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# Toward an Integrative, Learning-Based Model of Psychotherapy Supervision: Supervisory Alliance, Educational Interventions, and Supervisee Learning/Relearning

C. Edward Watkins, Jr.
University of North Texas

Douglas J. Scaturo
Syracuse VA Medical Center, Syracuse, New York, State University of New York Upstate Medical Center, Syracuse, New York, and Syracuse University

Psychotherapy supervision, it could be maintained, lacks for a common language. Drawing on work from the fields of learning, educational psychology, and teacher education, and extrapolating from the learning-based model of psychotherapy presented by Scaturo (2005, 2010, 2012a), we propose a tripartite, common-language structure—Alliance Building and Maintenance, Educational Interventions, and Learning/Relearning—for thinking about and guiding psychotherapy supervision practice. The supervisory process is envisioned as involving both new learning and relearning (corrective cognitive, corrective affective, and corrective behavioral experiences). Each stage is linked predominantly with a particular learning domain and specific type of learning, common features and factors of transtheoretical significance across stages are identified, and research studies that support different facets of the model are briefly considered. Although the Alliance Building and Maintenance stage is seen as being the foundation and touchstone of our conceptualization, the model is presented as a largely nonlinear vision of supervision that involves continued supervisee cycling and recycling through the feel-think-do (or some variation) of the perspective's three stages. This learning-based view is a useful conceptual structure for thinking about supervision within a more unified framework.

*Keywords:* learning-based psychotherapy supervision, integrative psychotherapy supervision, supervision alliance, supervision interventions, supervision learning/relearning

Psychotherapy supervision has long been recognized as a (if not *the*) chief means by which the traditions, practice, and culture of psychotherapy are taught, transmitted, and perpetuated (Hess, 1980; Hess, Hess, & Hess, 2008; Watkins, 1997b). It continues to hold a place of considerable eminence in the training of mental health professionals across diverse areas of specialization (e.g., Cutcliffe, Hyrkas, & Fowler, 2010; Falender & Shafranske, 2004; Gold, 2006; Ladany & Bradley, 2010; Munson, 2001). Goodyear (2007) has even identified psychotherapy supervision as the mental health professions' defining, binding "signature pedagogy"—an instructional approach that epitomizes the professional preparation of practitioners (Bernard & Goodyear, 2009). In that sense, supervision transcends discipline boundaries, curricular lines, and professional heritage and remains a crucial educational practice by which competence can be developed and enhanced across mental health trainees (cf. Kaslow & Bell, 2008).

For our purposes here, psychotherapy supervision will be defined as: ". . . an *intervention* (emphasis added) provided by a more senior member of a profession to a more junior mem-

C. Edward Watkins, Jr., Department of Psychology, University of North Texas; Douglas J. Scaturo, Syracuse Vet Center, Syracuse VA Medical Center, Syracuse, New York and Departments of Psychiatry and Family Medicine, State University of New York Upstate Medical Center, Syracuse, New York, and Department of Psychology, Syracuse University.

Correspondence concerning this article should be addressed to C. Edward Watkins, Jr., Department of Psychology, University of North Texas, 1155 Union Circle # 311280, Denton, TX 76203-5017. E-mail: watkinsc@unt.edu

ber or members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see(s); and serving as a gatekeeper for those who are to enter the particular profession" (Bernard & Goodyear, 2009, p. 7; cf. Thomas, 2010). The key elements of that definition revolve around: Relationship, evaluation, duration, professional enhancement, quality monitoring, and gatekeeping (Watkins, 1997a). Although that definition may not be perfect in all respects (see Ellis, 2010; Milne, 2007; Turpin & Wheeler, 2011), it still tends to capture the contemporary landscape of supervision quite well and provides a useful point of orientation for our subsequent discussion.

Over the course of this past century, three primary guiding visions of supervision have emerged: Psychotherapy-focused, developmental, and social role or process models (Bernard & Goodyear, 2009; Falender & Shafranske, 2004). Psychotherapy-focused approaches are oriented around the learning and practice of a specific form of psychotherapy (e.g., psychodynamic or cognitive–behavioral), and it is the specific psychotherapy being implemented that provides the supervision process with its own unique stamp of order, focus, and organization (Falender & Schafranske, 2010; Watkins, 2012c). Developmental approaches are conceptual metamodels that are oriented around (a) the growth process or stages through which therapists pass in their learning journey and (b) the ways in which supervisors can best intervene in that process to facilitate therapist development (see Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Social role or process approaches are also conceptual metamodels, but their primary emphases center on (a) the various learning needs that students present throughout the course of the supervision experience and (b) the specific ways in which supervisors can optimize that experience by effectively selecting and utilizing particular roles (e.g., teacher, consultant) that best match supervisee needs (see Bernard, 1997; Holloway, 1995, 1997). As distinct metavisions of supervision, developmental and social role approaches can be readily integrated into any psychotherapy-focused supervision endeavor.

Our focus here will be on the more specific visions that are given voice in the psychotherapy-focused approaches to supervision. Such views merit attention because: (a) as long as there are distinct approaches to psychotherapy, there will most likely be distinct approaches to psychotherapy-focused supervision; (b) all indications suggest that psychotherapy-focused supervision approaches have been and will remain quite vital and vibrant visions of supervision (Hess et al., 2008; Watkins, 2012a, 2012d); and (c) the importance of revisiting and renewing such psychotherapy-focused approaches has even been recently recognized and accentuated (Falender & Shafranske, 2010). More pointedly, Falender and Shafranske (2010) have gone so far as to state that the advancement of supervision actually requires revisioning and reaffirming the unique role of psychotherapy-focused supervision in professional training.

With their continuing relevance and importance acknowledged, psychotherapy-focused approaches, however, are not without issues. Two of the more significant, pressing issues would seem to be (a) their ignoring of or failure to adequately capture the truly integrative nature of supervision (Ladany & Inman, 2012) and (b) their lack of a common language to guide and unify understanding and practice. Just as varied psychotherapy approaches lack for a common language (Goldfried, 1995; Marks et al., 2005; Marks et al. 2011; Scaturo, 2005, 2010, 2012b), psychotherapy-focused supervision approaches understandably and repeatedly perpetuate that same problem by: (a) building on and teaching their respective therapy's vernacular as the predominant language of treatment understanding and (b) using certain therapy constructs to actually inform and explain some aspects of the supervision process itself (e.g., the examination and correction of supervisees' dysfunctional thoughts in cognitive therapy supervision; Liese & Beck, 1997). Although that self-sustaining cycle is useful in keeping particular therapy and psychotherapy-focused supervision approaches alive, monitored, and thriving, it can also lead to ideological isolation, construct confusion, and compromised clinical insights and research findings (Brooks-Harris, 2008; Scaturo, 2010).

Might there be some useful unifying metric by which we as supervisors across orientations could profitably consider and conceptualize our

supervisory efforts, meaningfully discuss case dynamics and action within the context of a common, integrative language, and perhaps even speed supervision's evolution as a science? In this article, we would like to address those questions by proposing and explicating a tripartite, learning-based model of psychotherapy supervision that: (a) has both integrative and common language properties, (b) is grounded in the foundational building blocks of learning theory and educational psychology, (c) is transtheoretical in structure, and (d) is informed by and seemingly compatible with existing psychotherapy-based supervision approaches (e.g., Beck, Sarnat, & Baranstein, 2008).

Although supervision is an educational activity that would seemingly feature an educational process model (Hess, 2008), that has typically not been the case at all: Psychotherapy-focused approaches to supervision have generally not been based in or linked to learning theory and educational process in any way. We indeed feature such an educational model subsequently, striving to ground the entirety of our tri-phasic view within a learning framework.

If we are to consider commonalities across psychotherapy-focused supervision approaches, then we first need the beginnings of a common language in place in order to do that. If we are to look more specifically at psychotherapy supervision as a supremely educational process, then we need a vision of supervision that is informed foremost by an educational perspective. Our effort is an attempt to capture, within an educationally grounded framework, some of the most salient facets of supervision that are shared across the diversity of psychotherapy-focused supervision approaches.

## Psychotherapy Supervision, Learning Processes, and Learning Domains

In educational psychology, it has long been recognized that there is more than one type of learning (Scaturo, 2010, 2012a). Bloom and his colleagues (Bloom, Engelhart, Furst, Hill, & Krathwohl, 1956; Krathwohl, Bloom, & Masia, 1964; Simpson, 1972) identified three domains of learning: cognitive (intellectual), affective (emotional), and psychomotor (behavioral). *Cognitive learning* involves the acquisition of factual knowledge and the development of intellectual skills, abilities, and thought processes (Bloom et al., 1956). *Affective learning* involves the ways in which people process information and stimuli emotionally. Emotional learning and development are essential to the construction of the learner's feelings, values, and motives and are at the foundation of one's receptivity to information (Krathwohl et al., 1964). Finally, *psychomotor learning* involves behavior and activity connected with one's perceptual responses to inputs, to the activity of imitation (modeling), and to the manipulation of one's environment (instrumental learning; Simpson, 1972). The original Bloom, Engelhart, Furst, Hill, and Krathwohl (1956) conceptualization and its more recent revision (Anderson & Krathwohl, 2001; see entire 2002 issue of *Theory Into Practice,* which was devoted to the taxonomy's revision) are relevant to any and all learning. Indeed, the Bloom taxonomy continues to be valued and remains the "*de facto* standard" in the field of learning (Forehand, 2005).

Psychotherapy supervision, as presented here, is considered to be an educational process in which various types of personal and professional learning occur. Drawing upon the seminal works of Bloom and his colleagues and students (Anderson & Krathwohl, 2001; Anderson & Sosniak, 1994; Bloom et al., 1956; Krathwohl, 2002; Krathwohl et al., 1964), the cognitive, affective, and psychomotor domains of learning can be posited to occur in psychotherapy supervision as well. These domains are viewed as being primarily knowledge-based (think), attitudinal-based (feel), and skills-based (do) and capture the primary ways in which varied learning tends to be realized. Within the cognitive domain (with its focus on the acquisition of factual knowledge, development of intellectual skills, and thought processing), identification, comprehension, analysis, synthesis, and evaluation are viewed as highly important components of cognitive function. Some supervision-relevant examples that would reflect cognitive domain activities are: recall of pertinent patient data, identifying and evaluating interpersonal patterns, and formulating case conceptualizations. Within the affective domain (with its focus on the ways in which we process and use emotional information and stimuli), feelings, values, motives, and attitudes emerge as most important here. Some supervision-

relevant examples that would reflect affective domain activities are: being able to actively and attentively listen, being able to identify and empathize with the patient's plight and the supervisee's struggle to learn, actively participating and meaningfully engaging in treatment/supervision, and coming to prize and value one's patients. Within the psychomotor domain (with its focus on the use of behaviors, movement, and activity to facilitate, "stamp in," and refine response acquisition), practice, imitation, and repetition emerge as highly important to successful learning. Some supervision-relevant examples that would reflect psychomotor domain activities are: practicing specific techniques by means of role play in supervision, repeating empty chair with a client over sessions, and deliberately focusing on and reflecting cognitive or affective content in one's responses.

Although learning across domains can to some extent overlap, perhaps the best way to view these three domains would be: Learning that occurs in the cognitive, affective, and psychomotor domains can be thought of, respectively, as *predominantly* cognitive, affective, and psychomotor in nature. These types of learning, though dynamic, interactive, and not absolutely, discretely, and completely separable, can be reasonably conceived of as domain *preponderances* (e.g., within the affective domain, learnings tend to be preponderantly affective as opposed to cognitive or psychomotor). Thus, we propose that, in correspondence with these three domains, three broad learning processes—cognitive, affective, and psychomotor—occur during and, in varying degrees, throughout the course of the psychotherapy supervision relationship and experience. Regardless of theoretical perspective, supervisor skill in effectively addressing and facilitating each of the three types of learning can be considered crucial to effective supervisory process and outcome and, ultimately, mastery of the supervisor role.

In conceptualizing an integrative, learning-based model of supervision process, we propose a three-stage supervision structure that corresponds to the three types of learning: (a) Supervision Alliance-Building and Maintenance (predominantly affective learning); (b) Educational Interventions (predominantly cognitive learning); and (c) Learning/Relearning (predominantly psychomotor learning or "putting it into practice"). Within this perspective on supervision, both new learning and relearning (i.e., letting go of and replacing dysfunctional responses or mindsets) occur over the course of the supervisory endeavor. Relearnings, as we conceive of them here, can be thought of as largely "corrective"; in that sense, supervision to some extent entails supervisee corrective cognitive experiences, corrective affective experiences, and corrective behavioral experiences.

Our model is built upon, informed by, and extrapolated from recent efforts to apply a learning-based approach to psychotherapy (Scaturo, 2005, 2010, 2012a). Because we begin with the assumption that supervision is foremost an educational process, and because we are attempting to align our supervision approach foremost with an educational foundation, we believe that the tripartite learning-based perspective is an especially good fit for psychotherapy supervision. We would like to illustrate how we think that to be so by: (a) examining in some detail the supervision alliance-building and maintenance, educational interventions, and learning/relearning stages; and (b) considering how cognitive, affective, and psychomotor learnings are respectively stimulated across the model's stages. Table 1 provides some of the specifics of our stage by learning model. Although professional development for some of our supervisees may occur in a linear fashion, we believe that their professional socialization and maturation is most likely to be nonlinear in nature (Aten, Strain, & Gillespie, 2008). Therefore, although alliance-building and maintenance remain the foundation for and touchstone of all supervisory efforts, supervision is presented here as primarily an ongoing, nonlinear process of cycling and recycling through the three stages.

## Alliance-Building and Maintenance in Psychotherapy Supervision: The Affective Domain

In this section, we wish to examine the contribution of the following factors to building and maintaining the alliance in psychotherapy supervision: (a) secure base/facilitating environment; (b) empathy, genuineness, and positive regard; (c) remoralization; (d) alliance rup-

Table 1
*Tripartite, Learning-Based Conceptualization of Psychotherapy Supervision*

| Alliance building and maintenance | Educational interventions | Learning/relearning |
|---|---|---|
| Secure base/Facilitating environment | Case conceptualization | Behavioral practice |
| Empathy, genuineness, positive regard | Stimulus questions | Mental practice |
| Remoralization | Feedback | Corrective behavioral experiences |
| Alliance rupture/repair processes | Modeling | |
| Supervisee readiness/preparation | Stimulus control | |
| Corrective affective experiences | Corrective cognitive experiences | |

ture/repair processes; (e) supervisee readiness and preparation; and (f) corrective affective experiences. Each of those factors, so often considered in regard to psychotherapy, has also increasingly gained currency in how supervision is thought about and practiced. Furthermore, although some of those factors may be far more aligned with a particular approach to supervision than otherwise, each factor has transtheoretical implications and can be seen as instrumental in fostering supervision of any ideological stripe. Across the affective domain, the primary components of supervisee learning are (extrapolating from Krathwohl et al., 1964): Receiving (or receptivity to supervision), responding (or responsiveness in supervision), valuing (developing conviction about the meaningfulness of psychotherapy; Chessick, 1971), organizing (beginning to form the psychotherapy experience into some sort of wholistic conceptualization), and internalizing (developing an internal supervisor; Casement, 1985; Rock, 1997).

**Secure base/facilitating environment.** Receptivity, responsiveness, and internalization are critical facets of affective learning, and the creation of a safe, secure supervisory space (Mollon, 1989) has long been recognized as pivotal in fostering supervisee receptivity toward, openness in, and active engagement in the supervisory process. Borrowing from concepts originally pioneered by Bowlby (1969, 1988), Winnicott (1965), and Bion (1962), the supervision environment and atmosphere have been likened to a holding environment, safe haven, and secure base where trust, emotional containment, and safety predominate (Alonso, 1985; Chazan, 1990; Gordan, 1996; Kaslow & Bell, 2008; Pistole & Watkins, 1995; Watkins, 2011b), where constructive attachments are formed (Fitch, Pistole, & Gunn, 2010; Neswald-McCalip, 2001), and where a relationally rich and accepting context is developed within which affectively laden learnings can be acquired (Frawley-O'Dea & Sarnat, 2001; Sarnat, 2010, 2012). In supervision, a secure hold ultimately contributes to the "freeing" of supervisees and stimulating their growth possibilities.

As part of that hold, the supervisor also frequently assumes the broader role function of a *mentor* for the trainee. According to Levinson, Darrow, Klein, Levinson, and McKee (1978), a capable mentor in young adulthood is analogous to Winnicott's (1965) "good enough" parent in childhood. In addition to modeling professional behaviors that can be emulated by the trainee, the mentor also nurtures the emotional development of the novice by providing advice, mature judgment, moral support, and encouragement in critical moments during the trainee's occupational socialization (Keith, Scaturo, Marron, & Baird, 1993). Not a parental surrogate, but rather an amalgam of parent and peer, the mentor is often experienced by the trainee as a "responsible, admirable older sibling" (Levinson et al., 1978).

Although the hold, containment, and haven concepts may be most identified with psychoanalytic thought, the importance of a "good enough" relationship has been accentuated to

some degree across all supervision approaches (Bernard & Goodyear, 2009; Falender & Shafranske, 2004). Although the supervision space and relationship can be viewed in varying ways (e.g., Liese & Beck, 1997; Reiser & Milne, 2012; Sarnat, 2010, 2012), a constructive working relationship and supervision milieu—where safety, collaborative engagement, openness, and nondefensiveness reign supreme—seem to generally, readily and uniformly be valued and agreed upon as fundamentally significant for the actuation of effective supervision process and outcome (Alonso, 1985; Bernard & Goodyear, 2009; Binder & Strupp, 1997; Bogo, Paterson, Tufford, & King, 2011; Falender & Shafranske, 2004, 2008, 2010; Fleming & Benedek, 1966; Gill, 2001; Gold, 2006; Hess, 2008; Jacobs, David, & Meyer, 1995; Ladany, Friedlander, & Nelson, 2005; Rock, 1997). Thus, in facilitating and stimulating affective receptivity to and responsiveness in the supervision experience, a grounded and grounding supervision relationship appears to be a transtheoretical must.

**Empathy, genuineness, and positive regard.** The core conditions of empathy, genuineness, and positive regard can be conceived of as central to the development of a secure base or holding environment in supervision. Those conditions—so central to humanistic conceptualizations of psychotherapy (Cain & Seeman, 2002; Rogers, 1942, 1951, 1980) and now seemingly regarded as important in all forms of psychological treatment (Beutler et al., 2004)—play a crucial role in fostering supervisee receptivity, trust, and building of the supervisory alliance (Farber, 2012; Rogers, in Goodyear, 1982; Young, Lambie, Hutchinson, & Thurston-Dyer, 2011). The desired effect is to create a climate in supervision in which fear and anxiety are minimized, and an optimal learning situation is created (Patterson, 1997). That type of accepting, facilitative atmosphere, then, tends to contribute substantially to making successful educational experiences increasingly possible (cf. Patterson, 1964, 1977, 1983). Over the decades, supervisees have tended to rather consistently cite the factors of supervisor empathy, warmth, genuineness, understanding, acceptance, respect, and a nonjudgmental attitude as favorably contributing to their supervision experiences (see Carifio & Hess, 1987; Falender & Shafranske, 2004; Henderson, Cawyer, & Watkins, 1999; Russell & Petrie, 1994; Shanfield, Hetherly, & Matthews, 2001; Watkins, 2011a). As Keith, Scaturo, Marron, and Baird (1993) have aptly noted: "As professionals, we learn to empathize best by experiencing empathy from our role models. We learn caring by being cared for. We learn to tolerate uncertainty by being supported in our uncertainty" (p. 380).

**Supervisory alliance ruptures/repairs.** Rupture in the therapeutic alliance has been identified as a highly significant transtheoretical phenomenon (Safran, 1993). Rupture in the supervision alliance can be considered a transtheoretical phenomenon of considerable significance as well. Bordin (1983), building on his tripartite rendering of the therapeutic alliance (Bordin, 1979), first proposed a vision of the supervisory alliance centered around three key variables: *bond*, *goals*, and *tasks*; he further viewed the supervisory endeavor, much like the therapeutic process, as being characterized by a series of relationship rupture and repair events. Extrapolating from the working alliance literature, a supervision alliance rupture could be defined as a strain, breakdown, or deterioration in relatedness and communication in the interaction or the failure to develop a collaboration at the outset of the supervisory relationship (Safran, Muran, & Proskurov, 2009; cf. Safran, Muran, Stevens, & Rothman, 2008). Some possible examples of rupture events or triggers would include: supervisees having feelings of being controlled or managed by their supervisor's suggestions or interventions and, accordingly, responding in a psychologically reactant manner (Brehm & Brehm, 1981); supervisors becoming overly defensive at having their case comments or recommendations questioned by supervisees; supervisees becoming overly defensive in having their own behaviors or "motivational states" examined in relation to treatment process; and supervisors inducing supervisee negativity through acting in a dictatorial fashion.

Although the supervision alliance rupture process has gone virtually unresearched (with but one exception; Burke, Goodyear, & Guzzard, 1998), there now seems to be growing consensus among supervision researchers and practitioners that a type of rupture−repair process does indeed get enacted in the supervisory situation and that the potential for alliance rupture is transtheoretically ubiquitous (Bernard &

Goodyear, 2009; Bordin, 1983; Ladany et al., 2005; Safran et al., 2008). Much like therapeutic process, the supervision process can be punctuated by a series of strains, tears, and repairs in the supervision alliance over the course of supervision; whenever such relational disruptions occur, focus on the supervisory relationship should take top priority whereby impasses are examined in much the same way as therapeutic ruptures (Safran et al., 2008). Extrapolating from Safran et al. (2008), if the supervisory alliance is one of the key mutative factors in psychotherapy supervision, then learning how to examine and repair supervision alliance ruptures should be a significant transtheoretical focus of supervision. Through being ever mindful of and, when needed, circumspectly addressing the rupture/repair process in supervision, the supervisory alliance can increasingly be better protected, maintained, and strengthened; accordingly, supervisee receptivity, responsiveness, and development throughout the supervisory process can potentially be more effectively facilitated.

**Remoralization.** Because supervision calls upon students to expose their nascent, raw, and undeveloped therapist selves, it has the potential to be a far more personally threatening and deeply disturbing experience for supervisees than their didactic coursework and seminars (see Eckler-Hart, 1987; Ford, 1963; Friedman & Kaslow, 1986; Lerner, 2008; Stoltenberg & McNeill, 2010; Talbot, 1995; Weatherford, O'Shaughnessy, Mori, & Kaduvettoor, 2008). For example, patients who seek psychotherapy have often undergone some profoundly disturbing life experience or trauma that has encumbered them with a profound sense of human suffering (Miller, 2004), and learning to bear that suffering with patients can be therapeutically taxing for supervisees. Patients who suffer from symptoms of posttraumatic stress disorder can often evoke substantial and disorienting countertransferential feelings in clinicians, particularly young clinicians, for which discussion with a sage and trusted colleague or supervisor may provide the primary emotional compass (Wilson & Lindy, 1994) to help the supervisee get back on track and find an appropriate and balanced empathic response (Wilson & Thomas, 2004). Thus, this transition from classroom to clinic (Weiner & Kaplan, 1980) can indeed be punctuated by episodes of doubt, anxiety, and confusion. Furthermore, beginning supervisees—due to also being increasingly mired in the ambiguities and struggle of the therapist identity development process—can become despondent, deflated, and demoralized (similar to what Frank and Frank [1991] described with regard to psychotherapy) and, in turn, come to increasingly question their ability to truly be a therapist; where that is the case, supervisee "remoralization" has been identified as a critical transtheoretical task that may well require supervisory attention and action (Lampropoulos, 2002; Watkins, 1996, 2012b).

At this juncture, the crucial question for supervisors becomes: What can I do at this moment to help my supervisee *find hope* within the work that she/he has been and is now doing therapeutically? Within the context of this affectively steeped supervision event, the supervisor's charge is the arousal of hope in their supervisees' sense of being effective with their psychotherapy patients (cf. Frank, 1968). In many respects, remoralizing—in order to be emotionally received and processed—requires supervisee trust in the supervisor, "belief" in the supervisor's authenticity, and willingness to be highly vulnerable in the supervisor's presence: It is largely intertwined with and made possible by the cultivation of a healthy supervision alliance and its maintenance over time. From a developmental perspective, remoralizing can be seen as a potentially important and necessary balm and buffer for therapist identity struggles that know no theoretical lines.

**Supervisee readiness and preparation.** Because supervision is an educative, learning process at its core, the crucial question for supervisors at the outset of supervision becomes: What are the particular learning needs of this particular supervisee that most require attention at this particular point in time? Thus, assessment of supervisee readiness for and learning needs in supervision are considered to be preeminent concerns that merit addressing early on in supervision. The need for that assessment appears to be guided by what has come to be a widely embraced tenet across most if not all supervision approaches: Supervisees vary in their therapeutic knowledge, skills, and readiness for practice, and to best facilitate supervisee development, supervisors need to gain an informed understanding of their supervisees' current practice knowledge and skill strengths

and deficits. Just as psychotherapy needs to be tailored to the patient (Norcross & Wampold, 2011), a similar realization appears to have increasingly become a crucial part of the supervision landscape: To be most effective, supervision should be individualized—tailored to fit the needs of each supervisee—rather than being prosecuted to "fit the tailor" (Aten et al., 2008; Alonso, 2000; Beck et al., 2008; Bernard & Goodyear, 2009; Carroll, 2009, 2010; Falender & Shafranske, 2004, 2008, 2010; Farber, 2010, 2012; Frawley-O'Dea & Sarnat, 2001; Hess et al., 2008; Kaslow & Bell, 2008; Ladany & Bradley, 2010; Reiser & Milne, 2012; Sarnat, 2010, 2012; Stoltenberg, 2008; Stoltenberg & McNeill, 2010; Watkins, 2012c; Young et al., 2011). That fundamental tenet now seems to generally hold across all models of psychotherapy supervision. It is incumbent upon supervisors to accommodate and adapt their supervisory interventions and teaching methods to meet the learning styles of their supervisees, not vice versa (Carroll, 2010).

In arriving at a learning needs assessment, developmental stage (Stoltenberg & McNeill, 2010) or stages of change (Aten et al., 2008) frameworks can prove instructive. For example, Stoltenberg (2008), in determining supervisee developmental level and learning needs, indicated that he used (a) client chart reviews, (b) discussion of supervisees' client perceptions, (c) viewing therapy videotapes, and (d) review of supervisees' preceding practicum conceptualizations, treatment plans, and case notes. In describing their developmental approach to assessment, Young, Lambie, Hutchinson, and Thurston-Dyer (2011) gave focus to three primary variables: Reflectivity, affective qualities, and adaptability (see their Table 1, p. 8). Aten, Strain, and Gillespie (2008) provided a stages of change framework (based on the work of Prochaska & DiClemente, 1984) that could also be used to guide assessments about learning needs in and readiness for psychotherapy supervision. Supervisee self-assessments have been identified as being quite useful in this process as well (Kaslow & Bell, 2008). Clearly, "one size does *not* fit all" in clinical supervision (Carroll, 2010), and the purpose of a learning needs assessment is to better ascertain what size fits the particular supervisee before you.

The preparation of supervisees for supervision has increasingly emerged as another transtheoretical factor of vital supervisory importance. In order to benefit most from supervision, supervisees must prepare for supervisory sessions and be active participants both within and between meetings with their supervisor (Pearson, 2004). Although supervisee preparation can be achieved by means of different avenues (e.g., role induction; Bahrick, 1990; Ellis, Chapin, Dennin, & Anderson-Hanley, 1996), the supervision contract or agreement has come to be a chief method by which supervisees are currently made ready for supervision. Although the contract seemed to play a limited role in supervision in decades past, that is far less so today. The majority of supervision practitioners now appear to use some type of contract in their work (Ellis, Siembor, Swords, Morere, & Blanco, 2008), but any such agreements can widely vary in their formality. As a preparatory tool, the supervision contract is foremost about clarification, education, transparency, and collaboration in the supervisory relationship, specifically detailing such variables as: supervisor and supervisee roles and responsibilities; supervision structure; evaluation procedure; confidentiality limits; supervision risks and benefits; and professional disclosure (e.g., supervisor credentials and theoretical orientation; see Alonso, 2000; Bernard & Goodyear, 2009; Ellis et al., 2008; Falender & Shafranske, 2004; Osborn & Davis, 1996; Sutter, McPherson, & Geeseman, 2002; Thomas, 2007, 2010). Whether highly formal or more informal in design, the supervision contract is a way of "making it perfectly clear" (Osborn & Davis, 1996), and there are valuable reasons for doing so: clarification of methods, goals, and expectations; encouragement of professional collaboration; upholding of ethical principles; documentation of services to be provided; and alignment of supervision with treatment services (pp. 123–126).

**Corrective affective experiencing.** We propose that, to some degree, supervision is itself a type of corrective affective experience: In learning to be a therapist, supervisees oftentimes have to let go of interfering (though sometimes natural) affect and adopt a way of being that is emotionally foreign to them at the outset of training. For example, the ability to tolerate ambiguity and appreciate that facet of treatment is not typically a part of the beginning supervisee's repertoire (Pica, 1998; Skovholt & Ron-

nestad, 2003); neither is the ability to tolerate, nor appreciate the need for, "optimally frustrating" patients. In learning to be therapists, supervisees must be able to eventually contain and meaningfully transform the affectively charged components of those experiences (e.g., where therapist anxiety and tension give way to "settling down" and "settling in") for therapy to be successful. To a great degree, the supervision alliance provides the laboratory and container within which that transformative learning can begin to occur across approaches (cf. Beck et al., 2008; Sarnat, 2010, 2012).

**Summary.** In this section, we identified and examined six variables of transtheoretical significance for defining an alliance-building and maintenance stage of supervision: (a) secure base/holding environment; (b) core conditions; (c) supervision alliance ruptures/repairs; (d) remoralization; (e) supervisee readiness and preparation; and (f) corrective affective experiencing. In one way or another, those variables are considered to stimulate supervisee receptivity, responsiveness, valuing, organizing, and internalizing learning experiences across the affective domain during psychotherapy supervision.

## Educational Interventions: The Cognitive Domain

In this section, we wish to examine the contribution of the following factors to the educational intervention process in psychotherapy supervision: (a) case conceptualization, (b) stimulus questions, (c) feedback, (d) modeling, (e) stimulus control, and (f) corrective cognitive experiences. Those six possibilities, although by no means an exhaustive list, seemingly capture some of the more commonly used interventions that are employed by supervisors across most if not all supervision approaches. The primary cognitive components of supervisee learning are (extrapolating from Anderson & Krathwohl, 2001, and Bloom et al., 1956): knowledge (acquisition/remembering), understanding, application, analysis, synthesis, and evaluation (cf. Granello, 2000). As supervisors, we hope to ultimately facilitate supervisee movement toward a higher-order cognitive organization of therapeutic process (e.g., identifying recurring interpersonal patterns or dysfunctional thoughts, meaningfully synthesizing disparate elements of patient treatment presentation). The educational interventions identified here contribute to the stimulation of learning process across the cognitive domain.

**Case conceptualization.** Case conceptualization has always been and will always remain a core, decisive educational element of the psychotherapy supervision situation. In large part, supervision is about striving to meaningfully apprehend the specifics, uniqueness, and dynamics of each therapy case as well as the specifics, uniqueness, and dynamics of each therapist−patient relationship. Without a sound case conceptual framework, supervision can become rather haphazard (Neufeldt, 2007). Across supervision approaches, case conceptualization allows for a theory-informed lens to be brought to bear on the individual psychotherapy case—thereby providing understanding, organization, direction, and guidance for the treatment process and nuclear focus for the supervision process: It is a crucial, pivotal transtheoretical educational intervention in psychotherapy supervision. Abundant testament to that fact can be found throughout the supervision literature (e.g., Beck et al., 2008; Neufeldt, 2007; Norcross & Halgin, 1997; Rubinstein, 2007; Stoltenberg & McNeill, 2010).

**Stimulus questions.** Reflective questioning appears to be a commonly used intervention that is employed to stimulate and expand supervisees' critical thought processes. Because the development of supervisee reflectivity tends to be regarded transtheoretically as a crucial supervision goal (e.g., Neufeldt, Karno, & Nelson, 1996), such questioning or "active inquiry" (Neufeldt, 1999) holds a special place in encouraging supervisee understanding, application, analysis, synthesis, and evaluation. The process of reflection during supervision is a search to understand the psychotherapy session, with attention being given to the therapist's own thoughts, feelings, and actions (Neufeldt et al., 1996). The initial task of the supervisor may well be to create a context within which reflection becomes possible (Bernard & Goodyear, 2009). Helping supervisees to engage in reflective clinical practice is best developed by example. The reflective supervisor demonstrates a natural curiosity and interest in patient behavior, motivations, and concerns, remains ever eager to entertain rival hypotheses in initial case

conceptualizations, and welcomes new information and clinical data.

Although reflective questioning in supervision can take varied forms, it ideally is a process that is guided by method and purpose. Overholser (1991) has accentuated the supervisory importance of systematic questioning, that is to say, a series of progressive questions aimed at stimulating supervisees' critical thinking, identification, and self-correction of illogical therapeutic reasoning, and developing a critical attitude toward their own performance within the context of therapy (see Overholser's, 1991, Appendix for case example). Nassif, Schulenberg, Hutzell, and Rogina (2010) recommended the use of Socratic Dialogue in supervision, viewing it as a facilitative intervention designed to bring forth distinct resources of the human spirit by deep contemplation and self-reflection. Young et al. (2011) suggested that reflective questions, although vitally important in stimulating growth, need to be varied based upon the supervisee's developmental level. For example, for beginning supervisees, they recommended that supervisors consider using their own inquiring guesses (e.g., "I wonder if. . ." or "I wonder what. . .") early on, but soon thereafter shift to the formulation of joint hypotheses or reflections with the supervisee (see Young et al., 2011). Through such reflective questions and the totality of the reflective process, the hope is that these supervision interventions will lead to changes in the supervisee's perceptions, changes in clinical practice, and an increased ability to make meaning of in-session experiences (Neufeldt et al., 1996).

**Feedback.** Over 30 years ago, Goldfried (1980) identified the therapist's giving of feedback to patients as a crucial element of treatment process across all psychotherapies; it is no different for supervision process: The *supervisor's giving of feedback* to supervisees is a crucial component of the supervision process across all supervision approaches (Bernard & Goodyear, 2009; Carrol & Gilbert, 2005; Falender & Shafranske, 2004; Hess, 1980; Hess et al., 2008; Watkins, 1997b). Supervision feedback refers to the information that supervisors provide that demonstrates whether or not supervisees are approaching clinical competence (Green, 2011; Phelps, 2011). Positive feedback has been described as "those instances when supervisors affirm that supervisees are on the right track . . ., although negative [or corrective] feedback is described as communication in which a supervisor notes that a supervisee is off track and should consider making a change" (Phelps, 2011, p. 14). The nature of that feedback can be expected to vary according to the theoretical lens or focus that informs supervision (e.g., Hyman, 2008; Woods & Ellis, 1997), but such a constructive, educative giving-receiving feedback process is to a great extent the transtheoretical spine that supports and guides supervisee growth and development.

**Modeling.** Across the decades, research has tended to support the value of modeling in the learning of psychotherapy skills (Bandura, 1971; Hill & Lent, 2006; Rosenthal & Bandura, 1978). Modeling—"to show to do"—is equally valuable in the process of psychotherapy supervision (Hess, 2008, 2011; Holloway, 1995; Jacobs et al., 1995): Supervisors serve as models of professional behavior and practice (Holloway, 1997). It is perhaps no wonder that so many psychology trainees and interns comment on how they value the "apprenticeship model" of learning in which they have the opportunity to coconduct initial assessment interviews and the even rarer opportunity to conduct cotherapy with a respected supervisor. Although modeling (like feedback) can be expected to vary according to the theoretical lens or focus that informs supervision, it appears to be a vital, readily used intervention across supervision approaches.

In a recent chapter that was cowritten by experts in cognitive and psychodynamic psychotherapy supervision (Beck et al., 2008), that vital yet varied utilization of supervisory modeling was nicely on display. In explicating her cognitive vision of supervision, Beck indicated that—because both cognitive supervision and therapy sessions share a similar structure and techniques—supervisor modeling serves a particularly valuable function in teaching and showing therapists what to do. In explicating her psychodynamic vision, Sarnat noted that relational psychodynamic supervision and treatment also share many features in common, but that the relationship itself is considered to be the catalyst for change; in supervision, the relationship is the medium *and* message for such instruction. What we see here is: For Beck, the supervision relationship can be viewed as a medium for modeling much of what is needed in cognitive therapy; for Sarnat, the supervision

relationship can be viewed as both medium and message for modeling much of what is needed in psychodynamic psychotherapy; but for both, modeling is seen as playing a crucial role in supervisory practice.

**Stimulus control.** "The process of stimulus control involves avoiding or mitigating stimuli believed to impede growth or elicit problem behaviors resulting from supervisees' ongoing adaptation to supervision and the supervisory relationship" (Aten et al., 2008, p. 4). Stimulus control, or what we see as *the judicious exercise of environmental manipulation*, entails the supervisor's close, careful monitoring of supervisory process, evaluating when problematic supervisee issues or concerns arise or could arise, and intervening to produce the most favorable learning outcome for the supervisee. Aten et al. (2008) present the potentially crippling effects of supervisee shame (see Alonso & Ruttan, 1988; Talbot, 1995; Yourman, 2003) as one example where supervisor intervention could be required to help mitigate such an experience. Case review and selection would be yet another way in which supervisors generally intervene to best arrange the supervisory experience and environment for supervisees, at least early on. We want to be sure that, in beginning their work as therapists, our supervisees are not thrown into the deep end of the treatment pool without a life preserver (e.g., being assigned a borderline case as one's first client). We hope to select cases and clinical experiences that will serve to develop a foundation of basic clinical skills first, to then be followed with greater sophistication and complexity as readiness is demonstrated by the supervisee. We maintain that, across all supervision approaches to varying degrees, judicious use of environmental manipulation is used interventively to enhance supervisory experience. In doing so, the supervisor should be cognizant that ongoing modification of the supervisory context is needed to meet the evolving needs of supervisees (Aten et al., 2008).

**Corrective cognitive experiences.** We propose that, to some extent, supervision is also a type of corrective cognitive experience: In learning to be a therapist, supervisees oftentimes have to let go of interfering, inappropriate, and dysfunctional treatment mindsets or beliefs about the therapy role itself. Such problematic perspectives need to be addressed over the course of supervision (and perhaps in personal therapy as well) and ultimately replaced if the supervisee is to be able to most successfully provide therapeutic services. We maintain, then, that the provision of "cognitive correction," although taking varied forms, appears to generally be a part of the supervision process across approaches.

For example, beginning supervisees can sometimes view their treatment function as more akin to advice giver, motivational coach, or savior than otherwise. Therapists can also hold different perceptual biases about what may or may not be helpful to patients based upon their own defensive styles and theoretical biases. Scaturo (2005) has speculated that, along the repression−sensitization dimension (Byrne, 1964), therapists who cope with stress via introspection may be inclined toward insight-oriented methods of intervention, whereas therapists who cope through avoidance are likely to choose methods such as thought-stopping and desensitization. Because better psychosocial adjustment tends to take place in the middle range between these two extremes, there is an adaptive value to eclecticism—where the best method is selected for a given patient rather than through theoretical bias. Having a supervisor aid in discovering one's biases and how those might interfere with the proper intervention for a particular patient is a multilevel supervisory task requiring considerable finesse.

**Summary.** In this section, we identified and examined six variables of transtheoretical significance for defining the educational interventions stage of supervision: (a) case conceptualization; (b) stimulus questions; (c) feedback; (d) modeling; (e) stimulus control; and (f) corrective cognitive experiences. In one way or another, those variables can be considered to stimulate supervisee learning across the cognitive domain—contributing to the acquisition of knowledge, understanding, application, analysis, synthesis, and evaluation with regard to psychotherapy and its practice.

## Learning/Relearning: The Psychomotor Domain

In this section, we wish to examine the contribution of the following factors to the learning/relearning process in psychotherapy supervision: (a) behavioral practice, (b) mental practice, and (c) corrective behavioral experiences. Those three possibilities, although by no means an exhaustive list, seemingly capture some of

the more commonly used interventions that are employed by supervisors across most if not all supervision approaches. The primary behavioral components of supervisee learning are (extrapolating from Dave, 1970; cf. Harrow, 1972; Simpson, 1972): imitation, manipulation, precision, articulation, and naturalization. Within this domain, movement (or actual observable performance) progressively winds its way from less refined to increasing refinement through to expertise (or naturalization). As supervisors, we hope to ultimately facilitate supervisee movement toward a more seamless, polished behavioral organization and presentation of therapeutic process (e.g., where practice proceeds comfortably and therapeutic interventions are offered with greater craft and precision). The learning/relearning factors identified here are considered to substantially contribute to the stimulation of learning process across the psychomotor domain.

**Behavioral practice.** Experiential learning is the foundation of good supervision (Carroll, 2009). Regardless of supervisory approach, consensus has long been, continues to be, and will no doubt remain that: Actual prolonged therapeutic practice is indeed *sine qua non* if supervisees are to best learn how to do psychotherapy. Through supervised practice, the goal of meaningfully integrating declarative and procedural knowledge seemingly has a far greater chance of becoming reality. With behavioral practice, the experiential learning cycle is initiated (Kolb, 1984): doing, reflecting, learning, and application. That learning cycle—practicing to learn—has been demonstrated to be a very prominent part of the supervisory process (Milne, 2009; Milne & Westerman, 2001). Bennett-Levy (2006; cf. Bennett-Levy, McManus, Westling, & Fennell, 2009), in discussing how to experientially engage beginning cognitive therapists, offered the following:

> Taking the example of cognitive therapists learning to create successful behavioral experiments, novice therapists may learn these skills through a series of teaching strategies: a brief lecture, and classroom demonstration, followed by a role-play setting up a behavioral experiment with another trainee and getting feedback. Next, they transfer these newfound skills to clinical situations. With repeated use, evaluation and feedback, they refine these basic skills until they become relatively automatic and fluent. Didactic learning, modeling, practice and feedback therefore form the key learning mechanisms for the relative newcomer (p.60).

That process nicely captures graded efforts to address matters of therapist imitation, manipulation, precision, articulation, and naturalization through training and supervision.

We appear to also now see that behavioral practice in both clinical and "clinical-like" situations can increasingly have a valued place in psychotherapy education. For instance, Binder (2011) has encouraged the use of Patient Avatars as an aid to therapist development—virtual human reality technology that can serve as an intermediate practice bridge between therapy skills training and real-life therapy. Just as the concert stage is not the best place to first practice basic piano technique, neither is the therapy relationship the best place to first practice treatment technique (Binder, 1999). Sarnat (2012) also affirms the use of learn-by-doing "deliberate" practice models where interactive computer programs and videotapes are used to prepare therapists (cf. Barnett, 2011). The effective clinical supervisor encourages and fosters reflective learning and creates a rich, educational atmosphere that supports supervisees in learning from clinical practice (Carroll, 2009). It indeed seems that graded behavioral practice—employing first "clinical-like" therapy situations and then introduction to actual therapy situations—can have enormous benefits in best preparing therapists/supervisees to more effectively engage in psychotherapy and, perhaps, contribute to their making the most of the psychotherapy supervision experience as well. The Declarative-Procedural-Reflective training model appears to be one recent effort that does a nice job of capturing those important educational elements (see Bennett-Levy et al., 2009).

**Mental practice.** Reflection is best accomplished before and after therapy sessions rather than in the midst of them (Carroll, 2010). We define mental practice as: mindful processing of, preparing for, and repeating in vitro actions or possibilities of action that can or will occur in psychotherapy. As supervisors, we encourage our supervisees to "think about" various therapeutic situations and eventualities before and after therapy and before, during, and after supervision. Some common examples would include: thinking out how one wishes to introduce and provide patient orientation for psychotherapy; considering how you wish to (ideally) respond when a patient asks _____; practicing how you want to introduce and provide patient

orientation for specific interventions; and practicing actual interventions imaginally (e.g., one's relaxation patter, delivering constructive feedback, formulating and delivering mutative interpretations). In some way or other, mental practice appears to have a role across the variety of supervision approaches and is very much a part or extension of the reflective process itself.

**Corrective behavioral experiences.** Just as supervision can be cognitively and affectively corrective, we further propose that, to some extent, supervision can also be a type of corrective behavioral experience: In learning to be a therapist, supervisees oftentimes have to let go of inappropriate or dysfunctional verbal or physical behaviors that can interfere with their implementation of the therapy role itself. Some such examples would be: constantly interrupting patients; fidgetiness; slouching posture; being overly intrusive and controlling; or asking nothing but questions ad infinitum. Such troubling, even potentially derailing, therapist behaviors will require redress in supervision and, ultimately, supervisee correction and replacement if treatment is to most viably proceed.

The supervision experience can also be considered a type of counterconditioning process, whereby supervisees: (a) are exposed to a new and anxiety-provoking situation in which their therapy behavior is scrutinized, (b) receive constructive supervisory feedback over time about that behavior, and (c) learn to adapt to and derive benefit from the supervisory situation. The review of recorded therapy sessions is one such counterconditioning intervention: It offers supervisees the opportunity to observe their clinical work, receive direct feedback about how they are doing, and discuss session content (Aten et al., 2008). Thus, to be successful, supervision to some degree must become a successful educational "exposure" experience.

**Summary.** In this section, we identified and examined three variables of transtheoretical significance for defining the learning/relearning stage of supervision: (a) behavioral practice, (b) mental practice, and (c) corrective behavioral experiences. Those three variables can be considered to stimulate supervisee learning across the psychomotor domain—contributing to imitation, manipulation, precision, articulation, and naturalization in psychotherapy and its practice.

## Research on Supervision Alliance Building and Maintenance, Educational Interventions, and Learning/Relearning

In this section, we will briefly consider research studies that have relevance for and offer support for some facet of this three-stage model. As Reiser and Milne (2012) have aptly indicated, research on supervision interventions generally lags far behind psychotherapy research. Although that is also the case for supervision research collectively, a growing body of research studies—particularly focused on the supervision alliance—has begun to accumulate.

**Alliance building and maintenance.** Research on this stage has addressed four areas: (a) the supervision alliance; (b) empathy, genuineness, and positive regard; (c) supervision rupture/repair processes; and (d) supervisee readiness/preparation.

***The supervision alliance.*** The vast majority of supervision alliance research is a product of the last 15 to 20 years: Across all studies, the importance of the supervision alliance has tended to be affirmed (Burke, Goodyear, & Guzzard, 1998; Chen & Bernstein, 2000; Efstation, Patton, & Kardash, 1990; Gatmon et al. 2001; Gnilka, Chang, & Dew, 2012; Inman, 2006; Ladany, Brittan-Powell, & Pannu, 1997; Ladany, Ellis, & Friedlander, 1999; Ladany, & Friedlander, 1995; Ladany & Lehrman-Waterman, 1999; Ladany & Inman, 2012; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Ladany, Walker, & Melincoff, 2001; Mena & Bailey, 2007; Patton & Kivlighan, 1997; Quarto, 2002; Ramos-Sanchez et al. 2002; Sterner, 2009; Walker, Ladany, & Pate-Carolan, 2007; Watkins, 2010, 2011b; Wester, Vogel, & Archer, 2004). Favorable supervisee perceptions of one or more of the three alliance components—bond, goals, and tasks—have been found to be related to favorable perceptions of supervision, supervisor ethical behaviors, supervisor self-disclosure behaviors, task and goal clarity, agreement on the importance of cultural/diversity issues in treatment/supervision, and supervisor/supervisee interactional complementarity (e.g., Chen & Bernstein, 2000; Inman, 2006; Ladany et al., 1999; Mena & Bailey, 2007; Sterner, 2009; Ramos-Sanchez et al., 2002; Quarto, 2002). Unfavorable perceptions of alliance components have been found to

be related to perceptions of supervision conflict, supervisor gender role stereotyping, stress and burnout, and dissatisfaction with supervision, and supervisor unethical practices (e.g., Gatmon et al., 2001; Inman, 2006; Ladany et al., 1997; Ladany et al., 1999; Ladany & Friedlander, 1995; Ladany & Lehrman-Waterman, 1999; Walker et al., 2007). Although those empirical findings are primarily correlational, they still reflect consistency across studies and seemingly offer us a critical suggestive consideration for supervisory practice: The supervisory alliance is at the center of effective clinical supervision (Inman & Ladany, 2008; Ladany, 2004; Ladany & Inman, 2012).

***Empathy, genuineness, and positive regard.*** As indicated earlier, supervisees have tended to rather consistently embrace supervisor empathy, warmth, understanding, and genuineness as favorably contributing to the establishment and maintenance of the supervisory relationship (Carifio & Hess, 1987; Falender & Shafranske, 2004; Henderson et al., 1999; Russell & Petrie, 1994; Shanfield et al., 2001; Watkins, 2011a). As with psychotherapy process and outcome, we also suspect that these common factors favorably impact and to some extent are even pivotal for successful process and outcome of psychotherapy supervision.

***Supervision rupture/repair processes.*** Because the psychotherapy supervisor can serve multiple and, at times, conflicting roles, the supervisory situation can consequently be rendered increasingly vulnerable to the possibility of periodic alliance ruptures. For example, supervisors' role as supportive mentor may at times come into conflict with their evaluative role as a "gatekeeper" to the profession. To our knowledge, only one study—descriptive, naturalistic, and correlational in nature—has been conducted thus far about the supervision alliance rupture/repair process (Burke et al., 1998); in that clinical, multiple case study, Burke et al. (1998) found that the power differential between supervisor and supervisee and the evaluation element of supervision itself both contributed to some weakening incidents that required supervisor reparation. Unfortunately, 15 years later, that descriptive investigation (where the data were actually collected approximately 8 years before its publication; Burke, 1991) continues to stand alone in what would seem empirically to be a potentially rich area of much needed, even vital, supervisory inquiry.

***Supervisee readiness/preparation.*** Research on preparing supervisees for the supervision experience is virtually nonexistent. Where role induction has been employed, it has been found to have a favorable effect on supervision (Bahrick, 1990; Ellis et al., 1996).

**Educational interventions.** Some limited data offer support for: (a) feedback and modeling as contributing positively to the therapy training experience (Alberts & Edelstein, 1990; Ford, 1979; Herschell, Kolko, Baumann, & Davis, 2010; Hill & Lent, 2006; Lambert & Ogles, 1997; Matarazzo, 1978; Matarazzo & Patterson, 1986; Russell, Crimmings, & Lent, 1984); and (b) reflectivity as a (if not the) core process of the supervisory experience (Neufeldt et al., 1996). (Although we recognize the importance of distinguishing between therapy skills training and therapy supervision [Goodyear & Bernard, 1998], we have chosen to include selected therapy skills review findings here because such skills are sometimes a part of therapy supervision as well.)

**Learning/relearning.** Some limited data offer support for practice and rehearsal in facilitating the learning of therapy skills (Alberts & Edelstein, 1990; Ford, 1979; Herschell et al., 2010; Hill & Lent, 2006; Lambert & Ogles, 1997; Matarazzo, 1978; Matarazzo & Patterson, 1986). But practice has been studied only infrequently as a distinct method of clinical training (Hill & Lent, 2006). Still, it would seem to have some relevance for thinking about supervision. For instance, mental practice has come to be a widely utilized method for helping athletes better focus and prepare for athletic performance; in our view, that method can also be every bit as valuable for helping therapists better focus and prepare for psychotherapeutic performance, but we have little to no research in that area as yet.

**Summary.** Some limited research supports some facets of this learning-based model. Although primarily correlational and ex post facto in design, alliance studies are the most abundant and seem to be the most supportive overall. As Lambert and Ogles (1997) have noted, there is no shortage of issues for future study in psychotherapy supervision (cf. Ellis & Ladany, 1997).

## Conclusion

In this article, we have presented a tripartite, integrative, learning-based model of psychotherapy supervision—Alliance Building and Maintenance, Educational Interventions, and Learning/Relearning—that seemingly has transtheoretical applicability. We lack for an educationally grounded, common language model of psychotherapy supervision. Our model is offered as a way to consider how those missing elements might begin to be addressed.

Psychotherapy supervision has long been and remains a critical means by which the culture of psychotherapy is taught and perpetuated. Supervision is now readily recognized as a core competency in psychological practice; its eminence in psychotherapy education seems well established and well assured (Falender & Shafranske, 2007; Roth & Pilling, 2008). As we work to provide competent, effective supervision services, our current conceptual supervisory Tower of Babel does us no favors. Much as considered efforts are now being made to derive a common language for psychotherapy (see Common Language for Psychotherapy Project; www.commonlanguagepsychotherapy.org; Marks et al., 2011), considered efforts to derive a common language for psychotherapy supervision also seem needed.

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