CHAPTER SIX

SOLUTION-FOCUSED SUPERVISION

The Coaxing of Expertise

Frank N. Thomas

A
n episode of the hit television series “Northern Exposure” featured a conversation between a young filmmaker and a Native American artisan. The filmmaker was putting together a documentary to preserve the art of flute making, a painstaking process involving the creation of a ceremonial flute from a tree branch. As the sixty-eight-year-old woodcarver began to craft, the conversation turned to the philosophy of the art, and the woodcarver said, “The branch will tell me how to carve it . . . Each piece of wood has its own shape, which you must respect. . . . In each . . . branch lies a flute; [my] job is to find it.”

This example defines a context for understanding the philosophy and process of solution-focused supervision as it is currently being interpreted in the field of family therapy. Based on models known as solution-focused (Berg & Miller, 1992; de Shazer, 1988, 1991; Furman & Aholo, 1992), solution-oriented (O’Hanlon & Weiner-Davis, 1989), brief (Cade & O’Hanlon, 1993; McFarland, 1995), narrative (White & Epston, 1990), competency-based (Durrant, 1993, 1995; Durrant & Kowalski, 1993; Thomas & Cockburn, in press) and possibility (O’Hanlon, 1992; O’Hanlon & Beadle, 1994) therapies, this approach to supervision is significantly different from

Note: Special thanks are due to “Chip” Chilton, Hung-Hsiu Chang, Mallika Samuel, Kristi Krorpp, and Jack Cockburn, who along with others have taught me that teachers are useless without learners.
other models of family therapy supervision. The major tenets of solution-focused brief therapy (SFBT)—curiosity and respect (Berg & Miller, 1992)—are also the primary focal points of the solution-focused supervision model in that the model seeks to coax and author expertise from the life, experience, education, and training of a supervisee/therapist rather than to deliver or teach expertise from a hierarchically superior position (White & Epston, 1990). This chapter correlates some of the basic tenets of solution-oriented therapies with the supervision context to supply the underpinnings necessary for a theory and practice of solution-focused supervision.

### What Therapists Want from Supervision

Very little can be gleaned from the family therapy literature regarding therapist perceptions of supervision (Gershenson & Cohen, 1978). Because of this paucity of research, Heath and Tharp (1991) examined the supervision process in an attempt to build understanding of therapists’ needs, desires, and requirements in this learning system. The themes that developed from their research seem particularly relevant to the discussion of supervision models that may utilize solution-focused approaches:

1. **“We want relationships based on mutual respect.”** Respect is a philosophical principle of solution-focused models of therapy (Berg & Miller, 1992), and it is fitting that a supervisory experience based on this cornerstone assumption would be in line with therapist expectations.

2. **“You don’t have to be a guru.”** Because the client is the expert within solution-focused models (de Shazer, 1988; Durrant & Kowalski, 1993; O’Hanlon & Weiner-Davis, 1989), an appropriate way to supervise would be to create an atmosphere of collegiality with the therapist as opposed to a traditional, more hierarchical relationship.

3. **“Supervise us or evaluate us; not both.”** One of the most difficult distinctions to draw within the supervision relationship involves the evaluative process inherent in many academic, agency, and training settings. The focus of a solution-focused supervision process should be the achieving of well-defined goals set by the therapist/supervisor team; therefore, evaluation should also be a cooperative experience based on goals and change.

4. **“Assume that we’re competent. We’re hard enough on ourselves already.”** Believing that the client has the capacity and ability to solve his or her own problems is a foundational assumption of solution-oriented therapies (Durrant & Kowalski, 1993); therefore, solution-focused supervision should likewise assume that the therapist-in-supervision is competent to bring about change when necessary, to
continue successful skills and conceptualizations, and to adjust when necessary
to a more useful position, strategy, or orientation.
5. "Tell us what we're doing right. Affirm us. Empower us." The recognition and amplification of success are foundational in these models (O'Hanlon & Weiner-Davis, 1989; Weiner-Davis, de Shazer, & Gingrich, 1987) and should lead to a supervisory experience of empowerment based on the therapist’s successes and competencies.
6. "Listen to us. Make supervision a human experience." Just as the therapist relies on the client to be the expert on her or his life and complaint, within this model the therapist, not the supervisor, must be the expert on the therapist’s life, abilities, and experiences (Kowalski & Durrant, 1990; Walter & Peller, 1992). It naturally flows that when the supervisor listens with curiosity and respect in order to bring about change, the human factor will become primary in the relationship (Berg & Miller, 1992; George, Iveson, & Ratner, 1990). (These concepts will be discussed further later in the chapter.)

Applying these themes to a solution-focused supervision approach is not simple, nor is their implementation necessary. However, given the cooperative nature of the therapeutic model, this research offers a starting point for the creation of a supervisory relationship based on respect, competence, and cooperation.

The Concept of Isomorphism in Family Therapy Supervision

A solution orientation to supervision can be very useful when one considers an important aspect of the process: the expectations and anticipated needs of the therapist. An equally important aspect to be considered in supervision is the relationship between the supervisory approach and the model being utilized by the therapist. The most common understanding of this issue in the family therapy supervision literature involves the concept of isomorphism.

"As clinical training programs change, it is being discovered that a theory of therapy and a theory of training are often synonymous" (Haley, 1976, p. 170). This supervision concept is known as isomorphic, or equivalent, structures. “The word ‘isomorph’ applies when two complex structures can be mapped onto each other in such a way that to each part of one structure there is a corresponding part in the other structure, where ‘corresponding’ means that the two parts play similar roles in their respective structures” (Hofstadter, 1979, p. 49). An isomorphic relationship is not duplication or repetition; rather, it signifies an overlap and a sense of connection. According to Levinson (1972, p. 36), the “structure, or form, is constant in spite of changing content.”
Within family therapy, the isomorphic structure of the supervisory relationship continues to be the most acceptable metaphor for understanding training and development. For example, within structural and strategic therapies the training task is to narrow the perception and views of the therapist toward more "contextually sensitive, systemic" orientations (Liddle & Saba, 1983, p. 5). This is achieved through goal setting, mirroring of sequences, increasing intensity, enactment, planned interventions, and other strategies inherent to these models. When supervision is organized isomorphic to these models, a hierarchical relationship between supervisor and therapist "will naturally organize" itself; it is "inevitable" (Liddle & Saba, 1985, pp. 35–36).

Perhaps the most significant "difference which makes a difference" (Bateson, 1972/1985) that is created when one formulates supervisory relationships using a solution-focused model involves this concept of hierarchy. Within the solution-oriented models, the relationship between client(s) and therapist is cooperative and respectful. Because the therapist assumes that the client both is the expert on (Berg & Miller, 1992) and has the resources to resolve her or his complaint (O'Hanlon & Weiner-Davis, 1989), the therapist seeks to discover ways to cooperate with the client's desires, definitions, goals, and language. Isomorphically, solution-focused supervision seeks to set up a cooperative, goal-oriented relationship that assumes that the therapist possesses the strength, ability, and resourcefulness to resolve a complaint and achieve training goals. It naturally follows that the supervisor is not the expert on the therapist's situation—the supervisor defines the goals, directions, and options with the therapist to construct a participatory experience through consensus and teamwork. Supervision proceeds as a future-oriented endeavor, setting up positive expectations and building on the unique assets of the therapist.

Some Guiding Assumptions for Solution-Focused Supervision

In supervision, it is more important to know where one begins in the process than where one ultimately goes (Cantwell & Holmes, 1995). O'Hanlon and Weiner-Davis (1989) have supplied the psychotherapy field with a set of well-formed assumptions regarding solution-focused therapy and competency-based models in general. Other chapters in this book thoroughly address solution-focused assumptions, both theoretical and clinical, which are seminal to the model; therefore, this chapter will not attempt to defend the adequacy or accuracy of the listed assumptions. Because of the isomorphic relationship between the therapy and supervision models, these assumptions have been adopted with commentary regarding how they can be understood and adapted to the supervisory experience.
Most of the assumptions discussed are derived from O'Hanlon and Weiner-Davis (1989), and they closely parallel Cantwell & Holmes's (1995) social constructionist supervision principles. Additional assumptions are noted with citations.

*It is not necessary to know the cause or function of a complaint in order to resolve it.* In solution-oriented models, there are no "symptoms" of underlying problems. The person is not the problem; instead, "the problem is the problem" (White, 1989). Many therapists have problem-saturated views of themselves and their therapy. Seeking a "cause" or "function" of a problem perpetuates this focus. Instead of attempting to resolve the "issue" identified by either the supervisor or the therapist, the supervisor needs to focus on what prevents the problem from being resolved in the therapist's present experience. A case example may be helpful to illustrate this concept.

Jim, a therapist at the university’s family therapy clinic, had a case he affectionately titled, "She Is My Mother." After Jim struggled for six months with a client who was a carbon copy of his own mother, a live consultation was arranged, which I observed from behind a one-way mirror. During a break, Jim proceeded to explain to me his connections to the client (she was the same age as his mother; she had a son with the same name as his brother, and so on), believing, perhaps, that explanation would lead to his understanding why he was stuck, and to direct change. Assuming that additional insight was unnecessary for change in the situation, the conversation focused on what Jim was doing when the treatment was progressing:

*Supervisor:* When in the session does she experience change?
*Therapist:* When I keep her on task and hold her to the topic.
*Supervisor:* How do you do that?
*Therapist:* I interrupt her!
*Supervisor:* Could you do more of that?

The case terminated in five weeks, with the client experiencing rapid change in her relationship to her children and husband. Jim attributed the change in the client’s situation to his change in approach: doing what worked and diminishing his views on the importance of understanding his relationship to the client. He relates that he never did discover why he was stuck—he simply got unstuck.

*Therapists know what is best for themselves.* Because the goal of supervision is to establish a "contextual reality of competence" (M. Durrant, personal communication, October 9, 1992), this model assumes that therapists have access to the resources necessary to solve therapeutic dilemmas. It is unfortunate when supervisors become didactic before it is necessary, for the model assumes that the therapist is capable of drawing on resources to break the binds currently blocking his or her change with one case or one specific skill.
There is no such thing as “resistance” (de Shazer, 1984). The supervisor’s task is to find ways to cooperate with the learning experience and style of the therapist. “Stuckness,” or escalating sameness (Keeney, 1983), is often maintained collaboratively by supervisor and therapist; the supervisor’s task is to discover ways to cooperate so that the therapist is free to choose new options and directions.

The supervisor’s job is to identify and amplify change. The focus of supervision in this model is on solution talk, not problem talk. Because the constructivist position “believing is seeing” seems to apply (von Foerster, 1984), the supervisor is in the unique position of being able to bring attention to whatever he or she sees as relevant in the supervisory process. Paramount within this model are increasing the occurrence of successes and amplifying changes the therapist makes.

A small change is all that is necessary. Within this model, the best experience is a small success. Launching a small change will lead to a recursion of change (Keeney & Thomas, 1986). Likewise, increasing feelings of competence will lead to drawing upon different resources, which in turn will lead to additional successes and change. This “snowball” or “ripple” effect, as it has been called, is a time-tested systemic assumption in the therapy arena that begs application to supervision (O’Hanlon & Weiner-Davis, 1989).

Change is constant, and rapid change is possible. “If you assume change is constant, you will behave as if change were inevitable” (O’Hanlon & Weiner-Davis, 1989, p. 35). No supervision “problem” remains the same, nor do “problems” in supervision follow a prescripted course. The meanings, attitudes, and experiences of events are altered by time because the assignment of meaning to events requires context (Keeney, 1983). Since nothing remains the same, the responsibility of the supervisor is to locate differences that are inevitable and then to signify them. Changes in supervision may be progressive or discontinuous as the therapist develops, and the supervisor must allow himself or herself to be surprised.

Pat, an experienced therapist continuing her education by pursuing a doctorate, was exposed to the ideas of systemic perception in a clinical class. One night, while lying awake in bed, Pat cried tears of joy when she made the discovery that she could “see” systems, interactional patterns, and connections between people. This very significant change greatly accelerated her goal of working systemically with her clients—a goal she says she never would have achieved by simple progressive learning and experience. The rapid change was not anticipated, nor could it have been predicted; however, it was accepted and integrated into her learning because this model allows persons to change at their own pace and within their own limits.

Supervision should focus on what is possible and changeable. Within a solution-focused supervision experience, one should leave the impossible alone and work instead with what is possible and likely. In this regard, recognizing capabilities is more
important than accentuating the intractable deficits, experiences, and beliefs of the therapist. Since one cannot undo what has been done, the supervisor should focus on what can be done next—that is, move forward with what is realizable and feasible with the therapist in the time available.

Some supervisors who implement this model may miss the “good ol’ days” of meat-and-potatoes, issue-driven, pathology-defined supervision that is loaded with tears, painful insights, and arduous self-discovery. In fact, solution-focused supervision may not even feel like real supervision at first. However, recognizing that in the current managed care atmosphere psychotherapy supervision will go the way of psychotherapy practice, ways must be found to offer effective supervision without the luxurious time spans of the past. Helping therapists get on the right track and grow without an ongoing formal supervisory relationship may be the requirement of supervision in the twenty-first century.

There is no one “right” way to view things. Because solution-focused therapy follows a constructivist view (von Glasersfeld, 1984), “different views may be just as valid and may fit the facts just as well” (O’Hanlon & Weiner-Davis, 1989, p. 46). For this reason, it is not necessary for the supervisor to convince the therapist of the “rightness” or “wrongness” of the therapist’s particular view. Rather, the supervisor’s task is to develop “fit” with the therapist so that the therapist may entertain additional views (de Shazer, 1988). By so utilizing the language and perception of the therapist, the supervisor empowers the therapist with alternative and viable choices when he or she is stuck in a particular mode of thinking, feeling, or behaving.

One of the most valuable components of a solution-focused approach to supervision is the supervisor’s respectful questioning of absolutes. Therapists in group supervision settings notice how the supervisor handles ideas, and in such a context therapists can often perceive as disrespectful the supervisor’s correcting of their understanding or decisions. When supervisors ask such questions as How do you see yourself working differently in a similar situation? and What also might be true? they allow therapists to question their own conclusions with minimal threat. Consistency in questioning reified positions is essential; however, without kindness and respect, little may be heard.

Curiosity is indispensable (Berg & Miller, 1992). A genuine desire to know the opinions and perspectives of the therapist is rudimentary. The best way to expand the therapist’s views and options is for the supervisor to seek to comprehend the therapist’s interpretation of the complaint and to act in cooperation with this understanding. The therapist is the expert; therefore, useful knowledge begins with the therapist’s knowledge. Two supervision examples may be helpful in illustrating some of these assumptions.

Keith is a middle-aged professional with years of people experience. At the first supervision meeting, he related that since he had never had any formal psy-
chotherapy training he felt very inadequate for the tasks ahead. Keith had a full pad of paper, several sharpened pencils, and an audiotape recorder, intending to catch every drop of wisdom his supervisor had to share! After taking out a pad of paper and a pen, the supervisor turned to Keith and asked, “What strengths do you bring to this learning context?” Keith was dumbfounded! It took most of the initial session to work out how his expectations of passive learning from the “master” and the supervisor’s expectations of amplifying his existing skills would fit together, creating a common goal focusing on Keith’s own learning objectives and particular style. In the next few weeks, Keith set three-month goals for himself that were quite simple yet elegant: to use questions more than statements (that is, interpretations), to consistently apply the major assumptions of SFBT in 50 percent of his sessions, to read three books on SFBT, to transcribe thirty minutes of what he considered to be his best work to give himself a different view of the therapy, and to share fifteen minutes of videotape in individual supervision each week, balancing “when I blow it” with “when I’m doing well.” At the end of this initial supervisory term, Keith had achieved all of these goals and had developed an effective style in the therapy room that delighted clients, colleagues, and supervisors alike. This beginning, based on cooperation and therapist motivation, laid what Keith calls a “firm foundation” for all of his future learning in the field.

Marguerite is a doctoral student with nearly fifteen years of clinical experience. Although she had rarely done any couple or family work, she brought sharp clinical eyes and ears to the supervision process. At the beginning of the supervisory relationship, her theoretical ideas were “a jumble” (her words), a “mish-mash” (again, her description) of linear and systemic concepts that did not fit together well for her. Instead of challenging her to resolve her confusion and bringing force to bear on her nonsystemic beliefs, the supervisor simply asked her to write out her goals for the next supervision meeting. When she presented her goals the next week, she was excited by the fact that the supervisor thought she could achieve many of the aims she had set for herself. Together, they fine-tuned her goals so that both of them would know whether and when she had achieved them, working as a team with the common purpose of improving her clinical skills. From this point on, these goals were used as a focal point in supervision, carefully bringing Marguerite’s sufficiency and resources to bear on the challenges she had set for herself. The result: instead of deteriorating into a debate of presuppositions each week, the supervisor and student converged to reach achievable goals that both were motivated to attain. Another result: Marguerite gave her best effort to move beyond the limits of her earlier learning and experience, choosing to learn a competency-based model and to apply her skills to mastering new approaches in the clinical arena.
It is hoped that these two supervision examples illustrate connections between SFBT and a supervision approach based on similar assumptions. Bringing a focus of cooperation to supervision may radically alter the supervisory process. The following sections give practical examples on implementing a solution orientation in this context.

**Becoming Solution-Focused in Supervision**

It is not enough simply to *know*—supervision is an inventive art, not an ivory-tower concept. Working with therapists who come with diverse experiences is a challenge for any supervisor; within this model, several ideas may guide the supervisor toward consistency with the assumptions outlined earlier. The questions that follow, which are in keeping with the solution-oriented models of O’Hanlon and Weiner-Davis (1989), Durrant (Durrant, 1993; Durrant & Kowalski, 1993; Kowalski & Durrant, 1990), de Shazer (1988), and Berg and Miller (1992), may help the supervisor (or the therapist) in the pragmatics of supervision in this model. (The categories in which the questions are organized are adapted from Kowalski and Durrant, 1990, except where noted.)

**Socializing**

How one introduces the supervision sets the expectations, tone, and context for future supervisory experiences. Given the assumptions identified earlier, the supervisor needs to begin applying himself or herself to the task of developing a collaborative context for supervision. The very act of joining—often called hosting (Furman & Ahola, 1992) or socializing (Kowalski & Durrant, 1990) should seek to establish and optimize a cooperative relationship.

The supervisor should inquire into subjects that are success-possible. Topics might include “good” cases, positive training experiences in the past, interests, and life experiences that the therapist brings to the supervision relationship. Here are some questions a supervisor might ask (Kowalski & Durrant, 1990):

- What do you do well with regard to your therapy and supervision?
- How has your life prepared you thus far for this step in your training?
- How have you successfully guided your supervision in the past?

**Saliency**

What is important to discuss should be co-created in supervision (Berg & Miller, 1992). Seeking the therapist’s personal, contextual, theoretical, pragmatic, emotional, and historical views is cardinal. Questions that may help the process include:
What would be most helpful for us to focus on?
What is the most important thing I need to know about your therapy and supervision at this time?

In maintaining a solution focus in the interaction, the following questions may be helpful:

With which types of problems (people, situations, families, and so on) do you do well?
How has your therapy improved since our last consult?
When things are better (with regard to a complaint), what are you doing differently?

Setting Goals

The questions that guide this area of inquiry should focus on the therapist's desire for change: how does the therapist wish things (feelings about therapy, behaviors, a specific case, and so on) to be different? At this point the supervisor should follow solution-focused therapy guidelines for goal development in defining achievable goals (for valuable information, see Walter & Peller, 1992).

The goals should be positively framed and as specific as possible. Further, any goal should be primarily within the control or agency of the therapist; that is, achieving one's goal should not be dependent upon "correct" client change. Also, goals should be couched in the therapist's language in a process form—that is, it should be possible to identify change and success during the course of supervision. Examples of questions to utilize include the following:

How will you know when things have improved for you?
What will be different when your therapy is better (Kowalski & Durrant, 1990)?
How will we know when it is time to move on to something new in supervision?
What will be happening differently when the issue you are complaining about is better?

The Miracle Question

One of the most important elements of goal setting involves what de Shazer and his colleagues (Berg & Miller, 1992; de Shazer, 1991; O'Hanlon & Weiner-Davis, 1989) have termed "the miracle question." By projecting the problem into
the future, the supervisor asks the therapist to envision therapy without the problem and to describe activities, feelings, and perceptions without the influence of the problem. If the therapist has difficulty picturing life without the problem, asking the following questions and seeking descriptive examples of difference will allow the forming of an achievable goal:

If a miracle were to happen tonight while you were asleep and tomorrow morning you awoke to find that this obstacle was no longer a part of your life, what would be different?

How would you know that this miracle had taken place?

How would I be able to tell without your telling me?

Small Changes

Essential to the process of setting goals is understanding what small changes can be made toward the objective. As many theorists of the solution-focused model have noted, it is critical to think small to secure immediate success for the supervisee. When pursuing the goal, it is important for the supervisor to be as concrete as possible and to offer sincere compliments to the therapist when progress and change are identified. Questions in this area might include:

What will be a small sign, something that you might notice this week, that will tell you that things are looking up for you in this area (Kowalski & Dur- rant, 1990)?

What is a small step that you could make in the direction of the goal?

What will be the first thing I (or another person) will notice about your therapy when it improves?

Scaling Questions

One particular technique, called "scaling" (Berg & Miller, 1992), has been particularly useful with clients and translates well into the supervision process. Redefining a goal from a dichotomy (either/or, success/failure) to a range (1 to 10) allows for the discerning of small changes and the recognition of progress before finally achieving the goal. Examples of questions using this scaling technique follow:

On a scale from one to ten, with one being failure and ten being complete success, how would you rate how you’re doing with your problem right
now? And when you rate yourself at [one or two points higher than the therapist’s response], what will you be doing differently (Kowalski & Kral, 1989)?

Since you have a pretty good idea where you stand with your problem, pay attention this week to when it is just a little better. We’ll discuss what you’re doing to make that happen the next time we meet.

Identifying Exceptions to Problems

Within this model of supervision, problems are defined by the therapist—the supervisor rarely identifies problems for the therapist, except in situations that require ethical and/or legal consideration before professional development (Thomas, 1992, 1995). Exceptions, according to Kowalski and Durrant (1990), are “those bits of experience, behavior, interaction, or self-perception which serve to challenge the dominant description.” These are moments or events in which change has been evident to the supervisor, the therapist, or people in the therapist’s context. Since exceptions are assumed to exist in any problem description in this model, the supervisor must seek to identify these exceptions and build upon them for future change. Questions might include:

I’ll bet there are times when you expect the problem to occur and it doesn’t. How do you explain this? How do you make that happen (Kowalski & Durrant, 1990)?

When is the problem less frequent (intense, severe)?

When is the problem just a little different?

When are you doing some of what you want to do in relation to this problem?

Making Exceptions Meaningful

Investing agency or control in the person’s story is one helpful path toward change (this category was identified by Kowalski & Durrant, 1990; see also Anderson & Goolishian, 1992; Durrant & Kowalski, 1993). Questions can be formed by the supervisor that make an opening for explanation that puts solving the problem within the control of the therapist. Examples include:

[When an exception has been identified] How do you account for your ability to do this (Kowalski & Durrant, 1990)?

How did you decide to do this?
Did you know you would be able to influence your problem?  
Was this easy for you to do or was it difficult?  
How have you managed to decrease ______ since our last consult?  
So, the problem isn’t much better—what have you been doing to keep it from getting worse?  
How have your mistakes, errors, and so on made you a better therapist?  
What was different about you when you stood up to (changed or influenced) the problem (Kowalski & Durrant, 1990)?  
What did your clients notice about you when you had an influence on this problem?

**Future Orientation, or Keeping the Changes Going**

The supervisor using this model is committed to amplifying positive change as the therapist experiences it. Once exceptions have been identified, the supervisor’s task is to find additional exception experiences that, it is assumed, will lead to further progress toward the identified goal. Questions that relate to this concept include the following:

Let’s assume you beat this problem—what will be different for you (Kowalski & Durrant, 1990)?

Now, you’ve got this problem on the run! What are you continuing to do this week to perpetuate the change?

All you have to do is keep up this change, right? How will you do that?

What specifically do you need to focus on doing this week to keep the problem from returning?”

---

**Other Ideas for Implementing Solution-Focused Concepts**

**Accessing Therapist Resources**

As with most relationships, supervision requires time and information for change to occur. Since a focus on resourcefulness is a major premise of SFBT, this supervision model works best when both therapist and supervisor share information that will create a strengths-based relationship. As a supervisor, I am very open about what I believe is usually helpful (and what is not helpful) in the supervision
process, and my attempts to "flatten out" the seemingly inherent hierarchy of supervision have been met with equal openness from therapists.

An exercise created in a therapy context (Thomas, 1994a) has proven useful in supervision contexts as well. In the early meetings, the therapist is asked to buy a spiral-bound notebook and then to ask the following question of two or three friends or relatives who will be truthful yet kind: "What do you value about how I relate to people?" The therapist is to record each person's comments on the first sheet of paper in the notebook and bring the list to the next supervision meeting. Comments are generally one-word or short-phrase descriptions, such as "honest," "patient with children," "good listener," and "caring." At the meeting, the therapist is asked to separate those comments that "fit" (those that the therapist agrees with) from those that he or she disagrees with. Then the therapist is asked to write each comment separately at the top of the next notebook pages (so that page 2 would have "honest" at the top, page 3 would have "good listener" as a header, and so on). The supervisor then tells the therapist how to use the notebook to inform the supervisor of his or her strengths:

During the next two weeks, I would like for you to write down examples for each and every one of these ideas. If you experience a moment of "honesty" with a client, friend, lover, or stranger, please record the particulars of that event under "honesty" in your notebook. Noting the time, place, and people involved as well as your own brief reactions or feelings will help me better know how you see yourself. If an event fits in more than one category, please feel free to place it wherever it fits. At the end of two weeks, I hope you will have a resource notebook that I can copy and return to you, and I believe this will be invaluable as we work together on accessing your strengths with people and applying them to your practice of therapy.

This exercise can be one of the most popular activities in supervision! Therapists find it affirming and helpful in their steps toward effectively working with people in the counseling setting. One could improvise upon this theme by asking therapists to continue the notebook throughout their time in supervision, adding additional descriptions and examples as their experience in therapy broadens.

Using Presuppositional Language

Nearly everyone considered to be a major author in the SFBT area emphasizes the importance of language. Joining with therapists in their particular use of words is essential to relationship formation, and creating common understandings of
experiences is certainly integral. Supervisor feedback also points to the use of presuppositional language as the most influential practice within this approach.

From day one, the supervisor should phrase questions and statements to include the assumption of competence. One therapist commented to me about this aspect of supervision, stating that “I knew you believed in me, even though I didn’t believe in me!” This response was directly related to question formation. I begin every solution-focused supervision workshop (Thomas, 1990, 1992, 1995) with the question, “What do you do well?” The audience is initially pensive, but this thoughtfulness quickly segues to spirited dialogue among the members as they articulate their clinical strengths aloud and bask in the audience glow. Other questions that readers might find useful in eliciting evidence of competence include:

What do you want to further develop? [Assumes current development]
How did you know to do that at that moment? [Assumes prior knowledge]
What strengths would your clients say you bring to the therapy room? [Assumes positive client knowledge]
If you were to access another side of yourself at that moment, what might change (be more acceptable to you)? [Assumes flexibility, choice, and the ability to alter one’s actions to create a different outcome]
What does your success in this situation say about your skills as a therapist? [Assumes that the therapist’s skill was integral to the successful outcome]
I’d like your evaluation of the supervisory/learning process so far. What has been most helpful? [Assumes the therapist has valuable knowledge about the supervisory process]

The research of Swann and his colleagues (Swann, Giuliano, & Wegner, 1982) lends support to the idea that the person asking presuppositional questions will solicit information supporting the assumption from the subject, even if the interviewer knows the questions were drawn at random and are not based on what is known about the person. In addition, they found that the interviewers come to believe in the presuppositions. Supervisors cannot not be affected in a competency-based direction if they approach the supervision context in this way.

**Group Supervision**

In addition to utilizing this particular exercise in individual consultation, work in the group supervision setting should take much the same form. Following the assumptions outlined previously, therapists in group supervision can become “resource consultants” to each other. Andersen (1991) gives guidelines for
competency-based group consultation: all statements must be positive, all observations and opinions must be stated in a tentative form, and the therapist has the right to a final response.

The meeting usually takes the following format: a therapist is scheduled to show a portion of videotape that he or she feels would be helpful to show and allow for responses from the group, all within a forty-five-minute frame. This format allows the therapist latitude in choosing to show the group examples of greater or lesser success. Following introductory comments to inform the group of the particular case, the therapist tells the group how he or she best learns in the group process. “I’d like for you to hold your questions until the end” and “Feel free to ask me to stop the tape anytime” are two ways therapists often inform the group of their learning preferences. Then the therapist shows the tape, stopping and starting it at his or her discretion. Group members are free to comment, but they are asked to restrict themselves to (1) being helpful according to the therapist’s definition and (2) following the format requested by the therapist. Comments from these colleagues are usually begun with such phrases as, “I was thinking . . . ,” “I wonder if . . . ,” “What I saw was . . . ,” and so on. A strong theme of “noticing” often emerges: “I noticed that you said . . . ,” “I noticed that the client stopped . . . ,” and so on. Finally, after the tape has been shown, the supervisor solicits comments from the therapist by asking the following questions:

What did you learn about your clients, your therapy, and yourself today?
What did the group contribute that was most helpful?”
What could we all do differently next time to make it better for you?

To enhance the possibilities for learning and to reinforce the positive change taking place, a videotape of the group supervision session can be made for the therapist to keep and review. This review is often useful for therapists because they can then review the particular comments and reflect on their significance in private, removing themselves from the (often) uncomfortable position of public praise, yet retaining the shared perspectives.

The value of such a format is still experimental; however, the response from therapists has been overwhelmingly positive. As one therapist confided, “It was a time for most of us when the grain of sand began to resemble a pearl. . . . It was always a place for constructive DIA-logue and informed academic support” (Chilton, 1995). Maintaining the dignity of the therapist and his or her clients is perhaps the guiding metaphor for this type of group structure. It is a simple extension of the curiosity/respect stance of Berg and Miller (1992), and it seems to support optimal learning and growth.
Goal Setting

As in SFBT (Walter & Peller, 1992), one cannot hit a target without a target. In fact, like Geertz’s (1973) proverbial Mexican peasant, it would always be better to shoot a hole in the fence first and then paint the bull’s-eye around it! In keeping with the isomorphic relationship between therapy and supervision, therapists should be goal oriented in their learning.

The maxim “If at first you don’t succeed, change your definition of success” should be one’s guiding principle. Three-month goals that are observable, measurable, and verifiable seem to work well with a wide range of therapist experience and personal ambition. Normally, supervisors do not participate in the goal-setting process until the therapist has written down a few goals. Then, the process of clarification involves both supervisor and therapist. Some goals may not be verifiable from the supervisor’s perspective. For example, if a therapist has a goal of utilizing the SFBT model in 50 percent of his or her cases, then the therapist is in the best position to assess progress and/or need for change. Other goals may be accessible to supervisors’ scrutiny and evaluation. For example, a therapist has a goal of having fifteen consecutive minutes of therapy within which he or she only asks questions. This could be verified by both therapist and supervisor via videotape or audiotape replay. The completion of certain readings could also be assessed through oral or written review in supervision. Finally, the use of one-to-ten scales or percentages gives therapists room for change without mastery. If a therapist sets a goal for himself or herself to “be consistent with the model” or “focus on client resources,” then the supervisor might approach with a request for clarification: How consistent do you want to be? How do you behaviorally define “consistent”? What would be a realistic goal for the next three months—25 percent of the time? More? Less? With the therapist’s first-draft goals in hand, the supervisor can guide the clarification process, creating small steps in the right direction.

Every case, question, and session can be related to the therapist’s goals. Much like the emphasis placed on goal setting in SFBT (Walter & Peller, 1992), supervision goals should guide discussions and decisions whenever appropriate. For example, Bob had set a short-term goal of “holding consistently to solution-focused brief therapy assumptions 50 percent of the time.” When he became stuck with a client couple, his analysis was that they were resistant and he was trying hard to change them. It just so happened that a primary problem the couple had was that each was trying to change the other! The following conversation with his supervisor took place:

Therapist: So, now that I know what I’m doing wrong, how do I stop?
Supervisor: Well, let’s take a quick look at your goals for the semester. What did you think was important to believe about your clients?
Therapist: I need to be consistent with the solution-focused assumptions.

Supervisor: What might apply here, which of those assumptions?

Therapist: I guess it would be de Shazer's assumption that "there is no such thing as resistance."

Supervisor: OK, if you were to be more consistent with that assumption, what would change?

Therapist: I would stop viewing the couple as resistant! But that's not easy, you know!

Supervisor: It's just a habit. What perspective could you play with to get out of that stuck position?

Therapist: OK, I think I need to believe there must be a different way for me to cooperate.

At this point, the conversation moved toward Bob's change and away from labeling clients and attempting to solve the impasse with the unsuccessful approach he had been taking.

There are, of course, many therapeutic and supervisory problems that will not relate to a therapist's goals. However, utilizing the goals as a touchstone allows for constant re-vision of the entire process connecting clients, therapist, and supervisor. Focusing on this connection keeps change on track and helps in the evaluation process at the end of the contract period. Such goal watching also helps the therapist avoid trying to change everything about his or her therapy. Being goal focused allows for the spotlight to be shared, giving both the therapist and the clients center stage part of the time in the supervisory process.

Evaluation

One of the most difficult positions in professional life is the dual role of supervisor/evaluator. Critics of a "centrarchical," or cooperative, relationship in supervision often state that hierarchy must be maintained (or cannot be avoided) when the supervisor is also the one who must assess the performance of the therapist for purposes of promotion, grades, raises, and so on. There are two flaws in such a conclusion. First, dichotomous thinking (that one must either be a collegial supervisor or "the boss") is not only inaccurate but may also be detrimental to the supervision process. It seems that the responsibilities of evaluator always override the responsibilities of providing quality service to the public and helping therapists improve their craft. However, such an absolute hierarchical arrangement is not an inherent part of the process, and maintaining such distinctions may say more about the supervisor than it does about the context in which he or she conducts supervision.
Second, there is no intrinsic reason why supervisors cannot clarify when they are “supervisors” and when they are “evaluators.” It is true that this attempt to clarify is not a unilateral move but is dependent on the meaning constructed by both the supervisor and the therapist (Bobele, Gardner, & Biever, 1995); however, initiating such a dialogue is probably the supervisor’s prerogative, as attempts to co-create a relationship that maximizes value for all involved probably require some deliberateness on the part of the supervisor. Taking up the challenge from Heath and Tharp’s (1991) earlier observation that therapists may want supervision and evaluation to be separate, one could begin the supervision relationship with attempts to clarify when one is supervising and when one is formally evaluating the performance of the therapist. Since we must all act on the G. Spencer-Brown imperative to “Draw a distinction!” (cited in Keeney, 1983), moving away from the secure, traditional positions that focus on hierarchy toward roles that are more fluid could effect unexpected cooperation in settings normally defined as oppositional and symmetrical.

A challenge for those defined into dual roles (such as an academic required to grade student progress) would be to experiment with alternative supervision and evaluative arrangements. Initiating mutual evaluation criteria can lead to goals that fit the therapist, the supervisor, and the organization. Seeking the opinions of the therapist on his or her performance keeps the supervisor consistent with the constructionist positions that brief and family therapists have espoused for decades (Anderson & Goolishian, 1992; von Glaserfeld, 1984).

Conclusions

“it is our contention that, as therapists, we have a choice about the basic ‘stance’ we wish to adopt. To see people in terms of pathology or to see them in terms of competence is a matter of choice rather than one of truth” (Durrant & Kowalski, 1993). This idea is vital to the practice of solution-focused or competency-based supervision—therapists must be viewed as incomplete and imperfect yet competent colleagues who seek out the supervisor in order to bring about progress toward their goals.

This model of supervision may be adapted for use with varying levels of therapist expertise. There is wide variety in perception, organization, and participation by clinicians, and varying levels of expertise should be carefully considered when applying any supervisory model (see Benner, 1984). Resting on the assumption that competence is based on experience and knowledge found in many areas of the therapist’s life, solution-focused approaches to training can be adapted to fit with any therapist’s level of expertise, experience, and learning style.
Future research could focus on the ways therapists respond to solution-focused supervision and the optimal approaches for differing levels of competence. Qualitative inquiries regarding "fit" between therapy and supervision models would be a substantial contribution to the field. Also, the experience of fit between the approach to supervision and the level of therapist expertise is sorely needed for both this supervision model and family therapy in general.

Portions of this model may be adopted as techniques to be utilized within most other supervision models (Thomas, 1994b; Wetchler, 1990); however, those who supervise therapists who are practicing solution-oriented therapy models should consider the quality of the fit between those models of therapeutic change and the model of supervision being utilized. The assumptions of the supervision model and the guiding questions outlined in this chapter provide a plan that creates an opportunity for fit that will hopefully optimize the supervisory experience for both the therapist and the supervisor. For this model begins and succeeds with this assumption: within each therapist lies expertise; the supervisor's job is to bring it out.

Questions from the Editors

1. Solution-focused and competency-based therapies are often touted as brief, short term, and time limited throughout the life cycle. Could you please say something about the typical duration and/or depth of the solution focus as applied to the supervisory process?

I believe that supervision is isomorphic to the practice model, but not identical. Since therapists seek supervision for a variety of reasons, it would be overly simplistic to believe that a solution-focused approach to supervision would be short, long, or in between. It has been my experience that incorporating ideas of competency into a therapist's acting and knowing is dependent on his or her motivation to learn, opportunities for application, and fit with current approaches used with clients. For example, a therapist who is already fairly goal oriented in his or her therapy might take less time to work comfortably within a competency-based approach than one who has not had much practice in goal formation. And since this model is built upon assumptions of "first steps" rather than finished products, the focus of supervision is placed on the foundational ideas and behaviors one adopts more than on the character development, wisdom, and experiential knowledge one gains throughout the course of one's therapy career.

2. How does the solution-focused or competency-based supervisor deal with a supervisee who may be engaging in risky, unethical, or potentially dangerous behavior within the context of treatment?
This question bubbles up at every workshop I give on this supervision model. The first thing to consider is this: within every supervision relationship, one should begin with a clear contract regarding responsibility. My degree of purposeful control in supervision is directly tied to my own comfort level, trust in the therapist’s abilities, and ethics; therefore, there may be times when I become more directive with regard to behaviors (the client’s and/or the therapist’s) that I consider dangerous or unethical. If my contract with a therapist involves usurping the therapist’s right to act independently in extreme situations (such as supervising master’s students in a university clinic), I may have greater latitude in which to act than I have within another supervision situation in which the therapist is an independent, licensed professional (and I possibly have no legal right to interfere). In clinical situations the supervisor deems extreme, I suggest posing the situation as a dilemma and openly discussing it with the therapist. Taking as much time as needed to explain my ethical, legal and clinical opinions in an open dialogue has a much greater likelihood of creating cooperation and clinical safety than a heavy-handed, “I’m taking charge” position. In the end, I have to act according to my conscience and best judgment. However, I always try to keep Heinz von Foerster’s ethical imperative in mind: “Act always so as to increase the number of choices” (1984, p. 60). In supervision, this includes choices for the client(s), the therapist, the supervisor, and the relationships between them.

3. **What role does teaching play in solution-focused or competency-based supervision?**

I have done some changing through time in my approach to teaching within supervision. I used to think that assumptions like “Clients have all the resources they need to resolve their problems” would be true in all situations. What I found is that Harry Goolishian was right: You should fall in love with an idea, but you should never marry it (personal communication, November 1989)! I feel that my least favorite option is to become didactic in the supervision setting; however, if I hold to the premise that supervisees know what they need, there will be times when they will seek information from me and avoiding a didactic response might be off-putting or unethical. I hold to the assumption that people change in a variety of ways, and supervisees know when reading, reflection, dialogue, critique, and teaching are the best ways in which they learn. I do not believe I am a repository of therapy information, so didactically disbursing knowledge is a less comfortable approach to supervision for me than it might be for others. I believe that the goals of the learner give guidance at this point. In the cooperative creation of goals, supervisor and therapist have the opportunity to negotiate how to best achieve these aspirations. Working with a learner and creating the best fit between a therapist’s needs and a supervisor’s talents allows for optimal use of multiple learning milieus—including teaching.
Notes

1. Copyright © 1995 by Universal City Studios, Inc. Courtesy of MCA Publishing Rights, a Division of MCA Inc. All rights reserved.
2. Throughout this chapter the term “therapist” will usually be used to designate the person traditionally known as the supervisee, learner, or trainee.
3. All names have been changed to protect the privacy of the therapists.

References


at the American Association for Marriage and Family Therapy Annual Conference, Dallas, TX.


