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METHODS OF FEMINIST FAMILY THERAPY SUPERVISION

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Although feminist family therapy has been studied and practiced for more than 20 years, writing about feminist supervision in family therapy has been limited. Three supervision methods emerged from a qualitative study of the experiences of feminist family therapy supervisors and the therapists they supervised: The supervision contract, collaborative methods, and hierarchical methods. In addition to a description of the participants' experiences of these methods, we discuss their fit with previous theoretical descriptions of feminist supervision and offer suggestions for future research.

Much has been written about feminist family therapy (e.g., Goldner, 1991; Goodrich, Rampage, Ellman, & Halstead, 1988; Hare-Mustin, 1978, 1987; Hare-Mustin & Merecek, 1986; Libow, 1986; Roberts, 1991; Storm, 1991), but little has been written about feminist family therapy supervision (Ault-Riche, 1988; Avis & Braverman, 1994; Wheeler, Avis, Miller, & Chaney, 1989). These important theoretical writings have provided a foundation from which to learn about how some feminists envision and provide systemic supervision and have indeed provided a beginning point for many of us. However, there has been scant research on feminist family therapy supervision to inform us what we are actually doing in our supervision and how we make it feminist. This article reports and discusses a portion of the results of a study (Prouty, 1996) of supervisors' and clinicians' experiences of feminist family therapy supervision.[1] This article is focused on describing the supervision methods described by the eight supervisors and the therapists with whom they worked.

LITERATURE REVIEW

There has been only one previous formal study of feminist family therapy supervision. Avis (1986) conducted a Delphi study in which a panel of prominent feminist family therapists identified characteristics of a feminist-informed approach to family therapy training and supervision. Most pertinent to the present

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research, Avis's panel agreed that feminist supervision involved constantly questioning all assumptions, considering alternatives, openly discussing sexist remarks, discussing attitudes about healthy family functioning, and making issues of power explicit. The panel proposed that feminist supervisors shared and modeled their feminist awareness, minimized competitiveness among trainees, addressed personal and political issues, and helped trainees to learn about themselves without turning supervision into therapy. Finally, the panel thought that feminist supervisors helped therapists to develop their own style and techniques based on their strengths.

Avis's (1986) groundbreaking study reported what feminist family therapists thought feminist supervision should be. However, more than 10 years later, there have been no studies about what feminist family therapy supervisors actually do. Given the paucity of research, this study was exploratory. The researcher (AP) tried to minimize her preconceived notions about feminist supervision and what the participants should say; for example, conducting the formal literature review of feminist supervision theory after the data collection. However, it would be naive to say that the supervision and the interviews were truly separate from the feminist family therapy culture and literature, as the researcher and many of the participants had studied or contributed to this literature. Therefore, in order to remain congruent with the research process, the theoretical feminist family therapy supervision literature is used as a source of comparison and context for the results of this study, rather than as a primary point of departure, and it appears integrated within the discussion section.

THE RESEARCH PROCESS

A collaborative, qualitative research process was adopted to minimize potential power differentials between the participants and the researcher. Grounded theory provided a framework for data collection and analysis (Strauss & Corbin, 1990) and helped the researcher to develop a description of feminist supervision methods. Equally important, grounded theory supported the feminist research values of (1) giving voice to feminists about their ideas; (2) gathering knowledge from several different perspectives, including those with less power; and (3) reducing the power of a single researcher through collaboration with the participants and a team of feminist colleagues. This let the researcher build a description of feminist supervision methods that was consistent with feminist ideals and empirically rooted in the data.

Participants

Criterion-selective sampling (Rafuls & Moon, 1996) was used to obtain participants known to have experience with feminist supervision. Supervisors were American Association for Marriage and Family Therapy (AAMFT) approved and identified themselves as feminist family therapy supervisors. Therapists were recruited after the supervisors, and they were not screened with regard to theoretical orientation—some described themselves as feminists and others did not. Hereafter, the word "participants" refers to both supervisors and therapists.

One supervisor and one therapist were included from each of the eight practice sites. There were seven female supervisors, one male supervisor, five female therapists, and three male therapists. Four supervisors provided supervision in both academic and community settings. Five therapists received feminist supervision in a master's program practicum, one in a private practice, one in a post-master's practicum, and one in a doctoral program practicum. Participants' identities were kept confidential; thus neither the supervisor nor the therapist was told if the other had participated.

The supervisors averaged 13.8 years in marriage and family therapy (MFT) practice and had been AAMFT-approved supervisors for an average of 6.2 years, ranging from 6 months to 12 years. The therapists averaged 3.1 years in MFT, with a range from 1 to 7 years. The supervisors were from 33 to 47 years of age, and the therapists' ages ranged from 23 to 55 years. Two of the therapists also had family therapy supervisor credentials, and some had experience doing other types of psychotherapy prior to their MFT training. Although attempts were made to recruit Canadians and participants of color, all were United States citizens and all were white, with ancestors from countries in Asia and Europe, and self-identified as Jewish, Christian, or agnostic.

Data Collection and Data Management

Data collection. The researcher collected and managed all data. All interviews were in person, consisted of open-ended questions, and ranged from 45 to 110 min. These were audiotaped and transcribed verbatim by the researcher. The opening question of each interview was, for supervisors, "tell me about your supervision" or, for therapists, "tell me about your supervision with [supervisor's name]." As the data were coded between interviews, subsequent interview questions followed up on what past participants had talked about and pursued ideas from previous interviews. The data became repetitive after the sixth interview, as later participants repeated earlier themes, but two more sites were included to verify data saturation. Four sites provided a videotape of a supervision session, and participants from those sites were asked to identify any similarities or differences between the videotaped session and a typical supervision session.

Quality assurance. To enhance the quality of the data and credibility of the study, the data were triangulated by employing a variety of sources and methods. Triangulation increased internal consistency (internal validity), dependability, and confirmability and enhanced theoretical sensitivity to the data (Patton, 1990; Strauss & Corbin, 1990). Triangulation was used at three levels: Theoretical perspectives (phenomenological, symbolic interactional, and systems theory), data sources (by interviews of both the supervisor and the therapist and by videotapes of a supervision session), and interpretive perspectives (views of the researcher, the participants, and a feminist interpretive team). Internal validity (Seidman, 1991) was also displayed by the consistency of the responses between therapists and supervisors, between different supervision sites, and between the interviews and the videotapes.

Data Analysis

Coding. The researcher coded the interview and videotape transcripts using open and axial coding methods. After each interview, the participant reviewed her/his coded transcript. All participants returned approved transcripts, and seven made some type of change to the codes, sometimes making explanatory notes in the margins. Revised transcripts were then sent to the feminist interpretive team each of whom read 12 of the 16 transcripts and made many suggestions about the coding and future interpretation. This team consisted of two feminist family therapists, trained in supervision, one of whom had served as the pilot study's supervisor. They were, as noted above, a cross-check on the researcher's judgements. Throughout the coding and interpretation process, the qualitative analysis software program ATLAS/ti, designed for grounded-theory research, increased the speed and accuracy of coding, sorting, and finding relationships among the data.

Interpretation. Like coding, preliminary interpretation was done in between interviews so that each interview could inform the next. As a result, the data collection informed the emerging theory, which in turn instructed the data collection. This constant comparative method of data interpretation allowed themes to emerge from the data (Glaser, 1992) that could be investigated in subsequent interviews and videotapes. Preliminary themes were tested in subsequent interviews by pursuing them if participants mentioned them or by asking a participant an open-ended question about the topic. After all the data were collected, they were repeatedly reviewed to verify relationships and construct themes. These interpreted data were then sent to the interpretive team for review and suggestions. The researcher incorporated the team's ideas and constructed a description of feminist supervision grounded in the experiences of the participants as reflected by the data. Supervision methods, the focus of this article, was one of the four themes of feminist supervision described by the participants.

RESULTS: FEMINIST METHODS

Figure 1 provides an overview of the three supervision methods identified in the study: Supervisor–therapist contracting, collaborative, and hierarchical methods. Although there is some procedural overlap (as when call-ins were used in collaborative as well as in hierarchical ways), the three methods and their techniques can be distinguished. They were equally important in the supervision work of all participants. Within a supervision session, supervisors chose whether to use collaborative or hierarchical methods in a given situation, but all of the supervisors began the supervision relationship with a contract.

FIGURE 1
Feminist Supervision Methods

Contracting	Collaborative methods	Hierarchical methods
Therapist's goals	Fostering competence	Directives
Mutual evaluation	Multiple perspectives	Modeling
Therapist's responsibilities	Options	Call-ins
	Call-ins	
	Mutual feedback	

Method One: The Supervisor–Therapist Contracting Process

As with many forms of supervision, feminist supervision began with a supervision contract. As the left column in Figure 1 indicates, the contract (usually a verbal understanding) included three processes: Defining therapist goals, mutual evaluation, and clarifying therapist responsibilities. Participants agreed that supervisors were responsible for establishing and maintaining the contract, and therapists were responsible for contributing to and updating their needs within the contract.

Supervisors talked about the contract as a way to be clear about their ideas and methods of supervision as well as a way to ensure that the relationship fulfilled the therapist's clinical needs. One supervisor summarized it well:

> I like, for lack of a better word, to go through the process of contracting. For me that means sorting out what are the goals. What are the supervisee's goals for supervision and what are my goals? Then I talk about what I think my role is. I like to have some clarity around boundaries; what I will and won't do, what they can and can't expect, and then what I expect.

All supervisors reported having taken notes outlining therapists' requests and goals, although not all therapists were aware of this. Periodically supervisors checked in with therapists to see if revisions of the contract were needed.

Therapist's goals. Training goals were elicited at the beginning of the supervision relationship. These goals were identified by the therapist who had the power to change or discard them. Participants also talked about therapists having case-based goals that emerged from their work with each family. As described by a therapist:

> Whatever my goal is, even for that hour session, she'll [the supervisor] keep that in her mind while watching the tape and while listening to whatever it is that I say. And she's constantly bringing that thread back in and saying, 'Okay, what if you want to keep this goal, are you doing what you need to do for that? Or maybe you need to do this instead of that?' It's really helpful because she holds onto it. I can be all over the place, she constantly puts it back in there. But she gets it from me. I give it to her at the outset.

The supervisors agreed that they wanted the therapists to tell them what they needed and how to help them. Some questions supervisors used to elicit therapists' goals were: "So when supervision is over how would you like to look, or what do you want to work on, what is your cutting edge?" "What is it that you're having difficulty with now and how is it that I can be helpful?" And as demonstrated by this quotation from a videotape:

> *Supervisor:* What do you want from us today?
>
> *Therapist:* What I need from you today is to look for how I could not get hooked by this family.

Therapist responsibility. In addition to establishing their goals, the participants talked about two aspects of supervision that were the therapist's responsibility. The first was to be an active contributor in supervision. The second was to keep the supervisor informed of what was going on with their clients and their therapy. As one therapist said:

> My role is to bring the cases to supervision and to keep [my supervisor] informed with what's going on with all of my cases. Any concerns or problems, it is up to me to talk to [my supervisor]

about it. I also feel like it's my responsibility or obligation to disagree with [my supervisor], with something [my supervisor] is asking me to do or some advice [my supervisor] gives. And to tell [my supervisor] where I'm coming from and to come up with a mutual decision as to where it should go. Because I look at it as my case, [my supervisor] is not there, [my supervisor] doesn't have the relationship.

Although the case loads varied among sites and therapists, the participants agreed that it was the therapist's responsibility to keep the supervisor apprised of what was happening with each case. They also agreed that the therapist should be responsible for requesting live supervision and for being prepared to present cases for supervision. Hence, regardless of the supervision format (live, videotape, audiotape, or case report), the therapist took primary responsibility for being prepared in order to get the most out of the supervision process.

Mutual evaluation. At the academic sites both the supervisor and the therapist formally evaluated each other. A supervisor describes the process:

We each fill them [evaluations] out separately and then we bring them and talk about them and work them out together. And I'll make additional notes after hearing their input and then we both sign that. So it's collaborative, interactive as much as it can ever be as long as it's still in a training institution. I think there is something to be said for when you're in a position of training and having some expertise. You have to be responsible for that, being in that position.

Therapists could challenge and make additions to their evaluations before they became part of their records. Often, a special time was set aside for the evaluation session. As one supervisor described: "I'll spend one session at the end of each semester talking about the process. How has this been for you, how has this been for me, what can we do differently, what we want to do the same?" All supervisors provided evaluation criteria to the therapist during the initial contract session. In addition, the supervisors often used the therapist's goals as one criterion for evaluation, emphasizing the importance of knowing whether the therapists had met their own goals.

When asked about the supervisors' responsibilities, the participants talked about the entire supervision experience, including the supervision techniques that fell into the following two supervision methods: Collaborative and hierarchical. This is not to say that the experience was only the supervisor's responsibility but that they acknowledged that the supervisor was in a position of power, and therefore, she/he had more responsibility for making supervision a positive experience.

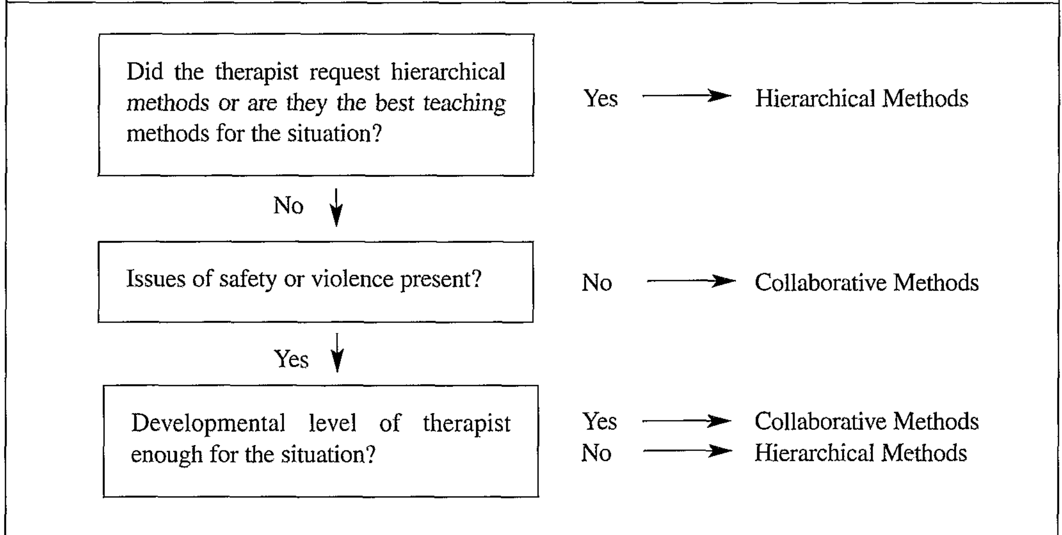
Deciding When to Use Collaborative and Hierarchical Methods

Before we describe the collaborative and the hierarchical methods, it is important to provide some of the supervisors' decision-making strategies. One of the central issues for supervisors was how they chose whether to use collaborative or hierarchical methods and how they made this a feminist-informed choice. Supervisors talked about the degree of collaboration and hierarchy in the supervision process as affected by what they thought the therapist needed based on the situation and the therapist's level of clinical ability, taking into account that therapists learn from "teachable moments" and working at their edge under supervision. Figure 2 illustrates the decision-making process between supervisors and therapists. It delineates when supervisors use collaborative methods and when they instead choose more hierarchical methods. Although both supervisors and therapists supported the use of hierarchical techniques, the supervisors clearly preferred collaborative supervision.

Collaborative Methods

The second column in Figure 1 delineates the five techniques of collaborative supervision. The techniques include fostering competence, applying multiple perspectives, providing options to therapists, making suggestions during call-ins, and encouraging mutual feedback between supervisor and therapist. Collaboration was the most frequently talked about supervision method and had the richest description and the most techniques. Supervisors also found it "easier to do" than to be hierarchical, and participants talked about it with enthusiasm. They agreed that collaboration was the place where the relationship would go once therapists were more experienced and they needed less authoritative direction to do effective therapy. As one

FIGURE 2
Decision Tree for Balancing Collaborative and Hierarchical Methods



supervisor put it: "My intention is really about collaboration and mutuality, so that you can feel like you're gonna (sic) learn."

Fostering competence. This concept emerged in the first interview and resided at the heart of collaborative feminist supervision. Supervisors described it as a process of eliciting clinical knowledge from therapists, thereby assuming existing competence and the ability to integrate new clinical ideas with existing ones. For example, one supervisor said:

> I think I work a lot more at bringing out what is inside someone as opposed to putting on to them an answer or a model. So in supervision that would be much more trying to help the supervisees understand what's going on for them, to learn to trust their own sense of what's happening in the therapy room, to help them feel more like experts and trust their knowledge than to apply a particular model.

In addition, therapists reported feeling empowered by knowing that the supervisor trusted their competence: "[my supervisor] takes the approach that we have the answer, and [my supervisor] elicits that from us."

Fostering competence represented the ways that reflected the supervisor's confidence in the therapist that she/he could do a good job in the therapy room. As one fairly new supervisor put it:

> Recently I've been trying to be reluctant about the advice I give. Instead of just immediately diving in and saying: 'What if you did this?' Or 'what if you did this?' I've been moving to the place where I ask: 'What are some of your thoughts about where you might go?' I think that sends the message that they can do it and they can figure it out, and I'm here to help them figure it out.

Multiple perspectives. The most common response when asked what the feminist supervisor did to make supervision collaborative was that she or he elicited each therapist's perspective when doing dyadic or group supervision. This category encompassed two related ideas: There were many ways to look at a situation, and there were many ways to do therapy. As one therapist said, "If she does give me suggestions, it's clear that it's just one way to do it. It's not just that I have to do it her way." Along with these two ideas the participants explained that the therapist's ideas were just as valuable as the supervisor's. For example, in one of the videotapes the supervisor summarized what she thought the client's process had been and then asked: "Would you say so or do you see it differently?"

Honoring multiple perspectives also involved having confidence in the therapist when they chose not to follow through on a suggested intervention. As one supervisor described it,

> Sometimes I call in and say 'I need you to do such and such' and they say, 'I need to take a break,' and then they come back and help me see why it's not a good idea because I missed something . . . [from an earlier] session. So I would always want them to give another perspective on it.

Supervisors at academic sites also encouraged therapists to work together in some manner on each other's cases. These therapy teams were a method of learning from each other and of developing multiple perspectives outside of the supervision process: "She encourages us to team on other cases, she encourages us to work together." Thus feminist supervisors used collaboration with and between supervisees as an important part of developing therapeutic skills, developing professional relationships, and encouraging therapists to practice within a professional community that valued diverse views. Talking about feminist-informed clinical work and about people's ideas about the many types of feminism, as well as whether or not they agreed with them, was also part of the process of being a feminist supervisor. As one supervisor related it:

> If I have a student who isn't feminist and I am, we talk about it. She has one way of seeing the world and I have another, and it's okay that she doesn't see it my way. She doesn't need to be like me. And there may also be ways in which she defines herself as not feminist, but I have a much broader definition.

Gender and gendered power dynamics were reported to be important issues discussed throughout supervision as they related to both supervision and therapy (Prouty, in press). Participants talked about issues such as men talking more in supervision and on cotherapy teams, and these were important dynamics to be dealt with when it came to fostering multiple perspectives.

Options. In this study, the therapists often mentioned therapy options as an example of a way they felt supervision was a collaborative process. As one therapist put it: "She offers things in the form of suggestions. She generally starts off with a compliment and 'now do this' or 'you might think about this' or 'what I'm hearing is . . .' or 'think about these questions'." The supervisors differed in their styles of giving options. Some gave them only hesitantly when the therapist wanted more ideas and when the ideas from other therapists were exhausted. Others provided options with an open understanding that the therapist could take the option, change it, or discard it for other ideas. This understanding and the more collaborative language differentiated options from hierarchical directives.

Collaborative call-ins. Participants clearly believed that live supervision call-ins were used more often as a form of collaboration than as hierarchical directives. Collaborative call-ins involved providing choices or multiple perspectives to a therapist in session. Because of their collaborative nature, these call-ins could be made by the supervisor or by a team-member therapist. As one supervisor explained: "Sometimes the call is driven by the other student behind the mirror with me. We're back there talking and we're excited about something and we want to give her some information." Hence collaborative call-ins were a vehicle for providing alternatives and for facilitating a team approach to learning therapy.

Mutual feedback. The informal way of providing compliments, requests, and constructive criticisms between the supervisor and the therapist was a mutual process and most often took the form of check-ins during supervision. As a therapist described it:

> The informal feedback is on an ongoing basis. [My supervisor] continuously asks me: 'Does this make sense? Does that fit for you?' When I'm explaining the way that I see something I'll ask her: 'Do you see it the same way?'

Participants also reported that mutual feedback occurred more often when encouraged by the supervisor. Supervisors reported that therapists, especially more novice ones, engaged them more about their supervision methods when repeatedly invited to do so. By these invitations, the mutual feedback became a part of the supervision methods. As one supervisor put it: "I invite the supervisees to disagree with me. I'm happy to be challenged. Usually, though, I have to invite that."

Hierarchical Supervision Methods

The supervision process relied primarily on collaborative techniques unless the clients were not safe, as in the case of violence, or when the situation was beyond the therapist's current therapeutic abilities. In addition, some supervisors seemed to interject hierarchical methods when they determined it was the best

way to quickly, clearly, and effectively capture a teachable moment or when the therapist requested hierarchical supervision.

The third column in Figure 1 shows hierarchical supervision methods, including supervisor directives, supervisor modeling of appropriate professional conduct, and directive call-ins. Hierarchy was acknowledged to exist in all supervision relationships, and participants welcomed it as a necessary part of supervision. From a supervisor's perspective: "I think it's important to have an understanding that they are in a less powerful position. No matter how much you collaborate. . . . They are dependent on you." Several therapists expressed the notion that hierarchy could "feel bad" but somehow their feminist supervisors made it "feel good." How the supervisors did that was the focal point of the interview questions about hierarchy. From a therapist's perspective, "It's not been a power thing at all, but it's obvious she's the supervisor. She listens to my input. She respects what I have to say. It's not like, 'I know what you need to do and you don't,' which would be a power thing." From these and other therapists' comments, it also appeared that mutual feedback and open and consistent communication from the collaborative supervision contributed to making the hierarchical methods work for them, as opposed to hierarchical methods used by previous nonfeminist supervisors, which they had experienced as less helpful or even "bad." Participants described three types of hierarchical methods: Directives, modeling, and directive call-ins.

Directives. Supervisors used two types of directives: Behavioral directives and reading directives. Behavioral directives were instructions to the therapist to do exactly as told in the therapy session. Usually this involved using specific words or intervention. Directives were more commonly used with less experienced therapists and in situations of risk, such as suicide, violence, or substance abuse. As one therapist put it, "[my supervisor] would become more hierarchical if I really screwed up. If I did something that was completely out of line. I mean, I could see [my supervisor] becoming really directive if there was abuse that was talked about and it wasn't reported." And supervisors described clear instances of when they would become directive. For example, one supervisor explained, "I would be directive with issues of safety. If there's something . . . that seems to suggest danger, then I'm not collaborative. I tend to be pretty sensitive about family violence kind of things and will usually err on the side of caution." Another supervisor talked about how these directives fit in with her ideas about being a feminist:

> My directiveness is quite feminist informed. I cannot be in [a] relationship with less integrity; that's really important to me. Like when I think what the supervisee is doing is unethical. That's when I would do that. If I'm watching a videotape or I'm behind the mirror and there's something in the therapy room that I think is really oppressive and the therapist is letting it go—I will stop it. Or I will stop the videotape and say: This is not feeling safe to me right now, and I need to tell you why.

The other type of directive mentioned by supervisors was assigning the therapist something to read. However, when the therapists talked about assigned readings, they described them as "suggestions" by the supervisor for a greater understanding of a case. It is possible that sometimes therapists did not understand the difference between a directive to read something and a collaborative option.

Modeling. Sometimes a supervisor showed the therapist how to do something either through joining a therapy session (modeling) or by doing a role play with the therapist until she/he felt comfortable with the process. One therapist described how a supervisor might enter a session during live supervision this way:

> She never comes in and acts as if she's an authority. She'll come in and introduce herself. She's very calm, and when she talks with the client, she speaks with them in a way that is respectful. She tries not to come in like a whirlwind or gangbusters and turn things upside down.

And a supervisor, discussing a similar situation, stated, "Sometimes the beginning therapist is hesitant because they really don't feel competent at this point to do what I've asked them. So I say, 'would you like me to come in?' And they tend to always say, 'great'."

In-session modeling and role plays seemed to be used more with beginning therapists and less with more advanced practitioners as the supervisors deemed it could hinder the therapist's progress toward increasing creativity and self-confidence, qualities that were valued by supervisors. Hence there seemed to be a balance between role modeling and encouraging therapists to develop personal styles and competencies. In this latter case, supervisors modeled trust through the message: "I know you can do this."

Directive call-ins. Both the supervisors and the therapists agreed that calling in to a live therapy session to talk to the therapist could be either hierarchical or collaborative. During directive call-ins the supervisor phoned in an intervention for the therapist to do. The supervisors reported that unless the called-in directive was short, they preferred to bring the therapist out of the session for a break. Participants also reported that if the therapist did not follow the directive, or if it failed, the supervisor would call in again. "If there's a case in session where I'm trying to work with the student to make a particular process piece different and the first intervention didn't work, I'll call in again."

The therapists in this study talked more about how the supervisors used hierarchical call-ins than did the supervisors, who talked more about call-ins being used for collaboration. This might have been an area where therapists more clearly experienced hierarchy within the supervision relationship. As one therapist recalled:

> She has called in and told me what to do. To tell you what to do is pretty damned hierarchical, in (sic) just like, 'do this.' But she really believes that's the best way people learn. It's a challenge for me sometimes. She's challenged me about multiple different ways of being a feminist. At first I wanted to fight it and be more equal, but I've come to appreciate it now that I trust her more. It's probably the most clear that she comes across, and for live [supervision], I want her to be clear.

This therapist brought up a key question: How is being hierarchical still feminist? She went on to describe in detail how she felt that it was. It was the way it was done: With clarity, respect, and within the collaborative context of their relationship. This therapist also talked about the directive call-ins being a response to her own request for the supervisor to be brief and clear during her live supervision. Hence directive call-ins were one way this supervisor utilized, in one supervisor's words, "teachable moments."

Summary

In this study, being a feminist supervisor required establishing a clear and mutual contract for work with the therapist. The supervision methods employed, whether collaborative or hierarchical, were developed to help therapists develop therapeutic skills and self-confidence and to value multiple perspectives when providing therapy. The supervisors also talked about the importance of training the therapist to notice and to deal effectively with potentially dangerous situations. Supervision methods reflected the value of collaborative interaction and the minimization of hierarchy within professional relationships while simultaneously acknowledging the expertise of the supervisor and using it to teach.

DISCUSSION

The supervisors in this study were self-identified feminists—people who held feminist values and tried to live them while training other family therapists. We were surprised how quickly the data became saturated and how quickly similar methods of feminist supervision emerged in the interviews. After we had obtained a picture of these methods, we looked to the feminist family therapy supervision literature to compare participants' experiences with what others had written. In the following section, we integrate issues from this literature with our findings.

The Supervision Contract

In this study, as we have seen, the supervisors used contracts to minimize hierarchy, to promote clarity, and to help therapists use supervision to meet personal goals. Participants talked about how establishing a contract was one way for supervisors to elicit from therapists the standards by which their work would be evaluated, thus empowering therapists by making the process more collaborative. They also all reported mutual evaluation as part of this process, giving a chance for both therapist and supervisor to discuss their experiences of supervision.

Expanding on the application of clear, consistent, and open communication, the use of mutual feedback was an extension of the mutual evaluation process promoted by Wheeler et al. (1989), who asserted that feedback should exist in an atmosphere that promoted therapists' abilities, strengths, and responsibilities. Our participants reported that mutual feedback occurred continuously and thus was available whenever the

therapist and the supervisor needed to request or provide information to the other so as to do their best work. Providing feedback in the time it can be most useful is fundamental to the process of promoting both the therapist's and the supervisor's abilities and responsibilities. Like the participants in this study, Wheeler et al. saw this as a means for empowering the therapist by helping the therapist to negotiate her or his supervisory needs. Wheeler and her colleagues also, like Goodrich et al. (1988), saw such a process as helping to demystify supervision and allowing it to become a relationship based on feminist-endorsed values of consistency, predictability, and mutual respect—important issues for all the participants in this study.

Collaborative Methods

Participants' descriptions of the collaborative learning environments developed in their supervision fit descriptions of the work of several feminist scholars (Belenky, Clinchy, Goldberger, & Tarule, 1997; Stanton, 1996). Indeed, the supervisors in our study used collaborative techniques not only to teach but to create a collaborative learning environment in which the therapists applied previous knowledge, taught each other, and actively participated in their own learning. According to the participants, collaborative learning environments also encouraged rich client case analysis and therapeutic creativity, as suggested by Avis (1988).

Discussions of openness to other peoples' ideas are abundant in the feminist family therapy supervision literature. Goodrich et al. (1988, p. 32) suggested that feminists "show willingness to hear a difference and to experiment with alternatives." Good, Gilbert, and Scher (1990) encouraged feminists to be egalitarian collaborators, and Wheeler et al.'s (1989) model of feminist supervision included mutual feedback and mutual evaluation. They also advised supervisors to encourage a balance of voices within training groups, with special attention to valuing female input equally with that of males. Encouraging multiple perspectives and teamwork is a way to set up the overt rule that everyone's ideas have value.

Wheeler et al. (1989) also discussed the use of feedback, videotaped, and live supervision to provide opportunities for the supervisor to challenge the therapist's stereotypes about power and gender and to present feminist-informed alternatives. The supervisors in this study talked about mutual feedback and the use of case report, videotaped, and live supervision. Participants did use these structures to ask feminist-informed questions about supervision and therapy processes (Prouty, in press), to initiate supervision discussions, and to offer suggestions for action. Within the collaborative methods, the emphasis was on helping therapists to learn to think for themselves and to build upon the therapy skills with feminist-informed questions but not necessarily to demand that every therapist agree with every feminist value of the supervisor. Indeed, the participants were very clear that, although supervisors expected the therapist to examine the sociopolitical context of their lives and their clients' lives, the therapist did not have to become a self-identified feminist.

Supervisors in this study defined clear, open communication as feminist because they used it in ways that minimized hierarchy. This is congruent with other feminists' descriptions of feminist therapy and supervision (Goodrich et al. 1988; Wheeler et al. 1989). Wheeler et al. (1989, p. 149) explained that the use of clear, uncomplicated language "reduces power and status differentials and facilitates learning" because it is harder to dominate therapists when the supervisor explains her ideas, gives reasons for her actions, and provides other resources for learning. The therapist not only hears the supervisory output but is also exposed to the supervisor's cognitive and emotional decision-making processes. Participants described this transparency as contributing to the collaborative feeling of the supervision. The collaborative methods described by the participants also fit Avis's (1986) Delphi study panel's belief that feminist supervision would not be authoritarian and that it would minimize competitiveness among the trainees.

Hierarchical Methods

We were struck that the supervisors in this study only used hierarchical methods when they felt that collaborative methods would not be sufficient. The use of power within the relationship seemed to be experienced by the participants more often as a "power to" enhance their abilities and competencies rather than as "power over" to condemn, belittle, or control them (Goodrich, 1991, p. 8). Using one's power to

empower others is, in this sense, feminist, whether it be to challenge someone to grow or to protect someone.

Directives, modeling, and call-ins are not necessarily feminist, so what did these feminist supervisors in this study do to make the therapists feel, as one therapist put it, "hierarchy in a good way [and that supervision was] not a power trip"? The contract used by the feminist supervisors established clarity and mutual expectations so that the use of hierarchy occurred within a collaborative, relational context. Ault-Riche (1988), Avis (1988), Libow (1986), and Nelson (1991) have asserted the importance of women supervisors modeling personal power and expertise. What we found in this study was that sometimes the content of the modeling also contributed to making the supervision overtly feminist. Supervisors modeled interventions that examined gender and power (Prouty, in press) similar to the suggestions of Avis (1986) and Nelson (1991). With this use of self through modeling, the supervisor encouraged the therapist to examine ideas often associated with feminist family therapy such as people's construction of gender and power within relationships and their cultural context.

The supervisors in our study seemed to use directives, directive call-ins, and modeling as hierarchical tools that promoted the "good" hierarchy that the therapists described. We conclude that in this study, clarity, consistency, and debriefing during and after the use of hierarchical methods enabled the participants to experience these hierarchical methods as being congruent with feminism. The hierarchical methods were used to capture teachable moments, to protect the safety of clients, to respect the therapist's developmental level, and to honor the therapist's supervision requests. And, of importance, the participants described hierarchical methods as being used infrequently as compared with collaborative methods. Perhaps when used sparingly, with respect and with explanations, hierarchical methods are experienced as empowering.

Balancing Hierarchical and Collaborative Methods

Terry and Preli (1991) proposed a developmental MFT training model incorporating feminist-informed values. They argued for the importance of balancing collaborative and hierarchical relationships in supervision and for implementing hierarchical and collaborative models with flexibility and clarity. They proposed that the key was to expand upon supervision methods that helped therapists to know when and how to be autonomous, help seeking, and interdependent. Similarly, Wheeler et al.'s (1989) model of feminist supervision proposed minimizing hierarchy by sharing the responsibility for change and learning through contracting, shared evaluation, therapist initiative, and by the supervisor's attention to nonsexist and empowering language.

Wheeler et al. (1989) provided lists of skills to be gained in supervision that suggests a process of mastering specific abilities. Although the goal of supervisors in our study was to teach many of these therapy skills, they believed the most effective method depended on the therapist's level of competence and experience. Taking a developmental approach to supervision was seen as both common sense and as feminist, judiciously balancing of the use of collaborative and hierarchical supervision methods. When talking about family violence or other safety issues, for example, the participants agreed on the importance of making safety a primary part of the therapy and supervision process, and this often involved taking a more hierarchical instead of a collaborative stance. This emphasis on safety is consistent with feminist ethical models and guidelines (Peterson, 1994; Porter & Yahne, 1994). Supervisors also talked about the need to help therapists learn to know when either a client or a session was not safe and to learn to feel comfortable asking pertinent questions. Goodwin (1993) argues that a systematic, educational approach, which, by definition, is somewhat hierarchical, is necessary in training therapists about our accumulated knowledge of relationship violence and related issues, both in the MFT classroom and supervision. She points out that we, as supervisors, must also remember that the therapists with whom we work could have personal experiences with violence, although this issue did not appear to arise in this study. The supervisors' goal was for the therapists to grow out of the need for hierarchical direction but to continue to consult with colleagues (multiple perspectives) and increase their understanding of safety issues, a goal consistent with Goodwin's point.

IMPLICATIONS AND CONCLUSIONS

This study suggests methods on which feminist supervisors can build. The participants applied their feminist values to create a process of supervision that was feminist. The methods they described are practical and applicable for both experienced and novice supervisors and for therapists. Supervisors can integrate some of these proposed methods, understanding that there are varied approaches to feminist practice (Avis, 1988; Dankoski, Penn, Carlson, & Hecker, 1998).

The results of this study are intended to contribute to a foundation on which a richer and more complex framework of feminist supervision can be built. To do this, feminist supervisors must use, critique, and further research these feminist methods. We hope here to encourage discussion about ways to do feminist supervision and, specifically, about the roles of hierarchy and collaboration within feminist family therapy supervision. We also hope to encourage more research into how feminists construct and practice supervision, addressing such questions as: What additional supervision methods are informed by feminism? How does feminist-informed training differ when provided for persons of different cultures? Seeing that most of our participants were Anglo-American, would a feminist systemic supervisor choose different methods with a therapist, for example, who expects more hierarchical supervision or for whom asking directly for their needs to be met in an overt contract feels inappropriate? Another endeavor might be to use the results of this and future research to construct a feminist supervision assessment tool similar to those for feminist family therapy (Black & Piercy, 1991; Chaney & Piercy, 1988) or a supervision skills chart similar to those found in Wheeler et al.'s (1989) model of feminist family therapy.

We hope that practitioners examine our participants' experiences and develop new approaches for incorporating feminist methods into supervision. This study is thus a preliminary step in establishing an understanding of feminist supervision in MFT.

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NOTE

1. Although it is a false separation, a discussion of the supervision relationship and traditionally feminist issues (e.g., gender, power, diversity, and emotion) can be found in a separate article (Prouty, in press). A third article focusing on mentorship in feminist MFT supervision is currently in progress.