), diffusing hostile exchanges, minimizing blaming attributions, and promoting a relational or systemic view of the problem behavior (Diamond, Siqueland, & Diamond, 2003; Johnson, 2004; Sexton & Alexander, 2005).

An essential precursor to developing a therapeutic alliance in CFT is treatment engagement, the process of facilitating the couple's or family's attendance at initial treatment sessions. Successful strategies for overcoming access barriers to family therapy include telephone outreach before the first therapy session, 24-hr-a-day therapist availability, home-based services, multiple-family therapy groups, a focus on strengths, and well-defined goals set collaboratively by the therapist and the family (Celano, Croft, & Morrissey-Kane, 2002; Snell-Johns, Mendez, & Smith, 2004).

*Understanding Family-of-Origin Issues*

According to family-of-origin models of CFT, problematic interactions in the present stem in part from patterns of family interaction or relationships that are replicated from one generation to the next. Although empirical research has not tested the efficacy of these models, understanding of family-of-origin issues is valued by several evidence-based CFT models. For example, in emotionally focused couple therapy, the therapist considers family-of-origin issues as they influence emotional sensitivities and reactions in the couple's current interaction (Johnson, 2004). In addition, a focus on family-of-origin issues is consistent with two broad conceptual models that inform CFT: (a) a developmental psychopathology perspective, in which problematic childhood environments influence the development of relationship behaviors linked to adult outcomes; and (b) attachment theory as it is applied to adult relationships. Consistent with these theories, emerging research demonstrates that observed family-of-origin interaction patterns are replicated in offspring's later marital interactions (Whitton et al., 2008).

Understanding of patterns of relationships across generations is considered a core intervention (Seaburn, Landau-Stanton, & Horwitz, 1995), in part because it may elucidate family beliefs and problem-solving efforts that are no longer adaptive. Greater comprehension of intergenerational patterns also can provide a cultural context for interventions addressing parenting, trauma or loss, and negotiation of developmental transitions (e.g., leaving home).

*Reframing*

Reframing refers to redefining or expanding the family's or couple's definition of the presenting problem to elicit more constructive and relational attributions. Reframing shifts the treatment goal from fixing the patient to improving the quality of family relationships. It relabels con-

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straining ideas in positive ways consistent with family members' realities. Reframing is recommended only after the therapist and family have established a strong alliance and understand the meaning of the symptom to family members and its function in their relationship system (Weeks & Treat, 2001). Recently manualized so that it can be implemented consistently by practitioners and outcome researchers (Pote, Stratton, Cottrell, Shapiro, & Boston, 2003), reframing has been well articulated in functional family therapy (Sexton & Alexander, 2005), attachment-based family therapy (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002), and emotionally focused couple therapy (Johnson, 2004).

*Managing Negative Interactions*

Conflictual interactions between family members are a common presenting problem in CFT, and hostile or negative interactions in session have been linked to poor therapy outcome or premature termination (Diamond & Josephson, 2005). Highly negative and conflictual family interactions may be reduced by carefully timed therapist interventions (Robbins, Alexander, & Turner, 2000). These interventions may include: asking questions about exceptions to the criticism, selectively attending to positive statements about family members, reframing problems in such a way to minimize or reduce blame, and amplifying thoughts and feelings that promote constructive dialogue or mutual understanding among family members. The systemic therapist may also address conflict directly by uncovering the underlying affects and family-of-origin issues or by teaching conflict resolution skills.

*Building Cohesion/Intimacy/Communication*

All evidence-based CFT models include interventions designed to enhance interactions so that members feel a greater sense of belonging and have more positive communication. Techniques for accomplishing this goal vary by theoretical orientation and presenting problem. In attachment-based family therapy, the therapist may temporarily support the adolescent's perspective and attempt to change the parents' affective tone from blame to disappointment and loss, prompting the adolescent to feel less hostile and guarded, and more likely to disclose the affects and conflicts that fuel the arguments with parents (Diamond et al., 2002). In behavioral couples therapy, the therapist increases the overall positivity in the couples relationship with the behavioral exchange technique (Atkins, Dimidjian, & Christensen, 2003). In object relations couple therapy, the therapist helps the couple build a mutual holding environment and contain each other's projections, which is associated with more concern for other and greater intimacy (Scharff & Scharff, 2008).

*Restructuring/Parenting*

Improved parenting is a focus of many interventions. Such interventions as parent–child interaction therapy, Triple P-Positive Parenting Program, and parent management training are associated with enhanced parenting and reductions in children's behavior problems (Degarmo, Patterson, & Forgatch, 2004; Thomas & Zimmer-Gembeck, 2007). These evidence-based models target behavioral skills of parents, including monitoring and supervision, contingency management, and negotiating of limits and roles. However, CFT parenting interventions are driven by a systemic formulation that considers the fit between the identified problem and the broader family/community context, and are implemented only after positive family relational patterns have been enhanced (Sexton & Alexander, 2002).

*Understanding and Applying Evidence-Based CFT Models*

Given the bewildering array of family processes that may be uncovered by a systemic formulation, a treatment model is needed to guide the systemic therapist in deciding what to do when during the process of therapy. Although debate exists about whether common factors, therapist factors, or ingredients of evidence-based models explain the bulk of change in CFT (Blow, Sprenkle, & Davis, 2007; Sexton, Ridley, & Kleiner, 2004), the field is gradually accepting the movement toward evidence-based practice (EBP) already embraced by medicine and professional psychology (APA Presidential Task Force on Evidence-Based Practice, 2006). In most cases, integrating research findings into clinical practice is recommended over rigid application of existing evidence-based CFT models, as the latter have not yet been demonstrated to be effective

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with individuals varying in comorbidity, personality, race, ethnicity, and culture.

Given the integration of research with practice in EBP, systemic therapists should be familiar with evidence-based treatment models in CFT. Some models provide a framework for therapy through principles of change (e.g., multisystemic therapy; Henggeler, Schoenwald, Rowland, & Cunningham, 2002). Others delineate therapeutic tasks according to the phase of the work, such as functional family therapy (Sexton & Alexander, 2005) and emotionally focused couple therapy (Johnson, 2004). A few models (Breunlin, Schwartz, & MacKune-Karrer, 1997; Pinsof, 1995) articulate how to integrate CFT with other modalities and interventions. The Society for Family Psychology's Task Force on Evaluating Evidence-Based Treatments in Couple and Family Psychology developed EBP guidelines for evaluating available treatment models in CFT, and hopes to identify transcendent principles for effective CFT across treatments (Sexton et al., 2007).

## Foundational and Functional Competencies Informing CFT Competency

Although the core foundational and functional competencies identified in the competencies cube and Benchmarks document have been applied to family psychology (Kaslow et al., 2005), their relationships to essential components of CFT have not been examined. It is beyond the scope of this paper to touch on all of these. Thus, for illustrative purposes, we focus on three key foundational and two functional competencies as they pertain to CFT. Although these five competencies are not specific to CFT, there are ways in which they have either unique characteristics or particular salience related to the CFT competency.

### *Foundational Competencies Essential to CFT*

The ability to demonstrate reflective practice, self-assessment, and self-care informs all essential components of CFT. The CFT therapist reflects on cotherapy processes (when applicable); his or her interactions with each family member, subsystem, and the family as a whole; and the ways in which his or her behavior is a function of unresolved family-of-origin dynamics. Self-of-the-therapist work, particularly vis-à-vis one's family of origin, must be a centerpiece of one's clinical work that is reflected on individually and addressed in supervision and consultation. As impasses with families often resonate with family-of-origin dynamics, personal reflection and supervision/consultation must focus on developing a more flexible use of self in CFT through the working through of unresolved family-of-origin dynamics (Haber & Hawley, 2004). To integrate the common factors approach and the model specific perspective for maximum clinical effectiveness, systemic therapists must dedicate themselves to an evidence-based intervention paradigm that is congruent with their personal worldview (Simon, 2006). This requires an appreciation of one's own world view, an understanding of the theory that undergirds each perspective, and the capacity to develop a sophisticated ability to utilize the CFT approach that is the optimal match for one's personal view of the human condition.

Another foundational competency salient to CFT practice is the application of ethical and legal standards to professional activities. Legalities and ethics are complex in CFT, given that multiple individuals are simultaneously receiving treatment and a traditional "identified patient" may fail to exist. Major ethical considerations include confidentiality, informed consent, privileged communication, therapeutic power and responsibility, family secrets, therapists' values, and the handling of termination (Goldenberg & Goldenberg, 2008).

Individual and cultural diversity is a salient foundational competency that imbues all aspects of the systemic therapy process. When working with families, cultural diversity must be considered across a multitude of domains (Banks, 2001). CFT therapists must consider how a family's cultural background may influence how they view the presenting problem, choose to seek help, and their preference for family versus individual therapy (McGoldrick, Giordano, & Garcia-Preto, 2005). Issues related to diversity may contribute to the system's functioning; it is not uncommon for there to be conflicts within a family related to diversity (e.g., interfaith/interracial couples, conflicts between members of different generations related to differing levels of acculturation). CFT therapists need to help families address how their diversity status influences their interactions within the larger social context and how diversity qualities of various members of the system influence relational patterns.

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*Functional Competencies Essential to CFT*

The competency of assessment provides the framework for developing a systemic case formulation, which necessitates examining individual, relational, and macrosystemic factors, and CFT treatment planning (Nutt & Stanton, 2008). Assessment may include a clinical interview with the family and various subsystems, traditional psychometric measures and observational techniques, and family systems specific techniques (e.g., genograms, enactments, etc.). The practice parameters developed for conducting a family assessment with children (Josephson, 2007) illustrate what is entailed in a thorough evaluation that leads to a systemic case formulation and associated intervention plan. For a child with a psychiatric disorder, this assessment might involve gathering history to ascertain family factors associated with the child's presentation; identifying family interaction patterns linked to the child's difficulties; organizing clinical material related to family structure, communication, beliefs, and child development; exploring cultural considerations that inform child rearing; ascertaining family strengths; and sharing a systemic formulation with the family.

Consultation is another salient functional competency. CFT therapists utilize a systems framework to guide their communications with individuals from other disciplines with regard to assessment, diagnoses, conceptualizations, intervention planning/maintenance, and findings. Further, a systemic framework is a useful guide for consultation (Kazak, Simms, & Rourke, 2002).

## Psychotherapy Competencies in the Supervisory Process

Historically, CFT supervision has been influenced by models rather than by the goal of developing core competencies. As the field moves toward evidence-based practice and a competency-based approach, integrative models of supervision will be in greater demand. Integrative supervision supports trainees' efforts to develop a wide repertoire of competencies and a conceptual frame for identifying which interventions to apply to meet a family's needs (Todd & Storm, 2002). This section discusses how the essential components of the CFT competency can be addressed in an integrative supervisory approach.

*Developing a Systemic Formulation*

An integrative model helps trainees develop a systemic formulation. We use a biopsychosocial perspective to synthesize multiple-systemic processes and theories about human functioning. During the middle and end phases of treatment, we keep the systemic formulation in the foreground of supervision by asking trainees how session content informs or extends the systemic formulation of the case.

Consistent with the goal of achieving greater self-awareness in ourselves and in our trainees, we pay attention in case formulation to contextual variables and consider how these factors as well as our (supervisor's and trainee's) personal and family experiences influence the formulation and supervisory process. When culture-specific information is needed, we arrange for a cultural consultation, thus modeling the process of identifying the limits of one's expertise, developing case-specific questions to facilitate a comprehensive systemic formulation, and evaluating and applying the new information.

*Forging a Systemic Therapeutic Alliance*

We teach how to engage families in therapy, attend to contextual factors that present barriers to attendance, and discuss therapist behaviors that facilitate engagement (Celano et al., 2002). As the first session is critical to engagement, we devote time to preparing the trainee for the session and later reviewing the interactions that unfolded between the trainee and the family. We prefer raw data (live observation or videotape of session) to evaluate the quality of the developing therapeutic alliance. We use live supervision and cotherapy to demonstrate how to develop, enhance, and repair an alliance. Cotherapy offers the opportunity for supervisor modeling and a collaborative partnership with the trainee and family (Kaslow et al., 2005), and works best when the supervisor and trainee have a mutual understanding of the supervisor's involvement during the session. As treatment progresses, we use the concept of isomorphism to illuminate interpersonal processes in the supervisory relationship that parallel interactional patterns in the family or therapy.

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*Reframing*

We encourage trainees to understand reframing in the context of a given model. Specific supervisory approaches depend on the trainee's level of comfort and experience with reframing, and include: modeling, "practice" reframing interventions during supervision, live observation, and review of recorded or recalled interventions. Trainees are invited to consider timing and developmental and cultural acceptability of reframing interventions.

*Managing Negative Interactions, Building Cohesion, and Restructuring/Parenting*

These three competencies represent the "meat" of CFT, flowing from a systemic formulation and successful goal setting with the family. Thus, the first supervisory challenge is to help the trainee determine, for each family, which (if any) of these interventions is needed. Consistent with the value of research-practice integration, we recommend that trainees use findings from process research on risk and resilience in families to guide their assessment efforts. For example, trainees would consider escalating, aversive parent–child communication as a risk factor for child externalizing behavior problems, and overcontrolling or intrusive parenting as a risk factor for a childhood anxiety disorder.

The second supervisory challenge is to facilitate trainees' confidence and competence in these areas. Negative family interactions are important to address early in supervision, as they heighten trainees' anxiety and potential to avoid or distort related clinical material. To help trainees become comfortable managing negative family interactions, we demonstrate how to do so and allow them to practice in role plays, giving appropriate feedback, before we ask them to manage negative interactions in a session. Ideally, we demonstrate how to manage negative interactions during a session, and use live supervision or cotherapy to refine their skills.

Interventions to reduce family conflict and improve couple/family cohesion, communication, or parenting are best considered in the context of the model in which they are embedded. We encourage trainees to become proficient in at least one model, and to consider the timing and priority of interventions to build cohesion/intimacy versus manage/reduce conflict.

An integrative biopsychosocial perspective is critical in effective implementation of parenting interventions, as many factors contribute to poor parenting, including parental psychopathology, marital conflict, family trauma, child temperament, and cultural and environmental influences. To help trainees adeptly implement parenting and cohesion-building interventions, we use didactic instruction, modeling, role-playing, video demonstrations, live observation, live supervision, and cotherapy. For families with poor intergenerational boundaries, we encourage trainees to utilize structural therapy techniques such as boundary marking and enactment.

*Understanding and Applying Evidence-Based CFT Models*

An integrative supervision approach is ideal for assisting trainees in identifying, evaluating, and applying evidence-based treatment strategies for a particular case, in assessing outcome, and in adapting interventions accordingly. In cases in which trainees rush to implement an empirically based intervention solely on the basis of the index patient's diagnosis, we invite the trainee to consider the extent to which the proposed intervention is consistent with the systemic formulation, acceptable to the family, and of proven efficacy for clients with similar family and cultural characteristics. We explore the intervention's possible relational consequences for the family and the trainee's relationship with the family, as well as the trainee's comfort in implementing the intervention.

## Case Illustration

The following case illustrates how the essential components of CFT can be applied in the supervision of a trainee at a therapeutic impasse with a family, and the resulting consultation session.

A trainee sought supervision for a low-income, urban, African American family consisting of a 35-year-old mother, an 18-year-old son who was disabled, and a 16-year-old daughter with poor academic performance, depression, and oppositional behavior. The trainee had seen the daughter in individual therapy for 6 months, with the mother present during the first two sessions only. Although the daughter's depressive symptoms had diminished, she remained isolated at home and wanted to drop out of school; the mother

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complained that her daughter was disrespectful and acted "too grown." The trainee, a psychology intern with little family therapy experience, wanted the supervisor to assist her in reengaging the mother in the daughter's treatment.

Asked about her systemic formulation, the trainee indicated that the daughter's problems stemmed from her anger toward the mother for her substance abuse, which had led both children to be placed in foster care a few years ago, and from the mother's inconsistent parenting driven by guilt for neglecting her children. Prior to family reunification, the daughter had run away from her foster care placement and lived "in the street," working as a prostitute. The supervisor inquired about the family-of-origin issues that might shed light on the mother–daughter relationship; the trainee indicated that the mother's own mother was not able to raise her due to psychiatric illness and alcohol abuse, causing the mother to be placed with her grandmother as a child. Discussion of the mother's childhood history allowed the trainee to perceive the mother as anxious about the daughter's safety and fearful of rejection by her rather than disinterested and guilt-ridden, permitting a more balanced systemic alliance.

The supervisor and trainee, both White, discussed contextual and cultural barriers to the mother's attendance and decided how to present the consultation session in a manner that the mother would be likely to attend. In individual conversations with mother and daughter, the trainee reframed the daughter's oppositional and withdrawn behavior as a mother–daughter relational problem, and she negotiated with both parties a goal of discussing and improving their relationship in a meeting with the supervisor present. The supervisor and trainee then met to plan the session; the trainee indicated she felt anxious about the expected hostile communication between mother and daughter, and the threat this experience would pose to her alliance with the adolescent. During the session, the supervisor modeled ways to manage the escalating, hostile exchanges between mother and daughter, reframing the mother's demands as efforts to protect the daughter from harm; the trainee followed suit by reframing the daughter's oppositional behavior as efforts to reclaim her independence. To assess the strength of the mother–daughter relationship, the supervisor refocused the discussion on the mother's and daughter's perceptions of their relationship: at what point during the last several years did each party feel most accepted by the other, and when did the relationship become strained? It became clear that both mother and daughter felt rejected and betrayed by the other over a similar time period, yet were unwilling to completely "give up" on their relationship.

Although both trainee and supervisor demonstrated empathy for mother and daughter, only the supervisor asked pointed questions of the daughter or confronted her when she attempted to manipulate the therapists into pressuring her mother to let her drop out of school, as the trainee felt that confronting the daughter in the mother's presence would cause the daughter to feel betrayed by her therapist. To improve the mother–daughter relationship, the trainee asked each party to comment on what would be the "tiniest possible sign" that the other party cared about her. The trainee processed the discussion with both parties at the end of the session, and expressed her hope that additional mother–daughter sessions could strengthen their relationship. The family and the trainee then negotiated a treatment plan consisting of biweekly individual therapy for the daughter to address her depression and problematic peer relationships, and mother–daughter sessions on the alternate weeks to improve their relationship. The supervisor was not present during subsequent sessions, as neither trainee nor supervisor felt that her presence was needed. The trainee clarified the supervisor's contribution in the consultation as "helping us change direction," and indicated that she would continue to supervise the work, joining the session if therapist, supervisor, or the family thought that a more engaged collaboration would be beneficial.

As this case illustrates, it is important for the supervisor to consider the trainee's readiness to implement essential CFT components as well as his or her comfort in doing so. The systemic formulation should be elicited and, if necessary, expanded before planning the consultation or the next step in the intervention. To facilitate treatment engagement and maintain high ethical standards, the supervisor's role should be articulated, and the goal of the consultation session should be negotiated with the family. Finally, the case demonstrates how supervision can support the integration of a systemic intervention into a treatment plan that includes individual therapy.

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