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To cite this article: Héctor Fernández-Alvarez (2016) Reflections on supervision in psychotherapy, *Psychotherapy Research*, 26:1, 1-10, DOI: [10.1080/10503307.2015.1014009](https://doi.org/10.1080/10503307.2015.1014009)

To link to this article: <https://doi.org/10.1080/10503307.2015.1014009>



Published online: 09 Mar 2015.



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HONORARY PAPER

Reflections on supervision in psychotherapy

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(Received 30 May 2014; revised 10 January 2015; accepted 21 January 2015)

Abstract

The aim of the author is to share his reflections on supervision as a central topic in therapists' education and training programs. The concept of supervision, its functions and effects on the training process along with the contributions of different theoretical models to its evolution are addressed. Supervision alliance, the roles of supervisor and supervisee, evaluation as a central component and the influence of socioeconomic factors are discussed. The conclusions depict the most interesting paths for development in the near future and the areas where research needs to be further conducted along with the subjects most worthy of efforts in the supervision field.

Keywords: psychotherapist training; supervision; development

I have been involved in supervision throughout my professional life, either as a supervisee or a supervisor. In the first few years, this task was a natural extension of my clinical practice. In the last 20 years I have been collaborating diligently on developing a formal model that will be useful both to individuals and to the institution where I work. My ideas regarding the nature and purpose of supervision have evolved as I formulated recommendations for our work groups, prepared general and specific seminars for supervisors, and, particularly, when I began to think about research in this area.

I want to share some of my reflections on supervision, specifically those concerned with the boundaries of supervision, and with some aspects of supervision that have been overlooked or barely touched upon in the scientific literature. My goal is to propose some themes or possible lines of inquiry which, I believe, can contribute to the development of supervision.

On the Nature of Supervision

I start by discussing the meaning of supervision, its typical components, and its functions. Then, I address the role of supervision in the training of

psychotherapists as part of the history of psychotherapy and how it relates to various theoretical models. I next describe my personal experience with supervision. Then I deal with the past and the present of supervision and describe its evolution to date. In addressing the common factors in supervision, I highlight the issues of the supervisory alliance, assessment in supervision, and the importance of sociocultural factors. The conclusion pinpoints future directions as well as proposals for continuing this work from the perspectives of practice, training, and research. In short, where do we currently stand in the field of supervision? What are the most promising paths for research in this field?

I begin by specifying what we mean by the concept of supervision, as we understand it. Supervision is an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession (Bernard & Goodyear, 2014, p. 9). There is wide consensus on this definition, to the point that the American Psychological Association (APA) has adopted it officially. However, as a discipline evolves so do its definitions, as Bernard himself points out when he writes that one of its

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components—“a task that involves people of the same profession”—does not currently hold true to the general practice of supervision. Indeed, as interdisciplinary work has become more prevalent in the field of mental health, members of supervision groups may belong to different professions (and this is often advisable). It is noteworthy to point out that the recently adopted Law of Mental Health in Argentina (my country) actively promotes the interdisciplinary model.

More of the definition remains in need of revision. For example, the main sentence which holds that supervision is an action provided by a more senior member of a profession to a more junior colleague is probably not completely accurate, for its reach is not universal and requires clarification. Supervision is, in general, an action undertaken by an expert and directed toward less-developed professionals, but it is not only that. This can be shown, for instance, by how important peer supervision has become. Peer supervision is a space where several professionals with a similar level of expertise gather in workgroups to supervise the work of one or several members. The relationship between supervision and training is also studied in the industrial and organizational fields (Dierdorff & Surface, 2008).

A common and particularly interesting situation takes place when a supervisee's intervention generates insight for the supervisor. Supervisees may shed light on aspects that underpin a “bottom-up” approach to discovery in the relationship that defines their interaction with the supervisor. For this to happen the supervisor must have an open mind and facilitate an affirming atmosphere for the supervisee. In my daily routine as a supervisor I have found that such situations allow us to discover talented novice therapists with promising professional futures. In fact, an excellent research topic might be the observation of situations where the supervisee's performance generates surprising, unforeseen new ideas or different perspectives about a clinical situation. Such a study could involve both quantitative and qualitative approaches. For example, it would be interesting to survey supervisors on how they appreciate the quality of supervisees' interventions. In particular, how supervisors identify original or surprising ideas by supervisees, ideas which then produce some change in the format of supervision, or in how it is performed. This survey could be complemented by an exploration of how receptive supervisors have been to supervisees' novel interventions, especially with those in which supervisees believed they were contributing something new or different. This assumes that the information received is reliable and stems from a good supervision alliance.

For a more in-depth analysis of the definition's scope, I find it interesting to examine the meaning the word “supervision” has in everyday language, in common-sense psychology. Supervision is part of most human activities dealing with the production of goods and services. At the production line of a workshop or factory, supervisors busy themselves with making sure that the norms set out for production are followed in order to arrive at an end product. Supervision is, basically, a task, which is inherent to the control of quality during production. A supervisor is expected to detect problems or difficulties in that chain and to enact changes in that production line in order to optimize the final result. The role of the supervisor in service activities is similar: To assess the way in which a function is being discharged in connection with users or clients, such as the case of a public agency, a financial institution or bank, an airline check-in counters, and others. In all cases, supervisors must fulfill their tasks, generally without being noticed. They are fairly invisible to consumers, but their presence is very much real to the agents, employees, or professionals who are in charge of the operational aspects of their activity. For these people, supervisors may be a watchful presence who keeps tabs on their work, and/or a supporting figure who helps them deal with difficulties along the way. In short, supervisors are in charge of (i) quality control of the activity and its products, (ii) helping the agents when they are in trouble or lack necessary knowledge, and (iii) take action when there is a complaint by a user.

How do we, ordinary consumers in our everyday lives, notice the presence of a supervisor? When a problem arises and we believe the service we expected is not being rendered, or when the object we have purchased is not satisfactory. In such cases, we require the presence of supervisors, who will emerge from the shadows and carry out their task in order to address our complaint.

Of the three typical functions usually performed by supervision in everyday life, the first two are also covered in a therapeutic environment. The first one occurs primarily in institutions. The second one is usually the most well known and is twofold: (i) providing care to the therapist/supervisee and (ii) providing information or knowledge. Supervisees require this, especially, when facing critical situations. The connection and/or overlap between both goals and the difficulty to clearly tell them apart has brought about controversy in the field, in particular, because supervision goals have often been inaccurately defined.

The third function is rarely practiced in psychotherapy. I am not making reference here to a patient's rights being infringed upon when physically

damaged or hurt during therapy, as this scenario is governed by ethical or legal requirements. My focus is on the doubts or questions that patients might have about their therapeutic process and eventually the goals of therapy. I believe it would be useful to include this third function in the systems that regulate psychotherapy. Patients would then have another resource as participants in the process, and therapists would have another means of support and a safer frame of reference to account for their practice. I have no doubt this issue can be controversial. But its usefulness depends on the alliance between supervisor and supervisee being strong enough so that any action taken on the basis of these complaints (even a change in therapist) can both safeguard the role of the therapist and respond to the patient's needs.

Usually, patients do not see supervisors during their treatment. In fact, patients might not even be aware of the existence of supervision or of how that relationship might work in connection to their therapy. There are valuable exceptions, however, especially in the field of systemic therapy, which suggests using live supervision as a common tool for certain therapy programs (Montalvo, 1973). This procedure has been used beneficially (and still is) with many patients. What are the effects of live supervision, especially in comparative studies with different deferred supervision models? There are no available conclusive empirical results; thus this could be a research line itself in order to provide data for both the study of supervision and of therapeutic effects. In fact, live supervision is a field that lends itself to many lines of empirical research. One example would be to conduct studies on similar treatments (analogous in format and duration, and in the same institutional environment) conducted by two groups of therapists, some who are receiving live supervision and some who are not. It would be interesting to compare (i) the reaction of therapists in each of these two conditions (especially how useful it is for their therapeutic interventions) and (ii) the type of change that is observable in treatment after the supervisor's intervention. Interactional settings such as group and family therapy are more accessible for these types of projects.

We have used live supervision in our health-care facility, not only within the frame of family therapy sessions but also for group therapy. As is usual in these cases, patients are informed that it is part of research and they provide their consent for it. The patients' habitual reaction is usually positive, and the prevailing feeling among them is that therapy is being carried out with the utmost care. There is, of course, the possibility that the effect will be the opposite: That supervision makes the patients feel

that they are overly exposed and that their personal therapy space may not be private enough. These differences deserve to be looked into, thus providing a good opportunity to know the patient's assessment of the tension between the "safety of the procedure" and the "confidentiality of the information."

Obviously, both live supervision and audio or video recording are highly controversial issues, particularly from the perspective of certain therapeutic approaches. It is evident that we must guarantee the patient's confidentiality. This notwithstanding, securing certain records and obtaining clinical material are key factors toward advancing patients' benefit. Uncompromising positions on this issue are roadblocks to carrying out certain studies. In fact, when trying to do research on particular trans-theoretical aspects it is particularly difficult to obtain clinical material from some therapists who argue that there are theoretical impediments to do so. It is necessary to have a deeper debate about this issue, as it is paramount for supervision's further development.

It could be quite positive, under certain conditions, that patients have access to consultation with a supervisor (obviously something quite different from co-therapy). This is already occurring in certain health-care systems, in which patients consult with supervisors if they believe the service rendered to them by the therapist has been unsatisfactory. One of the research goals on this topic could be the effect that this procedure could have on different types of patients. The problems that might arise could be solved by the intervention of another supervisor or of a supervisor of supervisors. It would be interesting to adopt this general principle in all practices, and especially in long-term treatments, thus providing the ability to confirm or rectify the course of a treatment (e.g., to facilitate changing therapists in stagnant relationships), but it could also be of great help to repair therapeutic impasses and to resolve situations in which patients are particularly reactive. Also, it could aid in identifying the main variables that mediate the course of treatment when the supervisor intervenes with the patient, either through therapist or patient initiative. There are two topics to investigate: (i) the relationship between the therapist and the supervisor and (ii) the patient's reactions to the use of supervision resources. In the latter it would be of great interest to explore the rhythm and narrative changes that may take place during and after the patient's meeting with the supervisor.

Our experience is that patients feel more cared for than scrutinized when they know of the existence of a supervisor. Introducing this variable as a regular occurrence in different health-care models requires, of course, looking into the effects that it may have on the therapeutic alliance. However, under certain

conditions it could be a useful tool to strengthen that alliance. One of the most convenient ways to know how treatment works is an interview conducted after treatment completion and with the aim of knowing how patients evaluate the results of therapy and to what factors they attribute these results. This is a resource we frequently use. A worthy line of research in all of these situations would be to study, at the end of the patients' treatment, the impact that the presence of the supervisor has had. These studies would be extremely useful in order to better comprehend the relationship between supervision and therapeutic results.

My colleagues and I are certain that supervision is an activity that we therapists need on a permanent basis throughout our career. Even at advanced stages of our professional development we still encounter situations in which it is advisable to have a supervision space. Even after many years of work as therapists we frequently come across extremely complex and difficult situations. Are we attracted by this very complexity? Are we driven by our will to surpass ourselves? Surprise and doubt may appear again (and it is good for us to be open to them) and supervision may help us not only emotionally but also technically.

Although it might be useful to avail ourselves of the support of some solid hypotheses, in my view, it is not advisable that therapists go about their work believing they have complete control of the situation, without room for questioning. It is not good for therapists or supervisors to adhere to an absolute truth, even at the highest levels of their development.

Psychotherapy has made great progress in recent years and has been recognized by APA's Resolution on Recognition of Psychotherapy Effectiveness (approved August 2012). It has brought about better results and more benefits for patients. We have general empirical data on this (Lambert, 2013), as well as studies on how certain specific therapeutic approaches work (Hofmann, Asnaanin, Vonk, Sawyer, & Fang, 2012), and applications to specific clinical situations (Hanrahan, Field, Jones, & Davey, 2013). Nevertheless, there are still many limitations, including early dropout, relapse, and recurrence (Dimidjian & Hollon, 2010; Lampropoulos, 2011). We need to acknowledge this responsibly and be aware that a discipline matures when it owns and addresses its limitations.

In the same way that we must precisely define the advances in psychotherapy supervision, we need to take important steps to optimize our therapeutic interventions. Indeed, doing so will allow us to perfect our training programs and will also be of great help in better establishing the scope of specific factors in therapy. Such knowledge of the advances

in supervision is one way to advance our knowledge about variables of change.

The Role of Supervision in the Training of Therapists

Supervision has been an ever-present concept in the history of psychotherapy. Psychoanalysis was the starting point of psychotherapy, and it was this theory's creator who, early on, discussed the issue of supervision. Freud first reproduced with his followers what was already the norm in medical practices; supervision of clinical work meant to discuss the case, diagnosis, and further treatment. In such a context, the active principle of supervision was that the greater knowledge of an expert was imparted to those with less experience. But Freud went beyond this and put forth the idea that psychoanalyst candidates should themselves have experience as therapy patients. Thus it became the norm to require didactic analysis, formally established by the 1922 Congress of Berlin, as fundamental for training. The core of this requirement established that in order to become psychoanalysts candidates needed to subject themselves to analysis, carried out by an officially recognized senior psychoanalyst and focused on the candidates' work with some patients, with the intention of dealing with the unconscious conflicts that are inherent to the practice and role of a therapist.

Two overlapping concepts began to circulate in the discipline, together with heated debates and controversy: session control and didactic analysis. The first connoted the active vigilance derived from the concept of supervision in medicine. Controlling the analyst work meant to observe and evaluate the way in which professionals carried out their practice and was especially geared toward preventing personal issues from interfering with countertransference which made it harder to conduct good therapy. The second was a clinical act performed in the context of a therapeutic intervention and with the purpose of training a candidate. Supervision was thus branded, from its inception, with two points of intersection, which gave rise to debates (sometimes quite fiery) that are yet unsettled. Such heated debates concern the principles of professional authority and the role of institutions in the structure and regulation of therapists. This central issue of power is still alive and deserves to be treated as honestly as possible.

Supervision has been defined as an activity that is halfway between education (training) and clinical work (treatment). This dichotomy still gives rise to misunderstandings. However, we currently emphasize the academic aspect, where supervision work is

clearly labeled as part of training and differentiated from interactions derived from the supervisee's personal therapy. The work of a supervisor, somewhat halfway between a teacher and a therapist, can be properly done within the framework of training. But what happened to the other theoretical models? What have been their contributions to the issue? The models that stem from original psychoanalysis and, to a certain extent, the different humanistic and existentialist approaches maintained an analytical perspective and therefore did not introduce significant changes. With the emergence of cognitive behavioral therapy, however, a clear difference was delineated and supervision began to be thought of as a way of evaluating the accuracy of interventions (with an emphasis on technical aspects). Deep down, every therapeutic model has recognized the importance of supervision, but to a great extent each new model only proposed fundamental extensions of their own theoretical structures, based on the guiding principles of experts within that theoretical camp. For many years, the theoretical diaspora of the psychotherapy models was replicated in the field of supervision.

What happened then was to be expected. Each model held firmly to its principles, which in appearance had ironclad logic: The best framework for supervision seemed to be strict theoretical uniformity among its participants, especially to the extent that the supervisor was considered an expert in a specific type of model. However, this warrants a more in-depth exploration. To what extent does supervision benefit from this theoretical uniformity? Can differences in types of supervision turn out to be enriching? If so, under what conditions and in which cases? If so, how useful and feasible might the experience of that diversity be, both for supervisees and supervisors? What might be the limits of those differences? This is another interesting area for further rigorous research and could be studied both from a perspective of vertical or horizontal (peer) supervision especially in the context of a hospital or professional association, with therapists who have been trained in different theoretical approaches. It would be interesting to assess previous expectations and to compare them with the effects (benefits and obstacles) that arise in sessions. Another area of interest is to look at how supervision works with a group of supervisees sharing a specific theoretical-technical approach and receiving supervision from supervisors of different approaches. It would be interesting to ask supervisees to discuss how useful supervision has been for them and to tell of their personal experiences. In addition, crossing such variables might allow us to infer criteria relative to the modalities of each supervision approach.

Even if it seems obvious that supervisees must share a theoretical model with their supervisors, this could create a substantial challenge. Psychotherapists-in-training, in the initial stages of their training, usually take part in supervisions with different theoretical frameworks. In many universities this is compulsory. This diversity starts to decrease as therapists evolve in their training and usually disappears when they decide to be a member of a professional association. Sometimes this concludes with a sort of theoretical endogamy. Conversely, it often happens that when many therapists reach the middle of their professional lives, they seek a change in the orientation of their supervision when they find themselves developmentally stuck or having hit a ceiling. The change they typically seek at such time, both in new training programs and in choosing a new supervision format, may be considered a model to be followed consistently throughout a professional career. To create supervision spaces with different theoretical models would make practice richer and may even help to refine the basic theoretical model that a therapist works under.

It is a fact that supervision is sometimes associated with negative experiences, and we can try to go deeper in our discussion if we examine the causes for this, as the conclusions might allow us to make some changes. To go in that direction, I think it is interesting to draw from my own experiences and take a short journey of self-disclosure.

My personal experience with supervision goes back to the early stages of my professional career and has two opposing faces. The first was when, to fulfill the requirement of my university, I had to face two supervisors who instilled in me fear and anxiety because of their evaluations. These evaluations generated strong feelings of insecurity and threatened my feelings of therapeutic efficacy. Both professionals were of the psychoanalytic genre, in accord with the Kleinian approach prevalent in my university at the time. They expressed anything but empathy, especially for those who, like me, showed little inclination for the theoretical orthodoxy they espoused. Fortunately, shortly thereafter and during my residence in a psychiatric hospital, I had another supervisor who had a completely opposite manner. He was also a Kleinian professional, but one who conducted the supervision of the severe cases we treated with an attitude of support and helped me to face work-related anxieties. This boosted my interest and my motivation in psychotherapy, and it strengthened my self-assessment of my therapeutic competencies.

This anecdote has several sources. On the one hand, it is a tribute to the work of Nick Ladany previously published in this journal (Ladany, 2004). His writings on supervision memories seemed, in

this context, a good model for reflecting upon our own practice. I believe that understanding where we come from and why we are interested in the subject of our research helps a great deal to validate the experience. In the end, I believe it honors the importance Kuhn gave to the context of discovery in the development of scientific research. It also highlights that memory is relevant because from that moment on, it was clear in my mind that the level of encouragement given by supervisors does not depend on the theoretical model which they espouse. I learned early on that with supervisors, as with therapists, factors dealing with the bond and relationship with the supervisee have a great influence and might even be more important than the formal principles of the model they are based on. Common factors! Just that? I think not.

A third reason drove me to include this memory. At that time I had concerns about adhering to the predominant psychoanalytic theory and particularly to the object relations approach that was being taught in our institutes. But what worried me the most was not those doubts about theory, but the oppression I felt when faced with the dogmatic institutional structure that demanded strict adherence. This is what was imposed by my first supervisors and what became the biggest obstacle for my development. Critical thinking and disagreement made me feel marginalized, but these feelings were mitigated when I started working in two health-care facilities where a different theoretical framework was used. In this new context I could see that there were also supervisors of many theoretical types who were “persecuting” and those who were “supporting,” those who were “orthodox,” and those who were “flexible.” But beyond this, I developed the awareness that power is a central issue that can make our development easier or more difficult, and it is a decisive factor when we try to make our reflections and productions heard. Power also plays a role when developing the competencies needed to help patients.

During my professional career I went through several stages. After being at first marginalized, I managed to move forward by entering the sidelines of our society’s psychotherapeutic mainstream. Little by little, and with many colleagues, we succeeded in entering a space of professional recognition. I finally belonged, and feeling this belonging was very comforting. This road traveled surely speaks of my long-time interest in integration in psychotherapy. On the matter of integration, I feel it is important to point out that inflexibility and dogmatism can also exist under the umbrella of integration. I recently read an impressive motto: “Integration is the word” (Gelso, 2011). This speaks of a *zeitgeist* from which we expect

an open-minded and tolerant attitude, but which could disappear if not managed sensibly enough.

Supervision: Past and Present

The history of supervision can be divided into two great historical periods. The first is that of “classic” supervision, where traditional models of psychotherapy are predominant and which is a foundation on which the processes of supervision were built. Second, the more “modern” period during which we have seen the rise of so-called second-generation models (Bernard & Goodyear, 2014). The transition between the two periods was gradual and took place between the 1970s and the 1980s, overlapping with the drive for integration that started spreading in the discipline. The following discusses the differences between both periods, the main supervision components of the modern era and some of the strongest challenges we have yet to face.

In classic supervision there were no specific models of supervision or training programs for specialized supervision (beyond some fledgling efforts). The act of supervision was akin to a statement or spontaneous account on the part of the supervisee, something with some cathartic content, and often associated to quite critical events that had taken place with a patient. The presentation of the case was rarely supported with direct records. Finally, the structure of supervision sought to adapt the supervisee’s actions to the theoretical framework of the supervisor. The criteria to assess the supervisee’s behavior were objective and extrinsic to his/her experience, and learning was measured by the capacity of the supervisee to master a specific method for working with patients.

Modern supervision promoted the development of new models whose main goal was to create work programs which would not be mere extensions of the psychotherapy models. This relative autonomy of the new models allowed us to practice a type of supervision that is freer from institutional constraints. This new way of enacting supervision left behind (as a dominant model) the spontaneous presentation of doubts and difficulties by supervisees in an earlier era and started to incorporate a flexible case formulation that guided next steps. More work is needed on this type of supervision, for example, it could be useful to look into the differences that arise when supervisee and supervisor are part of an integrated team that formulates cases and/or shares an institutional framework vs. situations in which a supervisee attends a supervision session to discuss a previously formulated case without any agenda beyond seeking professional help from the supervisor. Some very elaborate conceptual elements (Eells, 2007) and detailed guidelines have been developed in the

former regard (see British Association of Counseling and Psychotherapy). As these modern supervision guidelines indicate, case formulation is not reduced to diagnosis, and it involves a link of the clinical condition to a consistent explanatory model. It is meant to build a patient narrative so that supervision is focused on experiential aspects.

In this newer approach, the supervision focus moved to supervisees and their needs and away from adjusting to a formal work model. This change was similar to the one previously undertaken in the training field when the focus on theory-centered programs was changed to trainee-centered programs. From this perspective, the quality of a supervision process is now based on inter-subjective truth principles, prioritizing the importance of the supervisee's experiential learning (Milne, 2009). A radical form of that conception proposes that supervision should be a process of modeling one's critical abilities (Shohet, 2011).

Modern supervision has advanced from three main working principles: (i) identification of its components; (ii) focus on training and competencies; and (iii) the construction of developmental models for supervisor and supervisee. As a whole, these propositions have been linked to an integrative conception of supervision. A first step for the production of a general map has been aimed at identifying the components that are involved in any act of supervision. Experts have worked at identifying the different roles and functions at play in that field. They found themselves in a very similar situation to that of researchers who work with personality and its dysfunctions. It is such a complex phenomenon that it requires drawing up lists and inventories of variables and properties that may allow doing a sort of anatomy of the supervisee, the supervisor, and their relationship itself. Several proposals (e.g., Bernard & Goodyear, 2014; Holloway, 1995; Watkins, 1995) have presented valuable catalogs with many points in common (beyond certain differences) which have been very useful for research.

Another significant advance has been the development of supervision programs based in competencies (e.g., Falender & Shafranske, 2004). This new approach centers on the supervisee as the focus of learning and goes beyond simply mastering abilities. A fundamental base for those programs is the production of supervisee development models, probably one of the most remarkable consequences of the new supervision model. They are aimed at using frameworks that may allow us to identify a supervisee's stage of evolution, so that supervisors may tailor their supervision for maximal benefit. So far, several models have emerged. Their differences are

not outstandingly striking, and they make us wonder if a common thread can be found to unify them. Nevertheless, as happens with psychotherapy, it might not be necessary to erase those differences for now. The time for unification will arrive when it arrives. Similarly, many descriptive models dealing with supervisors' stages of development have emerged in line with these formulations, allowing us to have a more complete mapping of appropriate times for certain types of supervision.

All these developments converge at a common point: the importance of research and of empirical and translational studies. We have recently gone into the field of evidence-based studies (Milne, 2009), which is an important step forward. However, given that evidentiary proof does not serve solely one purpose, we need to specify the level of research involved in each study. At the same time, a combined model of quality levels of empirical data collection and theoretical principles (David & Montgomery, 2011), originally created to assess the quality of psychotherapy, could be quite useful when applied to supervision programs.

Common Factors in Supervision

An inescapable conclusion when reviewing supervision development would be that, among all the aspects mentioned, alliance is as important in supervision as it is in psychotherapy. We know there is a very close link between the components of psychotherapy and those of supervision, so much so that alliance has been a topic of concern in supervision from the very beginning. The study of parallel processes and their occurrence with participants and processes still claim experts' attention. It would be interesting to develop a program of supervision to explore ruptures in the supervision alliance, as well as possible strategies to repair them.

Those who hold that a supervisory alliance is the basic component for supervision to work properly are correct. There is impactful literature which confirms this, especially in connection with (i) supervisors' personal characteristics and styles; (ii) supervisee variables; and (iii) ways in which the supervisory bond is developed, including communication. The matter of assessment in supervision (that surely has several valuable instruments) initially set the focus on studies concerning the assessment of supervisors by supervisees (Friedlander & Ward, 1984). We have subsequently refined these instruments and improved the quality of our studies, achieving satisfactory evidence about the importance of bonds in the construction of the supervisory alliance. To obtain more detail about the incidence of common factors that contribute to achieving a

good supervision alliance, it would be quite useful to look into what views supervisees have on the aspects and situations in which their supervisors have helped most, as well as the more negative aspects. It would be especially important to be able to build profiles (from the supervisees' point of view) of supervisors with their positive and negative features and also of the supervisory relationship. This would be useful for particular contexts, cultural environments, and unique work situations. For instance, the study of Geller, Farber, and Schaffer (2010) is an early example. The goal of the study was to investigate the ways in which therapists, during training, build mental representations of the relationships they have with their supervisees and use them for their own professional development. Although we emphatically recognize that the supervisory alliance also includes agreement on goals and tasks, these latter components are quite under-represented in the literature. We have left them alone in our research, in the same way that we have in psychotherapy to a certain extent. I think this is an especially important issue to look into because of its strong connection with assessment, one of the distinguishing features of supervision. In order to look into the goals (and especially the tasks) that were agreed on, it would be useful to compare two types of supervision groups: One which is systematic and formal and another which espouses a spontaneous and reproductive model. Then a comparison could be made of results and especially on some variable of the therapeutic process such as how strictly patients complied with treatment.

The most clearly addressed aspect in this field has been the importance and ways of communicating the evaluation the supervisor will use during the process of supervision. It is doubtless necessary to be as explicit and detailed as possible in this aspect, so that the supervisees will feel the necessary trust to express themselves with the utmost sincerity. In academic circles this is strongly connected to the anxiety felt about advancement in studies, while in professional circles this is connected to the anxiety felt about labor stability. We may assume that those supervisors that are perceived by supervisees as inflexible or intimidating might elicit from the supervisee a lack of self-disclosure and even dishonesty in conveying information. Many other aspects that have to do with agreement on the tasks and goals of supervision also await for further research. What criteria can be useful to define proper ways of agreeing upon the goals of supervision? How do we establish a proper system to agree on these tasks (for example, the records system and the processing of home assignments)? This issue includes many aspects that could be explored.

Evaluation is, indeed, one of the most widely accepted and recognized components of supervision. Moreover, it is one of the issues where a supervisor's intervention differs more radically from the intervention of a therapist. It is an essential component, for ultimately it allows deciding on the quality of the therapeutic processes. But it has also had undesirable consequences, which have not always been recognized. In that context, evaluation makes the relationship between supervisor and supervisee a power struggle, and the most important discussion becomes who holds the truth and who is empowered to decide on matters of institutional hierarchy. One of the most important components of a good supervisory relationship is, therefore, a respectful and responsible management of this power on the part of the supervisor. Unfortunately, this does not always happen, and deviations from this norm face few regulatory consequences. Some critical opinions have had ample repercussions in history. One of these was dramatically expressed by Lacan when denouncing the prevailing "subject-supposed-to-know" as an institutional oppression that forced him to leave the International Psychoanalytical Association. Indeed, the issue of power is a vast area which therapists, in general, do not give enough attention, despite its importance and its high level of cultural saturation. Lately, cultural diversity has been fully integrated into psychology as a relevant issue, and this has translated to the field of supervision. Within this space, issues of gender and race have become particularly important. However, I believe the issue of power is no less important and has several sides: The struggle for hierarchical achievement in professional and academic institutions is at first glance the most evident, but equally significant are issues such as the distribution of wealth, social inequalities, and other matters connected to the circulation of power.

These matters permeate the field of supervision, as is the case with the therapeutic relationship, and are made obvious in the eventual socioeconomic differences, and of opportunities among the participants. How does the socioeconomic inequality between supervisor and supervisee impact supervision? How does the supervised patients' socioeconomic situation influence the context of supervision? I also think that in many cases differences attributed to race actually conceal social differences and not addressing this issue in practice and research is mainly due to the fact that in developed countries (where there is greater production of knowledge) these inequalities are not nearly as serious as they are in other countries. The question of gender has a more universal nature, although I also believe that there may be a similar bias concerning this issue,

because the extent and type of violence against women might also greatly depend on the socio-economic conditions of the society in which they take place. The social condition is an issue that is constantly interwoven with our discipline, and it is also a subject that merits more research focus.

Conclusions

Throughout this article, we have planted some seeds that I believe can bear the fruit of knowledge production. As I approach the end of these reflections, I find myself wondering which could be the most interesting paths for our development in the near future. Where should we aim our research efforts? This is always a necessary question, for we all know the scarcity of resources we have to deal with when doing research in our discipline. What do we need to know? Which are the subjects most worthy of our efforts in the field?

Direction of Research

Until not many years ago, it was possible to completely (or almost completely) review all the literature published in the field of supervision (Bernard, 2010). This is not possible today because in the last 25 years, production has grown exponentially. This is in reference to theoretical works as well as articles with different scopes. Going over the specialized literature, it is possible to see the great amount and diversity of topics addressed, including a great variety of technical proposals and specific procedures.

Research in the field of supervision has increased significantly in recent years, and that has caused some important breakthroughs (Hill & Knox, 2013). To keep moving ahead, we need to establish networks that link practice and research, clinical cases and theory. Moreover, we need for studies to have as much transcultural representation as possible, relying on well-informed multicenter studies. A promising example is the start of the SPR Interest Section on Therapist Training and Development, and in particular the study which explores the observation of supervisors concerning the progress of supervisees.

Training of Supervisors

This is a subject of high priority. We have already mentioned that until recently supervisors did not receive any specialized training. There were no university or professional training programs, and those who started performing supervisory duties were renowned teachers or outstanding therapists who took on the task themselves.

It is evident that the same competencies are not needed for a psychotherapist as for a supervisor. Therefore, being an expert therapist does not guarantee being an expert supervisor. However, the opposite idea was prevalent in our profession for a long time. We know today that a long professional career can be a negative starting point to becoming a supervisor for several reasons. For instance, the supervisee might feel pressure to adapt to a model, or the supervisor may inadequately reproduce strategies that were useful in another context, without considering new clinical conditions. Therefore, we should focus on discussing and testing supervisors' training programs. We can be optimistic, for there are already programs like these at work in places such as Sweden and Australia. Along those lines, studies on the level of development of supervisors are of great help (see Hess, 1986; Stoltenberg, McNeill, & Delworth, 1998; Watkins, 1994).

Group Supervision

Group modality in supervision has been practiced with growing frequency. There are two instances in which this format is used: group supervision and peer supervision. There are many reasons to think that group work can be especially valuable in an instance where the focus is on training, because of the added value that vicarious learning provides. Nevertheless, it is necessary to know how group interaction works as a specific exchange model in order for these benefits to materialize. It is not enough to gather people in a space of supervision to make good use of group action and benefits.

New Technologies

In recent years, the field of supervision has seen the use of resources originating in new technologies, as happened previously with *psychotherapy*. Distance supervision, the use of the *Internet*, smartphones, and other resources (including virtual reality) give us the possibility of extending our practice modalities to meet growing demand. Kazdin and Blase's (2011) warning on the urgency of rebooting the field of *psychotherapy* is also applicable to supervision.

Impact of Supervision

Last, but not least, we have a fundamental need to know the positive impact that supervision can have on the outcome of patient's treatments. The data we have thus far are quite pessimistic, for there is no proof that supervision adds value to a treatment's performance (Watkins, 2011). Obviously, this does not mean this is the case, or that the benefits

supervisees can obtain do not translate into strengthening their therapeutic alliances with their patients. We supervise to monitor supervisees. We supervise to guarantee the quality of our services. We also need for the patients, who are the raw material that feeds the supervision process, to derive tangible benefits from our interventions, as they are our main goal. We have to prove that what we do benefits them.

In the end, I cannot stop thinking of the truth in the proverb “There is nothing new under the sun.” Everything I have just written is, to a certain degree, part of previous texts. In any case, the drive to communicate these ideas is not so much its novelty but the sharing of nuances, details, and unique issues.

Acknowledgment

I thank Andrés Consoli and Melissa Morgan Consoli for their help with the English version.

References

- Bernard, J. M. (2010). Special issue on clinical supervision: A reflection. *Canadian Journal of Counseling*, 44, 238–245.
- Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Boston, MA: Pearson.
- David, D., & Montgomery, G. H. (2011). The scientific status of psychotherapies: A new evaluative framework for evidence-based psychosocial interventions. *Clinical Psychology: Science and Practice*, 18(2), 89–99.
- Dierdorff, E. C., & Surface, E. A. (2008). Assessing training needs: Do work experience and capability matter? *Human Performance*, 21(1), 28–48. doi:10.1080/08959280701522072
- Dimidjian, S., & Hollon, S. D. (2010). How would we know if psychotherapy were harmful? *American Psychologist*, 65(1), 21–33. doi:10.1037/a0017299
- Eells, T. D. (2007). *Handbook of psychotherapy case formulation*. New York, NY: Guilford.
- Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.
- Friedlander, M. L., & Ward, L. G. (1984). Development and validation of the supervisor styles inventory. *Journal of Counseling Psychology*, 31, 541–557. doi:10.1037/0022-0167.31.4.541
- Geller, J. D., Farber, B. A., & Schaffer, C. E. (2010). Representation of the supervisory dialogue and development of psychotherapists. *Psychotherapy*, 47, 211–220.
- Gelso, C. J. (2011). Emerging and continuing trends in psychotherapy: Views from an editor's eye. *Psychotherapy*, 48, 182–187. doi:10.1037/a0023448
- Hanrahan, F., Field, A. P., Jones, F. W., & Davey, G. C. (2013). A meta-analysis of cognitive therapy for worry in generalized anxiety disorder. *Clinical Psychology Review*, 33(1), 120–132. doi:10.1016/j.cpr.2012.10.008
- Hess, A. K. (1986). Growth in supervision: Stages of supervisee and supervisor development. *The Clinical Supervisor*, 4(1–2), 51–58. doi:10.1300/J001v04n01_04
- Hill, C. E., & Knox, S. (2013). Training and supervision in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 775–812). New York, NY: Wiley.
- Hofmann, S. G., Asnaanian, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, 36, 427–440. doi:10.1007/s10608-012-9476-1
- Holloway, E. L. (1995). *Clinical supervision*. Thousand Oaks, CA: Sage.
- Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science*, 6(1), 21–37. doi:10.1177/1745691610393527
- Ladany, N. (2004). Psychotherapy supervision: What lies beneath. *Psychotherapy Research*, 14(1), 1–19. doi:10.1093/ptr/kph001
- Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 169–218). New York, NY: Wiley.
- Lampropoulos, G. K. (2011). Failure in psychotherapy: An introduction. *Journal of Clinical Psychology*, 67, 1093–1095. doi:10.1002/jclp.20858
- Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice*. Chichester: Wiley-Blackwell.
- Montalvo, B. (1973). Aspects of live supervision. *Family Process*, 12, 343–359. doi:10.1111/j.1545-5300.1973.00343.x
- Shohet, R. (2011). *Supervision as transformation*. London: Jessica Kingsley.
- Stoltenberg, C. D., McNeill, B. W., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco, CA: Jossey-Bass.
- Watkins, C. E. (1994). Considering psychotherapy supervisor development: A status report. *Psychotherapy Bulletin*, 29, 32–34.
- Watkins, C. E. (1995). Psychotherapy supervisor and supervisee: Developmental models and research nine years later. *Clinical Psychology Review*, 15, 647–680.
- Watkins, C. E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor*, 30, 235–256. doi:10.1080/07325223.2011.619417