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The Clinical Supervisor-Practitioner Working Alliance

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The Clinical Supervisor-Practitioner Working Alliance:
A Parallel Process

Lawrence Shulman

SUMMARY. The focus of my presentation this morning is the core dynamics and skills of the supervisor-practitioner working alliance, or what I will refer to as the working relationship. I will present a model that suggests that the use of certain communication, relationship and problem-solving skills by the supervisor can influence the development of a positive working relationship with the supervisee, and that this working relationship is the medium through which the supervisor influences the practitioner. I stress the words “influence” because a central assumption of this approach is that both supervision and direct practice are interactional in nature. The supervisor and the supervisee each play a part in the process. The outcome of supervision is the result of how well each contributes to the process. This morning’s presentation focuses on the supervisor’s role. One of the discussions is the concept of the “parallel process.” While the role of the supervisor and the purpose of supervision are quite different from counseling and therapy, nevertheless there...
There are striking parallels in the dynamics and skills. There is a suggestion that “more is caught than taught” and that our supervisees watch us very closely. Whether we like it or not, whether we are aware of it or not, our supervisees learn more about practice from the way we work with them than from what we say about their actual practice. Supervision is not therapy. In fact, supervisors who are seduced into a therapeutic relationship with their supervisees actually model poor practice since they lose sight of the true purpose of clinical supervision and their role in the process.

**KEYWORDS.** Clinical supervision, parallel process, supervising, supervisors role, supervision outcome

**INTRODUCTION**

The focus of my presentation this morning is the core dynamics and skills of the supervisor-practitioner working alliance, or what I will refer to as the working relationship. I will present a model that suggests that the use of certain communication, relationship and problem-solving skills by the supervisor can influence the development of a positive working relationship with the supervisee, and that this working relationship is the medium through which the supervisor influences the practitioner. I stress the words “influence” because a central assumption of this approach is that both supervision and direct practice are interactional in nature. The supervisor and the supervisee each play a part in the process. The outcome of supervision is the result of how well each contributes to the process. This morning’s presentation focuses on the supervisor’s role.

Another theme of the presentation is the concept of the “parallel process.” While the role of the supervisor and the purpose of supervision are quite different from counseling and therapy, nevertheless there are striking parallels in the dynamics and skills. I will be suggesting that “more is caught than taught” and that our supervisees watch us very closely. Whether we like it or not, whether we are aware of it or not, our supervisees learn more about practice from the way we work with them than from what we say about their actual practice. I want to emphasize that supervision is not therapy. In fact, supervisors who are seduced into
a therapeutic relationship with their supervisees actually model poor practice since they lose sight of the true purpose of clinical supervision and their role in the process.

**UNDERLYING ASSUMPTIONS**

There are a number of assumptions underlying this morning’s presentation. First, I believe there is a core to the supervision process that is central to all helping relationships. This core consists of the dynamics and skills that make up the “constant” elements of any form of helping. The working relationship, often referred to as the therapeutic alliance in practice, is the medium through which help is offered. The development of this relationship begins in the first session and continues to evolve throughout the counseling or supervision process. My definition of the term “working relationship” has emerged from my research on practice and supervision. The variables I have used to define the working relationship between practitioner and client, supervisor and practitioner, and doctor and patient include **rapport**, **trust**, and **caring**. For example, in one of my child welfare studies (Shulman, 1978, 1991, 1993) parents were asked to respond to my questionnaires or in an interview, and rate the following statements:

- “I get along with my counselor” (**rapport**).
- “I can say anything on my mind.” “I can risk my failures as well as my successes” (**trust**).
- “My counselor cares as much about me as she/he cares about my children.” “My counselor is trying to help me, not just investigate me” (**caring**).

In a simultaneous and parallel study (Shulman, 1991) discussed in more detail later in this presentation, the same elements were examined in practitioner/supervisor relationships. For example, one of the **caring** questions was adapted as follows: “My supervisor cares as much about me as she or he cares about my clients.” One **trust** question was phrased: “I can tell my supervisor anything on my mind.”

Second, there are “variant” elements of the helping process introduced by many factors. For example, in our direct practice, variables such as age, the nature of the problem, whether the client is voluntary, mandatory or semi-voluntary, and the modality of practice—individual, family or group—all may affect interactions between the person offering
help and the person seeking it. In a like manner, there are variant elements that affect supervision such as the degree of authority of the supervisor and the age and experience of the supervisee.

Third, important variations are introduced by the discipline of the supervisor and the practitioner, and the setting in which the practice takes place. The work of a school psychologist in an elementary school, a nurse practitioner in a hospital, a psychotherapist in private practice or a social worker in a family counseling clinic may all appear to differ in certain ways. Their supervision may be varied as well; however, the core dynamics and skills are the same.

Finally, as I stated in the introduction, a parallel process is inherent in the supervisory relationship, meaning the way in which the clinical supervisor interacts with the supervisee models what the supervisor believes is at the core of any helping relationship. In addition, the parallel process may work at several levels as the supervisee may “act out” during the supervision process the problem he or she is experiencing in practice. A defensive supervisee, at times, may be indirectly (and unconsciously) saying to the supervisor: “Show me how to deal with a defensive client by dealing effectively with me.”

During the balance of this presentation, I would like to do the following: explore the four central assumptions I’ve outlined above, both in direct practice and in clinical supervision; describe and illustrate the core dynamics and skills in the beginning or engagement phase of direct practice; discuss how these dynamics and skills also relate to the beginning phase in clinical supervision, highlighting the similarities in both processes and share some of my research findings in this area. I’d like to conclude with an illustration of the model with examples from clinical supervision.

**THE PHASES OF WORK**

The helping process in either practice or supervision is complex. Building on the work of a friend and mentor, William Schwartz (Schwartz, 1961), I have found it helpful to consider these processes against the backdrop of time. Every counseling or supervisory relationship can be understood as having a preliminary, beginning, middle and ending/transition phase. Each phase, both in practice and supervision, has unique dynamics and requires some unique skills on the part of the practitioner or supervisor. For example, in the beginning or “contracting” phase, both client and supervisee must make a “first decision” as to whether or
not to engage meaningfully with the helping professional. The purpose of the work and the role of the helper must be explicitly defined and the supervisee/client must see a connection to the work. Issues of authority must also be addressed, for example, evaluation in the supervisory relationship or the mandated nature of a client’s participation.

The middle, or work phase, is when the work is actually accomplished. In this phase the supervisor and the practitioner must be alert to the “illusion of work,” referring to the ability of both client and supervisee to appear actively involved when in fact they are dealing with surface issues or “near problems.” The skill of making a “demand for work,” a facilitative confrontation challenging the illusion can lead the client or supervisee to make the “second decision,” that being to deal with the more difficult and often emotionally powerful issues.

Finally, the ending and transition phase anticipates the work coming to a close and the client or staff member leaving counseling or the agency, or a supervisor leaving his or her position. This phase is often marked by what is commonly referred to as “door knob therapy,” when the client or staff member raises the most important issues as the work is coming to an end. This can be considered making the “third decision.”

The model I have discussed will be used here to describe the life of the work in practice and clinical supervision over time, as well as a means to better understand each individual session or conference. For example, there is a preparatory, beginning, middle and ending/transition phase for each supervisory session. Let me illustrate this framework and explore the four assumptions listed earlier by considering the preliminary and beginning phases first in practice and then in supervision. I believe this will help to illustrate the parallel process most clearly.

**THE PRELIMINARY AND BEGINNING PHASES IN PRACTICE**

In the preliminary phase, the practitioner prepares for a first session by using a skill called “tuning in” (Shulman, 1994, 2005, 2006). Practitioners put themselves into the shoes of their new clients and develop a preliminary empathy about what their client may be thinking and feeling about the engagement. It is equally important for practitioners to tune in to their own thoughts and feelings in preparing for the encounter. This preliminary empathy can help the practitioner connect to what the client may be feeling and thinking but expressing only through indirect
communications. Thus, the practitioner can be a better receiver of these communications and develop strategies for “responding directly to indirect communications.”

For example, a question on the mind of the new client or patient is: “Who is this counselor and what kind of person will he or she be?” This concern can be viewed as part of a general “authority theme.” While the question is important, issues of authority are usually considered taboo, and like other taboo subjects clients will tend to raise them in an indirect manner.

We professionals are not immune from this concern about directness with persons in position of authority. I assume, for example, that all of you have experienced at one time or another, a boring presentation or workshop. Now tell me, have any of you came back from a break, raised your hand and told the presenter: “This is really boring”? I’m not surprised that none of you are raising your hands right now. When I do have workshop participants raising their hands in response to that question they usually went to Berkeley University in the ’70s. You have communicated that you were bored to the speaker, but you did it indirectly. What were some of the ways you let the presenter know you were bored?

- Coming late, leaving early or not showing up—what I call voting with your feet.
- Falling asleep or your eyes glazing over.
- Reading a newspaper, staring out the window or looking at your watch.
- Encouraging what I call the “deviant member.” This is the person who confronts the instructor, asks the challenging questions or even changes the discussion to an irrelevant but more interesting area of conversation. I say you encourage him or her because during the break a number of you say: “Keep it up. I will hold your coat.” This person is speaking for you.

Why are we so indirect? Politeness is one reason, but also we have all learned to be cautious when dealing with people in authority especially in new encounters. Even when a teacher or supervisor invites honest feedback we witnessed them, at times, responding defensively or responding to even a gentle negative comment by cutting the participant down.

To your clients and to your supervisees you are the symbol of authority. In the beginning phase, they will be cautious. This may continue un-
til they feel safe and sense a solid working relationship has been estab-
lished. If the authority theme is not addressed early in the relationship,
authority issues can remain below the surface, growing in power, and
ultimately may haunt the engagement, blocking effective work.

Let me share a common illustration from direct practice. You are su-
 supervising a student intern or a new counselor who has just graduated
from school. The intern is young and unmarried with no children. In a
first interview with a family the mother asks the young practitioner the
dreaded question: “Are you married?” or “And how many children do
you have?” There are other versions of this question, often asked indi-
rectly, such as: “Have you walked the walk and talked the talk?” The
client is asking if the practitioner has been addicted and participated in a
recovery group. Other variations include: “You’re white; I’m Afri-
can-American–how could you understand me and my family?” Or simi-
larly, “You’re straight; I’m gay.” The authority theme issues in the
practitioner-client relationship will often emerge indirectly since the
issues deal with taboo areas. For my purposes this morning, I’d like to
use the parenting question to illustrate the importance of the skill of
“tuning in.”

It is not uncommon for the new practitioner or student to feel defen-
sive in response to such questions. Unless the supervisee has been
helped by the supervisor to tune in to the underlying question, the re-
sponse will often come from the feeling of being challenged as incom-
potent. The result may be defensive responses, including:

• “I may not have children but I have taken a number of courses on
  child behavior theory.”
• “A doctor does not have to have an illness in order to be able to
cure it.”
• “We are here to talk about you, not me!” (The classic response of-
ten taught in skill training programs.)
• “I came from a big family.”
• “Why do you ask?” (Responding to a question with another ques-
tion.)

If we tune in to the underlying meaning of that question we can infer
that what the client is asking may be one or a combination of the follow-
ing:

• “How can you understand what it is like for me?”
• “How can you help me?”
“Can I trust you or will you be like other professionals I have dealt with who have criticized me?”

It is easy in retrospect to see how defensive responses to reasonable questions may negatively impact the development of the working relationship rather than enhance it.

If we understand the mother’s question about the practitioner’s parenting status, what would be an example of a direct and non-defensive response? I have termed this skill “responding directly to an indirect cue.” I’d like to share one version of a response. Before doing so, I want to set out three criteria I believe should be met when responding directly to any authority theme question or actually, to any client comment.

First, the response must convey a sense of genuineness—that is the practitioner must feel or come close to feeling what it’s like for the client. All too often students are trained to use mechanical responses, such as reflection, without connecting to the emotions the client is experiencing. For example the client may say: “I am angry at the staff at my child’s school!” and the practitioner would echo: “You are angry at the staff at your child’s school.” This hollow, mechanical response might rightly cause a client to think: “Dummy, I just told you I was angry!”

Another version is the common “I hear you saying . . .” repeating the client’s comment but without real feeling. In one video taped interview, one of 120 hours of individual and group direct practice examined in another of my studies (Shulman, 1981), after a practitioner responded: “What I hear you saying is . . .,” the client said, with strong emphasis: “You heard me say that?” The counselor’s comment wasn’t even close to what the client was feeling because the counselor was using the words without feeling the emotions. In my research studies I have found that clients were most often aware of whether their counselors were really connecting to them. This was also true for supervisees and their supervisors.

The second condition is that the client must be able to hear the genuine empathy expressed by the counselor. For some of our clients who are not ready to engage, to face their problems, or perhaps are addicted and in the “pre-contemplation stage,” or are angry if they have been mandated into counseling, they simply are not able to hear empathy at that moment. Genuine empathy can have an impact only if it is heard and accepted by the client.

Finally, I believe it is important that the practitioner find her or his own voice and express personal artistry guided by evidenced-based sci-
ence. It is what I have referred to as the integration of our personal and professional selves. One of the tasks in the supervisory process is to help supervisees find their own voice and to feel safe in expressing their artistry in a professional manner.

If these conditions are met (the practitioner is genuine, the client is able to hear and appreciate the empathy, and the words used reflect the artistry of the practitioner), consider the potential impact if the counselor’s response to the parenting question were the following:

I’m not married and I don’t have any children. Why do you ask? Are you concerned that I may not understand what it’s like for you? I’m concerned about that as well. For me to help I’m going to have to understand, and in order for me to understand, you are going to have to tell me.

Would this response or one like it, have a more positive impact on the development of the working relationship (rapport, trust, and caring) than would a version of “We are here to talk about you, not me?” My research has indicated that the core skills contained in the response I offered above, when used in early sessions, tended to enhance the working relationship which again is the medium for providing help.

Let’s break down the four elements of the response and identify the skills, all of which I will argue in the second part of this paper, are the same skills used by the supervisors in implementing their functional role.

First, “I’m not married and I don’t have any children.” The practitioner is being honest. Honesty does not mean we must answer every question. I have worked with teenagers who have asked questions I would not answer. I still could be honest by saying: “I don’t feel comfortable answering that question.” My central point is that I believe we have tried everything else in the helping professions; why not give honesty a chance?

Second, “Why do you ask? Are you concerned that I may not understand what it’s like for you?” This is an example of articulating the client’s feelings one “half-step” ahead of the client. Reflection, a simple repetition of what the client has just said, keeps the practitioner behind the client. I don’t believe the question, “Why do you ask?” offers enough help for the client. If the client could honestly answer that question the subject would not be taboo. This intervention is a complex one in that it also displays the practitioner’s interest and concern in what the
client thinks and feels; it validates the concern; and it encourages discussion in a taboo area.

I’m aware that some models of practice would argue for “open ended questions,” not “leading the client,” etc. The fear is that we may be wrong and end up putting words into the client’s mouth. My practice and my research have taught me that we make more mistakes of omission, failing to say something, than mistakes of commission, saying the wrong thing. What if the client denied it was a problem, perhaps saying: “You seem like a nice person. I’m sure you would understand”? While encouraging direct responses to indirect cues, I think it is important to respect the client’s defenses, especially in early encounters. Therefore, I would not insist on my interpretation that this was an issue; however, I would give the client a “second chance” if they demurred. For example, I could say: “It wouldn’t surprise me if you have met other professionals who have not understood.” By giving the client a second chance I also make clear that I’m really ready to discuss the authority theme. If the client refuses my second offer I could say: “OK, but it is important to me to understand how you are feeling. If you ever feel I’m not I would like you to let me know.”

Third, “Because I was concerned about that as well.” This is an example of the skill of sharing the practitioner’s feelings, something I was taught never to do. My professional training required that I separate my personal and professional selves. My practice and research have taught me that I actually have to integrate my personal and professional selves, rather than separating myself from the process. In my view, this is a life-long professional learning task. Of course, as with answering clients’ questions, sharing every feeling obviously is not appropriate. Even if the practitioner felt like responding to the parenting question by saying: “You’re absolutely right! What is my supervisor doing sending me out to work with you and your family. I’ve never even changed a diaper or heated a bottle,” I don’t believe the client wants to hear this. These are concerns and feelings that should be shared with the practitioner’s supervisor. In a questionnaire response to a question in my practice research one client said the following about her practitioner: “I really like her! She’s not like a social worker she is more like a real person.” I think all helping professions need to be concerned if the perception that we are not real persons is widely held by our clients.

I realize the use of this skill raises all kinds of questions about counter-transference, the expressing of inappropriate affect, etc. This is the reason I argue that the personal needs to be integrated with the professional. This is not an argument for simply acting out. In my research
studies in the areas of practice mentioned earlier, the skill of sharing feelings—being a real person—had the strongest positive impact in developing the working relationship of all of the skills studied. In fact, where there were differences between practitioner and client, for example differences of race, gender, ethnicity, class, sexual orientation, etc., the practitioner’s honesty was even more important. It is ironic that this is the very skill I was cautioned against using during my professional training.

I believe we borrowed this artificial dichotomy between personal and professional from the medical profession. However, my observation and research has indicated that making this separation does not work for doctors either. In my study of medical practice (Shulman and Buchan, 1982), patients were well aware of their doctor’s attitudes toward them (positive, neutral, or negative), and the doctor’s attitude was a strong predictor of patient comprehension, rapport, willingness to refer friends and family members, and even compliance as measured in self-reports one week after seeing the doctor.

Finally, “If I’m going to help you I have to really understand and for me to do that you are going to have to tell me.” This is a complex comment with a number of elements. It credits the client’s life experience since the client is the expert on their own life. It starts the contracting process with the client, including an explanation that the helping process is not something the practitioner will do to the client, but rather is something they will do together. The practitioner’s role is not to be the expert on life, even though there is some knowledge that can be shared, but rather to listen to and to understand what the world looks like to the client. I liked what one respondent in one of my early studies wrote in the comment section of her questionnaire: “My worker is very young but I think I can educate her!”

Let me summarize these practice skills that emerged in the example above, and then make the transition to supervision in the next section. I will argue that the same dynamics, processes and skills can be seen in the supervisory working relationship, keeping in mind that the functional role of the supervisor is different from that of the therapist, and that the purpose of supervision is not therapy. The skills contained in the example response were:

- Honesty with appropriate self-disclosure.
- Articulating the client’s feelings a half step ahead of the client.
- Demonstrating interest and concern in the client’s feelings.
- Validating the client’s concerns and feelings.
Sharing the counselor’s own feelings (integrating personal and professional).
Validating the client’s life experiences.
Contracting to work with the client not on the client.

Of course the question of the practitioner’s parenting experience is not always raised so politely. One of my students described his first meeting in a hospital with a group of mothers, all of whom had a child with a serious chronic illness. Taking over from a departing social worker, my student tuned into a number of potential themes and rehearsed with his supervisor direct responses to certain issues should they arise. These included issues related to his gender, his status as a non-parent, the fact that the mothers may know more about the illness then he did, and left over anger at the social worker who left in the middle of the year. By tuning in and rehearsing he believed he was ready for everything—except what happened.

Before he could start, one client confronted him in an angry voice and said: “I want you to know what we think of this dammed hospital. We have doctors who don’t listen to us, nurses who push us around, and we keep getting young social workers like you who don’t even have kids.” I asked the student what he felt like saying at that moment. He responded that he felt like saying: “I may be in the wrong room!” I asked him what he did say and he revealed that he had responded spontaneously and said: “I may not have kids but I have a mother just like you!”

There was a momentary stunned silence in the group with him thinking, as he later reported, “Oh, oh! Can I tell my supervisor about this?” The client was probably thinking “What kind of social worker is this?” In her initial comment she had related to him as a stereotype. In his response, he was anything but stereotypical. The group members quickly changed the subject and initiated a superficial discussion that was an example of an “illusion of work.”

In my class discussion of this example I told the student he had made a “beautiful mistake.” He was a bit shocked by that comment. I went on to point out that at least he was honest and spontaneous. I thought a worse mistake might be to say what I was taught to say in situations like this, which was: “Thank you for sharing that” or “Do you want to go with that feeling.” I also argued that developing practice skill involved
shortening the distance between when one makes a mistake and when
one catches the mistake. It is crucial that supervisors and educators help
young practitioners to be willing to risk, to make mistakes and to learn
from them. We need to help practitioners understand that they can learn
from “active” mistakes as opposed to “passive” mistakes.

In the class, the student then tuned into the underlying issues associ-
ated with the anger and he began the next group session as follows:

Mrs. X, I want to comment about last week. It was my first time
leading a group and as a result I didn’t understand the pain and dis-
appointment that was under your comment. You have met many
helping professionals who simply didn’t understand what it was
like to have a child who is sick and never seems to get better. When
you saw me you thought: “Here comes another one.”

There was silence in the room after his comment. The student was
prepared for what might be inside of the silence. The group members
may have been having different reactions including: “he thought about
us during the week; this discussion is going to get real; he is trying to un-
derstand,” and most important, they may be experiencing the pain to
which he referred. The angry mother began to cry and pointed out she
was the only one in the group who did not have a partner to share the
load. A member next to her said she was married—“big deal.” She went
on to describe a husband who worked all the time and avoided discussing
the child.

The student began to understand the first woman’s anger represented
“fight” and the husband’s working all the time represented “flight”
(Bion, 1961). Both were maladaptive ways of coping with the pain. The
angry mother in the first session was really saying: “Do you want to see
how I push people away when I need them the most?” The additional in-
sight the student gained from this incident was how often the process in
his work closely connected to the content of the work. This was an im-
portant start in understanding and rejecting another false dichotomy–
process versus content.

THE PRELIMINARY PHASE IN SUPERVISION

As with direct practice, there are constant and variant elements that
can affect the supervisory relationship, including among others:
The amount of authority and accountability carried by the supervisor.
Whether the supervisor is promoted from within the staff group or is hired externally.
The education and experience of the supervisee.
Clinical supervision may be a very structured and intense process for students and new and inexperienced supervisees or case consultation for those practitioners with substantial experience and skill.

Just as in the beginning of the practice relationship, issues related to the authority theme may be raised, often indirectly. For example, in workshops I have led common issues faced by new supervisors promoted from within include:

- Having to supervise former peers, two of whom applied for the same job;
- Coming into the coffee room on your first day as supervisor and having everyone become silent—and you fear they were talking about you;
- Dealing with active and passive resistance;
- Having to supervise friends and former colleagues.

Another common issue raised in my workshops by new supervisors brought in from the outside is what I refer to as “the hired gun syndrome.” Direct and indirect questions emerge from staff asking “Which side the new supervisor will be on? Will he or she be with the administration or with the staff members?” Supervisors describe this as feeling “caught in the middle.” With experience, they learn they cannot do their job unless they are with both staff and administration at the same time.3

Just as the authority theme may be raised indirectly in the practice relationship, as I discussed earlier, it may also be raised in the supervisor-practitioner context. One common example is the practitioner who says to the new supervisor: “Well I’m glad you’re here now because our last supervisor was a real jerk.” This can occur in an individual session or a staff meeting. It usually puts the new supervisor on the spot, uncomfortable talking about their predecessor.

With some tuning in one can begin to understand that staff members may not be talking about the last supervisor. This is often an indirect way of asking: “And what kind of supervisor are you going to be?” Rather than changing the subject out of discomfort, the new supervisor
could respond directly by saying: “It sounds as though you feel you did not get along with your last supervisor. What kind of problems did you perceive?” Attention needs to be drawn to the word “perceive” since it does not represent an endorsement of the problems, just of the practitioner’s perception. The new supervisor is not asking the worker to complain about the previous supervisor since the conversation will immediately move to the current relationship.

Depending upon the response the new supervisor has opened up an opportunity for a discussion about his or her own approach to supervision—which is often the real underlying question. For example, if the practitioners complain about lack of availability the new supervisor could respond as follows:

I want you to know I see it as my job to be available for you not only when we schedule conferences but in between as well, if you need a quick consultation. I also realize that with the pressures I have to deal with and other demands on my time I may not always be able to respond right away. If you ever feel that is becoming a pattern—an ongoing problem—I want you to let me know.

The key here is that the new supervisor lets the practitioner know that he or she is aware that the concern is not about the previous supervisor, but rather about what kind of supervisor the new person will be. The supervisor is also extending an invitation for honest feedback from the front-line practitioners.

If staff concerns relate to the way the previous supervisor handled job management issues, the new supervisor might seize the opportunity to clarify his or her expectations and management approach. For example, the new supervisor might say:

Maybe this is a good time for me to let you all know my views about these issues. Occasional lateness, for example, is a problem we all may have but if lateness becomes a pattern then I see it as my job to meet with you and to discuss it.

In both examples the supervisor has brought to the surface the underlying concerns and questions about the way she or he will work with her supervisees, and has demonstrated willingness to be direct about what are often experienced as taboo issues. Most important, the supervisor is modeling exactly what is expected of the practitioner when a client
starts to raise concerns about the “last counselor” when actually referring to the new one.

Just as in practice, unless these underlying issues related to the authority theme are addressed in a direct manner they may fester under the surface, increasing in their power, and block the development of a sound supervisory relationship. Taboo subjects that are surfaced directly in the work tend to lose their power. Responding directly speeds up the process. Even more difficult for the new supervisor from the outside is when practitioners talk about how wonderful the last supervisor was. In one example a new supervisor described in a workshop I presented how, seemingly out of nowhere during a meeting, staff began to reminisce about the great food at a barbecue the last supervisor held in her backyard just before she left. The supervisor reported thinking: “And I don’t even cook!” In retrospect she realized there was more to this than just food. At her next staff meeting she raised the issue directly: “I was thinking about your reminiscing about Jane last week. You really sound as though you miss her. What was it that made her such a good supervisor? I’m not Jane, but I would like to be helpful as well.” Once again, this opened up a discussion of staff expectations of the supervisor and the supervisor’s expectations of staff. It also demonstrated the supervisor’s understanding and lack of threat about feelings and issues associated with the loss of the last supervisor. It modeled how practitioners can handle the same issue with clients when they speak about their former “terrific” counselors.

In the workshop in which the above example was shared, a participant who was a Catholic nun raised her hand and said: “Now I know what was going on at the hospital where I just took over as mother superior, replacing someone who had been there for over 25 years.” She continued, “I was in place only three weeks when it became apparent that I had replaced Mary Mother of God!” When the laughter died down she reflected that in her own anxiety about replacing a beloved predecessor she had ignored addressing the serious issues of loss experienced by her staff. She indicated she was going to re-open the discussion the next week since for nurses dealing with patients and their families, losses of any kind were important issues to be addressed.

**RESEARCH FINDINGS**

In one of my major studies of child welfare in the Canadian Province of British Columbia, I had six levels of participants, including 5 Execu-
tive Directors (macro areas of the Province); 10 Regional Managers; 10 regional Family and Children Service Coordinators; 68 Front-line District Supervisors; 171 front-line social workers; 305 Families; and over 449 children (Shulman, 1991). Mailed questionnaires were developed and tested for reliability and validity and then administered to both staff and clients over a period of two years. When possible, data was obtained directly from clients through personal interviews.

While the study was an effort to develop a holistic model of child welfare practice incorporating variables that took into account the context of the practice and supervision/management, demographic variables, skills variables, etc., for the purpose of this presentation, I will address only the findings related to supervision with an emphasis on skill use and the parallel process.

For each of the six levels of the study, we examined the association between the use of the skills described above and the development of a working relationship (rapport, trust, and caring) as well as satisfaction (the client with the worker; the worker with the supervisor, etc.) and their perception of helpfulness. Where appropriate, we also examined “hard” measures such as time spent in foster care, rate of return to biological families, etc. While much of the data consisted of perceptions (for example, the use of certain skills by practitioners as perceived by their clients), we built in a number of validity checks such as asking the supervisor to also rate the social worker’s level of skill. We then compared that to the rating given by the same social worker’s clients. We also adopted the position that the only variable that counted was the perception of skill use by the client or worker. Somewhat like the example of a tree falling in the forest making no sound unless someone is present to hear it, a skill such as empathy has no impact unless the client perceives it.

A scale of supervisor skill was developed that incorporated three of the supervisory skills that had been identified as important in an earlier study (Shulman, Robinson, and Luckyj, 1981) and through a general review of the literature. The core skills selected for the study and their wording on the questionnaires were as follows:

- Articulates the supervisee’s feelings (“My supervisor can sense my feelings without my having to put them into words”).
- Communicates the supervisee’s views to administration (“My supervisor effectively communicates my views about policies and procedures to the next level of the agency”).
Encourages negative feedback ("When I am upset about something my supervisor says or does, he/she encourages me to talk about it").

Staff on each level was asked to rate their supervisors or managers working a level above using a Likert scale. Thus, 10 managers rated the 5 executives; 62 supervisors rated their 10 managers; and 151 workers rated their 68 supervisors.

The findings, briefly summarized here, indicated the following:

- 40% of the managers “agreed” or “strongly agreed” that their administrators (the Executive Directors) were able to articulate their feelings.
- Only 21% of the supervisors “agreed” (none “strongly agreed”) that their managers demonstrated this skill.
- On the practitioner level, 26.5% “agreed” or “strongly agreed” that this skill was evidenced by their supervisors.

All three levels of administration scored lower on the use of this skill than their workers did when rated by their clients. In interviews with staff groups to discuss the findings, it was clear that one of the issues may be the perception by supervisors that empathic responses to supervisees might be construed as too close to “therapy” and thus they were less likely to use the skill. It was not always clear to staff that empathy when used in pursuit of their supervisory function was not therapy but rather supportive and effective supervision.

In contrast to the empathy findings, when asked about communicating views to higher levels of administration:

- 70% of the managers “agreed” or “strongly agreed” that their Executive Directors effectively communicated their views to administration.
- On the supervisor-manager level, 72.3% “agreed” or “strongly agreed” that their managers evidenced this skill.
- Only 53.7% of the front-line workers “agreed” or “strongly agreed” that their supervisors were as effective.

The findings for the third skill, encourages negative feedback, indicated that:
77.8% of the managers “agreed” or “strongly agreed” that their executives evidenced this skill.

Only 46.8% of the supervisors felt this way about their managers.

50% of the workers reported that they “agreed” or “strongly agreed” that their supervisors demonstrated this skill.

The supervisee’s perceptions of the supervisory relationship and supervisor helpfulness were also examined along with other variables. For the purpose of this presentation, I will report the correlation between supervisory skills, as defined by the average score on the three skill variables above, and four of the dependant measures. Supervisory skill demonstrated moderate to strong correlations with the social worker’s trust in the supervisor ($r = .75$), rapport ($r = .82$), helpfulness ($r = .76$), and positive morale ($r = .47$). These findings paralleled the analysis of the same or similar variables in the social worker-client level of the study.

The full study explored other variables such as the impact of job manageability, job stress, and availability of support and the impact of these variables on supervisor skill use. Supervisor skill use, in particular the empathic skill, also associated positively with worker perception of the supervisor’s helpfulness, the worker’s morale and the worker’s ability to manage the job. The availability of peer support for the supervisor was associated at high levels with the supervisor’s perception of the availability of emotional support for him or her, the ability of the supervisor to manage his/her job, lower job stress, and higher job manageability.

While it is important to keep in mind that these study results need to be considered in light of the limitations of the study, as described in the full report, they nevertheless suggest that the core assumptions of the model presented here are supported. There is a parallel process involved, meaning that effective supervision at all levels can increase the possibility of effective practice.

**ILLUSTRATIONS FROM CLINICAL SUPERVISION**

The first example illustrates supervision of a child welfare worker’s visit to a young, Native Canadian mother who had just moved to Vancouver, British Columbia, and was living in a single-room occupancy hotel with three young children. She was twenty-one years old and had fled the reservation because of fear of sexual abuse of her children. The worker visited because of calls to the agency’s hot-line reporting ne-
glect of the children. The counselor reported the details of her interaction with the client during supervision. The supervisor made use of “memory work” in that she asked the worker to describe the interview in some detail. While analysis of a brief written recording of the process of the interaction is valuable, it is not always available. The worker began by indicating she was concerned about the safety of the children. A portion of the supervision session follows:

Counselor: I explained to her that we had received a telephone call on the 800 line that raised concerns about her children not being cared for. As I talked with her, the two-year-old came over near her feet and she firmly asked her to move away and play with her toys. She came back again and this time the mother was quite angry. Finally, she grabbed the child and shook her angrily telling her to leave her alone.

Supervisor: What did you say to her?

Counselor: I asked her if she could find another way to tell her child to leave her alone. Oh, yes, I also told her about our parent effectiveness-training program.

Supervisor: How did she respond?

Counselor: She got very silent and I could see she was angry.

Supervisor: You know she probably felt you were being critical of her and that shut her down. Couldn’t you find a gentler way to talk to her about her behavior?

Counselor: Well I guess I could have, but you weren’t really there so you don’t know how bad it was.

In thinking about the supervision interview just described, ask yourself this question: With whom was the supervisor emotionally identified? That is, whose feeling was the supervisor experiencing? Clearly, she was tuned in to the mother. Now ask yourself, who was emotionally with the counselor? You can all sense that at that moment the answer is no one.

Pick up the conversation right at the point the counselor had described the client’s angry response to the child. The supervisor’s response was to ask the counselor to consider the mother’s feelings. Consider this alternative response:
Supervisor: How did it make you feel when the mother got so angry?
Counselor: I was upset that she was treating the child that way.
Supervisor: You must have also been angry at her for that behavior.
Counselor: I was angry. It’s just a little child. She shouldn’t be so angry with her.
Supervisor: Were you also worried about what she might do if she got angry when you are not around?
Counselor: Sure I was. I don’t want her hurting that child.
Supervisor: I can understand your reaction. Most people would be upset witnessing that kind of behavior. I agree that you also have to be concerned about the safety of the child. My sense is that at that moment you were understandably emotionally identified with the child. Who was with the mother?
Counselor: (pause) I guess no one.
Supervisor: I think the hard part of the work is to find a way to be with the mother and the child at the same time. To address issues of safety for the child, but at the same time to address the concerns of the mother. Let’s take a moment and think about what it must be like for the mother . . . (the supervisor and the counselor tune in to what it might be like to be a young mother, with three young children, recently moving off the reserve in a rural area and moving into single room occupancy housing with no family or other sources of support).
Counselor: OK, I can understand how tough it must be for her. I’m not sure what I could say at that moment.
Supervisor: Let me take a crack at it. What if you said to the mother: “Is this what it’s like for you all of the time? Do you never get a chance to be alone without the kids? You must be feeling lonely and overwhelmed.”
Counselor: I can see how that would make a better connection with the mother. She might not feel as threatened by me. But what about the safety issue?
Supervisor: You need to address that as well in an honest, direct and supportive way. You can tell her you are worried about her and the child. You can suggest that you can help with some of the resources available—particularly from the Native community (for example, Native housekeepers, respite care, legal help).

Counselor: I blew it, didn’t I?

Supervisor: Don’t be so hard on yourself. You reacted from your gut but you just weren’t clear about needing to be with both clients at the same time. Let’s work on how you can go back and start again with that Mom.

At this point in the conference, the counselor role played out how to take responsibility for not hearing the mom in the first interview and asking to start over again. The parallel is obvious. In the first example, the supervisor is asking the counselor to tune into and to empathize with the young mother while at exactly the same time she is not tuning into the counselor. She is actually demonstrating the opposite of what she would like the practitioner to do with the client. In the second example, the supervisor teaches by modeling the skills of being with the counselor and the client at the same time. To emphasize the parallels, if the first supervisor realized she had been criticizing the worker she could have returned later in the day and also said: “Can we start over? I was so concerned about the child’s mother I forgot to connect with how you must have been feelings.”

Of course, another question we could ask at this moment is who is with the supervisor? As reported earlier, my research has indicated that a supervisor’s ability to provide needed support for a front-line practitioner somewhat depends on the supervisor’s ability to find that same support from either their own supervisor or peers. This was brought home to me dramatically in a workshop I presented for a conference of social workers in pediatric oncology settings. Dealing on a daily basis with children and families where terminal cancer is not uncommon clearly would create tremendous stress on a practitioner and other staff as well.

A recently graduated social worker reported in the workshop an example in which a young mother was informed by the oncologist that her seven-year-old child had a terminal cancer and most likely had less than a year to live. The doctor sent the woman to see the social worker without dealing with the mother’s emotional turmoil. When she entered the social worker’s office, she appeared to be stunned and in a protective
shell. The worker asked the mother why the doctor had sent her to see a
social worker and she replied: “He just told me my baby is going to die.”
At this point the shell broke and the woman began to sob. The social
worker was deeply moved, took her hand and cried with her.

In my view, no words would have helped at the moment. I believe
what the mother needed was someone to “be with” her at this most pain-
ful and difficult moment. There are many ways to convey our capacity
for empathy, and for each professional it may vary as our personal self
dictates how it will be done. Remaining respectful and silent, facial ex-
pression, touch where appropriate and even tears send important mes-
sages to the mother. There would be time before the interview ended to
discuss how she would get home, how she would share this with the
family, and how she would take care of herself so she could take care of
her daughter. All of these issues are important; however, at this moment
I don’t think the mother would have heard a word.

The worker continued by sharing with the workshop participants that
her supervisor walked by her open door, saw her crying with the mother
and called her out into the hall. The supervisor told her to pull herself to-
gether, saying she had “lost it.” In my view, the worker had “found it.” I
asked the worker what she learned from the experience and she said: “I
learned to keep my door shut!”

I told her I didn’t think that was good enough because eventually, in a
position such as hers, she might find herself burning out. If she cut off
her feelings and tried to treat her work as a 9 to 5 job, she could easily
burn out. If she continued to allow herself to feel deeply the pain of her
clients, and if she did not get support from her supervisor, that also
could be the start of burning out.

When I inquired whether or not there was a support group for all of
the staff on her service—counselors, doctors, nurses, etc., she replied that
they met once a week for a staff meeting, but never actually discussed
their own feelings and their stress. The meeting, led by the oncologist,
focused on the patients and their cancer. I suggested that the doctor’s
avoidance of the mother’s feelings and the supervisor’s seemingly
harsh comment were probably indirect signals that something was miss-
ing in the service. My profession, social work, is rooted in a history of
both helping individuals and working for social change. I have termed
this the “two client” idea. I suggested to the worker that the hospital and
the oncology service were her “second clients.” We discussed a strategy
by which she could raise, in a professional manner, the issue of a sup-
port group for staff who had to deal with the pain of children dying and
grieving families. The social worker role-played how she could start
this conversation at the next staff meeting. The example opened up a
discussion for all of the workshop participants on the importance of
having their needs met if they were to meet those of the children and
their families.

CONCLUSIONS

I believe we have an important research and teaching agenda in the
area of clinical supervision. We must advance our research efforts to ex-
plor the common core in practice and supervision. We need to better
understand the variations on the themes or the “variant elements” of ef-
e ctive supervision. How are we the same as clinical supervisors and
how are we different as social workers, counselors, psychologists,
nurses, etc.? We need to more closely understand the way in which the
clinical supervisor’s interaction with the practitioner (the process) ei-
 ther reinforces effective practice concepts (the content) or models the
exact opposite.

I would like to leave you with a final story. I consulted with four men
who established in Vancouver, British Columbia some of the first North
American groups for men who batter. One described his last meeting
with the group of men when he told them he had a consultant named
Larry Shulman who told him he would learn from mistakes, improve his
group leadership, and then make more sophisticated mistakes. He went
on to ask the men how he had done. One man replied: “Don’t worry Jim.
You’re not making sophisticated mistakes yet.” I wish all of you and the
practitioners you supervise many sophisticated mistakes.

NOTES

1. I have most recently described this practice framework in a book entitled: The
2. This is the first stage in a change model developed by Prochaska and DiClemente
(1982) first employed in considering the change process for addicted persons.
3. The issue of caught in the middle is discussed in detail in my book “Interactional
Supervision” (1993).
4. This study followed an earlier project examining supervision skills in social
work, nursing and residential treatment settings from across Canada (Shulman, Robin-
son & Luckyj, 1981). There were 109 supervisors and 671 practitioners in that sample.
REFERENCES


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