Over the years, a considerable amount of research and theorizing about the supervision process, including how trainees change over time, has examined the supervision process as being different from the processes both specifically involved in therapy and those conceived from the perspective of psychotherapy theory (e.g., Loganbill, Hardy, & Delworth, 1982). Generally, in these supervisory theories, an implicit stage theory of therapist development is assumed and supervisory behaviors that are thought to be consistent with the hypothesized level of development of the therapist are specified (Stoltenberg, McNeill, & Crethar, 1994; Worthington, 1987). Focus on therapist change over time from both a quantitative and qualitative perspective serves as the critical difference between developmental and other approaches to supervision (Falender & Shafranske, 2004). Central to a competency-based approach to supervision is the ability to accurately assess the trainee’s competence within the context of his or her developmental status and trajectory. The integrated developmental model (IDM) provides a conceptual and empirical approach to development. This chapter briefly overviews the IDM and presents an example that shows how the approach can be implemented. The importance of assessing and intervening at different levels of supervisee development across domains (explained later) is highlighted.
Stoltenberg and Delworth (1987) and, later, Stoltenberg, McNeill, and Delworth (1998) have presented the most comprehensive and detailed model of therapist development and supervision to date, the IDM. The primary basis for this model includes the work of Hogan (1964), Loganbill et al. (1982), and Stoltenberg (1981); theories of human development; and several empirical studies of therapist development (see also Stoltenberg, 1993, 1997, 1998, and Stoltenberg, McNeill, & Crethar, 1995, for expansions of aspects of the IDM). The IDM uses three overriding structures to monitor trainee development through three levels (plus a final integrated level) across various domains of clinical training and practice, thus integrating quantitative and qualitative processes and providing markers to assess development across domains.

The three structures are self and other awareness (with both cognitive and affective components), motivation, and autonomy. These three structures are the developmental markers for change in the therapist-in-training over time across eight domains of professional activity. The self and other awareness structure indicates where the trainee is in terms of self-preoccupation, awareness of the client's world, and enlightened self-awareness. The cognitive component includes the content and quality of the thought processes, whereas the affective component accounts for the emotional experience of the trainee moving from anxiety-based uncertainty and lack of confidence (Level 1); through emotional reactions to the client, including empathy (Level 2); and culminating in an awareness of one's personal emotional experience (including an insightful emotional reaction to the client and awareness of countertransference), empathy with the client, and an ability to reflect on the experience (Levels 3 and 3i; see Table 3.1). Motivation reflects the trainee's interest, investment, and effort expended in clinical training and practice. The Autonomy structure addresses the degree of dependence or independence demonstrated by trainees over time. A particularly important aspect of this approach is the recognition that a trainee is likely to be functioning at different developmental levels for various domains of professional activity.

**CONTENT AREAS AND PROCESSES**

The domains of professional activity can be conceptualized in varying degrees of specificity. Stoltenberg et al. (1998) offer the following categories: intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics (American Psychological Association [APA] Ethics Code; APA, 2002; see also the APA Web site version at http://www.apa.org/ethics/). Although each could be further reduced to more specific domains, the general categories serve to high-
TABLE 3.1
Developmental Levels and Structures

<table>
<thead>
<tr>
<th>Level</th>
<th>Motivation</th>
<th>Autonomy</th>
<th>Self and other awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Motivated</td>
<td>Dependent; need for structure</td>
<td>Cognitive: limited self-awareness; Affective: performance anxiety</td>
</tr>
<tr>
<td>2</td>
<td>Fluctuating between high and low; confident and lacking confidence</td>
<td>Dependency–autonomy conflict; assertive vs. compliant</td>
<td>Cognitive: focus on client; understand perspective; Affective: empathy possible, also over-identification</td>
</tr>
<tr>
<td>3</td>
<td>Stable; doubts not immobilizing; professional identity is primary focus</td>
<td>Conditional dependency; mostly autonomous</td>
<td>Cognitive: accepting and aware of strengths and weakness of self and client; Affective: aware of own reactions and empathy</td>
</tr>
<tr>
<td>3i</td>
<td>Stable across domains; professional identity established</td>
<td>Autonomous across domains</td>
<td>Personalized understanding crosses domains; adjusted with experience and age</td>
</tr>
</tbody>
</table>


light the fact that one must carefully attend to the focal activity in which the trainee is engaging to adequately assess the developmental level at which the trainee is functioning at any given time. Intervention skills competence address the trainee’s confidence in and competence in carrying out therapeutic interventions. Assessment techniques address the trainee’s confidence in, and ability to conduct, psychological assessments. Interpersonal assessment extends beyond a formal assessment and includes the use of self in conceptualizing a client’s interpersonal dynamics. Client conceptualization incorporates, but is not limited to, diagnosis. This domain goes beyond an axis diagnosis and involves the therapist’s understanding of how the client’s characteristics, history, and life circumstances blend to impact adjustment. Individual differences includes an understanding of ethnic, racial, gender, and cultural influences on individuals, as well as the idiosyncrasies that form the person’s personality. Theoretical orientation involves formal theories of psychology and psychotherapy as well as eclectic approaches and personal integration. Treatment goals and plans addresses how the therapist conceptualizes and organizes his or her efforts
in working with clients in the psychotherapeutic context. Finally, professional ethics addresses how professional ethics and standards of practice are intertwined with personal ethics in the development of the therapist (see Exhibit 3.1).

According to the IDM, the twin processes of assimilation and accommodation induce a trainee’s upward movement. Piaget (1970) described assimilation as the process of fitting reality into one’s current cognitive organization. Accommodation, however, was defined as significant adjustments in cognitive organization that result from the demands of reality. Piaget considered assimilation and accommodation to be closely interrelated in every cognitive activity (Miller, 1989). Attempts to assimilate involve minor changes in the individual’s cognitive structures as he or she adjusts to new ideas, whereas accommodation involves the formation of new constructs through the loosening of old ones.

Additional models of development provide other ways of viewing the process of therapist development. For example, Anderson’s (1985, 1996) model of cognitive development describes changes from novice to expert status that includes more abstract representations in memory of relevant processes and pattern match. In addition, the ability to reason forward from known information, rather than reason backward from a problem statement, constitutes change from novice to expert. Expanding this to the clinical realm, one can see expert therapists engaging in forward thinking, leading to diagnosis and treatment from recognition of patterns displayed by clients with regard to personality characteristics, environmental circumstances, and therapist reactions to the client. Novice therapists are more likely to focus in on specific presenting problems or therapeutic processes and reason backward,
without recognizing broad patterns. Similarly, the concept of "schema development" (Gagné, Yekovich, & Yekovich, 1993) captures processes similar to what is delineated in the IDM regarding therapist development.

Essentially, the IDM suggests assimilation occurs within levels (Level 1, novice, through Level 3i, expert) and accommodation occurs between levels. In terms of cognitive development, initial formulation of simplistic schemata reflecting one's understanding of clients and the therapeutic process are refined into more encompassing concepts with more broadly associated links to other schemata. For the present case study, I used a practicum rating form for trainees (a rough estimate of developmental level) prior to and after the supervision experience. A rather extensive case conceptualization format provides the supervisor with useful information about the supervisee's clients and, more importantly, forces trainees to collect a broad spectrum of information about their clients, on which to build a conceptualization. Another measure was used, the evaluation of supervision form to evaluate the supervisee's perception of supervision.

Supervisory interventions, as one might expect, should vary according to the developmental level of the trainee (for any given domain). The IDM uses five categories of supervisory interventions to classify supervisor strategies. These are depicted in Table 3.2. Facilitative interventions are appropriate

<table>
<thead>
<tr>
<th>Intervention strategy</th>
<th>Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitative: nurturing atmosphere; conducive to growth, warmth, liking, respect; conveys trust</td>
<td>Reduces anxiety; allows for reflection and introspection</td>
</tr>
<tr>
<td>Confrontive: highlights discrepancies; compares and contrasts emotions, beliefs, and behaviors</td>
<td>Examination and comparison; achieve congruence</td>
</tr>
<tr>
<td>Conceptual: theories, principles, substantive content; gives meaning to events, ties together isolated events</td>
<td>Integrate theory and research; analytical thinking</td>
</tr>
<tr>
<td>Prescriptive: specific plan of action; direct intervention; prescribes treatment or specific instructions; eliminates certain behaviors</td>
<td>Gives guidance; ensures client welfare; satisfies dependency</td>
</tr>
<tr>
<td>Catalytic: promotes change; gets things moving; highlights, defines, articulates, or enhances meaning; processes comments</td>
<td>Stirs things up, promotes reflection and integration</td>
</tr>
</tbody>
</table>

across levels. For Level 1 trainees, in addition, prescriptive and conceptual interventions are useful. In late Level 1, catalytic interventions can be appropriate. For Level 2, in addition to facilitative interventions, confrontive, conceptual, and catalytic interventions are used regularly. For Level 3, facilitative interventions remain important; confrontive interventions are occasionally used; and conceptual and catalytic remain useful.

STRENGTHS AND LIMITATIONS OF THE APPROACH
FROM THE POINT OF VIEW OF THE SUPERVISEE

Entry-level knowledge and skills are expected of the trainees, with higher degrees of each consistent with more advanced levels. Values of the trainee should reflect consistency with the APA Ethics Code (APA, 2002). Reactions to the approach have been consistently positive, with an appreciation for the explicit acknowledgement of variability in knowledge and skills across levels of trainees. Some anxiety on the part of the trainee is expected, and desired, as a motivating influence on the trainee’s development (consistent with Piaget’s [1970] concept of “disequilibrium”). This can (and should) result in some level of discomfort for the trainee on an ongoing basis so as to stimulate growth (overly comfortable people do not grow). Typically, the process of engaging in learning psychotherapy provides sufficient motivating anxiety that additional stress need not be applied by the supervisor. Common challenges reflect accurate assessment of developmental level for the various domains of professional practice in play during any given supervisory relationship (or any given session). In addition, being flexible in one’s ability to respond to the appropriate developmental level for the different domains (often within one session) is challenging. Within the context that I conduct supervision, informal formative evaluation is ongoing, with summative evaluations given at midsemester (oral) and end of the semester (written).

DIVERSITY ISSUES IMPACTING THE SUPERVISING PROCESS

The supervisor can function most effectively when he or she is aware of the personal and professional values that impact his or her practice. Awareness of one’s own cultural background, that of the supervisee, and those of the clients are all important in enabling the creation of an effective supervision environment. Assessing the effects of culture in addition to, and apart from, therapist development is necessary. Gender differences are also important variables to monitor in the supervisory (and therapeutic) relationship.
EXPECTED FUTURE DEVELOPMENTS AND DIRECTIONS

I maintain that this approach is not bound to any one therapeutic orientation, but research has not yet been conducted across all current approaches. The content of supervision, however, will differ by therapeutic orientation, although the process should remain fairly consistent. I expect clinical and research advances to largely fit into the overall framework of this model.

AN EXAMPLE OF THE APPROACH

The following example describes the context in which the supervision occurred, the goals and processes, and the evaluation and outcomes.

Context of the Supervision

The supervision relationship occurred in our Counseling Psychology Clinic, which functions as a community mental health center in a city with a population close to 100,000. The clinic serves a breadth of clientele with diverse cultural backgrounds, ages, and socioeconomic statuses. Clients' presenting problems are typical of community mental health centers with a wide range of chronicity and diagnostic categories and tending to have clients near the lower end of the economic spectrum. Services provided include individual counseling and psychotherapy, family therapy, and marital therapy, in addition to a wide range of assessment services, all with sliding scale fees. Therapists are either master's students in community counseling or school counseling programs, or doctoral students in counseling psychology. Master's students spend their 1st year in the program engaged in practica at the clinic, whereas doctoral students spend a minimum of 2 full years in practica at the clinic (3 full years if they enter with a bachelor's degree but not a master's degree). All supervision of doctoral students is provided on site by faculty in the counseling psychology program. Supervision of master's students is provided by advanced doctoral students as part of a practicum in clinical supervision.

For the present case study, the student supervisee was a 28-year-old single Caucasian man in his 2nd year of the program. He was originally from the Midwest and grew up in a family of limited financial means. He entered with a master's degree in counseling (having had practica in his prior program) and experience working with an adolescent population. His primary theoretical orientation was client centered, although he had experience with cognitive behavioral, relational-cultural, and narrative approaches. During the course of this supervision relationship, lasting over 4 months (one semester), he worked primarily with individual clients, although he also had two married
couples in his caseload. He worked with a cotherapist (female doctoral student, 1 year behind him in the program) when engaging in couples therapy.

I was the supervisor in the case study. I am a married Caucasian man (51 years old at the time of the supervision), and I also grew up in the Midwest in a rural setting, in a blue-collar farm family. I have a PhD in counseling psychology and have been active in clinical supervision for 23 years. I am a professor in the program, as well as the director of training. At the time of this supervision relationship, I was responsible for eight supervisees (seeing them weekly for individual supervision and group supervision or case conference). My therapy orientation is integrative, relying on client-centered, cognitive behavior, and psychodynamic theories to inform my work with clients. As noted earlier, my orientation to supervision is developmental, following the IDM.

Supervision Goals and Processes

The supervisee had completed his 1st full year in the doctoral program, which included two long semesters and the summer session in practicum. I have supervised 2nd-year students in our program for 18 years, occasionally picking up other supervisees with less experience, but usually focusing on this group. Our students go through the program as a cohort, so the trainee had been in practicum for the entire year with the same other seven students. Barr ing significant experience in counseling, psychotherapy, or assessment prior to entering the program (typically 5 years or fewer as a practicing master's-level therapist), I expect most supervisees in this practicum to be functioning at Level 2 in at least some domains and probably Level 1 in others. Although I had access to prior evaluations of the supervisee completed by other supervisors, I chose to meet with him first before looking over the evaluations so as to approach him with fresh eyes and not be overly influenced by the perceptions of others for our initial meeting.

As is typical for my supervisory sessions, our initial meeting was spent getting to know one another and discussing general training goals for the semester. One of the primary assumptions of the IDM is that therapists personalize their understanding of the therapy process and how they engage in it. As one's personal attributes and characteristics are important influences on one's behavior as a therapist, I find it important to focus considerable attention on getting to know the supervisee. During this session, the supervisee told me things about himself that he saw as important, discussed how he perceived himself as growing through the training process, and shared some expectations for our work together.

Supervisee: I think I've grown a lot over the past year in my effectiveness as a therapist and for sure in my understanding about
how it all works. I've enjoyed being exposed to different orientations, and I think they add to my relationship skills.

**Supervisor:** So you see yourself as being good at developing facilitative relationships with your clients? What can I do for you this semester?

**Supervisee:** Yes, I think my clients trust me; they come regularly for sessions, and mostly, say I'm helpful. I guess what I'm hoping will come from this semester is more confidence in my abilities and some help understanding what I can do to move my clients along more quickly.

After some discussion of my view of counseling and therapy as well as the supervision process, we went over each of his five current cases, that is, three individual clients and two couples, as he familiarized me with his conceptualizations of them, his successes, and his frustrations. He was particularly interested in getting input regarding the couples with whom he was working.

**Supervisee:** I've had a course in marriage and family therapy, but it was a pretty broad overview of approaches. I'm not at all confident in my abilities in this area. For example, I've been working with this couple for nearly a year. [He hands the client chart over to me.] As I look at it now, there's really been no positive change. Their complaints and behavior are pretty much the same now as when we started.

**Supervisor:** This couple looks familiar to me; didn't I supervise you and another student for a session or two near the end of last fall? [As I peruse the chart I see that, indeed, I signed a couple of case notes the prior year.]

**Supervisee:** Yes, we started using the integrative behavioral couples therapy approach [IBCT; Jacobson & Christensen, 1996] under you, but we kind of moved to a communications approach and spent a lot of time doing client-centered stuff with each of them. Actually, they were both referred for individual counseling, too, but kept coming in for marital therapy.

**Supervisor:** As I recall, this couple had some real challenging baggage they were dealing with. Should be interesting to catch up with where they are now. Think you can bring in your most recent videotape of a marital session with them next time?

**Supervisee:** Yes, I was planning on that. I think things are going pretty well with my other clients, but I'll bring in videos of all of them, too.
My personal belief is that supervisors supervise in the dark if they do not see videos of their trainees’ work with clients or do some direct observation. I think this is true at all levels of training (I know I pick up on things when I view my own videos), but it is most important for the clinical work of those at Levels 1 and 2, according to the IDM. As humans, we have only a certain amount of attention or awareness that we can access at any given time. Thus, trying to pay attention to the client, ourselves, the process, and reflecting on events during the session can tax our memories and ability to focus. If supervisors rely solely on trainees’ reactions and memories of their sessions, they are severely limited in their work. Much occurs in any given session beyond the working awareness of most therapists.

In early supervision sessions, I spent considerable time doing initial assessments of the supervisee’s status on the three overriding structures delineated in the IDM, primarily for the domains of intervention skills competence, theoretical orientations, client conceptualizations, treatment plans and goals, and interpersonal assessment. Given one’s status on these structures, the supervisor can judge the trainee’s level of professional development.

Reviewing the supervisee’s client charts, discussing his perceptions of the clients and his sessions with them, and viewing videotapes helped me develop an early perspective on his development. In addition, the evaluation from his preceding practicum suggested that he was functioning at the expected level (roughly, a general rating of Level 2 for his work, with strong ratings for relationship skills). For his individual clients, it was clear that he had a good grasp of logical conceptualizations of the clients’ personal attributes (including diagnoses), life circumstances, and progress in therapy. He had worked with most of the clients for at least 20 sessions, so we had at least two completed treatment plans (the first done after 5 sessions and then again after each additional 10 sessions) and numerous case notes. I looked for (and found) consistency among written conceptualizations of the clients, their diagnoses, the subsequent treatment plans, progress notes on how treatment was progressing, and in-session behavior (as viewed on videos). This was augmented by the way he described his clients and his work with them.

Supervisee: I’d like to spend some time today looking at videos and discussing my client, Mary. I’ve been working with her for about a year. She’s been coming to the clinic for, I think, around 4 years.

Supervisor: Sounds good. Let’s take a look. [Supervisee puts in a video, and we begin watching.]

Supervisee: This is our most recent session from earlier this week. She’s depressed and anxious much of the time. She’s had regular problems with suicidal ideation, but she hasn’t acted on it. I’m seeing her twice a week now. She says she needs the support.
Supervisor: What changes have you seen in her over the past year?

Supervisee: Our relationship has developed really well, I think, over time. She wouldn’t open up much for the first few months, but she’s pretty good about sharing her thoughts and feelings with me now. I think we have a pretty good relationship.

Supervisor: She really seems down in this session. And so do you.

Supervisee: Yeah, she’s that way a lot. That’s one of the reasons we’re meeting twice weekly. She says she gets too depressed and she needs to check in with me more than once a week. [We continue to view the video in silence for a while.]

Supervisor: What kind of pull do you feel from her during this session?

Supervisee: Hmmm. I guess I’d say a pull to support her, take care of her. She gets so down, I find myself getting right down there with her.

Supervisor: How old does she seem to you at this point in the session?

Supervisee: She’s in her early 40s.

Supervisor: [Laughs.] Thanks, but I didn’t ask her age. Forget how old she is, or how old she looks; when you’re in the session with her, how old does she seem?

Supervisee: Hmmm. I guess about 9 or 10. I don’t know. She seems really young and dependent.

Supervisor: And how does that make you feel?

Supervisee: I guess I usually feel like I need to support her, but sometimes I get frustrated because she just can’t seem to get past the depression. And she really doesn’t seem to have the energy to do much between sessions.

Our work in this session was primarily within the domains of interpersonal assessment and client conceptualization. The supervisee appeared to me to dealing with Level 2 issues, primarily in the area of self and other awareness. He showed an ability to focus well on the client and he appeared to be experiencing empathy toward her, with a tendency toward, perhaps, over-involvement. It was clear in his case notes that he understood her feelings of helplessness in her daily life. He was, however, beginning to experience frustration with her lack of movement and her inability (or unwillingness) to work on much between sessions. Supervisory interventions used were primarily facilitative (many of these can be nonverbal), and catalytic (process comments and observations).

I find myself using analogies quite a bit in supervision. One I regularly use is “therapist development and the hole.” In this analogy, the Level 1
therapist stands at the edge of a hole, looking down at his or her client. He or she will try to comfort the client in this unfortunate situation, convey sympathy for the predicament, and maybe give some advice on how the client could climb out. The Level 2 trainee differs from Level 1 in that he or she climbs down in the hole with the client (i.e., the trainee feels and expresses empathy). The therapist can now better appreciate the depth of the client’s problem or problems, and the client feels understood and not alone. Unfortunately, often neither one knows how to get out. That is a bit like the situation in which the supervisee found himself with this client. He experienced empathy, was able to see her perspective on her life, and was able to communicate that to her. Unfortunately, there they stayed. To remain with the analogy, our goal was to find a way for both of them to climb out (Level 3), using acquired (or developing) knowledge and skills to achieve this goal. At this point, I believe, the supervisee felt he would need to throw the client over his shoulder and carry her out. We spent considerable time over the next few weeks examining ways he could help her find her way to the surface.

Through watching more videotaped sessions and processing what was going on with the client, the trainee, and the process, (through facilitative, confrontive, and catalytic interventions) the supervisee decided that he needed to encourage the client to monitor her daily activities more. She needed to monitor her thoughts, emotions, responses, and outcomes to daily events. He came to believe that the dependency the client had developed on him was slowing her progress, and he noted he had been periodically feeling like a “failed savior.” The supervisee felt comfortable in being responsible for decision making about the client, and derived most of his direction in response to observing what was going on in the sessions and reflecting on what he saw, as well as his thoughts and feelings about what he saw. My input remained largely supportive, with some confrontation (pointing out discrepancies among his thoughts, feelings, and actions), making process comments about what went on in the sessions or what he was currently experiencing (i.e., catalytic interventions), and using some conceptual interventions as we discussed how various theories could explain or impact his work with the client.

As we examined the documentation for his couples early in the semester, it became clear that little progress had been made, particularly for the couple he (and two different cotherapists) had worked with for 9 months. The case notes reflected week after week of supportive listening as the partners complained about each other, and attempts at teaching them to communicate more clearly resulted simply in more clear complaints and negativity. On viewing the videotapes, it became evident that the partners were communicating their displeasure with each other quite clearly, but this was not leading to improvement in the relationship.
Supervisee: I really don't think we're helping this couple. Week after week, they come in and complain about each other, and nobody's changing. I haven't had much training in working with couples, just a survey course. I'm feeling pretty lost, and my cotherapist has less experience than me and is looking to me to take the lead. I think I need help.

Supervisor: Let's take a look at the most recent session. Did you bring the video with you?

Supervisee: Yeah. Got it right here. [The supervisee loads the video, and they begin watching.]

Supervisor: What are you trying to do with the couple at this point in the session?

Supervisee: Hell, I don't know. Trying to get them to clarify the complaints they have toward each other. Ends up being a bitch session.

Supervisor: Judging by the case notes, you've had a few of those with this couple, eh?

Supervisee: Yeah, about 9 months of them.

Supervisor: You and your cotherapist look frustrated on the tape.

Supervisee: I know I am. My cotherapist will come in next week for supervision with me, and I think she'll agree we're both pretty frustrated. We referred them both to individual therapy, too, thinking that may help them clarify some of their own issues and help marital therapy.

Supervisor: Has it?

Supervisee: Not that I can tell.

Supervisor: Let me come clean here with some biases of mine. As I read the literature on marital therapy, there's not a lot of evidence that what many therapists do with couples seems to work. Especially if you take the same techniques and orientations you use in individual work and try to make them fit marital therapy. We typically need to introduce more structure when working with couples. Can't let them go ballistic on each other all the time in the sessions. I like to use integrative behavioral couples therapy when I work with couples. It has pretty solid theoretical and empirical support, and it's worked well for me.

Supervisee: Yeah, we started with that but then went a different direction when we switched supervisors. I really need some guidance here. Can I borrow a book or something?
Supervisor: Sure, got one here. If you like, we can go over parts of this tape again and I can help give you some ideas on what you could do differently.

Supervisee: That would be great. I hate feeling so lost in these sessions, and we don't seem to be helping this couple much.

Supervisor: OK, let's review what you know about this couple and start to put it into a framework.

In contrast to the supervisee's work with his individual clients, he admitted to a lack of direction, frustration with not knowing what to do, and concern that the marriage was not improving. In essence, he was acknowledging he was functioning largely at Level 1 here, experiencing cognitive confusion, anxiety, and a desire to depend more on guidance from the supervisor but highly motivated to learn and improve. In this session, I found myself using facilitative interventions to give him support and some conceptual interventions while beginning to move toward prescriptive interventions. There are times, particularly when a trainee is functioning at Level 1, when he or she simply needs input regarding what to do. In my experience, couples therapy is in a number of ways considerably different from what therapists do in individual work. Just focusing on facilitative interventions or, for that matter, confrontive or catalytic interventions at this point would probably serve to mostly frustrate the trainee. Sometimes he or she needs specific input on given theoretical orientations (conceptual interventions) and specific advice on how to implement them (prescriptive interventions).

Over the course of the rest of the semester, we spent considerable time going over videotapes of couples sessions. I continued to rely on facilitative interventions to make the supervisee (and his cotherapist, when she could join us in sessions) less anxious and supported in the process of learning to work with couples. Considerable attention was paid to conceptual and prescriptive interventions, too, as the supervisee was unfamiliar with the IBCT approach, was not married, and had limited couples counseling experience. As his familiarity with the approach increased and his comfort level improved, I was able to back off some on the use of both conceptual and prescriptive interventions and move more toward confrontive and catalytic interventions to allow him to more independently process his thoughts, feelings, and behavior.

Evaluation and Outcomes

By the end of the semester, the supervisee had made significant progress with his clients, particular the individual client, Mary, and the couple described above. Mary was down to one session per week and was completing weekly charts on her daily activities and her thoughts, emotions, adaptive...
responses, and perceived outcomes to critical events each week. She reported experiencing less depression most days, and she had become more energized. The supervisee felt good about his work with Mary but believed they had a ways to go before she could function more independently.

The marital therapy experience had, by all accounts, been a success. The couple reported (and demonstrated) more emotional acceptance of each other, and coupling behavior had significantly improved. They suggested toward the end of the semester that they felt they had improved enough to “go it alone.” Responses to the Dyadic Adjustment Scale (Spanier, 1976) were consistent with this perspective. The therapeutic relationship terminated with the supervisee noting that he would be available to meet with them on a one-time basis, should they need it, over the next 6 months before his practicum experience ended at the clinic.

My assessment of the supervisee at the end of the semester was communicated to him verbally and in written form with our standard practicum supervisee rating form. Our standard form asks us to rate a number of dimensions on a 5-point scale (1 = unacceptable to 5 = excellent) for the level of trainee development. I saw him as developing through Level 2 for his individual clients and showing transitions to Level 3. In terms of his work with couples, he had grown immensely, with dramatic increases in confidence and, in my opinion, his ability to conceptualize, develop a treatment plan, and implement it. Given that we often see trainees grow more rapidly in domains that are closely related to others in which they are more advanced, the supervisee’s therapy skills with individual clients enabled him to develop more quickly in the arena of marital therapy. With a better understanding of the theoretical basis of the work and a growing familiarity with the different interventions used in the approach, I saw him as solidly functioning in Level 2. For the items in the area of basic communications skills, I rated him 5, or excellent, as he demonstrated to me his strong skills set in this area. Similarly, I rated him excellent in the areas of single interview management skills and basic planning and treatment program implementation skills. I rated him 4s (very good) and 5s (excellent) for most items in advanced planning and counseling implementation skills, and in the area of personal characteristics and behaviors affecting professionalism and professional development. I am aware that our faculty supervisors tend to vary the range of ratings they give their supervisees; I probably err on the side of higher ratings, as I believe it is a way to acknowledge the work the supervisees put in to the process and to shape them toward continued growth. Ultimately, however, their performance needs to merit their ratings and verbal feedback. Finally, I recommended the supervisee seek additional experience with clients of different ages and cultural backgrounds than what he experienced in our work together. I also recommended that he continue to develop his skills and understanding of IBCT in working with couples in the future.
The supervisee’s evaluation of our supervision experience was communicated to me by him both verbally and in written form. As I was also supervising seven other trainees during this period, I did not know which written evaluation of supervision was completed by him (to encourage the most accurate written evaluations, I require them to be anonymous from the supervisees). I can note, however, that the average ratings of me by supervisees during this period were in the 6 (quite above average) to 7 (very much above average) on a range from 1 to 7 across the categories of evaluation (i.e., time and effort expended by supervisor, specific input on client management by supervisor, and dimensions of the supervisory relationship). Verbally, the supervisee voiced appreciation for the humor and respect he felt I brought to the process. He noted that he felt he could explore client issues, and issues he had as a therapist, in a safe environment without losing responsibility for his work and without feeling criticized. In the words of the supervisee:

I felt that I was encouraged to explore thoughts and feelings in my work with clients, and not feel like I was myself the client. Sometimes you’d just sit back, reflect some, and let me struggle. Other times you would propose pretty specific alternatives. I’m not sure how you knew which to do, but I think it really helped me grow.

CONCLUSION AND RECOMMENDATIONS

Supervisors constantly struggle with the balance of optimum service delivery for clients and supervisee training needs. I think the IDM, and the context in which I am able to use it, allows for an appropriate balance. Attending to the domains of clinical practice allows supervisors to be reminded that supervisees do not typically function at only one level of professional development but rather are often functioning at multiple levels for various domains. This is an important process to remember. In addition, monitoring the trainee’s progress according to changes in the overriding structures, for each domain, helps the supervisor assess the current status and training needs more accurately.

Unfortunately, there are no adequate pencil-and-paper instruments for conducting an appropriate assessment. The supervisee’s behavior with clients and in supervision provides the data from which the supervisor can make these assessments. These ongoing assessments then suggest the degree of structure for supervision and training to be provided by the supervisor (the more developed the trainee, the less structure provided by the supervisor) and types of supervisory interventions that may be used at any given point in the supervisory relationship.

It is important to once again note that this approach to supervision, or any other, cannot be adequately implemented without viewing the process of
therapy (or the process of other domains) directly through videos or observation. This not only allows for working with the therapy process that actually occurred (as opposed to memories or presentations of the process) but also can provide evidence for changes in supervisee behavior that can reflect the success (or lack) of supervision.

We are nearly at the point in setting up our clinic database when we will be able to more fully use therapy process and outcome data to more adequately evaluate the supervision process in our setting. Ultimately, it is our goal to monitor ongoing change in clients as indicated by self-report measures, standardized instruments, and observed behaviors as a function of issues addressed in supervision. Also, using qualitative methodologies to tap into changes in the perspective of supervisees and supervisors over time can add to our clinic supervisors’ understanding of the process.

REFERENCES


