

Continuing Education

A Bilateral Model for Clinical Supervision

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Abstract

A bilateral model for Clinical Supervision is presented.

Conceptual models for the supervision and training of clinicians in Transactional Analysis have not been adequately developed. Whether reviewing the TA literature or scanning ITAA conference programs, one finds that there are few articles or workshops addressing this issue. What does exist in the literature is largely devoted to techniques of supervision, definitions of what makes an effective transactional analyst, and descriptions of how the author structures supervision or what the author believes is the best way to supervise. What is missing, with a few exceptions, are conceptual frameworks for determining the content and direction of clinical supervision as a trainee progresses through a training program.

This characterization of TA supervision is reflective of the more general situation across disciplines and across the various psychotherapy methods. Allen K. Hess (1980) makes this point in his preface to *Psychotherapy Supervision: Theory, Research and Practice*, noting that even though supervision is a major activity of most mental health professionals, the theories and methods of supervision have not been sufficiently explicated. He depicts psychotherapy supervision as follows:

[Carl] Rogers' early recognition of the issues involved in training psychotherapists has gone unheeded and the current status of the field still can be accurately summarized by his quote [from 1957], 'Considering the fact that one-third of present day psychologists have a special interest in the field of psychotherapy, we would expect a great deal of attention might be given to the problem of training individuals to engage in the therapeutic process.... For the

most part this field is characterized by a rarity of research and a plentitude [sic] of platitudes.' (p. ix)

In his chapter on "Theories and Models in Clinical Psychology," Hess (1980) goes on to observe that supervision is based on, sometimes restricted to, and parallels, for the most part, the specific therapy method in which the supervisee is being trained.

In this article we will review the TA literature and examine TA training practices with respect to the development of conceptual models for supervision. We will also propose the "Bilateral Model for Clinical Supervision," which consists of two three-dimensional frameworks: (1) Therapist Operations in the Supervisory Process and (2) Supervisor Operations in the Supervisory Process.

Review of TA Literature on Supervision

There are two notable exceptions to the statement that conceptual frameworks for clinical supervision and training programs are lacking in the TA literature: Berne's (1966) categorization of therapists' motivations and fantasies regarding treatment and Erskine's (1982) recently proposed framework for out supervision based upon "the trainee's level of professional skill and acumen." In this framework, Berne (1966, p. 49) divides therapists motivations and fantasies into four categories: "procedural artifacts and slogans based on reading, training or the expectations of superiors (institutionalized component); directive, restrictive or protective attitudes (Parental component); rational or intellectual plans (Adult component); and archaic, instinctual, or exploitative fantasies (Child component)." Berne advocated beginning supervision before therapists started therapy groups. He stressed the importance of clarity of therapeutic aim and the candidness of the supervisor, because "the lives of the patients and their families are going to be strongly influenced, and there is no excuse for the in-

dulgence of the therapist's private proclivities at this point (p. 50).'' This model for examining therapists' motivations was used in the early San Francisco Social Psychiatry Seminars and is reported in the *Transactional Analysis Bulletin*. As a conceptual model for clinical supervision, Berne's categories can be used to consider not only the motivations, but also the areas in which supervisory interventions may be needed to facilitate learning and effectiveness. For example, the supervisor may assess to what extent trainees are actively utilizing each of the four components in their approaches to diagnosis and treatment and which, if any, areas are involved in therapeutic impasses.

Erskine's (1982) schema for supervisory planning and strategies is divided into beginning, intermediate and advanced stages of the trainee's professional development as a therapist. As he describes the aim, approach, and conceptual base for each stage, the basic criteria he is using to evaluate the trainee and to introduce a new level of supervision seem to be the following: extent of theoretical knowledge, ability to apply theory to clinical work, repertoire of clinical interventions, and the presence of personal treatment issues which interfere with clinical work. As Erskine describes the content and process of supervision, there is a progressive shift during the three stages from supervisor-determined supervision to self-supervision, with the supervisor determining when to make these shifts.

What remains in the TA literature on supervision and training is largely methodological approaches and descriptions of what the author does and believes is best to do in supervision. Curricula and guidelines for comprehensive planning of TA training include: Berne's (1966, pp. 161-183) basic curriculum for training in group treatment, which he described as a "somewhat idealized syllabus" and would be limited to large teaching hospitals or community agencies; the ITAA Education Committee's "Minimal Basic Science Curriculum" (1969), which is better suited for TA training in private settings; and the ITAA Training Manual (1977). There is rich resource material in the TA literature for specific approaches to supervision and training: Berne's (1977) staff-patient staff conferences, elaborated upon by O'Hearne (1977); microscopic supervision using

transaction-by-transaction analysis, introduced by Berne and described in greater detail by Barnes (1977) and Goulding (1978); James' (1977) excellent description of training programs and criteria for effective transactional analysts; and a few reported experiments in training programs (Haimowitz, 1975; Haimowitz & Haimowitz, 1976; Lessler, 1977; and Payton, Morriss, & Beale, 1979).

TA Training Practices

If regarded from the standpoint of basic approaches, we see that the emphasis in TA training and supervision has paralleled the therapy approach (e.g., the progression of tape supervision following the structure of the theory in proceeding from ego state analysis to transactional analysis proper to game analysis to racket analysis to script analysis). Unlike academic training, the resolution of personal therapy issues has been consistently emphasized and frequently integrated into the supervision session itself. This is accomplished either by using the method of peer-group supervision where the trainees receive supervision on their clinical work by doing therapy with other trainees, or by the supervisor doing therapy work with the trainee as a part of the supervision. As an alternative, trainees may be referred for personal treatment to other therapists or to therapy marathons.

Some of the current practices in TA training and supervision, in our opinion, contribute to and reinforce the lack of theory and conceptual development. Most TA training programs are offered outside traditional, academic settings, either under the aegis of an institute or the private training program of an individual TA trainer. The new generation of TA trainers are learning to teach and supervise other clinicians primarily through role-modeling and case-by-case discussions with their supervisors. And in both the training of TA clinicians and TA trainers, there is typically more emphasis placed on specific cases or situations than there is on overall planning and intervention strategies. Personal therapy for the trainee, whether offered by the supervisor or done in peer-group supervision, frequently dominates the agenda of training sessions. Discussions of theory and the clinical applications of theory may be limited to teaching workshops or

seminars; even then, many TA trainers rely on demonstrations and experiential exercises in preference to presenting conceptual material and engaging their trainees in critical thinking about the theory and its applications. Workshops at ITAA conferences, because of their length and considerations for audience appeal, are even more likely to emphasize demonstrations by the workshop leader and the application of techniques, rather than the exploration of ideas about TA theory and its applications. Though we recognize that this description does not epitomize all TA training, we do suggest that it reflects those features of TA training and supervision which tend to reinforce the lack of conceptual models for supervision.

In addition to TA training practices, the examination process itself has introduced certain features into TA supervision. The written examination tests for applicants' fund of knowledge and application of theory in specific clinical situations, but it does not test for ability to deal with abstract concepts. As they have been structured over the past 10 years, the oral examinations for certification as a Clinical Member in ITAA rely upon small segments of tape-recorded clinical work selected and reviewed by the trainee and trainer. The examiners are expected to evaluate the effectiveness of the therapist within a short period of time (usually no more than an hour) based upon these carefully screened and usually rehearsed tapes. This examination process has been recognized by the National Commission for Health-Certifying Organizations as superior to most examination procedures and has the distinction of examining on the basis of therapists' work with their own clients to demonstrate their clinical competence and excellence. However, this examination procedure has had ramifications for the supervision and training process. What has been emphasized are: (1) microscopic tape samples, (2) non-sequential supervision (tape segments rather than ongoing case consultation); and (3) emphasis on success of treatment rather than process of treatment. With these being focused upon, development of critical thinking and a broad understanding of the treatment process are de-emphasized.

The Bilateral Model for Clinical Supervision

The conceptual model we are proposing for clinical supervision (Figure 1) consists of two three-dimensional frameworks: "Therapist Operations in the Supervisory Process" (Figure 1-A) and "Supervisor Operations in the Supervisory Process" (Figure 1-B). Introducing two frameworks to be included in one conceptual model is based on the premise that there are two separate and distinct processes to be considered simultaneously whenever supervision is occurring: (1) the activities, focus of attention, and functional modes of the therapist being supervised (also referred to hereafter as supervisee or trainee); and (2) the activities, focus of attention, and functional modes of the supervisor. The term *bilateral* is used to emphasize the fact that a comprehensive model of supervision requires a conceptual structure that addresses not only the tasks and functioning of the therapist, but also those of the supervisor at the same time. The term *operation*, used to describe the three dimensions in each framework (activity, focus of attention and functional mode), is defined as a "process or series of acts performed to effect a certain purpose or result" (Morris, 1970). As can be seen in Figure 1, the *Functional Modes* of the supervisor and supervisee are the same, whereas the categories included under *Activities* and the *Focus of Attention* differ.

In developing this bilateral model we began with only one dimension — Therapist Activities. However, as we reviewed the literature and began to organize our material for this article, we discovered that our unidimensional model was limited. It focused only on the therapist being supervised, but it failed to include all the aspects of the therapist's functioning that we were considering as we did supervision, and it did not allow for consideration of our own functioning as supervisors.

As we reviewed the literature on supervision and psychotherapy training in other fields and other therapy methods, we found two common features: (1) supervision typically parallels the content and process of the therapy method being taught; and (2) though noted as significant and involving different considerations, the functioning and behaviors of the supervisor were not explicated. For the most part, in fact,

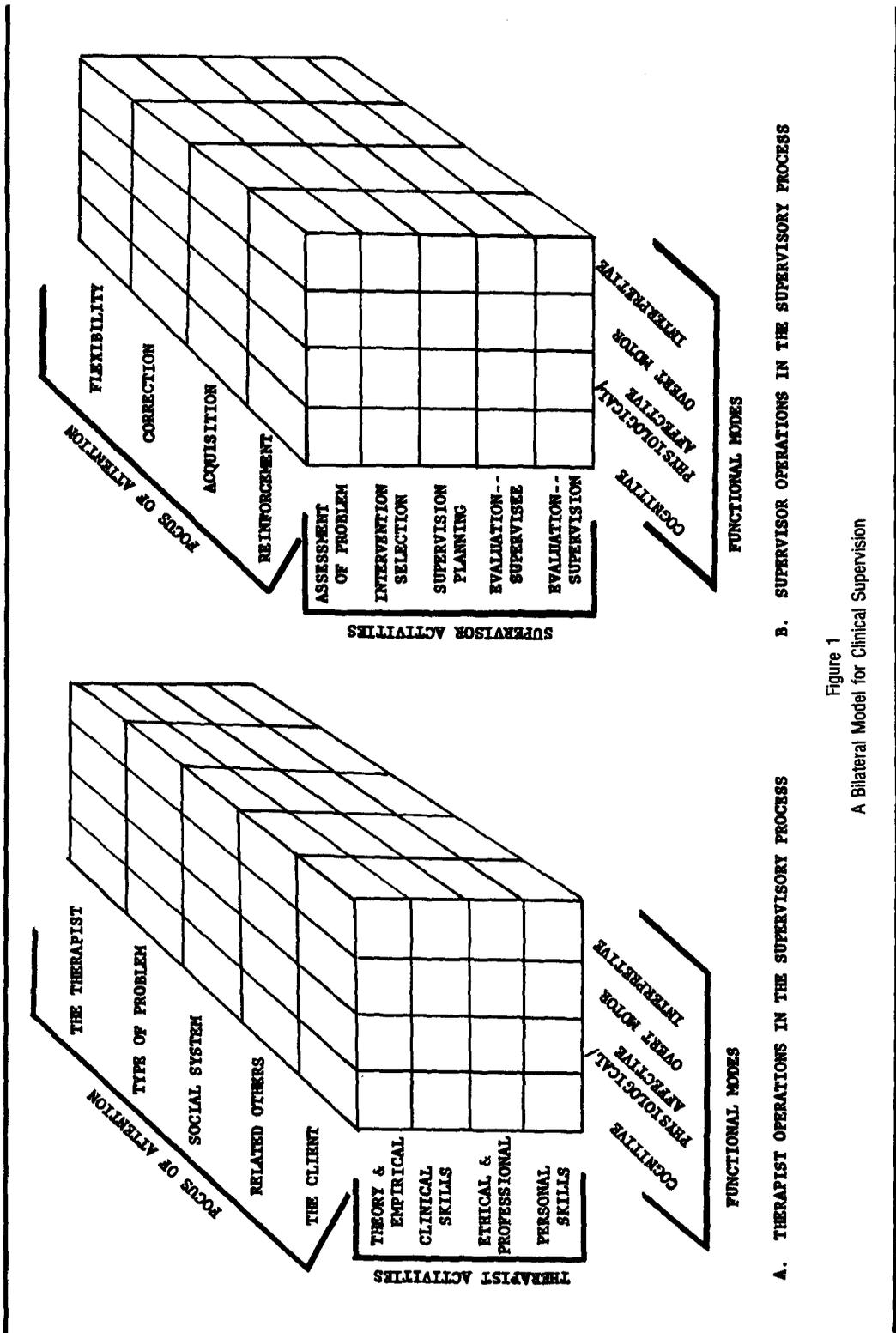


Figure 1
A Bilateral Model for Clinical Supervision

supervision has been conducted with the primary focus being on a specific client being seen by a specific therapist using a specific approach to clinical work; and it has been written about as though the supervisor can translate the therapy method directly into a supervision method. Supervision methods *per se*, then, have been therapy-method specific.

Linehan's (1980) description of a three-dimensional model for training behavioral therapists, though proposed for a specific method of therapy, is an excellent departure from the usual material. The three dimensions of Linehan's "Behavioral Supervision Grid" are: (1) "Target Systems," the goals of supervision; (2) "Methods and Procedures" used to achieve these goals; and (3) "Universes of Generalization" (e.g., settings, client types, therapeutic modalities) against which one wishes these goals to generalize. The Target Systems are the response systems of the therapist: overt motor (acting); cognitive (thinking); and physiological/affective (feeling). The Methods and Procedures are: response shaping and strengthening; response disinhibition; response acquisition; and response transfer. And the Universes of Generalization are: problems; clients; and settings. Linehan defines each category within the three areas and specifies the types of behaviors included in each.

It was Linehan's model that stimulated us to expand the model for Therapist Operations in the Supervisory Process from one dimension (Therapist Activities) to three. And, having developed the framework for conceptualizing the therapist's operations, we decided to tackle the issue of the supervisor's operations. Combining the two three-dimensional frameworks in one bilateral model is the result. We have borrowed directly from Linehan's model (which will be noted as we describe the two frameworks), and we have expanded upon her categories. Where we have departed significantly from her model is to create a framework for considering the functioning of the supervisor separate from the supervisee and to propose that both of these need to be considered together in one conceptual model as a bilateral process.

Therapist Operation in the Supervisory Process

"Therapist Operations in the Supervisory Process" (Figure 1-A) provides a framework for identifying and understanding how a therapist is functioning at a given time during the supervisory process. The therapist's operations may be considered from one of several perspectives: interactions that occurred beforehand with the client(s) being presented for supervision; responses at the time of supervision to the client or clinical situation being reported; or interactions occurring with the supervisor and/or other supervisees.

Therapist Activities

As one of the three dimensions of therapists operations, *Therapist Activities* have been divided into four major areas: *Theoretical and Empirical Knowledge*; *Clinical Skills and Expertise*; *Ethical and Professional Practices*; and *Personal Skills and Development*. Each of these four areas represents a separate and distinct aspect of the therapist's capacity to function. And, whether for one session or throughout the training process, each area needs to be monitored and evaluated.

Theoretical and Empirical Knowledge is defined as the capacity to remember, understand, and critically evaluate the theories of human behavior and research findings relevant to clinical work on an abstract, theoretical level. This aspect of a therapist's activities is separate from applying theoretical concepts to a particular client or situation. It is primarily an intellectual function, not a pragmatic or intuitive one. Having a conceptual understanding of a particular psychotherapy theory and how the various constructs and concepts of the theory are interrelated is, in our view, essential. Being able to distinguish between theoretical concepts, as such, and clinical techniques that evolve from the theory, is equally important.

Clinical Skills and Expertise is the area of therapist activities which includes the application of theory and clinical techniques to specific clients and clinical situations. Stated in another way, clinical skills are the therapist's demonstrated abilities to take a concept, specific problem, or treatment goal and translate it into action with clients. Clinical ex-

pertise refers to therapists' having a repertoire of clinical skills which enable them to work effectively with a diverse client population; this includes a high-level capacity to select interventions, predict outcomes, and successfully facilitate the direction of treatment to foster desired changes.

Ethical and Professional Practices refers to the functioning of therapists in a manner which is both consistent with ethical codes and within the purview of their professional training. In addition to the ethical codes of the profession and organizations to which therapists belong, attention needs to be given to therapists' personal values and to their discriminating between their values and the values they expect their clients to follow. Other important considerations in this area of therapist activities are: understanding the services of other mental health professionals and how to communicate with them; attending to the administrative and practical matters of developing and maintaining a therapy practice within a private or agency setting; and obtaining continuing education or specialized training.

Personal Skills and Development includes the ability of the therapist to function so that unresolved personal therapeutic issues do not interfere with clients' treatment. Being aware of and experiencing the process of resolving personal issues is expected to enhance the therapist's ability to understand and empathize with clients and their predicaments. *As important for consideration here* are the capacities of the therapist to relate with personal ease and style on a social level, and to develop a social network and personal activities that contribute to his or her overall sense of well-being and healthy functioning.

Therapist's Focus of Attention

Whenever clinical work is presented for supervision, the supervisee or the supervisor may choose to focus on one or more aspects: the *Client*, *Related Others*, the *Social System*, the *Type of Problem*, or the *Therapist*. It is possible that during any given supervision session all five areas will be covered. However, it is important to keep in mind that shifting from one area (focus of attention) to another will change the orientation or emphasis of the supervision. The supervisor needs to consider how

supervisees typically focus attention, what they may not be taking into account, and where they need to extend their knowledge or awareness. Failure on the part of the therapist to attend to one or more of these areas or overemphasizing an area may result in therapeutic impasses.

The *Client* as a focus of attention refers to all the information about the individual(s) being presented for supervision. This may include demographic data, diagnostic material, descriptions of behaviors in or outside therapy sessions, or a synopsis of therapeutic changes made to date, to name but a few.

Related Others are significant persons in the client's life, whether in the past (e.g., mother, father, family members, teachers or playmates during childhood) or present (e.g., lover, spouse, boss, etc.). Information about these significant others, how they interact with the client, and how they affect the client positively or negatively may be considered when *Related Others* is the focus of attention in supervision.

Social System covers a broad range of considerations from the client's family system or social network to the society and culture within which the therapist and the client are functioning. If the clinical work being presented is occurring in a therapy group, then the group itself may be viewed as a social system. Cultural mores and influences, such as sexual values or economic conditions, would also be pertinent considerations. The emphasis is upon the characteristics and dynamics of the *Social System* and how these may be influencing the client(s) and clinical situation.

When the *Type of Problem* is being focused on, the clinical problem rather than the individual client is emphasized. Whether a formal psychiatric disorder (such as anorexia nervosa) or a designated area of problematic behaviors (such as compulsive overeating) is being considered, what is known about the particular clinical problem with respect to symptoms, patterns of behavior, research findings, psychodynamics, prognosis, and most effective treatment approaches would be the topics discussed.

The *Therapist* as the focus of attention in supervision refers to the examination of the therapist's behaviors and responses to the client and the clinical situation and how these are influencing the therapeutic process. Observations

about how the therapist is responding to the client(s), the personal experiences and background of the therapist which are coming into play, and what investment the therapist has in the client or outcomes of treatment is the kind of information considered when the Therapist is the focus of attention in supervision.

Functional Modes of the Therapist

The four categories for the Functional Modes of the Therapist are: *Cognitive (Thinking)*; *Physiological/Affective (Feeling)*; *Overt Motor (Acting)*; and *Interpretive (Attributing Meaning)*. The first three categories for the Functional Modes are borrowed from Linehan's (1980) categories for the Target Systems, which she based on the tripartite theory of personality and behavioral functioning:

[The] essence of this approach is the belief that human functioning can be fruitfully conceptualized as occurring in one or more of three separate, although interrelated systems.... In less technical terms, this approach suggests that behavior can be thought of as involving thinking (the cognitive system), feeling (the physiological/affective system), and acting (the overt motor system). Lines between these systems are not always clear; at many points there may be overlap among the systems, and complex responses often contain elements from each of the systems. (p. 158)

Where we have departed significantly from Linehan's model is in adding the Interpretive Mode and in restricting our definitions to ways of functioning instead of specifying the therapeutic skills involved in each mode. The content of therapeutic skills is considered under Therapist Activities in our model; and evaluating the level of skills is assigned to Supervisor Operations.

The *Cognitive Mode* involves all those responses that are referred to as thinking. Gathering and processing information, comparing and contrasting ideas, and critically evaluating more complex conceptualizations are examples of functioning in the cognitive mode.

The *Physiological/Affective Mode* includes feelings, both emotional and physical. Emotional responses are viewed as always involving a physiological component; however, func-

tioning in the physiological/affective mode may involve physical responses which are not associated with specific emotions. The individual may be using body awareness or one of the five senses as data in doing clinical work or in responding to supervision without associating specific feelings to the experience.

The *Overt Motor Mode* designates the actions of the therapist, directly observable behaviors which include verbal, non-verbal and/or emotional expressions. Within the overt motor mode, an individual may be communicating ideas or expressing feelings (occurring in the cognitive and physiological/affective modes, respectively) or may be stating interpretations from the interpretive mode. However, the distinguishing characteristic of the overt motor functional mode is that the behaviors used by the individual to actively express or report on internal experiences *can be observed by others*.

The *Interpretive Mode* is the more complex function of interpreting or attributing meaning to what is being experienced. Thinking, feeling, and acting may be involved; but, the meaning attributed supersedes the basic data obtained from the cognitive, physiological/affective, or overt motor modes and influences what is selected for attention. Interpretations may be based on a set of principles derived from the individual's frame of reference, value system, beliefs, expectations, or past experiences; and the principles used in making interpretations may be consciously or unconsciously selected. What is perceived, emphasized and recalled will be influenced by how the individual is functioning in the Interpretive Mode: that is, an individual will be more likely to mistake interpretations for facts when the principles are selected unconsciously or are restricted to a limited or rigid set.

Supervisor Operations in the Supervisory Process

"Supervisor Operations in the Supervisory Process" (Figure 1-B) provides a schema for understanding how a supervisor is functioning at any given time. It has been designated to understand the supervisory process from the viewpoint of the supervisor and to distinguish the supervisor's operations from those of the therapist being supervised. It can be used to train and evaluate supervisors as well as to understand the supervision of therapists.

Activities of the Supervisor

The Activities of the Supervisor have been divided into five separate categories: *Assessment of the Supervision Problem*; *Selection of Supervisory Interventions*; *Supervision Planning*; *Evaluation of the Supervisee*; and *Evaluation of the Supervision*. These five categories represent the major activities in which a supervisor engages whether conducting a specific supervisory session with a therapist, planning a series of ongoing supervision sessions with one or more therapists, or designing a comprehensive training program. These are discrete categories of activity which require that the supervisor consider different kinds of information and use different levels of functioning depending upon what is being presented for consideration. These activities are defined below.

Assessment of the Supervision Problem entails the supervisor's considering what is being presented by the supervisee and deciding on the basis of the supervisee's level of training and clinical skill what aspects of the supervision problem to address. Using the framework, "Therapist's Operations in the Supervisory Process," is especially useful for this supervisor activity.

Selection of Supervisory Interventions refers to the supervisor's deciding upon which of the many techniques available would best fit the needs of the supervisee and most effectively and efficiently facilitate learning. The various techniques and methods for supervision described in the literature may be considered, or the supervisor may create a format individually tailored to the supervisee or situation.

Supervision Planning is a more complex activity of the supervisor which involves considering both the past performance of a supervisee and the areas in which further learning is needed. If the supervisor is considering a supervisory group, then all of the supervisees and what has occurred in the supervision group up to the point at which supervision planning is being done need to be taken into account. The result of this activity may be the supervisor's giving specific assignments to supervisees for completion between supervision sessions, or it may be deciding what to focus on or monitor in the supervision sessions which follow.

Evaluation of the Supervisee is the assessment of supervisees with respect to their progress in learning the particular therapy method being taught and applying it in their clinical work. This evaluation may be based on the Therapist Operations model or it may be in reference to the standards for certification of competence by an examination board. Both the strengths and the learning needs of the supervisees should be included in this evaluation.

Evaluation of the Supervision includes all those activities in which the supervisor is considering the effectiveness of the supervision being offered. This evaluation may be based on informal observations, consultations with a colleague, supervision by another supervisor, continued training and reading, or research studies. Whether informal or formal methods are used for evaluating and improving the effectiveness of supervision, this activity is essential for insuring the continuing growth and development of supervisors and their trainees.

Supervisor's Focus of Attention

For the supervisor's operations, focus of attention refers to the purpose of the supervisor, or, put another way, to the direction in which the supervisor intends to influence the trainee's behavior. The categories for the supervisor's focus of attention are: *Reinforcement*, *Acquisition*, *Correction*, and *Flexibility*. Definitions [based upon *The American Heritage Dictionary of the English Language* (Morris, 1970)] are given below and are to be understood as the orientation or direction focused upon by the supervisor when engaging in one of the supervisor activities.

Reinforcement refers to strengthening and supporting behaviors that supervisees already have in their repertoire and may include giving more force or effectiveness to specific behaviors.

Acquisition refers to teaching new behaviors or novel responses, including facilitating the supervisee's putting together a new combination or way of patterning previously acquired behaviors.

Correction refers to removing, remedying, or counteracting errors and ineffective behaviors of the supervisee, and to adjusting or modifying behaviors so that they meet a standard.

Flexibility refers to enabling the supervisee to be more responsive to changing conditions, to be capable of varying or modifying responses, and to be able to accommodate behaviors to fit the person, situation, or any new information they obtain.

The first three categories (Reinforcement, Acquisition, and Correction) parallel Linehan's (1980) categories for Methods and Procedures in her model (Response Shaping and Strengthening, Response Acquisition, and Response Disinhibition), but have been defined generally instead of using the specialized behavioral therapy terminology. Our fourth category of Flexibility differs significantly from Linehan's category of Response Transfer. Generalizing what is learned to other situations (Response Transfer) is included in our definition of Reinforcement. Flexibility implies creating, changing, and adapting behaviors to fit new circumstances and being able to shift easily to consider or initiate new behaviors.

The more significant departure from Linehan's model, as we see it, is that we have defined these as supervisor operations rather than types of supervisory interventions. Separating the purpose of the supervisor from whatever technique or method may be employed as supervisory interventions is essential. Considering the direction in which the supervisor intends to influence supervisees' behaviors before selecting interventions clearly distinguishes the supervisor's process from interactions with the supervisee.

Functional Modes of the Supervisor

The categories for and definitions of the Functional Modes of the Supervisor are the same as those of the Therapist.

Using the Bilateral Model for Clinical Supervision

The bilateral aspect is perhaps the most significant feature of this model for clinical supervision. In effect, we are saying that clinical supervision *cannot* be understood simply by focusing on the supervisees, their clients, and the clinical problems being presented. The supervisor must process a separate set of considerations which we have defined as Supervisor Operations: how the supervisor is responding (Functional Modes); how the supervisor intends to affect the supervisee's behavior

(Focus of Attention); and what goal the supervisor wishes to accomplish (Supervisor Activities). These operations describe supervision from the perspective of the supervisor and are different from the content and considerations that are discussed with the supervisee (Therapist Operations).

To illustrate how the bilateral model can be used, consider the supervisory situation in which the trainee presents the following problem: "What do I do when the client is ready to terminate therapy and I believe they should continue treatment?" Confronted with this issue, the supervisor can use the Supervisor Operations (Figure 1-B) to decide upon an initial approach. It is most likely that a supervisor would begin with the activity, Assessment of the Supervision Problem, emphasize the Cognitive Mode of functioning, and consider whether Reinforcement, Acquisition, Correction and/or Flexibility will be the Focus of Attention.

Then the supervisor would shift to the framework for Therapist Operations (Figure 1-A). Wanting to gather information about what the supervisee knows and how he/she is handling termination, the supervisor would begin with the Focus of Attention on the Therapist. The Functional Mode in which the supervisor would engage the supervisee would be the Overt Motor Mode — i.e., the supervisor would want the supervisee to express what he/she thinks, feels, does, and interprets when a client brings up termination. And, finally, when the Therapist's Activities are selected by the supervisor for discussion, a systematic, but separate, consideration of each area would be advisable in order to make a complete assessment. It is at this point — and only at this point — that a dialogue with the supervisee begins.

As we follow the process, the supervisor would proceed to gather information from the supervisee in the four areas of Therapist Activities. In the area of Theoretical and Empirical Knowledge, the supervisor would ask the supervisee what theoretical frameworks he/she uses to define what needs to be completed before a client is ready for termination. In Transactional Analysis, such concepts as script, social control vs autonomy, and treatment contract might be used.

When Clinical Skill and Expertise are considered with the supervisee, the supervisor

would ask about the experience the supervisee has had with terminations and how they prepare clients to move from specific presenting problems (such as problems with a boss) to therapeutic problems (such as patterns of establishing a symbiotic Child position with persons in authority). The ability of the therapist to work with script issues, to do affective or redecision work, and to effectively facilitate clients moving from social control work to resolving script issues would be considered in order to determine the level of clinical skills and expertise.

When Ethical and Professional Practices are discussed, it is especially important to determine on a practical level whether or not the therapist has structured his/her practice so that he/she is not financially dependent on keeping clients in treatment. A low rate of referrals or unstable financial situation could negatively influence the therapist's judgment about clients' readiness for termination. Ethical problems may be indicated if the therapist seems to be encouraging clients to continue in treatment when the clients do not need it, or the therapist cannot provide what is needed.

Finally, in the area of Personal Skills and Development, the supervisor would assess how the therapist handles differences of opinion (in this instance, a disagreement with clients about being ready to terminate). Whether or not the supervisee has the skills, practice, and confidence in his/her ability to confront others is an important consideration. Unresolved therapeutic issues are likely to be indicated when the supervisee is interpreting termination as a negative reflection on his/her competence, is experiencing difficulties in separating from clients, or is exaggerating his/her responsibility for or ability to affect others.

Throughout the process of assessing the supervision problem in each area of Therapist Activities, the supervisor would discourage the discussion of case examples. (The Focus of Attention selected from the Therapist Operations framework is the Therapist not the Client.) This is especially important in the area of Theoretical and Empirical Knowledge, because the emphasis is on the supervisee's conceptual understanding of how to determine when clients are ready to terminate. And, though the supervisor may elicit information about the supervisee's experience with terminations when

Clinical Skills and Expertise are considered, focusing upon a specific client and discussing whether or not the client is ready to terminate would be contraindicated. The task of the supervisor at this point is to make a general assessment of the supervision problem with the supervisee, not to select and implement supervisory interventions. Discussing specific cases would deter both the supervisor and the supervisee from the general purpose.

Once the supervisor has obtained information about the supervisee in all four areas of Therapist Activities, then, the supervisor would complete the activity of Assessment of the Supervision Problem by summarizing in which areas the supervisee is having difficulty with terminations and what the difficulties are. The supervisor might do this summarizing in the Cognitive and/or Interpretive Mode (thinking and processing silently) or in the Overt Motor Mode (expressing observations and conclusions verbally to the supervisee about the problems with termination).

To continue with this example, shifting back to Supervisor Operations would be the next step. The activity in which the supervisor would be most likely to engage is Supervision Planning, deciding upon the order in which the problems with termination need to be addressed and deciding whether the Focus of Attention needs to be on Reinforcement, Acquisition, Correction and/or Flexibility. If, for instance, one of the problems identified is in the area of Ethical and Professional Practices, especially where ethics are an issue, the supervisor may choose this as the first priority and focus upon Correction. Then, the supervisor would move to the activity, Selection of Supervisory Interventions, decide upon an approach to use, and initiate a discussion with the supervisee about the Therapist Activity of Ethical and Professional Practices.

The possible directions in which supervision would proceed are, of course, contingent upon what the supervisor has defined as the problem (Assessment) and decided is a priority (Supervision Planning). Whatever area of Therapist Activity is selected by the supervisor to address in the supervision session, obtaining more specific information from the supervisee and maintaining some flexibility in selecting and shifting the Focus of Attention for both the supervisee (Client, Related Others, Social

Systems, Type of Problem, or Therapist) and the supervisor (Reinforcement, Acquisition, Correction, or Flexibility) will be required. Both the supervisor and supervisee will be using the Overt Motor Mode when they are interacting. At the same time, however, it is important for the supervisor to monitor his/her own Functional Modes and elicit information about what is occurring in the Cognitive, Physiological/Affective, and Interpretive Modes of the supervisee. Overemphasizing a particular mode or lack of awareness about one or more modes may indicate a need for further exploration and interventions.

What we have described in this example of using the Bilateral Model for Clinical Supervision is supervision from the vantage point of the supervisor. In concluding this illustration, we would like to underscore several basic features of the model. First of all, the supervisor needs to be aware of and actively monitor two separate processes — Therapist Operations (Figure 1-A) and Supervisor Operations (Figure 1-B). Much of the processing the supervisor needs to do, especially with respect to Supervisor Operations, will not be evident in the interactions with the supervisee. In fact, when a supervision session is occurring, one would expect to observe only the Therapist Operations being discussed. However, in our opinion, if supervisors attend only to the Therapist Operations without simultaneously monitoring and actively choosing or considering their own Supervisor Operations, supervision will be less effective and more likely to replicate the therapy method being taught. While the number of variables and the possible combinations that the supervisor needs to keep in mind when using the Bilateral Model may seem awesome, developing a facility for using the model provides the supervisor with a framework for understanding supervision and for having many options available. Some of the options for the supervisor using the Bilateral Model are: shifting back and forth between the two frameworks, sometimes very rapidly, in order to be responsive to the supervisee; shifting within the Supervisor Operations; monitoring and making decisions to shift what is being discussed in the Therapist Operations; deciding to stay with a particular Activity or Focus of Attention in Therapist Operations in order to assess clearly or intervene with the

supervisee; and using the two frameworks to check what, if anything, is not being considered in the supervision process. The Bilateral Model for Clinical Supervision is proposed primarily for supervisors; however, sharing the model with supervisees is recommended for enhancing their participation in the supervision process and understanding what they can expect or request from the supervisor.

Discussion

In the preceding description of the Bilateral Model for Clinical Supervision, we have confined ourselves to defining the categories within each of the three dimensions of Therapist Operations and of Supervisor Operations and to giving an example of how the Bilateral Model can be used. In a second article, "Applications of a Bilateral Model for Clinical Supervision," we will describe and discuss how the model can be applied to TA training in particular and to a range of supervisory situations — i.e., one supervision session, an ongoing supervisory relationship, or a comprehensive training program.

However, in our view, the Bilateral Model for Clinical Supervision has wider applicability than what we will discuss in the second article. It is, first of all, not limited to TA supervision and training; in fact, the model is not intended to be therapy-method specific. If training and supervision were compared among different therapy methods, one might expect to find that the emphasis placed on the various Therapist Operations and, to some extent, the various Supervisor Operations would be different. It is also quite likely that certain features might be omitted from consideration (e.g., the interpretive mode in behavioral therapy supervision). But, as we have designed it, the model is intended to encompass all the areas of functioning and consideration in clinical supervision for both supervisees and supervisors regardless of the therapy method or clinical approach being taught. It could, for instance, be applied to social work field supervision as well as training in Transactional Analysis, Gestalt therapy, or Reichian therapy. The specific topics covered and the aspects emphasized would vary, but each of the categories would have relevance.

Our proposed Bilateral Model for Clinical Supervision has other applications as well.

Studies of interactions between supervisees and supervisors, comparisons of different styles of supervision, and assessments of supervisory impasses can be made using the whole model. By adding another diagram of Supervisor Operations (Figure 1-B) for the trainer of a supervisor, the supervision of supervisors can be conceptualized and processed. The Therapist Operations framework or the Supervisor Operations framework can be used separately to operationalize research designs and to define criteria for evaluating competence of therapists or supervisors. It is also possible to use the Therapist Operations framework to compare and contrast different psychotherapy methods.

Further work is needed, of course, to test our model. As a way of both concluding and beginning, we suggest the following questions for exploration:

1. Can the Bilateral Model for Clinical Supervision be applied to the supervision of both therapists and supervisors on a practical level? That is, is the model complete enough, yet simple enough, to be used by supervisors and their supervisees when they are doing or reviewing supervision?

2. Does the model provide distinguishable categories within each of the three dimensions (activities, focus of attention, and functional modes) so that it is possible to differentiate one from the other both in practical applications and in research studies?

3. Is it possible to design and execute research using this model?

4. What basic principles and dynamics are involved in the interactions between supervisors and supervisees? How does bilaterality work? How do the frameworks for Supervisor Operations and Therapist Operations interface?

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