SUPERVISION:
Methods and Issues

by
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Supervision means to **oversee** and, in industrial and field settings, this may be accurate, but when it comes to psychotherapy supervision, the supervisor (S) all too often is unlikely to 'see' anything, especially in the older forms of supervision. In this article I will briefly mention the problem of what it is that S is 'supposed to see' and then review the various methods used in the supervision process.

Psychotherapy training requires a combination of conceptual, experiential and behavioural learning in the constantly changing, never duplicated psychotherapy situation. There is very little agreement on what therapists actually do that leads to client improvement along specific dimensions. The implications for supervision are significant; what exactly should S be selecting as the most relevant skills to enhance with the supervisee (s)? Try making a list for yourself of the specific goals you would want from supervision and ask a therapy supervisor to do the same and then compare lists for agreement!

I thought of including goals of supervision, but got so bogged down in it, that I am studiously avoiding it. I think the ultimate 'value for money' lies in some kind of client improvement if supervision is to be considered effective. (I have never had **s** seek supervision with that as their goal, though it may be implied). Another problem related to goals of supervision is its very close relationship to training. Training **seems** to be primarily related to skill development, often outside the 'real' situation while skill enhancement, either during the therapy session and/or following it, falls into the supervision realm, though there is great overlap. One supervisory method which seems to be 'on the way out' is the post session discussion based on notes written by the **s**. Research has shown that the notes reflect serious omissions and distortions even when based on audio-recordings. More in vogue now are didactic instruction, supervisor modelling, direct observation of the **s's** sessions and intervention by the S during the session and, finally post interview discussion through audio or video taping.

Whatever the method used, however, one element seems crucial to effective supervision: the quality of **S-s** relationship and the S modelling of empathy, warmth, respect and genuine concern

towards **s**. The opposite situation is deleterious to learning (and this obviously is similar to the requirements in the actual therapeutic relationship. Greben (1976), for example, reports that when **S** treats trainees with respect and dignity, they, in turn, are more likely to treat their clients similarly.

One of the tasks in both the supervision and therapy situations is to guide interpersonal change. In supervision, does **S**, as a guide, therefore focus more on effective or ineffective responses made by **s**? Does **S** (as **s** may with their client) reinforce dependent or other comments which are pleasing to **S** and ignore more controversial or threatening areas? Who selects what shall be explored, and on what basis? Should **S** insist on raising issues from the therapy situation which **s** finds acceptable, but **S** does not? Does **s** omit from supervision their 'mistakes' which have been previously criticised, and thus only bring the more 'successful' material (which again has its parallels in psychotherapy). The reader may wonder what relevance these questions have to methods but, for example, in live supervision, **s** cannot 'hide' or control what material is brought to supervision, so some of these questions are resolved by the method selected. The reader should also be aware that several methods are combined during the course of supervision, or even during a single session.

Didactic input is rarely, if ever, the sole approach to supervision. It usually occurs when a broad issue is stimulated by an incident in therapy. The client may, for example, exhibit great dependency on the therapist. To **s**'s discomfort, **S** may want to review the theoretical implications of dependency with **s**, as well as revise various ways of effectively dealing with it in the sessions with the client. (S, depending on their orientation towards supervision may also feel it appropriate to include some personal exploration of **s**'s discomfort).

Nelson (1978) reported that for learning psychotherapy skills, psychotherapy trainees benefited most from observing their supervisor conducting a therapy session. Interestingly when in training myself, I asked several of the staff if I could hear one of their sessions (audiotape) - only one agreed. I did find it useful particularly when we could discuss some of his inputs. Further benefits can be obtained if the supervision focuses on parallels between **S**'s therapy session and **s**'s therapy session. Discussing problems common to both sessions, and interventions made by the therapist, which are useful for the supervisee's sessions, represent a good application of this method. Similarly while observing **S** conducting his/her therapy session, **s** could note approaches and solutions for his/her problematic areas for later discussion with **S**.

Several authors (Gershenson & Cohen, 1978; Nelson, 1978) reported very favourable supervision results with the direct observation method.

Here, it is **s** who conducts the session, with **S** observing. As you can well imagine, the biggest problem with this approach is the considerable exposure and anxiety which **s** experiences. Imagine you are conducting a session with both you and your client well aware that your supervisor is behind a one-way vision screen (or watching on a TV monitor). Suddenly a buzzer goes and you, the therapist, get up, walk to a wall phone and hear your **S** make a direct suggestion such as: "Rather than ask him about his mother, say: 'I wonder if maybe you are avoiding a deeper intimacy with your wife' ". Your **S** may then briefly elaborate but basically it would be expected that you would 'pick up' **s**'s intervention and carry it through with the client. Used in conjunction with video for post session supervision, it can be a powerful tool but it can be very difficult during the session to quickly comprehend **S**'s intervention, and then integrate it meaningfully into the session.

Less disruptive and therefore allowing more frequent interventions is the 'bug-in-the-ear device. **S** speaks into a microphone from behind the one-way mirror and **s** hears the message through a device which is like a hearing aid. It is effective in keeping **s** focussed on pertinent issues and aids in giving immediate directions which may be vey reassuring to the novice therapist. Problems similar to the phone are evident sometimes with rather amusing results. I could not hear **S**'s input at all and was subtly trying to signal my **S** that I could not hear. My client suggested that I just go and discuss it directly, which I did. Other times the intervention was so audible that my client also heard.

A supervisory method sometimes used in couple and family therapy is the therapist leaves the room three-quarters through the session and discusses it with the supervisor for about ten minutes. This helps to give a focus and a direction to the remaining portion as well as an integration of what has occurred in the session so far.

During 'live' supervision **S** may actually sit in the room but makes his comments or directions solely to **s**. Working with a family, I noticed that whenever the therapist asked the adolescent boy in the family a question, Mother invariably answered for him. Pointing this out to **s**, I then advises **s** to first ask Mother if she were aware of her pattern and then explore its meaning for this family.

In the direct observation method with its various forms of immediate intervention, there are obvious problems. Clients (although frequently adapting well) need to be prepared for this model of supervision. They may feel exposed and may wish to meet the Supervisor. Clients sometimes wonder why they cannot have the 'good' therapist although at recognised training Instiutes clients often understand that in exchange for free or low cost treatment they will be seen by trainee therapists.

Clients could come to overvalue S's interventions and devalue s's inputs. In practice, however, these issues are rarely a serious obstacle to effective therapy. From s's viewpoint, having S there, is often very reassuring, especially when s is facing a difficult session or experiences that awful situation of being 'totally lost or confused'. Overall, the advantages of immediate feedback and the interruption of ineffective inputs with more beneficial responses, far outweigh the difficulties.

Video tape is also popular and is widely used in the USA for training and supervisory purposes. It is effective with just solitary review by the trainee, and its utility is further enhanced by supervisor comments. One of video's advantages is the tape can be stopped. This allows ample time for discussion, a review of body language cues and role plays. Areas or moments of difficulty can be substantially explored. A further advantage is anxiety is less that in the 'live' method; there is a permanent record so that s can note their own progress over time. On the other hand, videotape supervision lacks the benefits of live supervision: immediate feedback and intervention, for example.

If video taping equipment, one-way screens etc. are not available, probably the post-session discussion (with or without benefit of audio tapes) is the most frequent format for supervision. (Of course, in both live supervision through direct observation and videotapes, post-session discussion is included as part of the process). In the post-session format S must obtain an accurate over-view of the session as well as specific therapist responses. (Written and verbal reports are, as indicated earlier, very unreliable due to omissions and distortions). All visual and auditory clues are also missing. S has to glean much more in this method. Often, in the supervision that I do in this way, s brings specific problem areas, usually relating to a segment of a session. We will disuss what sense s makes of it, what responses were made etc., and with what results. We may review the position in terms of the phase of therapy the client is currently in, or relate the client's particular pattern to a broader context. Role play (with me modelling therapist responses and s as client and vice versa) followed by discussion is particularly useful for clearer understanding and skill enhancement.

Given the advantages and disadvantages of the different supervision methods, which do supervisees themselves actually prefer? According to Nelson they prefer direct, live supervision and video for monitoring their therapy sessions. Observation of their supervisor conducting a therapy session provided the best learning opportunity. They favoured Ss who were flexible, permissive, out-going and self-revealing. Supervisees also praised supervisors who regularly conducted therapy sessions, helped trainees explore their feelings

towards clients and encouraged supervisees to develop their own style of therapy.

Taking all this into account, if I could design my 'ideal' supervisory method, I would, after the supervisee had obtained initial skills and client exposure, first invite **s** to sit in on my therapy session with a client. After the session we would discuss it together.

Initially I would have primary responsibility for the sessions. Eventually **s** would have primary responsibility (with a new client); I would supervise with a 'bug in the ear' with gradually decreasing interruptions until I was intervening only at crucial times. A video review would follow. The focus would have a broad range, from emotional aspects experienced by the therapist, to theoretical issues. Role playing, teaching, discussion and exploring alternative responses might be employed. Though I think it unwise to mix therapy and supervision, a more personal exploration might be beneficial in some instances, expecially when our sessions seem to be mirroring the therapy sessions, or when **s** is experiencing a strong emotional response or difficulties with their client (counter-transference).

The goals of supervision which I avoided in the beginning? Well, I will 'cheat' by quoting Levine & Tilker (1974) who suggest that the main goal of supervision is: '..... to provide the trainee with direct, unambiguous feedback about the trainee's functioning along with alternative ways the issue can be handled'.

References

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