

TOWARD A COMMON-FACTORS APPROACH TO SUPERVISION

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Despite the proliferation of supervision models, there is no evidence to suggest that any one model of supervision is in any way superior to any other. Many in the field have called for models that can bridge the various theoretical approaches to clinical supervision, and identify the essential elements of supervision. This article briefly explores the range of existing supervision models, and suggests a rationale for seeking factors common across the various models. The authors highlight the development of a new supervision model that synthesizes current thinking about supervision into three dimensions. The three dimensions are defined, and resulting supervisory roles explored. Implications for supervision practice, research, and training are discussed.

INTRODUCTION

The past several decades have seen rapid growth in the area of marriage and family therapy (MFT) training and supervision (Green, Shilts, & Bacigalupe, 2001; Liddle, Breunlin, & Schwartz, 1988; Todd & Storm, 1997; White & Russell, 1995). Few question the importance of good supervision in the development of competent clinicians. In fact, Everett and Koerpel (1986) noted that “the integrity of a profession is associated directly with the effectiveness of its clinical education and supervision in the training and socialization of new members” (p. 62).

Despite relative agreement on its importance, and the growth of research and writing about supervision, there is still little agreement about how to define the scope and content of supervision (Carroll, 1988; Storm, Todd, Sprenkle, & Morgan, 2001). Carroll (1988) stated that “There are few agreed definitions and certainly no agreed tasks, roles, or even goals of supervision” (p. 387). This lack of clarity and understanding is not unique to the MFT field. Although some models have achieved wide recognition and use, White and Russell (1995) assert that no comprehensive, agreed-upon model of supervision exists in any of the major clinical disciplines.

Additionally, there is little in the way of solid research to support any one model over another (Storm et al., 2001), and the disagreements about what supervision is and should be persist. The field of supervision remains in a condition characterized by a high degree of variation in definitions, tasks, and models. Berger and Buchholz (1993), reflecting on the situation, conclude that “supervisory styles are as varied as the proponents of these [different] models” (p. 87).

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Sprenkle (1999) noted that no one model of supervision could claim empirical superiority to any other, and argued for the need to begin examining the facets of supervision that transcend the various models. Similar efforts with clinical work are currently being explored and debated (for a brief but comprehensive review of the common-factors approach in clinical work, see Sprenkle & Blow, 2004). Although the term *common factors* is relatively new in supervision, the idea itself is not. Ekstein (1964) suggested that supervision has elements that cross theoretical borders and identified a focus on teaching, administration, and clinical work to be three such elements. Goodyear and Bradley (1983) examined the similarities and differences among the five most important supervision theories in the field of clinical psychology at the time (rational emotive, behavioral, client centered, developmental, and psychoanalytic). They believed that by examining supervision from diverse viewpoints they could uncover common practices among the models. After reviewing the five models, they “were struck with the extent to which supervision techniques must be similar across supervisors, regardless of theory” (p. 63).

At least one study found this to be true in practice. Goodyear and Robyak (1982) looked at the differences in beginning and more experienced supervisors, and found that the more experienced supervisors shared much of their emphasis in common, while the less experienced supervisors differed more in ways consistent with their individual theories of supervision. It seemed that with experience, the salience of a particular theory’s unique style of supervision faded in favor of more common supervision elements. Ellis, Dell, and Good (1988) asserted a need for research that investigates the underlying structure, the shared elements that unify the many different approaches under the heading of supervision.

The more recent work of White and Russell (1995) and Storm et al. (2001) continues the push toward identifying and applying a common set of supervision practices. If a set of common elements central to supervision can be identified, then these can form the basis for studying variation in the supervision process and outcome that is not necessarily confounded by theoretical differences. Such an approach could not only provide a template for supervision research, but also for teaching and providing supervision as well. The current article briefly reviews different models of clinical supervision and then details a process used to create a new common-factors model of supervision. Implications for research, practice, and education are offered. A later article will detail the creation and factor analysis of an instrument to measure these common factors.

MODELS OF SUPERVISION

Clinical Models

The earliest supervisors relied heavily on clinical models to provide direction for the training of new clinicians (Leddick & Bernard, 1980; White & Russell, 1995). These senior clinicians, who had little if any formal training in supervision itself, applied a particular theory of clinical work to the supervisory relationship (Nichols, Nichols, & Hardy, 1990). Supervisors from each of the various schools of clinical thinking have been encouraged to thoughtfully apply their theory of therapy to supervision (Heath & Storm, 1985), and even today this concept remains one of the most influential in supervision thought (Storm et al., 2001).

As a result, the MFT literature is replete with articles and chapters detailing how various clinical models serve as a basis for supervision. There are models of Bowenian supervision (Getz & Protinsky, 1994), structural/strategic supervision (Nevels & Maar, 1985), symbolic-experiential supervision (Connell, 1984), brief, problem-focused supervision (Storm & Heath, 1991), solution-focused supervision (Wetchler, 1990), and narrative supervision (Bob, 1999). The push in recent years to develop integrative clinical theories has also spawned accompanying integrative models of supervision. Rigazio-DiGilio (1997) cites examples of four such integrative models: the metaframework model (Breunlin, Schwartz, & MacKune-Karrer, 1992), the cognitive-developmental model (Rigazio-DiGilio & Anderson, 1994), supervision for integrative

problem-centered therapy (Pinsof, 1995), and the mythological perspective (Bagarozzi & Anderson, 1989).

While these clinical models of supervision make an important contribution, they also have several inherent limitations. First, supervision and therapy are not equivalent; supervision entails a different relationship, a different emphasis, and different skills than clinical work which are not adequately addressed by clinical theories (Russell, Crimmings, & Lent, 1984). Second, clinical-based models promote a sort of theoretical parochialism—a too narrow focus that assumes the superiority of the chosen theory over all others, and may prevent the incorporation of important concepts from other theories and clinical fields (Holloway, 1995). Currently, there is a distinct lack of empirical support for adopting one theoretical model to the exclusion of others (Storm et al., 2001).

Outside of the MFT supervision literature, some have sought to develop supervision models independent of any particular clinical theory. Bernard and Goodyear (1992) call these “conceptual” models and tout their direct focus on the unique aspects of supervisee-supervisor interactions as having an advantage over models which “have to make the leap from the assumptions of therapy to those of supervision” (p. 20). Two types of conceptual supervision models exist: developmental models and social-role models.

Developmental Models

In simplified form, the developmental models of supervision suggest that supervisees pass through a number of predictable, universal stages in their growth as clinicians, or in their supervisory relationships. Each stage is characterized by particular needs, conflicts, or tasks that the clinician must resolve to continue her or his growth. The job of the supervisor then becomes recognizing the supervisee’s stage-based needs, and adopting the focus, methods, or style of supervision to facilitate optimal development (Taibbi, 1990). In general, it is assumed that beginning clinicians need more structure and task focus, while advanced clinicians do better with a collaborative, conceptual focus.

Holloway (1995) cites at least 18 developmental models (see, for example, Rønnestad & Skovholt, 2003; Stoltenberg, 1981; Taibbi, 1990). Much of the growth in the supervision literature during the 1980s was dominated by the developmental approach. This was true in psychiatry, psychology, counselor-education, and social work (Worthington, 1984), with MFT as a notable exception (Everett & Koerpel, 1986). In the intervening decade of the 90s, this seems to have changed. Although MFT does not have a developmental model of its own, the basic tenets of the developmental approach have become “axiomatic” within the field (Storm et al., 2001). Much of the MFT supervision literature now calls for supervisors to tailor their supervision to the specific developmental level of supervisees (Rigazio-DiGilio, 1997; York, 1997), following the notion that beginning therapists require a different supervisory focus than more experienced therapists (Flemons, Green, & Rambo, 1996).

Although the developmental models are not bound by the theoretical narrowness of the clinical-based models, they too suffer from a lack of firm empirical support (Bernard & Goodyear, 1992; Storm et al., 2001). Sumerall et al. (1998) found that in practice, supervisors appear to provide the same sort of supervision to all supervisees regardless of their level of experience. Furthermore, the results of some studies contradict the very notion of supervisee developmental stages and changing developmental needs (Fisher, 1989; Wark, 1995). Three major reviews of the research on developmental models of supervision (Holloway, 1992; Stoltenberg, McNeill, & Crethar, 1994; Watkins, 1995) found only very limited support for the developmental assumption underlying these models. Moreover, all three found fault with the predominant cross-sectional design of the studies. In their study of 100 supervisees, Ladany, Marotta, and Muse-Burke (2001) found no differences in supervisee preferences based on experience level and suggest that developmental assumptions may be “based more on clinical lore than on research” (p. 215).

Social-Role Models

The other type of supervision model not directly tied to a particular counseling theory are the social-role models (Holloway, 1995). These models are more descriptive in nature and attempt to provide a schema for organizing the various things that supervisors do. Perhaps the most well-known model of this type is Bernard's discrimination model (Bernard, 1979), which suggests three functions and three roles of supervision organized in a 3×3 -celled matrix. The functions are to help supervisees master skills of process, conceptualization, and personalization. The roles are those of teacher, counselor, and consultant. Each cell represents a different way a supervisor might help supervisees master needed counseling skills, based on a specific supervisory situation. Lanning (1986) later made an important addition to the model by suggesting a fourth function or skill set, that of *professional behaviors*.

Holloway (1995) proposed a comprehensive model of supervision that bears some similarity in structure to that of Bernard (1979), but with greatly increased breadth and complexity. She proposes five functions of supervision: (a) monitor and evaluate, (b) instruct and advise, (c) model, (d) consult, and (e) support and share. She also proposes five tasks, or areas of focus for supervision: (a) counseling skills, (b) case conceptualization, (c) professional role, (d) emotional awareness, and (e) self-evaluation. She calls the 5×5 grid that forms when the functions and tasks are counterposed the "process matrix," and suggests that supervisors can use the matrix, much like Bernard's, to evaluate the effectiveness of particular combinations of focus and method. In addition, Holloway's model also considers the impact of four broad "contextual factors" on the supervision process. These contextual factors are characteristics of (a) the supervisor, (b) the supervisee, (c) the client, and (d) the setting where supervision takes place. Finally, Holloway notes the central role that the relationship between supervisor and supervisee plays in the supervision process.

Holloway's model bears considerable similarity to the important dimensions of MFT supervisory systems suggested in research by White and Russell (1995). Their goal was not to propose a model, but to identify the variables that are important to the outcome of MFT supervision. Using a modified Delphi method, a panel of AAMFT-approved supervisors generated variables that upon analysis clustered into five main categories: (a) supervisor variables, (b) supervisee variables, (c) relationship variables, (d) supervision process variables, and (e) contextual variables.

Both the Bernard (1979) and Holloway (1995) models seem to be largely atheoretical. Instead, they offer a way to describe what may take place in supervision, and in the case of Holloway, what other factors impact the supervision process. While highlighting important variables in supervision, they lack an underlying structure for organizing the various concepts, and their complexity (particularly with Holloway's model) makes their practical application in either research or supervision difficult. There is also little research which directly tests the social-role models (Holloway, 1992). However, the Supervisor Emphasis Rating Form was designed and revised to measure the use of Bernard's three functional areas (process, conceptualization, and personalization skills) along with professional behaviors (Lanning, 1986; Lanning & Freeman, 1994). Although the instrument proved reliable, its validity and utility was not clearly established.

One particular model of supervision is an interesting blend of the clinical, developmental, and social-role models. Hart and Nance (2003) have taken the Adaptive Counseling and Therapy (ACT) clinical model (Howard, Nance, & Myers, 1986) and applied it to supervision. The model suggests an optimal supervisor style (level of directiveness and support) based on the developmental level of the supervisee. Their study found little agreement between supervisors and supervisees on preferred styles, and similar to other research, the authors found that supervisee preference for style did not change as the developmental portion of the model suggested.

Objectives-Based and Feminist Approaches

Two other movements bear mentioning here. They both have influenced supervision, but are not necessarily supervisory models in and of themselves. The first involves setting certain skill-based objectives for supervisees to meet. These serve as criteria for measuring supervisee progress and can direct the focus of supervision and training experiences. Cleghorn and Levin (1973) suggested mastery of perceptual, conceptual, and executive skills as essential in becoming a marriage and family therapist. Adopting a developmental stance, they outlined specific learning objectives for supervisees at three different experience levels: basic, advanced, and experienced.

Tomm and Wright (1979) took the work of Cleghorn and Levin (1973) in a different direction. Instead of focusing on changes in skills based on supervisee experience level, they identified specific perceptual, conceptual, and executive skills needed at each stage of the client treatment process—engagement, problem identification, change facilitation, and termination. General competencies are specified for each stage of treatment, along with more specific perceptual/conceptual and executive skills that comprise the general competencies.

More recently, Briggs, Fournier, and Hendrix (1999) developed the Family Therapy Skills Checklist, and Nelson and Johnson (1999) developed the Basic Skills Evaluation Device. Both build on the previous work setting forth perceptual, conceptual, and executive skills as important. However, they each expand the skill sets to include skills related to following ethical codes, meeting standards of professional conduct and image, and skills related to self-awareness and self-management. One particular strength of the Basic Skills Evaluation Device is that it attempts to transcend any particular theory.

Notable outside most MFT circles is the microskills approach developed by Ivey (Ivey, Ivey, & Simek-Morgan, 1993; Ivey & Simek-Downing, 1980). The complex task of providing therapy is broken down into a number of very specific “microskills.” Training involves helping therapists master the techniques associated with each small counseling skill. The key strength of the microskills approach is that it does not merely suggest skills to be mastered, but provides greater direction than the other objectives-based approaches for how to train therapists in those skills.

The other influential movement is feminism. Wheeler, Avis, Miller, and Chaney (1986) published a landmark article on feminist supervision. Although there had been fairly extensive writing about feminist models of therapy, this was really the first article to articulate a feminist approach for supervision (Prouty, 2001). From that time, numerous others have joined (Ault-Riche, 1988; Crespi, 1995; Hipp & Munson, 1995; Porter & Vasquez, 1997). There appear to be two broad ways in which feminism may inform supervision. In the first, feminist supervision can be seen as a specialized method for training feminist therapists. To this extent, the feminist model of supervision is not much different from other clinical-based approaches to supervision.

However, what distinguishes the feminist approach from other clinical models is the great degree to which feminist ideas and values have been integrated into other theories of therapy and supervision. In her recent study, Prouty (2001) identified two major components of feminist supervision that may be used independently of a supervisee’s own theoretical orientation. These are the quality of the supervisory relationship and the centrality of feminist ideas in the supervisory dialogue.

Although many supervision models emphasize the importance of the supervisory relationship (Holloway, 1995; Schwartz, 1988), the feminist literature has paid particular attention to encouraging a collaborative, egalitarian-leaning relationship (Porter & Vasquez, 1997; Prouty, 2001; Prouty, Thomas, Johnson, & Long, 2001). The other critical feature of a feminist supervision model is the way that feminist ideas “saturate” the process of supervision (Prouty, 2001). In her study of feminist supervisors and their supervisees, Prouty identified five feminist concerns that played a central role in supervision. These were gender issues, power inequities, diversity issues, the role of emotion, and the process of socialization at work in people’s lives.

The focus on the quality of the supervisory relationship and the purposeful focus on feminist values in supervision does not require that a supervisee be a feminist (Prouty et al., 2001). These features have in many ways been adopted across the field. Major texts on supervision now not only include separate chapters on gender, power, relationships, and diversity, but also integrate these issues throughout (Todd & Storm, 1997). Although in practice these issues may not receive the same attention as they would from a self-identified “feminist supervisor,” the increasing recognition of their importance and the attention paid them from a variety of orientations is a testament to how feminist supervision is more than just one model among many, but a widely applicable, and increasingly influential “lens through which one views and understands realities” (Wheeler et al., 1986, p. 53).

Each of the aforementioned models and approaches to supervision has something to offer, yet each is also limited and often excludes important ideas. The field will profit from knowing what is helpful with whom and when, in a way that is not limited by the specifics of each model. Goodyear and Bradley (1983) concluded that “close scrutiny of what supervisors from diverse orientations actually do should unearth common practices which remain obfuscated when supervision is considered only at the level of theory” (p. 63). At about the same time, Russell et al. (1984) noted that “a conceptual model or schema that can synthesize the existing literature into a more consistent, organized structure would make it easier to examine the literature from a critical perspective and to note both the strengths and weaknesses in the current body of knowledge” (p. 641). In other words, what is needed is a way of looking at supervision that is expansive enough to transcend the boundaries of the various approaches, yet not so expansive as to lack focus or suggest that any activity can be called supervision. Such a model will have an underlying structure informed by the theory and research of the past half century, and will facilitate future research that can strengthen the process and outcome of our supervision efforts.

CLARIFICATIONS AND CAUTIONS

The common-factors approach has a long history as counterpoint to the various schools of psychotherapy, and attention to common factors appears to be growing (Sprenkle & Blow, 2004). However, before proceeding with our method for identifying potential common factors in supervision, a few clarifications and cautions are warranted. In psychotherapy, common factors are the “common mechanisms of change, which cut across all effective psychotherapy approaches” (Sprenkle & Blow, 2004, p. 114). These are variables associated with positive clinical outcomes, which are not specific to any approach, but which are shared by several or all approaches. More detailed reviews of common-factors models can be found in Sprenkle and Blow, and in Hubble, Duncan, and Miller (1999). The common-factors position is not without criticism, both of its empirical foundation and its theoretical and practical utility (Sexton, Ridley, & Kleiner, 2004). But the important point here is that common factors in psychotherapy have emerged from empirical studies on clinical outcome (Wampold, 2001, presents perhaps the most complete exposition of the empirical basis for common factors in psychotherapy).

Unfortunately, there is no comparable body of outcome research from which common potentiators of supervision change can yet be drawn (Bernard & Goodyear, 2004; Freitas, 2002; Watkins, 1998). This does not negate the potential benefits of identifying important elements shared by supervision models. It does, however, result in a different product than the common-factors models in psychotherapy. In supervision, the result possible given the state of the field will be more descriptive—identifying elements that the literature broadly suggests are important to the process of supervision, rather than those elements linked empirically with positive supervision outcome. As such, the model proposed here serves as a snapshot of what we as a field think is essential for supervisors to do, based on theory and the small but growing body of

research. These conceptual common factors may encourage and facilitate the kind of outcome research that is so scarce in supervision.

We believe that it is unlikely that any one model, common factors or otherwise, will ever emerge as the best way to supervise everyone under every situation. Human beings and the process of supervision are too complex to brook such hubris. But there are likely a set of elements that most good supervision will have in common. We are not, therefore, suggesting that supervisors drop their models and merely employ the common factors. Rather, the field is likely to benefit most from a both/and attitude toward specific models and common factors. As has been suggested for clinical common factors, we believe that specific models are the medium through which the common factors work (Sprenkle & Blow, 2004), and which provide the variety and diversity needed to match human complexity. Furthermore, specific theoretical models will always be especially well matched with particular supervisors, and this synchrony will likely positively impact their effectiveness for these supervisors. Our model here is intended as a first step toward better understanding what good supervision might have in common, and to provide a conceptual tool that can be used to evaluate and study supervision models, process, and outcomes.

IDENTIFYING COMMON FACTORS IN SUPERVISION

One of the first problems in identifying what may be common factors in supervision is the continued debate about the definition and goals of supervision. Bernard (1979) identifies the production of competent therapists as the chief goal of supervision. Certainly, it would be hard to argue with this, but others have expanded on it, identifying supervision as a method for promoting supervisee autonomy and personal growth (Loganbill, Hardy, & Delworth, 1982; Saba & Liddle, 1986), and as a means for preparing therapists for a career as clinicians (Watson, 1993). One of the few elements widely agreed upon is that supervision involves a relationship between someone of considerable experience and someone of lesser experience (Bernard & Goodyear, 1992; Holloway, 1995; Loganbill et al., 1982). These various definitions assist in building a common-factors approach by suggesting possible elements or broad content areas of supervision.

In a general sense, supervision seems to involve a structured relationship between a supervisor and supervisee with the goal to help the supervisee gain the attitudes, skills, and knowledge needed to be a responsible and effective therapist. This amalgam definition is not intended to resolve the controversy about what supervision is, but simply to point out that for many people, supervision is concerned with a variety of objectives. Borrowing a term from ecology, these broad areas of attention can be called domains.

An extensive review of the literature on supervision, both within and without MFT, was conducted by the first author to identify general foci of supervision that were commonly accepted across authors and models, as well as to develop a comprehensive list of potential supervision activities. The electronic search engines PsycInfo and ERIC were the principle search tools used to identify articles and chapters that spoke of what supervisors do. Search terms used in conjunction with the broad term *supervision* included combinations of the following: *activities, definition, emphasis, goals, instrument, objectives, research, roles, study, survey, and tasks*. Citation lists were also used to suggest further articles and chapters. Broad foci and specific activities were sought which could answer the question "with what is supervision concerned?" The results of this review identified a number of general supervision domains. Although the terminology varied, and not every article reviewed indicated each of the domains listed here, most authors mentioned at least several of them, and each domain was mentioned by multiple authors. The citations listed after each domain do not represent every article in which the domain was discussed, but are merely representative of the various writings that suggest each domain.

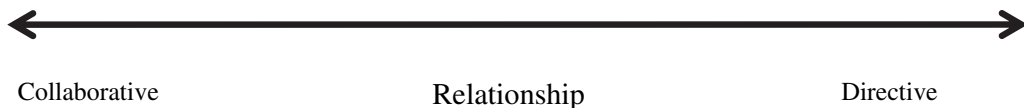


Figure 3. The relationship dimension of supervision.

much of the feminist writing on supervision emphasizes downplaying the hierarchy of the relationship and establishing a respectful, reciprocal, safe relationship (Hipp & Munson, 1995; Prouty et al., 2001). Some have taken this Zeitgeist to imply the incorrectness of directive forms of supervision, or to infer that directive supervision cannot at the same time be supportive. Although Hart and Nance (2003) suggest that supervisor styles low in support may be appropriate at times, the overwhelming evidence from a variety of studies (their own included) demonstrate that supervisees prefer to at all times have a high degree of support from their supervisors, regardless of how directive or collaborative the relationship is (Carifio & Hess, 1987; Hunt, 1986; Long et al., 1996; McCarthy, Kulakowski, & Kenfield, 1994; White & Russell, 1995; Worthen & McNeill, 1996).

Additionally, many note that the supervisory relationship has an inherently hierarchical structure which cannot be completely erased, particularly because of the need to protect clients and others from ethical or legal breaches (Storm et al., 2001). The multiple responsibilities of the supervisor require a balance between collaboration and direction according to Whitman and Jacobs (1998). Others, including some of the feminist writers, agree that it is not a question of either/or, but of thoughtfully employing both relationship styles as the needs of the situation dictate (Long et al., 1996; Prouty et al., 2001; Summerall et al., 1998).

In sum, the content of supervision—what supervisors do—can be expressed along two continua. Supervision may vary in its emphasis, from a focus on clinical competence to professional competence issues. Supervision may also vary in its level of specificity, from the idiosyncratic clinical and professional needs of each supervisee, to the professional and clinical mandates of the field at large. Finally, in a third dimension, the nature of the supervisor/supervisee relationship can vary from a collaborative to a more directive relationship.

Supervision Roles

When the first two supervisory dimensions (emphasis and specificity) are combined, they create a four-cornered plane (see Figure 4). Any given supervision activity can then be mapped to the plane, based on where it fits along each of the two dimensions. For instance, a supervisor helping a supervisee to plan an intervention for a particular case would fall somewhere in the upper left-hand quadrant of the plane, with other issues of clinical competence at a concrete level of specificity. Because the dimensions are conceptualized as continua, the four quadrants are not to be considered discrete cells, but as permeable, overlapping areas. This parallels the sentiment in the literature that supervisor roles are not mutually exclusive, but include a considerable degree of overlap with each other (Stenack & Dye, 1982).

The literature frequently describes what supervisors do through the use of role-labels. A variety of potential roles have been identified by numerous authors seeking to describe what it is that supervisors do. Some of the roles previously identified include teacher, educator, mentor, colleague, monitor, administrator, manager, guide, model, supporter, consultant, and psychotherapist (Bernard, 1979; Carifio & Hess, 1987; Hess, 1980; Schindler and Talen, 1994; Stenack & Dye, 1982; Taibbi, 1990). Using the two combined dimensions, and considering how the various domains and supervision activities can be mapped to the plane, labels were selected by the current authors to represent the four quadrants of the plane. The four roles represented by this dimension structure underlying supervision activities are Coach, Teacher, Administrator, and Mentor (see Figure 4). Specific descriptions for the four roles follow below.

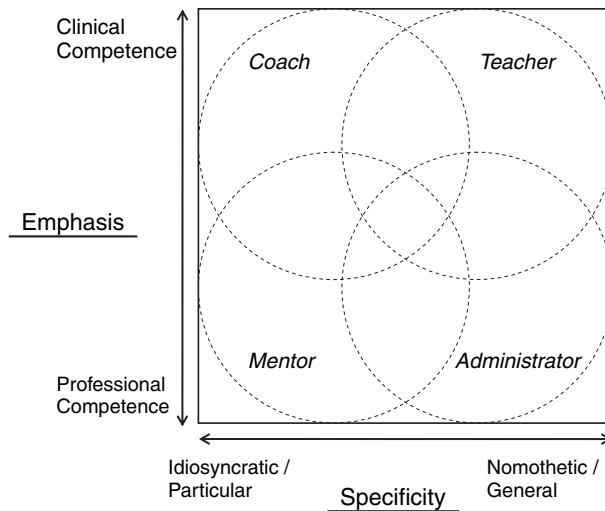


Figure 4. Supervisory roles as defined by the content dimensions of supervision.

The Coach role involves an emphasis on clinical competence at the idiosyncratic level. Within this role, the supervisor assists the supervisee's direct work with his or her current case-load of clients. The focus is on direct services to help clients achieve their therapeutic goals, while helping supervisees apply and refine their clinical skills. The use of the term *coach* here should not be confused with its use in Bowen Family Systems therapy as a person who guides a client through family of origin work (Nichols & Schwartz, 1995). Like an athletic coach, a supervisor operating in the coach role remains slightly detached from the action, but involved in helping supervisees to accurately execute certain skills in their clinical work. The coach role would include activities from the literature such as helping supervisees attend to the therapeutic relationship, applying assessment skills with clients, developing specific case conceptualizations, offering suggestions for how to proceed with a client, and offering specific positive and critical feedback about the supervisee's clinical work.

The Teacher role also emphasizes clinical competence, but at a more general or nomothetic level of specificity. As a teacher, the supervisor encourages and facilitates the acquisition of broadly applicable knowledge and information about clinical work. This may involve learning about general clinical skills, theories, possible client concerns, systemic concepts, and so forth. Other supervision activities in the teacher role include providing supervisees with readings or other resources to learn about clinical issues or interventions; discussing the broad impact of gender, culture, and socioeconomic status on people's lives; and helping supervisees understand principles of assessment and diagnosis.

In the Mentor role, the supervisor focuses on the personal development of each supervisee as a growing professional, helping the supervisee identify and address her or his own contribution to the therapeutic alliance, and helping each individual supervisee develop or maintain a role as a practicing member of the professional community. Mentoring activities include working on self-of-the-therapist issues that are related to clinical functioning, suggesting personal therapy when warranted, helping supervisees recognize personal strengths and limitations, nurturing professional and career development, and working on the supervisory relationship.

Finally, from the Administrator role, the supervisor focuses on the broad professional, ethical, legal, and other standards that guide the practice of psychotherapy. The supervisor ensures that such broad standards are met in the supervisee's work, thus helping protect clients, supervisees, and the profession. A supervisor may assist a supervisee with his or her clinical

documentation, or to resolve an ethical dilemma, to process an attraction to a client, or to learn and abide by agency policies regarding collecting fees and scheduling appointments. Additionally, the administrator role includes the evaluation of supervisee performance, based on the standards of practice accepted in the field.

It is important to again note that these roles are not mutually exclusive, but involve considerable overlap. Some activities in particular may be said to fit within more than one role, or toward the center of the four quadrants. For instance, offering praise and encouragement to a supervisee who does a nice job with a particular session would have elements of the coach role, but will also likely impact the supervisee's general level of self-confidence and professional development (mentor role) while also helping the supervisee generalize the lessons of that particular session to his or her broad understanding of clinical work (teacher role).

The literature asserts that good supervision involves the ability to work from within multiple supervisory roles (Allen et al., 1986; Bernard & Goodyear, 1992). Some describe the need for supervisors to be flexible in using whichever role best meets the demands of the changing situations in supervision (Bernard & Goodyear, 1992; Stenack & Dye, 1982). For instance, a supervisor may be operating as a coach, discussing the particular events of a recent therapy session with the supervisee. As it becomes apparent that the supervisee is stuck because of a particular blind spot related to a cultural bias, the supervisor will need to shift to a mentor role to help the supervisee recognize and deal with the blind spot. This may also involve some teaching, or sharing of broadly applicable knowledge about the cultural bias in question, and a discussion of the ethical implications of the bias. The point is that the supervisor will likely shift between the various roles, and may, as suggested by others, operate out of more than one role simultaneously (Haynes et al., 2003).

One additional aspect of the model bears mentioning again. At this stage, the model is purely descriptive. It carries no inherent prescription nor proscription for what supervisors should do in a given situation, beyond the broad support of the literature that each of the roles and relationship styles is important, and that in effective supervision, none should be ignored.

IMPLICATIONS

Having distilled a set of common factors and a relatively simple underlying organizational structure from the literature to create the three-dimensional model, we turn attention now to the implications of the model for practice, research, and training.

Practice

The three-dimensional model may be useful in supervision practice in a number of ways. From the standpoint of supervisors, the model provides a template for understanding the range of responsibilities, tasks, and roles that the literature suggests a supervisor should fill. Upon self-examination, supervisors may wish to adjust their own emphasis, level of specificity, and/or relationship so as to adequately address areas of neglect or preferential attention that may result in less than optimal supervision. The model also serves as a reminder of the need to be flexible in roles and relationships. In addition, supervisors might identify areas where they need further training or practice. The model also provides a language for articulating what supervisors do. As the supervisor is contracting with supervisees, or describing their supervision to other professionals, the model can help the supervisor articulate the various roles he or she will fill, and the types of interactions that others can expect from supervision.

The model may be similarly useful for supervisees seeking to ensure that the supervision they are receiving adequately covers all of the important supervisory domains. Supervisees can use the model to identify areas where they would like their supervisors to increase or reduce the focus, or adjust the relationship style. Used in conjunction with a set of learning objectives

(like Nelson & Johnson, 1999), the model could prove a helpful tool for clinicians to advocate for a particular supervisor role that will best meet their own supervisory needs.

Research and Theory

There are several ways the model might be used in research and theory development. In another article the authors will describe an instrument that might be used to study the extent to which these three dimensions vary in disparate settings or among supervisors of differing theoretical orientations. If the common-factors hypothesis holds for supervision as it does for psychotherapy, then these dimensions will be salient across models. Supervisor practice can be compared to the model (both through self-report and observation) in a descriptive way that allows comparison of supervision practice not only across theoretical orientation, but also by variables such as experience level, type of supervision training, practice setting, gender, clinical field, and so forth. The model may help us determine if different supervision practices or approaches are associated with positive supervisee and client outcomes in different situations. The developmental assumptions not fully supported to date in the literature (Storm et al., 2001) can be revisited empirically with the three-dimensional model, as the model would provide a common template for identifying some potential changes in emphasis across supervisor development.

Training

Clinicians wishing to become supervisors may use the model to guide their thinking about supervision, and supervision training programs can use the model as a teaching tool. Each dimension and role in the model could be discussed at length, with examples given of how each is important to effective supervision. Different theories of supervision can be mapped onto the model (by discussing how a given theory might emphasize the roles in different ways), and potential supervision situations can be discussed in light of which roles and potential relationship styles might be most helpful. In courses or workshops, future supervisors can identify their preferred roles or relationship styles and come to understand how their supervision practice may be limited without moving outside preferred roles and styles. In supervision of supervision, supervisee concerns can be mapped to the model, suggesting a possible role for addressing the concern, and again providing a common language for discussing what takes place in supervision.

CONCLUSION

The three-dimensional model of supervision, with the three continua and the four supervisor roles, attempts to answer the calls by Goodyear and Bradley (1983) and Russell et al. (1984) for a conceptual model that synthesizes common practices from the current knowledge about supervision. It combines the thinking in the field about what supervisors do and should do, with current thinking about the supervisory relationship. A subsequent article will detail the creation and factor analysis of an instrument for assessing the four supervisory roles. We invite supervisors, trainers, and researchers to consider how the model may advance their work, and to experiment with the model in ways that will promote deeper understanding of how to best train and supervise future generations of clinicians.

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