# CLIENT-CENTERED SUPERVISION

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Bernard and Goodyear (1992) group methods of supervision into two classes. The first includes those methods that derive from or are grounded in a theory or system of psychotherapy. The earliest, and still the major, such approach is that of psychoanalysis and its offshoots: "The psychotherapy-based supervisor is one whose supervision is based totally and consistently on the supervisor's theory of psychotherapy or counseling" (Bernard & Goodyear, 1992, p. 12). These authors include client-centered supervision in this category. They note that "there are fewer purely psychotherapy-based supervisors than one might think" (p. 13). Although these authors' eclectic supervision is theory-based, they say that "it must be noted, however, that the theoretical underpinning of these two theories [humanistic and behavior theories] are contradictory" (p. 19). It appears that eclectic supervision was included here because it does not fit into their second category.

The second major category of supervision includes the so-called developmental approaches. The recent and current literature consists almost entirely of discussions of these approaches. It is curious that the developmental approaches ignore the fact that both therapy and supervision are interpersonal relationships. The developmental approaches to supervision also ignore the theoretical orientations of both the supervisee and the supervisor. Yet each has an approach, or some idea about how therapy should be done, whether or not it is a conscious or recognized theory. The developmental approaches thus fail to consider how the supervisor and supervisee are to reconcile differences or reach agreement on what is expected of the supervisee--what the criteria for the supervisee's practice and performance are.

The client-centered approach to supervision, first described by Patterson (1964), is the focus of this chapter. It is a theory-based approach deriving from client-centered therapy.

## THE CURRENT STATE OF SUPERVISION

In actual practice, most supervision does not appear to follow either a theory-based or developmental approach, being atheoretical or eclectic. The reason is that most supervisors do not subscribe to or follow a particular theory of psychotherapy or of

supervision and consider themselves to be eclectic. This situation creates problems for supervisees.

There is little, if any, agreement on the preparation of the student for supervised practice. Courses on theory and practice may be taken from different instructors with differing theoretical orientations or with no theoretical orientation. Instructors may or may not have a commitment to a particular theory. They may have been discouraged from making a commitment to any particular theory, or they may have been encouraged to develop their own theory. Supervisors also may or may not be committed to a consistent philosophy or theory. If both student and supervisor claim to be eclectic, there may be little agreement on what this means in actual practice.

The current situation has led this author (Patterson, 1992) to suggest a change in the programs for the education of psychotherapists. Each program would commit itself to two or three theoretical orientations depending on the competence and expertise of its faculty. Each student would enroll in a theories course that covers the major theories in some depth, using a text such as Patterson and Watkins (1996) or Ford and Urban (1963). Students would then select the theory they prefer and enroll in an advanced course covering that theory, with an instructor who is an expert in it. Students would then continue in supervision with that instructor. If a student desires training in a theory that is not a specialty of a faculty member in that institution, he or she would be facilitated in transferring to an institution offering such training. This approach is considered an interim one, pending the time when there would be agreement on one system of psychotherapy-a universal system (Patterson, 1995; Patterson & Hidore, 1996).

This writer has attempted a similar approach to the education of psychotherapists. Early on (at the University of Illinois, 1956-1977) students in the supervised practicum had an introductory course with exposure to the major theories. In the supervised practicum, a seminar (4 hours per week) was conducted in which the students were exposed to a client-centered approach, reading Porter (1950), then later Patterson (1959, 1974).

More recently (at the University of North Carolina at Greensboro, 1984-1994), I accepted for supervision only those students who had had my course on client-centered therapy, requiring that they had read The *Therapeutic Relationship* (Patterson, 1985), among others.

In most programs preparing students for the practice of psychotherapy, students are assigned to supervisors without regard to the theoretical orientation of the student or the supervisor. The student may or may not have had a basic theory course with the supervisor. As a result, mismatches are common. This means that the early stages of supervision are taken up with (a) the supervisee trying to learn where his or her supervisor is coming from and (b) the supervisor engaging in teaching or informing the student about his or her approach. The process of supervision is thus slowed considerably.

# MY APPROACH TO SUPERVISION

The desirability and advantages of the supervisor and supervisee sharing the same theoretical basis for psychotherapy have not been adequately recognized. Matarazzo and Patterson (1986) are the only ones to address this issue. They write: "It appears important for supervisor and supervisee to have a similar theoretical orientation" (p. 838).

My position on this is clear. It is not simply desirable or important, but necessary that the supervisor and supervisee be committed to a theory-and the same theory:

"The supervisor has a commitment to a theory, and the supervisee must have at least a tentative commitment to a theory; it should be obvious that if learning is to occur, they must be committed to the same theory."(Patterson, 1983, p. 22)

## The Supervisory Process

*Orientation of the Supervisee.* Supervisees meet in a group prior to the first individual supervision session. Most recently (1990-1994), a videotape of a published interview (Freeman, 1992) with me on client-centered supervision was shown. This interview provides an orientation to the supervisory process and is followed by discussion with the supervisees. The points made in the interview and the following discussion include the following:

1. As a result of the course, supervisees are familiar with the client-centered therapist conditions of empathic understanding, respect, therapeutic genuineness, and concreteness (Patterson, 1985). Students recognize and accept that these conditions are necessary for therapeutic personality change (Rogers, 1957). The emphasis is that therapy is not a matter of skills, but of basic attitudes; nevertheless, it is necessary that therapists be able to implement these attitudes with clients. Three simple rules for the beginning therapist are emphasized:

a. The therapist listens, the client talks. Therefore, keep your mouth shut. You can't listen to the client while you are talking.

b. Never ask a question-unless you don't understand what the client is saying.

c. Remain in the responsive mode. The client initiates, the therapist follows.

2. It is not expected that supervisees should accept that the therapist conditions are sufficient as well as necessary for therapeutic personality change. It is emphasized that supervisees are expected to test the assumption that they are sufficient. This means that the supervisees are not to depart from these conditions, thus abandoning the assumption, and try other techniques. Although theoretically it may be that the assumption is not correct, supervisees are not prepared to go beyond them. Engaging in other practices would involve the supervisee's being irresponsible. As a corollary to this requirement, it

is emphasized that the supervisor is responsible for the supervisee's clients, and supervisees are not permitted to experiment on their clients.

Parenthetically, in my experience during some 35 years of supervision, supervisees have been universally successful in working with clients without going beyond these conditions, often to their surprise when they realize this at the end of the semester.

3. Supervisees are told the criteria by which they will be evaluated. These consist of effectiveness in providing the therapeutic conditions. Knowing these criteria, supervisees are able to evaluate themselves. Earlier at the University of Illinois, I gave supervisees the option of being evaluated on the basis of an audiotape of a therapy session they submitted at the end of the semester. The tape would be rated by trained raters. No supervisee chose this option to my evaluation.

4. Supervisees were expected to audiotape their sessions, provided their clients agreed to be taped. Clients seldom refused to be taped.

5. In preparation for supervision, supervisees are expected to review their tapes and make notes during the review, including questions they wish to bring into supervision. It is impossible for the supervisor to listen to all of the tape recordings; therefore, supervisees are expected to select tapes and sections of tapes that they wish to work on during supervision. Although it might be expected that supervisees would present their best tapes, this is not the case. They select those tapes and sections of tapes in which they realize they did poorly or were confused about their performance and on which they want help.

These practices allow for the development of a supervisory atmosphere that minimizes threat and anxiety for the supervisee. They provide a structure that facilitates supervisee learning (Freeman, 1993). Because the supervisee knows where the supervisor is coming from-they share the same theoretical system-and has the criteria by which he or she is being evaluated, evaluative comments or statements by the supervisor are practically nonexistent. Supervisees make their own evaluative comments. Similarly, the need for and the amount of feedback from the supervisor are minimized: The supervisee gives him/herself feedback. The stage is set for a relationship that is immediately productive. So-called stages in the process are not present. There is a smooth progression, or supervisee progress.

*The Actual Process*. The supervisor provides a client-centered-or supervisee-centered-relationship. He or she is genuine in the process, respects the supervisee, and empathizes with the supervisee's relationship with the client, putting her/ himself in the place of the supervisee in the relationship. The supervisee has the responsibility for the supervision process-selecting the taped material to be considered and raising questions, problems or issues.

1. Because the supervisor bears the responsibility for the supervisee's clients and not every tape, or a tape for each client, can be included in the supervisory session, each session begins with the supervisee reviewing each of his or her clients. This may be more, or less, detailed, depending on the client. Also, it is considered important that at least one continuing client is followed in some detail by the supervisor.

2. There is little concern with diagnosing or labeling clients and little if any discussion of personality dynamics. Such an approach views the client as an object to be analyzed and evaluated rather than as a person to be accepted and understood. Supervisees are, however, helped to be sensitive to evidence of severe disturbances or organic problems, as well as indications of conditions that would warrant referral. Such conditions become apparent in the course of a therapy that focuses on the client's frame of reference and perceptions.

3. The supervisor does not engage in didactic instruction to any great extent because the supervisee has had a course in the theory being practiced. When a question or problem involving an element of the theory or its application arises and it is considered by the supervisor to be an issue of interest or concern to other supervisees, it is brought up for discussion in a group meeting.

4. Supervision is not therapy. Nevertheless, both are interpersonal relationships, and they have some commonalities, as already noted: empathic understanding, respect, and genuineness. But these conditions are implemented somewhat differently. The focus is not on the supervisee's personality or problems, but upon his or her relationship with his or her clients. The supervisee's personality becomes of concern only if it detrimentally affects the therapy. Then it is dealt with only in terms of this situation, that is, the supervisor responds to the difficulty in the supervisee's relationships with his or her clients. Yet because of the overlap in supervision and therapy, "one should not be surprised to find at times the line between supervision and therapy becomes difficult to determine" (Bonney, 1994, p. 35).

If it becomes apparent that the supervisee's personal adjustment is pervasive and interferes with his or her ability to function as a therapist, psychotherapy should be recommended. In extreme cases, when clients could be hurt, the supervisee should be discontinued from the practicum or internship.

*Group Meetings*. Supervisees meet regularly in a group with the supervisor. Problems, questions, and issues arising in individual sessions are discussed. With the supervisee's permission, sections of tapes may be played. Professional and ethical issues are considered, including record keeping, privileged communication, confidentiality, duty to warn, referrals (e.g., because of suspicion of physiological or neurological conditions or indications of the desirability of medication), and other topics.

## EXAMPLE

The following excerpts are from a supervisory session with a supervisee who was interning at a family service agency. This session took place near the end of the third month of his internship. At the beginning of the semester, he reported that he was to see his first family group (one of those discussed later) that evening and that he was concerned about how to approach it, because he had not had a course in family therapy. I recalled for him what I had said in a brief discussion of family therapy in one of the class sessions in the course he had had with me: The function of the therapist in family therapy (and in group therapy also) is (a) as in individual therapy to listen and respond with empathic understanding and (b) to facilitate each person's understanding of the others in the family or group. If there is evidence that one participant fails to understand, or misunderstands, what another participant has said, respond with "It seems to me that what he or she was saying was . . ." or "I heard her or him saying . . ..." or a similar response, to help participants to more accurately hear and understand one another. In the group session the next day, he reported with satisfaction that the meeting had gone very well.

In the following excerpt, the supervisee begins immediately without the supervisor (this author) saying anything. He proceeds as usual by reviewing his clients, here in more detail than is often the case, as they are clients that we have followed closely in previous sessions. SEE is the supervisee; SOR is the supervisor. The family consists of mother, father, son, and daughter.

SEE: Well, I had a hard time-as I sat in group yesterday-I was having a hard time sort of recapturing all that's happened in the last week. Let me go through the clients and maybe that will spark fresh memories. [SOR: uhuh]. Ahh-I can't remember- did I tell you that the family with the boy who had been running off and making all those disruptive phone calls to his mother at work and at school-he-I guess two weeks ago tomorrow-that would have been after I last saw you-they took him down to the Baptist Adventure Camp.

SOR: Yeah-they were going to do that.

SEE: And that was hard. I talked to the mother that morning. The supervisor of the nursing program she is in had wanted some confirmation that the family was in counseling-she wanted some reassurance before the mother re-enrolled for the spring quarter [SOR: uhuh] and-ah-so I called the mother, as I wasn't going to talk to this woman-she had left a message on the machine-until I had permission from the mother, and in the course of talking to her about that it became apparent that she was pretty emotional about-understandably-about having to take her son off and leaving him somewhere. This was a significant milestone for the family in terms of the family development.... And I talked to her again on Monday, I guess and they had taken him down again [to the camp] on Friday, and I'm not sure whether it was Saturday or Sunday that he had run away and-oh-but they had found him and taken him back-and she was going to call that day to find out how he was doing-you know-he had no access to the

telephone there. I haven't heard anything more from them Again I invited her to be in touch if there was d need

So--let me get it all straight-the nine-year-old boy I have been seeing where the sexual abuse by his cousin came to light recently. I had a good session with him a week ago . . . [continues reviewing this case, including a meeting with the parents]. You know, it seems to me that ongoing couple's work, or some individual work for the father would be helpful for the boy. I guess I'm not real sure where my role is in broaching all of that. I guess it's still very much a gray area for me as to what my role is, as to sharing my perception-my thoughts about what might be useful. At this point I suspect the father-it seemed early to me to talk with the father about individual work....

SOR: Now you're going to continue seeing him twice [a week], then once.

SEE: I think so.

[SEE continues talking about the idea that the boy has an attention deficit disorder. There have been no apparent results of treatment with Ritalin®.]

SEE: But the mother did report that there had been some significant changes at home in his behavior, especially with homework.

SOR: But you're thinking that at some point you feel that he [the father] could benefit from individual therapy.

SEE: I think so. He described his own depression. Do you have any thought on that, on-

SOR: Well, uh, I'm thinking probably that at some point he may focus on himself when they are both there and you might just suggest that he might want to talk about these things without his wife present-then the problem would be whether you could do it. [SEE: uhuh]. It's been a kind of a pattern of parent education and it might not be easy to shift for both of you.

SEE: [Goes on to suggest the possibility of the father joining a parent group for male survivors of child abuse, at the agency-the father is such a survivor.] So I think if it came to that I would certainly refer him, rather than trying to do that myself- O.K., that feels better. So it appears that things are moving in a positive direction.

[The SEE goes on to review other cases for a considerable period of time. Several families were involved. Then]:

SEE: The 38-year-old woman who is on the tape called me and wanted to know if I could see her that morning. She went to work and was unable to stay, and-ah- said she was feeling like she was going to hurt herself. I was supposed to go to a workshop, but I hesitantly agreed to see her, and did. I think it was the right thing to do-hindsight, the

powerful tool that it is, tells me that she probably could have made it without it [the appointment]. But-I didn't know that at the time. [SOR: Yeah.] What I've learned since told me that. She brought her 200 Valiums® with her, poured them all out on the table during our session. We met for about an hour and a half during which she-ahh-well, it's amazing-I listened to the tape-I listened to part of the tape right after that session. She talked in the session about how up and down she felt. She-the night before-she takes Elavil® daily and was prescribed Tranxene® to help her sleep. [A psychiatrist monitors her drug treatment.] She had taken four instead of two the night before-said she had taken the four hoping she wouldn't wake up, but had. When she talked about the rapid cycling up and down I wondered if that was a product of the medication [SOR: uhuh] and suggested that we try to get in touch with her psychiatrist to find out whether that might be the case or not. So we did track him down and I talked to him a bit and told him what was going on and then he talked to her briefly, and she told him as she told me that she didn't want to be hospitalized. She had been hospitalized twice-once involuntarily-and she said, she had told me on the phone and she told me before and she told me in the session that she had a gun and that if either of us tried to have the police come and commit her involuntarily that she would have the gun out and she would force the police to kill her-that she wouldn't hurt them, that she would lead them to think that she might and force them to blow her away-to use her term. So she was pretty distraught, certainly. [SOR: uhuh] And by the end of the hour and a half I felt fairly certain that she wouldn't do anything to hurt herself. She called me later in the day-she called me several times during the day. I guess in the session I had talked to her about hospitalization in terms of it being a way for people who-ahh, felt like they might hurt themselves but still had some desire to live, to get help. Well, when she talked to me on the phone in the afternoon, I had an interesting, or what for me was a very illuminating misunderstanding. She almost always speaks in the third person and she said: "You don't do anything but sit there." (I had broached the topic of hospitalization again.) And I took that to be a criticism of me-that I didn't do anything in sessions but just sit there-so I responded-as clearly as I can remember-I wrote it down last night when I was listening to the tape, something like "so you're trying to provoke a different response from me." And then-I don't think she really understood that-she said: "No-up there at the hospital you just sit there and watch TV." So that was very interesting to me. What she was saying was that in the hospital all you do is just sit there-how is that going to help me? But because of where I was coming from I read that [SOR: Yeah, right] as "you just sit there."

SOR: She was picturing the hospital and herself.

SEE: So that was very interesting and instructive. And I think my response was a very appropriate one and it did in fact clarify what it was she was talking about. But it was telling me that I was somehow feeling at least mildly attacked or questioned or criticized [SOR: Yeah] and that's the way I read her comment. So she made it through the day.
[The SEE then talks for a time about the client calling him frequently on the telephone, sometimes at his home, and discusses the possibility of seeing her twice a week to reduce the phone contacts. Then]:

SOR: Let me express a feeling I have: What about the possibility you're doing something to create a dependency relationship with her?

SEE: Well, I think that has happened.

SOR: Yeah, but whether it is something you have contributed to . . .

SEE: [Pause] Well, I don't know. I mean, I wouldn't rule it out. I don't-I mean she's obviously a very needy woman who has very little [SOR: Yeah] support coming from anywhere else. I guess I would ask you, did you hear specific things [SOR: Well] that made you wonder about that or worry about that?

SOR: I listened to the tape from where you set it on to the end. You're presenting her with two different roles. Part of the time you're responding to her but then part of the time because of your concern about suicide you're taking over and questioning and probing. And these are inconsistent. You're showing this concern about possible suicide-getting a contract. [The SEE had picked this up from another course or his reading.] At one point she said she wouldn't do it-at one point you say: "Have you been feeling that way lately, that you might use them?" And when she said "No," you said "Good"-showing your own feeling. And I think you may be communicating to her that you're really worried about her-what she might do, what might happen. And I don't say she's manipulating you. But this is a possible reason why people-they talk about a suicide gesture-that she's using these things, talking about-a kind of gesture to get your concern, to get you involved in some way. So that she's becoming dependent rather than independent. I think she's getting two kinds of messages from you.

SEE: Yeah. Yeah. I see that. Uhuh. Well, it's interesting, because in thinking about that now I have felt that and I've-I think in the phone contacts since I haven't seen her since last Tuesday I've been-I've been more limited in my responses.

SOR: Yeah. Not more reassuring, maybe?

SEE: No. I think consciously-because I think the history of all these phone calls has told me as long as I offer that to her she's going to continue to seek it. And if I throw her back on her own resources that she's got more ability to do it than she would want me to think. An example of that being that her husband, from whom she is separated, was arrested for nonpayment of child support-from a previous marriage and she called me and was all teary about-she couldn't get anyone to cosign the bail bond-she was obviously, I think, wanting me to say I would. But I didn't even think of biting on that one-I guess the thing that you're raising the question makes me think more about is, should I have said I would see her today, you know. [SOR: Yeah] Do I need to, from here on out, say there are our scheduled appointment times [SOR: Yeah] particularly if there is a true emergency, there is a crisis response and assessment team at_____ hospital. I think that's what's going to be necessary. I think-I see what you're saying here. I guess what's still unclear to me in a

situation where you have someone who is talking about suicide is-uh-morally, ethically, is it sufficient to respond-is there a responsibility to do more.

SOR: But when you do that you're damaging your relationship.

SEE: Yeah. Then I guess the response is then to know what the potential hazards are if you see a need to do that and make the choice.

SOR: I think people in general-and the current literature and everything overemphasize the danger. Everybody who talks about suicide isn't going to do it. People who are vulnerable-like you-have got to protect yourselves and I think too easily panic and lose confidence in the client and take over.

SEE: Well, it's certainly been a good experience, working with her-very different than anybody I've ever worked with before certainly. And has raised this whole realm of boundary questions in a way I haven't had to deal with before. But I think it's caused me to think about what was the cost of intervening in that way at this point, and-ah-I can see in this session too-of this tape-which was a long session with her last Tuesday, that I skated between different roles at that time too.

[There is a period of listening with the supervisee to a portion of a tape with the client. In addition to the difficulty of listening to a tape recording of a tape recording, the client's voice has a childish pitch as a result of a recent experimental treatment for her stuttering, consisting of injection of a substance into her voice box.]

SEE: This tape is very hard to hear. [Tape not audible for a while. SEE then responds to the client. Ther. is the supervisee: Ther: There may be a part of you that wants to open up in the same way but it's been so tight for so long it's hard to accept that change.

SEE: A little bit of interpretation?

SOR: Yeah. [Client speaks inaudibly.]

SEE: She didn't really respond to it. I couldn't hear what that little bit was. I think she said "I'm just so tired." I was seeing it metaphorically, and she just didn't get it.

SOR: Yeah. Well, it seems to me that you have this hypothesis of a multiple personality and you're trying to find something.

SEE: Well, that was it. I was smuggling it in there as [my teaching assistant] would say-to see whether it would turn anything up.

[We continue to listen to the tape though it wasn't possible for the supervisor to hear clearly what the client was saying, partly because of her voice quality. The supervisee's statements were audible, and some of these were commented on by the supervisor.]

Ther. [to client]: With your voice being different now, do you sound more to yourself like you did when you were little? Younger?

Client: I never thought of that.

SEE: See, hindsight tells me that I could have phrased that-I could have commented on her voice [SOR: Yeah] instead of questioning her about it-towards the same-the same end, or by saying "Your voice has a childlike quality to it."

SOR: Yeah, right.

SEE: Even though I'm getting to be a more experienced counselor, I still feel-I guess I feel a lack of an experience base to help me temper expectations-especially with a very different client like this. [SOR: Yeah] I think that uncertainty-I don't know if it's impatience-I guess it is uncertainty as much as anything. [SOR: Yeah] It's part of what has led to my shifting gears and roles.

SOR: Yeah. It's difficult to get in and stay in her field of reference.

SEE: Yeah. At one point during this session she-she was saying "You can't know what my life has been like." And I simply said: "Yes, you're right. I cannot know." And that's really true. I can be with her, but . ... .

SOR: You can try, as far as you can.

SEE: But there's an obvious limit to that.

SOR: There's a limit with everybody, but with some much more than with others.

SEE: I don't have anything else pressing. Do you-any threads that you . ... .

SOR: I think this is an interesting case and I see a-I think I have some concern that-uh-the best way to help her is to give her all the responsibility-and yet-you feel you have some responsibility about the pills and the gun and those kind of things. And yet when you show your concern about it-it bothers you-it just communicates to her that this must be serious, and it can lead her without manipulating you, bringing up things like this when she wants your attention, and something from you. And yet in the long run that's not going to help her independence. She's got to take responsibility for everything all the time.

SEE: Yeah.

SOR: I think of_____ 's [a former student] case where for 30 years therapists took responsibility for her-she was hospitalized much of the time-and s_____is giving it all back to her, consistently and completely-with a miraculous change.

SEE: Yeah. Well, I've seen that and what you're noting on this tape really fits with what I've experienced in the past week in dealing with her-and-not seeking to be reassuring.

SOR: Right.

SEE: And I'm seeing more how she can do it for herself.

SOR: Yeah. If you really let her, she can.

SEE: But what's become clear to me in the course of my time here talking about this is that-uh-my seeking to reassure her is probably going to only increase the likelihood that she will lose her job, for example. Now I can't say, as things go on, that she may not lose her ability to-uh-function well enough to hold her job. But neither can I take responsibility for that-but I think what you've pointed out and what I've experienced in the last weeks suggests that-well, to use the codependency lingo, the more I enable her to be irresponsible the more she will be.

SOR: Yeah. As you say, you're setting limits more, and in a real emergency she goes somewhere else. You'll see her twice a week and that's going to be it.

SEE: Because I think what I've seen is the real emergencies-is going to be a crisis that is going to require a response that I am not going to be able to provide anyway.

Well, it's interesting-I don't remember when it was-I remember-saying at some point-and I'd be interested in your response to this-that borderline personalities can eat up a client-centered therapist, and I've been mulling that over. And I guess what I've made of it is that there's an assumption there that-uh- because a client-centered therapist seeks to be responsive you're more apt to be manipulated. And may not set the kind of limits that are necessary-uh-

SOR: Yeah. The concept of borderline personality is very popular now-but it's very vague.

SEE: It's a catchall. [The session closes with a discussion of borderline personalities, or psychopathic personalities as clients.]

Little comment on this excerpt appears to be necessary. It is clear that the supervisee takes responsibility for the session, explores issues and problems, and comes to his own insights and decisions. The supervisor listens, responds, and follows the lead of the supervisee.

## THE SUPERVISEE'S PERCEPTION

The supervisee was interviewed briefly on videotape by Suzanne Freeman, following his viewing of the videotape of her interview with the supervisor (Freeman, 1992). IOR designates the interviewer and IEE the interviewee.

IOR: Can you give us a little information about what your thinking and expectations were before supervision?

IEE: Well, I'd had Dr. Patterson for his advanced theories course, so I had developed something of a personal relation with him through that. I think I was intrigued by the notion of being supervised by someone of his experience and background so there was a sense of excitement and anticipation-a little bit of anxiety because I wasn't sure whether his approach would be one which was doctrinaire or whether he would have expectations that I didn't feel able to meet. But I thought of it as an opportunity that I didn't want to pass up, certainly.

IOR: Can you speak to how you felt-did he clarify for you the roles and responsibilities of you as a supervisee and him as a supervisor?

IEE: Yeah. That was really the first thing that he did. I think he refers to that as structuring the relationship. And that was done very clearly and overtly at the start of the semester. It was the only time he did anything of that sort, letting me know what the minimal expectation-letting me know it would be primarily my role to bring things to our supervision and for me to be responsible to determine what these sessions would consist of.

IOR: And, how did that occur-you taking responsibility for the sessions?

IEE: Well, it took the form of me having listened to audiotapes of my sessions, and bringing those, or segments of those, to the actual supervisory sessions. And- uh-making choices about what portions I wanted him to hear. How he was intent on developing an in-depth understanding of at least one of my clients, so that was something that could be built on session to session. But it also included my bringing questions that I had that came up either in the context of a session [with a client] or about some aspect of counseling that then provided the focus for discussion that came out of that.

IOR: Uhuh. Comment on this idea: If a student is being evaluated in supervision, and a student has the responsibility for what the student brings into the session, then likely the student is going to bring in their very best work. How did that work for you? How did you experience that kind of freedom?

IEE: Well, certainly there is the temptation to want to put a good face on things, but I think it became clear to me very quickly that I wasn't going to learn very much if that was

all I did. And my motivation to be the best I could for the clients I was working with ultimately led me to wanting to use Dr. Patterson for time in supervision to figure things out that were posing difficulties or things that represented hard spots for me. So I think I fairly quickly went beyond the urge to present things that would make me look or sound good.

IOR: Can you think of a specific time when you were struggling with a case and you brought the difficulty into the discussion? How was it handled? Did Dr. Patterson give you what you should have said, did he ask questions? How did he help you with the specific problem that you brought in?

IEE: Well, I can think of one particular instance where I was-uh-approaching termination with one of my clients and was concerned that I should have been more active in the session than I was, and I was seeking some clarification from Dr. Patterson about my perceptions of that, and as he listened to the tape to know of my question around that for the most part he reflected what it was I was raising and in a sense guided me as I thought about what I was concerned about and why and-uh-he helped me become clearer about what I had done in the session and whether that had been an appropriate response to what the client brought to the session or not.

IOR: Were you aware of the core conditions being present in that supervisory relationship? Empathy, respect-

IEE: Uhuh. Very definitely, and I commented to Dr. Patterson at the end of the semester that one of the things I found most impressive about the process-and about him as an individual was the fact that I experienced a high level of congruence between the things that I had heard about in his course and understand about a relationship based approach to counseling and seeing those things being demonstrated by him in his relationship with me.

IOR: O.K. Now, he says that he divides the didactic role-the teaching role-in one session, and the facilitative role in another session. How did that work for you?

IEE: Well, I think there was very definitely a distinction about how he functioned in those two roles. We had a group process at the same time under way with several of us graduate students and that tended to be more of a-well, to be the time in which didactic processes happened. Dr. Patterson would sometimes bring a specific topic to that group or he would respond to one that came out of a question or difficulty that one of us was having. But the time in individual supervision was much more-ahh-responding to what I brought rather than coming with an agenda of his own that he felt I needed to hear about or be part of.

IOR: Uhuh. In those individual sessions would you say that there was therapy going on for you, or would you say that it was therapeutic in some way within the session?

IEE: I think-it was therapeutic for me at different points-ahh-I worked at different things that were issues for me as a becoming counselor. I certainly did not feel that the process was therapy, or conceived as such. That was not my goal or was it his goal-that it be therapy for me. The focus was my clients and me in the process of being helpful to those people.

IOR: Over the semester do you feel that you changed as a counselor because of what went on in supervision?

IEE: Very definitely. I think that really for the first time in the program I felt both an invitation and an expectation to-ahh-submit to a discipline which was represented by the core conditions and the invitation to test the hypothesis whether the conditions were necessary and sufficient in doing psychotherapy with an individual client and-ahh-that discipline was not one that I submitted to easily but I'm grateful to have had the chance to do that, and I see real value in having had that experience, certainly.

IOR: O.K. Are there any other comments that you would like to make about the experience? Anything that . . .

IEE: Only to say that it really was a very productive experience. Qualitatively different than a previous supervisory experience, to the extent that I did feel a different responsibility placed with me for what the nature and the content of the individual sessions would be-ahh-and that was scary sometimes in the sense that it would have been easier to have been lazy and-abh-let that revert to Dr. Patterson as the supervisor. But I think, especially coming to a point of conclusion in a program, it was important to feel that responsibility and decide what I was going to do with it.

IOR: Thank you very much.

## CONCLUSION

The approach to supervision described here has several advantages:

1. The supervisor and supervisee have a common or shared philosophy and theory of psychotherapy, namely, client-centered theory.

2. The supervisor follows the principles of this system in the supervisory process.

3. The result is a climate or atmosphere in which threat and anxiety are minimized, thus providing an optimum learning situation.

4. The supervisor, in respecting the supervisee, allows the supervisee to direct the sessions by selecting and presenting the materials to be considered by the supervisor.

5. The supervisee knows the criteria by which he or she is being evaluated, thus allowing him or her to apply these criteria in evaluating him- or herself.

6. Supervision begins at a high level, precluding a slow process in which the supervisee must attempt to understand and adapt to the system and criteria of the supervisor. There is no long, drawn-out process of so-called stages in supervision.

7. Although this approach has been designated as client-centered, it is a basic, generic approach. The focus is on elements or conditions commonly recognized as client-centered, but that are actually elements common to all the major theories. Client-centered therapy does not have a monopoly on these conditions. Students or supervisees are informed that whether or not they eventually decide to continue as client-centered therapists, these elements are necessary in any system they might choose. Other elements can be added from their preferred theory. However, any additions can be, and usually are, inconsistent with client-centered philosophy, and the result is not client-centered therapy.

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