A BRIEF SUMMARY OF
SUPERVISION MODELS

by Kendra L. Smith, Ph.D., LPC, ACS
Gallaudet University
September 2009

Clinical supervision for mental health professionals started out much like "apprenticeships" in other fields. That is, a student/apprentice with minimal skill/knowledge would learn the work by observing, assisting, and receiving feedback from an accomplished member of the same field. It was believed that because the "master" was quite good at the work, he or she would be equally good at teaching/supervising. In fact, this is not the case. Today, we realize that, though clinical supervision and counseling have much in common (e.g., the ability to engage in an interpersonal relationship), the two tasks also utilize separate and distinct skills. This means that a "master" clinician may not be always be a "master" supervisor without the addition of training and competency in supervisory knowledge and skills. Furthermore, the concept of "master-apprentice" supervision evokes a hierarchy of power that favors the master as the "authority," a dynamic that is not supported in today's literature on supervision.

It is also documented that clinical knowledge and skills are not as easily transferrable as the master-apprentice model implies (Falender & Shafranske, 2008).   Observing experienced clinicians at work is without question a useful training tool, but is not sufficient to help students develop the skills necessary to become skilled clinicians themselves. Development is facilitated when the supervisee engages in *reflection* on the counseling work and relationship, as well as the supervision itself. Thus, clinical supervision is now recognized as a complex exchange between supervisor and supervisee, with supervisory models/theories developed to provide a frame for it.

In an effort to give the reader a foundation for understanding different supervision models, this article highlights information gathered from a variety of authors on the topic of supervision. It does not represent all models of supervision, nor does it provide a comprehensive description of each supervisory model presented. Rather, the following presents salient defining characteristics of selected models. For further learning, readings from the reference section at the end of this paper may be helpful.

Psychotherapy-Based Supervision Models

As explained above, clinical supervision started as the practice of observing, assisting, and receiving feedback. In this way, supervision follows the framework and techniques of the specific psychotherapy theory/model being practiced by the supervisor and supervisee. As the need for specific supervisory interventions became evident, supervisory models developed within each of these psychotherapy theories/models to address this need.

Psychotherapy-based models of supervision often feel like a natural extension of the therapy itself. "Theoretical orientation informs the observation and selection of clinical data for discussion in supervision as well as the meanings and relevance of

those data (Falender & Shafaanske, 2008, p. 9). Thus, there is an uninterrupted flow of terminology, focus, and technique from the counseling session to the supervision session, and back again.

Several examples of specific psychotherapy-based supervision models are described briefly below. Readers interested in learning more about a specific psychotherapy-based supervision approach are referred to the references for further reading.

Psychodynamic Approach to Supervision: As noted above, psychodynamic supervision draws on the clinical data inherent to that theoretical orientation (e.g., affective reactions, defense mechanisms, transference and countertransferece, etc.). Frawley-O'Dea and Sarnat (2001) classify psychodynamic supervision into three categories: patient-centered, supervisee-centered, and supervisory-matrix-centered.

Patient-centered began with Freud and, as the name implies, focuses the supervision session on the patient's presentation and behaviors. The supervisor's role is didactic, with the goal of helping the supervisee understand and treat the patient's material. The supervisor is seen as the uninvolved expert who has the knowledge and skills to assist the supervisee, thus giving the supervisor considerable authority (Frawley-O'Dea & Sarnat, 2001). Because the focus is on the patient, and not on the supervisee or the supervisory process, very little conflict occurs between supervisor and supervisee, as long as they both interpret the theoretical orientation in the same way. This lack of conflict or stress in the supervision sessions often reduces the supervisee's anxiety, making learning easier. Conversely, if conflict were to develop using this model, supervision could be impeded by not having a way to deal directly with it (Frawley-O'Dea & Sarnat).

Supervisee-centered psychodynamic supervision came into popularity in the 1950s, focusing on the content and process of the supervisee's experience as a counselor (Frawley-O'Dea & Sarnat, 2001; Falender & Shafranske, 2008). Process focuses on the supervisee's resistances, anxieties, and learning problems (Falender & Shafranske). The supervisor's role in this approach is still that of the authoritative, uninvolved expert (Frawley-O'Dea & Sarnat), but because the attention is shifted to the psychology of the supervisee, supervision utilizing this approach is more experiential than didactic (Falender & Shafranske).

Supervisee-centered supervision was adapted to fit several psychodynamic theories, including Ego Psychology, Self Psychology, and Object Relations (Frawley-O'Dea & Sarnat, 2001). Supervisee-centered supervision can stimulate growth for the supervisee as a result of gaining an understanding of his/her own psychological processes, but this same advantage can also be a limitation in that it makes the supervisee highly susceptible to stress under scrutiny.

The supervisory-matrix-centered approach opens up more material in supervision as it not only attends to material of the client and the supervisee, but also introduces examination of the relationship between supervisor and supervisee. The supervisor's role is no longer one of uninvolved expert. Supervision within this approach is relational and the supervisor's role is to "participate in, reflect upon, and process enactments, and to interpret relational themes that arise within either

the therapeutic or supervisory dyads" (Frawley-O'Dea & Sarnat, 2001, p. 41). This includes an examination of parallel process, which is defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Haynes, Corey, & Moulton, 2003).

Feminist Model of Supervision: Feminist theory affirms that the personal is political; that is, an individual's experiences are reflective of society's institutionalized attitudes and values (Feminist Therapy Institute, 1999).   Feminist therapists, then, contextualize the client's –and their own—experiences within the world in which they live, often redefining mental illness as a consequence of oppressive beliefs and behaviors (Feminist Therapy Institute; Haynes, Corey, & Moulton, 2003). Feminist therapy is also described as "gender-fair, flexible, interactional and life-span oriented" (Haynes, Corey, & Moulton, p. 122).

        The Ethical Guidelines for Feminist Therapists (Feminist Therapy Institute, 1999) emphasizes the need for therapists to acknowledge power differentials in the client-counselor relationship and work to model effective use of personal, structural, and institutional power. Though the Guidelines do not specifically address the supervisee-supervisor relationship, it can be assumed that the same tenets apply to this latter relationship. That is, the supervisor-supervisee relationship strives to be egalitarian to the extent possible, with the supervisor maintaining focus on the empowerment of the supervisee.

Cognitive-Behavioral Supervision: As with other psychotherapy-based approaches to supervision, an important task for the cognitive-behavioral supervisor is to teach the techniques of the theoretical orientation. Cognitive-behavioral supervision makes use of observable cognitions and behaviors—particularly of the supervisee's professional identity and his/her reaction to the client (Hayes, Corey, & Moulton, 2003).   Cognitive-behavioral techniques used in supervision include setting an agenda for supervision sessions, bridging from previous sessions, assigning homework to the supervisee, and capsule summaries by the supervisor (Liese & Beck, 1997).

Person-Centered Supervision: Carl Rogers developed person-centered therapy around the belief that the client has the capacity to effectively resolve life problems without interpretation and direction from the counselor (Haynes, Corey, & Moulton, 2003). In the same vein, person-centered supervision assumes that the supervisee has the resources to effectively develop as a counselor. The supervisor is not seen as an expert in this model, but rather serves as a "collaborator" with the supervisee. The supervisor's role is to provide an environment in which the supervisee can be open to his/her experience and fully engaged with the client (Lambers, 2000).

        In person-centered therapy, "the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship are the prime determinants of the outcomes of therapy" (Haynes, Corey, & Moulton, 2003, p. 118). Person-centered supervision adopts this tenet as well, relying heavily on the

supervisor-supervisee relationship to facilitate effective learning and growth in supervision.

Developmental Models of Supervision

In general, developmental models of supervision define progressive stages of supervisee development from novice to expert[1], each stage consisting of discrete characteristics and skills. For example, supervisees at the beginning or novice stage would be expected to have limited skills and lack confidence as counselors, while middle stage supervisees might have more skill and confidence and have conflicting feelings about perceived independence/dependence on the supervisor. A supervisee at the expert end of the developmental spectrum is likely to utilize good problem-solving skills and be reflective about the counseling and supervisory process (Haynes, Corey, & Moulton, 2003).

For supervisors employing a development approach to supervision, the key is to accurately identify the supervisee's current stage and provide feedback and support appropriate to that developmental stage, while at the same time facilitating the supervisee's progression to the next stage (Littrell, Lee-Borden, & Lorenz, 1979; Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987). To this end, a supervisor uses an interactive process, often referred to as "scaffolding" (Zimmerman & Schunk, 2003), which encourages the supervisee to use prior knowledge and skills to produce new learning. As the supervisee approaches mastery at each stage, the supervisor gradually moves the scaffold to incorporate knowledge and skills from the next advanced stage. Throughout this process, not only is the supervisee exposed to new information and counseling skills, but the *interaction* between supervisor and supervisee also fosters the development of advanced critical thinking skills. While the process, as described, appears linear, it is not. A supervisee may be in different stages simultaneously; that is, the supervisee may be at mid-level development overall, but experience high anxiety[2] when faced with a new client situation.

Integrated Development Model: One of the most researched developmental models of supervision is the Integrated Developmental Model (IDM) developed by Stoltenberg (1981) and Stoltenberg and Delworth (1987) and, finally, by Stoltenberg, McNeill, and Delworth (1998) (Falender & Shafranske, 2004; Haynes, Corey, & Moulton, 2003). The IDM describes three levels of counselor development:
- Level 1 supervisees are generally entry-level students who are high in motivation, yet high in anxiety and fearful of evaluation;

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[1] Different development theorists use their own nomenclature to describe each stage. "Novice" and "expert" are used here as representative of the labeled stages.
[2] Supervisee high anxiety is a Level-1 characteristic in Stoltenberg, McNeill and Delworth's Integrated Development Model (IDM) (1998).

- Level 2 supervisees are at mid-level and experience fluctuating confidence and motivation, often linking their own mood to success with clients; and
- Level 3 supervisees are essentially secure, stable in motivation, have accurate empathy tempered by objectivity, and use therapeutic self in intervention. (Falender & Shafranske)

As noted earlier, the IDM stresses the need for the supervisor to utilize skills and approaches that correspond to the level of the supervisee. So, for example, when working with a level-1 supervisee, the supervisor needs to balance the supervisee's high anxiety and dependence by being supportive and prescriptive. The same supervisor when supervising a level-3 supervisee would emphasize supervisee autonomy and engage in collegial challenging. If a supervisor was to consistently mismatch his/her responses to the developmental level of the supervisee, it would likely result in significant difficulty for the supervisee to satisfactorily master the current developmental stage. For example, a supervisor who demands autonomous behavior from a level-1 supervisee is likely to intensify the supervisee's anxiety.

While presenting a clear and flexible conceptual model of the developmental approach to supervision, the IDM does have some weaknesses. For one, it focuses predominantly on the development of graduate students in training, with little application to post-degree supervision. For another, it presents limited suggestions for specific supervision methods that are applicable at each supervisee level (Haynes, Corey, & Moulton, 2003). An alternative developmental model proposed by Ronnestad and Skovholt (1993, 2003; Skovholt & Ronnestad, 1992) addresses effectively the IDM's first weakness by providing a framework to describe development across the life span of the counselor's career.

Ronnestad and Skovholt's Model

This model is based on a longitudinal qualitative study conducted by interviewing 100 counselors/therapists, ranging in experience (at the beginning of the study) from graduate students to professionals with an average of 25 years of experience (Skovholt & Ronnestad, 1192). Ronnestad and Skovholt analyzed the resulting data in three ways, coming up with a stage model, a theme formulation , and a professional model of development and stagnation (Ronnestad & Skovholt, 2003). In the most recent revision (2003), the model is comprised of six phases[3] of development. The first three phases (*The Lay Helper, The Beginning Student Phase,* and *The Advanced Student Phase*) roughly correspond with the levels of the IDM. The remaining three phases (*The Novice Professional Phase, The Experienced Professional Phase,* and *The Senior Professional Phase*) are self-explanatory in terms of the relative occurrence of the phase in relation to the counselor's career.

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[3] Ronnestad and Skovholt (2003) dropped *stage* in favor of *phrase*, saying that the former denoted "hierarchical, sequential and invariant ordering of qualitatively different functioning/structures" (p. 40). *Phase*, they felt, emphasized "the gradual and continuous nature of changes therapists go through" (p. 40).

In addition to the phase model, Ronnestad and Skovholt's (2003) analysis found 14 themes of counselor development. These are:

1. Professional development involves an increasing higher-order integration of the professional self and the personal self
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.
4. An intense commitment to learn propels the developmental process.
5. The cognitive map changes: Beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise.
6. Professional development is long, slow, continuous process that can also be erratic.
7. Professional development is a life-long process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.
9. Clients serve as a major source of influence and serve as primary teachers.
10. Personal life influences professional functioning and development throughout the professional life span.
11. Interpersonal sources of influence propel professional development more than 'impersonal' sources of influence.
12. New members of the field view professional elders and graduate training with strong affective reactions.
13. Extensive experience with suffering contributes to heightened recognition, acceptance and appreciation of human variability.
14. For the practitioner there is a realignment from self as hero to client as hero.

In sum, Ronnestad and Skovholt (2003) note that counselor/therapist development is a complex process requiring continuous reflection. They also state that much like the client-counselor relationship's strong influence on treatment outcomes, research findings support "a close and reciprocal relationship between how counselors/therapists handle challenges and difficulties in the client relationship *and* experiences of professional growth or stagnation" (p. 40).

Integrative Models of Supervision

As the name implies, integrative models of supervision rely on more than one theory and technique (Haynes, Corey, & Moulton, 2003). Given the large number of theories and methods that exist with respect to supervision, an infinite number of "integrations" are possible. In fact, because most counselors today practice what they describe as integrative counseling, integrative models of supervision are also widely practiced (Haynes, Corey, & Moulton). Haynes, Corey, and Moulton describe two approaches to integration: technical eclecticism and theoretical integration.

> *Technical eclecticism* tends to focus on differences, chooses from many approaches, and is a collection of techniques. This path calls for using

techniques from different schools without necessarily subscribing to the theoretical positions that spawned them. In contrast, *theoretical integration* refers to a conceptual ortheoretical creation beyond a mere blending of techniques. This path has the goal of producing a conceptual framework that synthesizes the best of two or more theoretical approaches to produce an outcome richer than that of a single theory. (Haynes, Corey, & Moulton, p. 124).

Examples of Integrative supervision models include: Bernard's (1979) discrimination model, Holloway's (1995) systems approach to supervision, Ward and House's (1998) reflective learning model, and Greenwald and Young's (1998) schema-focused model (Haynes, Corey, & Moulton, 2003).

Bernard's Discrimination Model: Today, one of the most commonly used and researched integrative models of supervision is the Discrimination Model, originally published by Janine Bernard in 1979. This model is comprised of three separate foci for supervision (i.e., intervention, conceptualization, and personalization) and three possible supervisor roles (i.e., teacher, counselor, and consultant) (Bernard & Goodyear, 2009). The supervisor could, in any given moment, respond from one of nine ways (three roles x three foci). For example, the supervisor may take on the role of teacher while focusing on a specific intervention used by the supervisee in the client session, or the role of counselor while focusing on the supervisee's conceptualization of the work. Because the response is always specific to the supervisee's needs, it changes within and across sessions.

The supervisor first evaluates the supervisee's ability within the focus area, and then selects the appropriate role from which to respond. Bernard and Goodyear (2009) caution supervisors not to respond from the same focus or role out of personal preference, comfort, or habit, but instead to ensure the focus and role meet the most salient needs of the supervisee in that moment.

Systems Approach: In the systems approach to supervision, the heart of supervision is the relationship between supervisor and supervisee, which is mutually involving and aimed at bestowing power to both members (Holloway, 1995). Holloway describes seven dimensions of supervision, all connected by the central supervisory relationship. These dimensions are: the functions of supervision, the tasks of supervision, the client, the trainee, the supervisor, and the institution (Holloway). The function and tasks of supervision are at the foreground of interaction, while the latter four dimensions represent unique contextual factors that are, according to Holloway, covert influences in the supervisory process. Supervision in any particular instance is seen to be reflective of a unique combination of these seven dimensions.

Conclusion

Clinical supervision is a complex activity. "The competent clinical supervisor must embrace not only the domain of psychological science, but also the domains of client service and trainee development. The competent supervisor must not only comprehend how these various knowledge bases are connected, but also apply them to the individual case" (Holloway & Wolleat, 1994, p. 30). This article summarized various supervision models, with the goal of helping to increase the reader's theoretical knowledge base, thereby enhancing the foundation of supervisory competence.

As one can see from the above description, numerous models of supervision have been developed and applied. Some have had a limited constituency, while others have resonated with many practitioners, evolved, and thrived. No matter your chosen approach to supervision, it is important for it to be grounded in a theoretical framework. The aim of this article has been to give the reader an introduction to some of the supervision models available. You are encouraged to pursue further readings in order to identify or enhance your personal supervisory orientation.

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