A Working Alliance Based Model of Supervision

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Over the past six or seven years, I have been developing a theory of counseling and psychotherapy which attributes the power for change to two factors: the strength of the alliance between the person seeking change and the change agent, and the power of the tasks that are incorporated in the alliance. Although I have concentrated on the therapeutic situation, I believe the model is broadly applicable to many other change situations, including the student-teacher and even the child-parent relationship. In this article I will extend the application of this model to the supervision of counseling and psychotherapy.

This extension of my model is a very natural next step. As the various contributors to Hess' (1980) recent compilation on supervision have shown, there is an intimate connection between how one construes psychotherapy and how one construes supervision. Moreover, this intimate connection has certainly manifested itself in my own work, for my constructions of the role of the working alliance have evolved through my work as a therapist and as a supervisor.

I will begin this presentation by reviewing concepts about the therapeutic working alliance, the research base on which it currently rests, and how it is translated into the terms of the *supervisory* working alliance. Then, after establishing the conceptual vocabulary, I will discuss the various possible goals and conditions of this supervisory model with illustrations from both my own professional experience and from the published experience and research of others. Finally, I will offer some comments on the various implications of this model for evaluation.

The Therapeutic Working Alliance: A General Model

Working alliance has been a concept mainly associated with psychoanalytic writings. In my use, however, the psychoanalytic working alliance is only one kind. I have described it in a more general sense and have defined my terms in language applicable to all traditions of counseling and psychotherapy where change[1] has been sought (Bordin, 1979). In fact, I first introduced the terms of the working alliance as I reviewed and synthesized research on psychotherapy in general (Bordin, 1974). The working alliance is a collaboration for change for which I have identified three aspects: (1) mutual agreements and understandings regarding the goals sought in the change process; (2) the tasks of each of the partners; and (3) the bonds between the partners necessary to sustain the enterprise.

In the earliest stage in the development of these ideas, my aim was confined to providing a structure into which the various approaches to psychotherapy could be mapped. In this manner, I hoped to identify those places where research from diverse theoretical positions is mutually supportive, where it is contradictory, and where new or further research is needed. Then I took a leap and came to understand the working alliance as not merely a way of integrating the field of therapy, but as a description of the change process itself (Bordin, 1979). Following are brief explanations of the three aspects of the working alliance:

1. *Mutual agreements*: No change goals can be reached without some basic level of understanding and agreement between the principals involved. This applies to individual therapy, group therapy, and family therapy. The clarity and mutuality of that agreement will contribute materially to the strength of the working alliance. The kinds of change goals agreed upon, usually in terms of thought, feeling, and action or some combination, will contribute to the differentiation of the kinds of working alliances. How much change comes out of these working alliances will in most part be a function of the strength of each alliance.

2. *Tasks*: The strength of a therapeutic working alliance depends on more than the extent and clarity of agreement on goals. It rests also on a clear mutual understanding by the participants about the tasks that their shared goals impose on each. Embedded in various traditions of counseling and psychotherapy are a variety of tasks. These can be all-encompassing (e.g., the patient's task of free association in psychoanalysis), or they can be more specific (e.g., a double-chair exercise in Gestalt therapy or the compilation of a diary of pleasurable experiences in Beck's cognitive therapy). This same range of breadth can be found in the therapist's responsibilities that accompany the patient's tasks. Examples of these therapist responsibilities might include the maintenance of free-floating attention, the communication of understanding, or the selection of objects for double-chairing.

   These tasks are usually assigned by the therapist and are based on his or her therapeutic tradition and/or the incorporation of it with the therapist's personal predispositions into a therapeutic style. The strength of that working alliance will depend on how well the person seeking change understands the connection between the assigned tasks and the goal and on how well the demands of the task fit his or her ability to make a start on that task.

   If the therapist sets a task in which the client or patient is incapable of engaging, either currently or for an enduring time, then the therapist's capacities for adapting to the client with alternative or modified tasks will also have consequences for the strength of that working alliance. A current doctoral investigation at Michigan by Victor Cohen illustrates this point. He

has examined a therapy deadlocked by the therapist who had imposed on a patient a distanced, intellectualized, and analytic set as a stance toward her own feelings. The patient, however, could not fully accept it because this was exactly what he was trying to get away from. The investigator, who has access to tape recordings of the sessions plus interviews with the therapist following each session, reported his impression that the therapist, by virtue of her own personal style and problems (rather than through theoretical commitments) was unable to shift and thereby created or contributed materially to a therapeutic impasse.

3. *Bonds*: There are bonds associated with the carrying out of a common enterprise. For example, all of us have experienced how a rhythmic bond ("heave ho") has facilitated the moving of a very heavy object by a team of persons. However, there are also bonds which arise simply out of shared experience, whether of pleasure or pain. I started by thinking that different kinds of working alliances would require different kinds of bonds to achieve strength. But further observation and reflection have convinced me that all approaches will center around the feelings of liking, caring, and trusting that the participants share. The various combinations of goals and tasks will differ only in how much liking, caring, and trusting there needs to be to sustain that particular collaboration. The sheer time that the two persons spend together will surely influence the required level.

   Another equally important factor will be the public/private dimension of the relationship. To the degree that the sharing of private behavior and experience is a specified part of the therapeutic task, to that degree will these personal attachments contribute to the level of collaboration.

The Building and Repair of the Working Alliance

I have emphasized that the building of a strong therapeutic working alliance is a major feature of the change process and that the amount of change which results will, perhaps, be more a function of the strength than of the form of that collaboration. However, my ideas do not stop there, even though it would be neat to be able to say, "Technique and methods do not really matter; it is how strong a change alliance is developed that determines the outcome." In fact, this fits well the currently accepted conclusions about the data that have come from comparative evaluations (c.f., Luborsky,Chandler, Auerbach,Cohen, & Bachrach, 1971; Parloff, 1979). But this would be settling for an oversimplification. I believe that the amount of change is based on the building *and repair* of strong alliances (Bordin, Note 1).

The pains and dissatisfactions that bring a person to psychotherapy reside in the habits of thought, feeling, and action through which the individual defeats him or herself. In therapeutic treatment, the collaborative tasks I have discussed tap some aspect and/or level of the patient's self-defeating behavior. Through these tasks, the person's fundamental difficulty that is the object of change is brought into the collaboration. At this point, not only the building, but the repair of working alliances becomes significant.

To the degree that the therapeutic task or tasks succeed in tapping into these self-defeating habits of feeling, action, and thought, breaks in the working alliance that parallel self-defeat in everyday life will inevitably occur during the therapeutic collaboration. As these obstacles are overcome, the person is provided with new, more satisfying ways of thinking, feeling, and acting. Under the right circumstances, these changes will generalize beyond the working alliance to other areas of his or her life.

Thus, the building of a working alliance and its repair is not viewed as establishing a relationship in order to facilitate the person's acceptance of treatment. This building and repair process *is* the treatment. This perspective contrasts sharply with the older view of rapport as a relationship factor which is needed in order for the client or patient to be willing to accept treatment. Even the more sophisticated psychoanalytic notion of the working alliance has not quite penetrated to this level. On the other hand, the psychoanalytic emphasis on interpretation of transference resistance does come very close to this formulation. Similarly, behavioral contracting procedures in behavior therapy touch some of the same issues.

One of the values of this formulation is that it gives us a third alternative to seeing the therapeutic process as primarily a personal or a technical process. This position holds that it is both personal *and* technical. The technical part resides in the sureness of the therapist in selecting tasks that have the power to tap into that person's self-defeating patterns and facilitate the needed changes. Thus, the data base that can provide empirical support for the position must speak to the change power residing in strong working alliances and in evidence regarding the vicissitudes associated with particular tasks.

Much of the available data, while supportive, are not critical in the sense of ruling out other views. I have already cited the fact that evaluative research has failed to establish a clear superiority among the various therapeutic traditions. In earlier publications (Bordin, 1974, 1979), I have reviewed the research literature to show that the data available are compatible with the working alliance formulation, especially those aspects dealing with the strength of the alliance.[2] As might be expected from the relative recency of this formulation, direct tests of its credibility are more limited. The development of measures of strength of alliance takes time. Using a crude measure of strength of the working alliance introduced by Ryan (1973), Sarnat (1975) found better than chance relations between independently rated levels of collaboration and judgments of outcome, as well as to the occurence of premature termination. Using more sophisticated analyses of these same data, Lehrke (1978) developed observations of alliance building events as manifested in early interviews. She found that clients' expressions of attitude in therapy are predictive of both negative and positive outcomes. Negative client-in-therapy reactions to the demand to ally with the therapist's understanding were predictive of early attri-

tion; positive reactions were predictive of level of outcome (albeit with the limited criterion of therapist judgment of level of change). Concurrent investigations by the Strupp group at Vanderbilt, while failing to find a relationship between outcome and their measures of strength of alliance, did find that those aspects of the alliance caught in the interest and motivation of the patient do provide a basis for prognosis (e.g. Hartley, 1978). Lehrke did find, however, that equally as important as client attitude was the therapist's efforts to enlist the client's cooperation in treatment parameters and the nature of the therapist's response to the client's expression of concern regarding alliance related matters. A therapist's failure to respond to client concern except by listening was predictive of alliance failure and carried a negative weight in the prediction of outcome. Another set of observations weighing in on the supportive side is those by Luborsky (1976) in which he measured strength of the working alliance in terms of how the patient was experiencing the therapist. He distinguished a less mature or weaker alliance based on the patient being seen as experiencing the therapist as supportive from the later developing stronger alliance based on a sense of working together in a joint struggle against what is impeding the patient. He found evidence that improvers are highly likely to show at least the less mature kind of bonding in early interviews and some evidence of the more collaborative bond in later interviews.

I have recently argued (Bordin, Note 1) that there is a danger of a premature acceptance of the verdict, "no difference," regarding the technical aspects of therapy. The superficial level of prevailing evaluative efforts creates that danger. Only recently, have investigators turned their attention to the possibility that effectiveness will vary according to patient differences. But as yet there has been no systematic evaluation of our knowledge base regarding the various therapeutic tasks embedded in the variety of therapeutic traditions. Instead evaluation studies tend to concentrate on specific traditions which are likely to contain particular tasks in an unknown amalgam with other procedures which may turn out, at best, to be superstitious rituals or, even worse, detrimental to the changes sought. In this recent paper, I suggest that we need to develop a taxonomy of goals and tasks to provide a systematic program of assembling empirical tests of what various tasks require of the person engaging in them and the opportunities for change that reside in them. Further, I point out that considerable data are already available on the tasks of imaging (from both behaviorally and dynamically oriented research) and experiencing-focusing (from client centered research). I point to the large clinical literature on associating plus some beginnings of systematic research and the early beginnings of Gestalt oriented research on double-chairing.

The Supervisory Working Alliance

Just as the terms of the therapeutic working alliance permit us to transcend the varieties of therapeutic traditions and their associated goals, the supervisory working alliance allows us to incorporate the varieties of goals that have been posed for supervision. But before pursuing this further, we must transform the terms of the therapeutic alliance into those of the supervisory alliance.

Though Hess' (1980, p. 17) chart has great heuristic value, my list of supervisory goals is a little broader than his. Not all of them are change goals (see No. 8) and several of them represent finer distinctions within his groups. I prefer mine because for the most part they are stated from the point of view of the person being supervised, namely, what kinds of goals he or she would be seeking. My list follows:

1. *Mastery of specific skills.* An emphasis on this goal is likely to be an early response of the neophyte as the person seeks to reduce the confusion that complexity creates by concentrating on specifics. This form of the goal corresponds pretty well with those approaches to therapy which concentrate attention on specific procedures (e.g. empathy, assertiveness training).

2. *Enlarging one's understanding of clients.* If one goes beyond empathy as a procedure or as a primitive observational process, which happens as the therapist becomes more experienced, there arises an awareness of the need to deepen one's capacity to understand by broadening one's observational perspective both in time and in channels of communication.

3. *Enlarging one's awareness of process issues.* Here the emphasis is on tuning into the continuities in the process. This means being able to enlarge the units of process being observed so that instead of confining one's awareness to an immediate response, the therapist is alerted to that response as a continuity stretching back beyond the present hour to previous hours.

4. *Increasing awareness of self and impact on process.* A special sub-class of observations of the change process is those which sensitize the counselor or psychotherapist to his or her own feelings and what impact they may be having on the change process. The view that there is an important personal as well as technical element in psychotherapy highlights this goal.

5. *Overcoming personal and intellectual obstacles toward learning and mastery.* This class of goals arises most frequently when the therapist encounters persisting difficulties that appear to be sufficiently general to suggest that they are of his or her own making rather than functions of a particular client. This is the kind of goal that tempts supervisors to turn supervision into psychotherapy. In a sense supervision directed toward such goals is psychotherapy, but only those tasks and bonds appropriate to supervision are appropriate to the supervisory change process. There will be more discussion on this later.

6. *Deepening one's understanding of concepts and theory.* The opportunities for guided self and process observation that supervision provides are very conducive to deepening the student's understanding of the theory

and concepts acquired through didactic means and particularly their intimate connections to actions.

7. *Provide a stimulus to research.* Just as the clinical laboratory that supervision represents offers an opportunity for deepening understanding of the theoretical base, it also provides an excellent medium for identifying researchable questions, either of those beliefs not yet verified by systematic observations or observations that contradict belief and therefore cry for further investigation.

8. *Maintenance of standards of service.* While this one is not a change goal, it is one that supervisor and supervisee can share. Indeed, the supervisory alliance is in trouble if mutuality regarding this goal is weak or absent.

The tasks assigned in supervision have been drawn from both therapeutic and didactic orientations. My review of the various approaches to supervision leads to the following list of tasks and their connection with the goals listed above:

1. The therapist prepares an oral or written report of the hour or hours under review. When the goal is mastery of a specific skill, the complementary supervisory task is that of the coach, giving feedback as to where the therapist has departed from some ideal response or seeking to illustrate what the ideal response is. Sometimes, the supervisor offers response alternatives, not so much as representing ideal or preferable responses, but with the aim of expanding the therapist's repertoire. Since this particular therapist task in supervision is a fairly traditional one, it has been used in connection with each of the other goals of supervision. Depending on the goals being sought, the supervisor might be engaged in focusing attention on the therapist's feelings, understanding of the client's feelings, and how they relate to both immediate actions and the actions and experiences that brought this person to counseling.

2. Participation in objective observation of therapeutic hours, either through sound or videotaped recordings or through direct observation, e.g. one way vision screen. Without such direct observation, we might argue that the supervisor will be severely handicapped in his or her task of contributing to goals three to five. The therapist's report has the virtue of dramatically illustrating the selectivity in his or her self-observation and recall. It is important that the supervisor not be a prisoner of that selectivity. On the other side of the argument, it is true that many perceptive supervisors, especially as data accumulate, will be able to sense where gaps in the report are occurring and make inferences about what is being left out. Even when such supervisory acumen fills those gaps, the reliance on therapist reports has the disadvantage of diminishing the opportunities for self-discovery of the gaps and the personal and intellectual sources of such lacunae that access to recordings provides. Without that access, the mutuality of the working alliance may be undermined should the therapist begin to feel pushed against his will. To some extent this same concern will apply to direct observation by the supervisor. It becomes more difficult to help the therapist recognize his or her selectivity when there is the possibility that the difference in report is to an extent, as it must be, a function of the supervisor's selectivity.

3. Selection of problems and issues for presentation. This is a task that I and other supervisors, who may be in the minority, assign to the supervisee out of our emphasis on the working alliance. In place of a routine review of all hours intervening since the last supervisory meeting, the therapist is asked to take a more active stance in which special questions are identified and attention directed accordingly. To be of use, the supervisor must be able to judge how this question bears on the goals of supervision, be able to recall what the treatment goals in this care are, and be able to connect the process issues to them and previous process events. If the supervisor is working with more than one supervisee around multiple case loads, carrying out these tasks is no mean feat. I am not reluctant to do some reviewing to make sure that I am not blending several cases. These difficulties diminish as the duration of the treatment lengthens.

The bonds required in the supervisory alliance typically fall somewhere between those of teacher to class members and therapist to patient. This would apply even to group supervision. The individualized performance character of the process turns us toward the bonds between a player and coach. Clearly, it is important for the learner to respect the coach, to watch how the coach does it during a demonstration. Too strong a narcissistic delight in his or her own skill can create a discouraging demand for perfection. Admiration taken to unrealistic levels becomes an obstacle.[3]

An important bonding problem is created by the inescapable evaluative element in supervision. Whether or not actual grades are involved, supervisors are part of a professional gatekeeping apparatus designed to protect the public and the profession. Even if that were not so, so much is at stake for the neophyte in terms of realizing highly valued aspirations, that any feedback, even for one's personal use, is approached with trepidation. All of this makes the trust necessary for confronting one's innermost experiences and its impact on therapy a not easily attained state.

The Supervisory Process

As should be evident from the foregoing discussions, my view of the supervisory process emphasizes its one-to-one character. In fact a great deal of supervision is carried on with a supervisor working with a single supervisee, most frequently a student in training through a practicum or internship arrangement and usually preceded by didactic and experientially oriented courses designed to introduce the students to concepts and skills. In observing the operation of service-training agencies it has always been a wonder to me at the abruptness with

which the clinician is transformed into the independent worker. One day he or she is being carefully supervised; the next day, that same clinician, diploma in hand, is a completely independent worker. There is such a big gap between this sequence of events and the realities of learning curves. Even insight dominated approaches to learning are likely to acknowledge the phenomena of working through in which further rediscovery of the insight and the fleshing out of its context and ramifications are contemplated. Thus, supervision in the form of systematic colleagual consultation needs to be arranged for within the work setting, with frequency and timing adapted to stage of professional development.

Even more than is the case with therapeutic process, we are heavily dependent on supervisor's accounts and comments on supervisory events with their highly selective character.[4] Much more rapidly than in the case of therapy, research has leaped into the analogue mode. This leaves me with disquieting feelings about the generalizability of our data base. It prompts me to call for studies aimed at verifying the bridges between the analogues and supervisory process much as some of us have done regarding therapy research (Bordin, 1965, Gelso, 1979).

Establishing the Contract

One of my earliest concerns in my meetings with a person that I am to supervise is the defusing of what Rioch (1980) has described as the up-down factor. She is referring to the inescapable tension associated with the status difference between supervisor and supervisee and the cultural and psychic pressures around that difference. As should be evident from the foregoing discussions, I rely on the process of building a strong working alliance to counteract this potentially interfering tension. In these early meetings, I seek a relaxed discussion of the supervisee's previous didactic and field experiences and discuss my own experience and theoretical commitments. From here it is a natural transition to where the supervisee finds him/herself. If he/she has had previous supervision, are there issues left over from that work to which attention should be given? Of the kind of work that we are going to review, with which does he/she expect difficulties? To what parts of his/her interviews does he/she want us to give particular attention? The product of this kind of review is a written list summarizing the mutually agreed upon goals. It might include: "My ways of interpreting a Strong and Edwards," "my use of interpretations," "my dealing with anger in women clients." The list might include expressions of research interest in various phenomena or of the wish to observe and understand. I can recall no instance in which that list included the supervisee's goal of learning my perception of his or her general skill level, but I have learned to be sensitive to this unstated goal. At first, I thought that this goal would be satisfied by the feedback I was giving in connection with the more specifically stated ones. But I soon learned that such feedback was not enough. Despite our reviews of what the therapist was doing or not doing and of its appropriateness and effectiveness, the supervisee seemed uncertain how I evaluated him or her. Only as I offered the remark that I saw him or her as typical of (or even above or below) those of his or her level of training and experience was that need satisfied.

Having established a goal orientation which features how the counselor or therapist is seeking to correct and enhance his functioning, we turn to the means by which we will seek to achieve this goal. It almost goes without saying that we will want to look at the supervisee's interviews with particular attention to those aspects he or she has selected for attention; my supervisees regularly start a supervisory meeting by saying some variant of "I want to talk about my meeting with Ms. x or Mr. y because I think it illustrates my difficulties with interpretations." Although I do not insist that there be a specific problem formulated in advance of presenting any case, I do exert a gentle pressure in that direction. In the absence of a statement, I may ask whether the interview being presented contains any specific difficulty for the presenter. This cast to the supervisory sessions gives them a tilted character, over-balancing attention to what the supervisee believes or actually has not mastered. This tilted state undoubtedly accounts for the manifested need for a summary evaluative feedback. Soon the supervisee begins to fear that in all of our attention to his mistakes in the process of achieving mastery, I will have overlooked how much he has mastered, giving rise to the need for reassurance. Thus, I have learned to explicitly voice acknowledgment of the skillful parts of an interview in addition to attending to the problematic parts being brought to my attention. Incidentally, I have found this kind of concern also when supervising doctoral level clinicians, whether supervising their therapeutic work or *their* supervisory work.

Although I feel that the greatest professional growth is likely to occur around review of sound or video-taped recordings of one's interviews,[5] I do not insist that the supervisee record immediately. We do have a discussion of this medium for our work in which I learn whether he/she has had any previous experience with it. Those who have had no experience vary greatly in how they feel. The large majority look forward to the experience and are grateful that I am willing to spend the time to review them. I do not give a blank check in this regard, promising to review only as much as time permits. I stress the usefulness to the supervisee of his or her own review prior to supervision. This review will enable the supervisee to leave the recording with me with the suggestion that I give attention to a particular segment of the interview or will permit us during the supervisory meeting to concentrate attention on that segment, summarizing the events leading up to it. I do insist that very early in our supervisory work there be an opportunity for me to review an actual recording so that I can get some sense of the style that lies behind the therapist's report of the events of the interview. This insistence is offered to the supervisee who has not yet experienced recording and evinces reluctance or ambivalence about it. I am giving this supervisee a choice as to which recording he or she will bring to me. My strongly prevailing experience is that, whether initially embracing it or approaching hesitantly, supervisees find recording so facilitating to their learning that they eventually embrace

it wholeheartedly, learning from their own review and eager to have me review as many of their recordings as my time permits. This eagerness is most manifest in early stages of our supervisory work. As supervision proceeds, these experiences provide the backdrop for an increasing emphasis on the supervisee's account with selective return to recordings when particularly puzzling difficulties are being encountered, the suggestion for review of recording coming from either one of us.

Supervision and Psychotherapy

I have already suggested that one class of supervision goals concentrates on personal obstacles toward mastery. These obstacles become evident because they transcend particular situations with one client or reappear with many clients. Concentration on them brings supervision into a close contiguous relationship to therapy.

It becomes evident that the personal conflicts that the counselor or psychotherapist experiences in, for example, responding to anger directed toward him or her is interfering with his or her understanding and ability to respond in a manner that will facilitate the change process. The tasks of supervision permit and require examination of these feelings, and their conflictual nature as they are experienced in this relationship.[6] The therapist may spontaneously remark on and even explore the personal significance that anger expressed toward him or her has. My response is to keep the focus on his or her mastery of therapy by bringing the supervisee back to how these feelings and explorations must be either incorporated or overcome in order to achieve an effective response to his or her task as a therapist. This represents an implicit communication that our task is supervision rather than therapy. If dealing with anger was already an explicitly stated goal, then there will have been at that time an explicit discussion of how our supervision might overlap with therapy and the ways that it will not be therapy. Sometimes the therapist is already in personal therapy elsewhere, which will be an occasion for discussion of the boundaries between the two. The specific occasion illustrated might lead to discussion of whether this issue has or has not yet come up in his personal therapy. If a supervisee seeks to dismiss an issue because he is taking it up in his own therapy, I am not likely to respond by simple acquiescence but to insist that we pay attention to that part that belongs in supervision: exactly how he is feeling at the time, its connection to his response to the client, what it does to and for the client, and what kind of response the client needs at that point.

Evaluation

I had the choice whether to treat this final section as a main heading in this essay or as a subheading under the supervisory process. It really belongs in both positions. First, let me speak to it as part of the supervisory process. In this context, what is to be evaluated is set by the specific goals identified in the supervisory contract. From the point of view of the supervisee, in addition to knowing my summary evaluation of him or her, he or she is interested in the observations we accumulate regarding his or her progress in mastering the specific aspects of his or her work on which we have concentrated attention. To facilitate this at a midpoint in our period of supervision, which is usually at the end of one term and the start of another, we go back to the originally stated set of goals, to see to what extent we have fulfilled our contract to work on them, to what extent they still loom as important, and to identify what new goals have become apparent. Similarly, at the end of our period of work, whether or not some written evaluation is required by some agent outside our partnership, we review the statements of goals, our sense of accomplishment, our identifications of how we worked together, our satisfactions, dissatisfactions and identifications of any obstacles in our alliance that we could not overcome. All this occurs at the midpoint and the end. Thus evaluation is both an ongoing and summary process in this model of the supervisory alliance.

In this face to face evaluative situation and with a well established working alliance, each of us usually feels free to give both adverse as well as favorable feedback. Thus, it becomes an evaluation of the supervisor as well as of the supervisee. The fact that it is an evaluation of our partnership allows each of us more readily to speak of difficulties and failures. For the most part, there are no surprises because the pattern I have described leads to the identification of goals, achievements and difficulties as an ongoing process. In fact, I set it up for a process of matching perceptions by suggesting that each of us prepare a summary in advance of the evaluative session.

These are, of course, subjective evaluations, vulnerable to all kinds of personal distorting influences. Yet a more formal final evaluation presents some difficulties. For example, an evaluation of the research stimulating portion of the goals of supervision would require follow-up at some time following the supervision to obtain the evidence. Although research such as that by Ivey and his associates (e.g., Forsyth & Ivey, 1980) goes a long way in that direction, there are still no well established and appropriately normed achievement measures of therapeutic skills that could be applied to individuals. If the agency has a well established operating system for regular evaluation of its services, these data could provide a basis for each supervisee to judge progress over the supervisory period. When a sample of supervisees is available, the supervisor may obtain an index of the effects of his or her supervision.

The evaluation of alternative models of supervision brings us back to many of the same concerns that mark research on counseling and psychotherapy. I have already remarked on the problems of generalizing from analogues to practice. In evaluating models of supervision, it will be important to obtain criterion measures relevant to each of the goals of supervision. It would be a mistake to reduce them to the eventual criterion of the outcome of the supervisee's counseling or to measures of mastery of skill. One model may be more effective in contributing toward certain goals and less effective in others.

However, such global evaluations are not enough. Research should be directed toward taking the model apart so that its specific components can be evaluated.

For my model, indices of the strength of the supervisory alliance, unfortunately, not yet developed, will be an important object for inquiry. How much can strength of alliance be shown to be related to outcome in terms of each of the goals? Equally important is an evaluation of the impact of each of the kinds of tasks that supervisors impose on their supervisees. Although I agree with Lambert's (1980) assessment about the paucity of studies of the process of supervision, we are not completely devoid of data. We have the results of a thorough program of research under Kagan's leadership (1980) that speak to the usefulness of having a supervisee review videotapes of his or her own interviews. I have seen no data which will tell us how much is sacrificed by having to rely on sound as compared to video-taped recordings. Informal observation tells me that vivid recall occurs very readily in response to just rehearing the interview. I think we are ready for a big leap in the number and sophistication of studies of supervision.

Reference Note

1. Bordin, E. S. Of human bonds that bind or free. Presidential Address, 1980 Annual Meeting of Society for Psychotherapy Research, Asilamar, California.

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Footnotes

1. This refers to change in the person as distinguished from change in the situation. Implicit in this distinction is the assumption that an individual's way of

thinking, feeling, and acting are products of interactions between situational press and what the individual brings to situations.

2. The most telling finding comes from the long term Menninger project where Horwitz (1974) found no difference in outcome between patients treated by psychoanalysis and those treated by more supportive analytically oriented methods. He concluded that this finding, contrary to expectation, was accounted for by the major contribution of the working alliance. He adds that the therapeutic alliance is not only a prerequisite for therapeutic work, but often may be the main vehicle for change.
3. Studies such as that by Hester, Weitz, Anchor, and Roback (1976) which demonstrated the impact of perceived skillfulness on supervisee's feelings of attraction to supervisors (the relationship was positive) only scratch the surface of this question.
4. For extremely rich supervisory accounts see Kell and Mueller (1966) and Mueller and Kell (1972).
5. Research by Muslin, et al. (1967) demonstrated how inadequately aspects of interviews of interest to supervisors are reported by inexperienced supervisees.
6. Ekstein and Wallerstein (1958) have heavily emphasized the parallelism between the problems experienced by the therapist in his or her therapeutic work and those he or she creates in the supervisory relationship. Doehrman (1976) has offered confirmatory evidence. This idea, of course, fits in to conceiving of the repair of supervisory alliances as a part of the change process.