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ORIGINAL ARTICLE

A Contextual-Functional Meta-Framework for Counselling Supervision

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Abstract In this paper, an approach to clinical supervision, entitled the Contextual-Functional Meta-Framework (CFM), is developed and articulated, based on a consideration of current literature and the author's extensive practice experience. First, the context for the development of the CFM, and its formative influences, are examined, followed by a review of its six main components: the administrative context in which supervision takes place; the culture infused supervisory working alliance; nine supervisory functions; the supervisor's and supervisee's theory of change; the service delivery system; and the phase of counsellor development. Finally, future avenues for the model's ongoing development and evaluation are discussed. As a meta-framework for the development of one's personal approach to supervision, rather than a model of supervision, the CFM provides a transtheoretical heuristic for clinical supervisors to develop their personal approach the supervision.

Keywords Clinical supervision · Counsellor education · Counsellor training · Teaching of psychology

Introduction

This paper examines and articulates a Contextual-Functional Meta-Framework (CFM) for counselling supervision. The context for the development of the model is outlined and a working definition of supervision is provided. Next, the major influences that underpin its development are examined. This material leads into an articulation of the CFM and its six key components. Finally, it is argued that the CFM has several particular strengths, and future directions for its implementation, evaluation, and research are proposed. The CFM provides a heuristic for clinical supervisors to develop their personal approach to supervision.

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Context for Development

The CFM emerged from the author's experience as a supervisor in agency work and independent practice, teaching in counsellor education programs, and operating a psychological services firm in western Canada. He has researched the developmental pathways of counsellors in training (Chang 2011). He is licensed as a psychologist and has earned the Approved Supervisor designation in the American Association for Marriage and Family Therapy (AAMFT).

This approach emerges from postmodern and pragmatic ideas (Amundson 1996; de Jong and Berg 2008; White 2007) and common factors (Duncan *et al.* 2010). The net effect is a practical approach to supervision that is sensitive to contextual and organizational demands, acknowledges the various "hats" that supervisors wear, focuses on what works, attends to the life stage of the supervisee, and sees supervision as a medium for lifelong learning. The goal is improved client service: "Counselling supervision enhances the counsellor's effectiveness in responding to the needs of the client" (European Association for Counselling [EAC] n.d., para 8).

Definitional Issues

Several definitions of clinical supervision have been advanced. Holloway (1995, p. 1) defines supervision as, "To oversee, to view another's work with the eye of the experienced clinician, the sensitive teacher, the discriminating professional…. an opportunity for a student to [learn psychotherapy] as articulated, and modeled by the supervisor, and… to recreate this process [as counsellors]." The EAC states, "Counselling supervision is a contracted, professional relationship between two or more individuals engaged with counselling activities, which leads to reflection on the counselling situation and its structure" (EAC, n.d., para 2). The AAMFT (2007, p. 11) characterizes supervision as "sustained and intense… clearly distinguishable from personal psychotherapy… contracted in order to serve professional goals," and provided by someone of "superior qualifications, status and experience."

Bernard and Goodyear's (2009) definition was selected as a consensus definition by the North American Association of Psychology Postdoctoral and Internship Centers (Falender *et al.* 2004): "Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. [It is] evaluative and hierarchical, extends over time, and [both] monitor[s] the quality of professional services and serve[s] a gatekeep[ing function]" (p. 7). Accordingly, for our purposes, supervision is defined as:

> Sustained, purposeful interaction between a more proficient or senior practitioner and a less proficient or junior practitioner, undertaken to support the clinical and professional development of the latter, and directly and indirectly improve clinical effectiveness.

This definition identifies supervision as a hierarchical endeavor (in graduate education, prelicensure, or workplace contexts), to be distinguished from "peer supervision." In the European context, peer supervision is generally seen as appropriate for practitioners with over 5 years experience (EAC, n.d., para 21)

Although some (EAC, n.d.; Falvey 1987; Henderson 2009) distinguish between *administrative* and *clinical* supervision, in the CFM they are seen as complementary. Administrative supervision requires a keen awareness of third party obligations that affect clinical supervision (Tromski-Klingshirn and Davis 2007). Agencies, employers, educational programs, and licensing boards may have fixed requirements like: a specific number of hours; a ratio of client contact hours to supervision; or, administrative requirements specific to an agency.

Moreover, competencies are either generic to professional practice or specific to particular areas of practice. American Psychologists Rodolfa *et al.* (2005) have referred to these as *foundational* or *functional,* while American MFTs Morgan and Sprenkle (2007) refer to these as *professional* or *clinical* competence. Generic competencies (*foundational*), required of all professionals, include: reflective practice/self-assessment; scientific knowledge and methods; interpersonal relationship skills; awareness of ethical, legal, and public policy imperatives; appreciation of individual differences and cultural diversity; interdisciplinary collaboration, interprofessional practice, and systemic awareness. *Functional* competencies, however, involve specialized, more particular knowledge or skill. Clinical supervision might then focus on one or more of the following: clinical assessment, diagnosis, or conceptualization; intervention or treatment; consultation; research and/or evaluation; supervision and/or teaching; management and/or administration in mental health. Additionally, both generic/foundational and specific/functional competencies are set against the need to tailor supervision to the developmental status of the supervisees.

Conceptual Background for the Contextual-Functional Meta-Framework

A systemic review commissioned by the BACP (Wheeler and Richards 2007) found that clinical supervision benefited supervisees, enabling general growth and development, specific skills, and self-efficacy. However, the connection to improved client outcome was tenuous. They pointed out that the duration of studies was typically brief, and participants were generally students, so it was difficult to ascertain the effects of longer-term supervision and other factors.

In the American context, Bernard's (2008) review noted that: supervisees find organization, availability, and clear and frequent feedback helpful; it is useful to intervene in accord with the supervisee's level of cognitive complexity; a strong working alliance and cultural competence go hand in hand; clashing theoretical orientations interfere; and, specific models of supervision seem to matter little. Accordingly, the CFM was constructed to maximize these factors and provide an organizing framework for supervision. As such, it relies on developmental or stage models of counsellor development, social role models, common factor approaches to supervision, models of supervision based on psychotherapy theories, and competency profiles in psychology, MFT, and counselling.

Developmental/Stage Models

Stage models of counsellor development rely on two premises: first, as counsellors in training develop competence, they progress through qualitatively different stages; and second, that counsellors at each stage require a different approach to supervision (Chagnon and Russell 1995). Developmental approaches dominated clinical supervision in the 1980s and -90s (Holloway 1987, Watkins 1995a). The best known and researched, the Integrated Developmental Model (IDM) (Stoltenberg and McNeill 2009), describes three stages of development of counsellors in training, and one further post-training stage.

Although developmental models of supervision are intuitively appealing, neither confidence nor years of experience correlate strongly with clinical competence or positive treatment outcomes (Lichtenberg 1997; Smith and Glass 1977; Stoltenberg *et al.* 1994; Strupp and Hadley 1977). Developmental models have little empirical support (Ellis and Ladany 1997; Goodyear and Bernard 1998), focus primarily on graduate school and prelicensure years (Goodyear *et al.* 2003), and have been criticized as simplistic (Russell *et al.*

1984; Stoltenberg 2005). Holloway (1987) suggested that stage models ignore trainees' personal lives, values, culture, and gender. Despite these limitations, there may be value in how a supervisor matches a supervisee's cognitive complexity (Mayfield *et al.* 1999) and style (Moore *et al.* 2004).

Social Role Models

Bernard's Discrimination Model

Bernard and colleagues (Bernard 1997; Luke and Bernard 2006) have developed and refined the Discrimination Model. It combines the supervisor's role as *teacher* (instructing, modeling, or providing feedback to a supervisee), *counsellor* (inviting supervisees to reflect on their thoughts, emotions, or actions), and *consultant* (acting as a resource). Within these roles, supervisors can focus on *intervention skills* (observable supervisee behaviors), *conceptualization skills* (making sense of client presentations, treatment planning, and intervention design), and *personalization skills* (warmth, ability to engage clients, nondefensiveness, *etc.*). Originally designed to assist new supervisors to organize their supervisory efforts, the Discrimination Model is atheoretical and parsimonious. It is implicitly geared toward the student and prelicensure years.

Systems Approach to Supervision

Holloway's (1995) Systems Approach to Supervision identifies five tasks of supervision, which align with counsellor competencies: counselling skills, case conceptualization, professional role, emotional awareness, self-evaluation. Across each of these tasks, the supervisor can fulfill five functions: monitoring/evaluating, instructing/advising, modeling, consulting, and supporting/sharing. Holloway invites supervisors to consider the institutional context; the supervisor, the client, and the trainee as contextual factors; and the supervisory relationship as a core factor. Holloway's model addresses the complexity of supervision, and emphasizes the administrative/organizational context of supervision, which, until recently has been underemphasized (Falender *et al.* 2004; Meek and Winters 2012).

Common Factors

Morgan and Sprenkle (2007) have proposed a common factors approach to supervision. They draw a parallel between counselling and supervision, noting experienced supervisors use common, rather than model-specific interventions (Goodyear and Bradley 1983; Goodyear and Robyak 1982) and focus largely on the supervisory relationship (Ladany *et al.* 1997; Patton and Kivlighan 1997). They distinguish between three dimensions that guide supervisors' practices: clinical competence (intervention and case conceptualization skills) vs. professional competence (ethics, cultural competence, professional work management skills), idiosyncratic (needs of the supervisee) vs. general (needs of the profession), and collaborative vs. directive relationship style.

Model-Based Approaches to Supervision

Approaches to supervision based on theories of counselling represent an historical moment in the history of counsellor education and supervision, which in my view, has now passed. Referring to the state of supervision 15 years ago, Watkins (1995, p. 570) stated,

"Psychotherapy-based models of supervision have generally shown an amazing amount of stability over the last 25–30 years, with… no truly new therapy-based theories of supervision emerging and… existing therapy-based theories showing limited changes or revisions…." Other than the recently articulated narrative approach to counseling and supervision (Winslade 2003), this has not changed.

The recent trends toward psychotherapy integration (Goldfried 2001; Norcross *et al.* 2005) and common factors (Duncan *et al.* 2010) appear to have extended into supervision (Efstation *et al.* 2004; Horvath 2004). Moreover, in community practice, supervisors work pragmatically. Most counselling organizations accept staff, students, and interns from across the theoretical spectrum, and emphasize the skills supervisees need for practice (Pearson 2007). Accordingly, supervision from a specific theory of counselling is largely a bygone practice. This is not to say that models of therapy are unimportant. They provide a clear guidance for clinicians' practice. Therapists at all career stages gravitate to models that *fit* for them (Chang 2011; Ronnestad and Skovholt 2003), which permit them to work coherently, consistently, and confidently, maximizing allegiance factors (Duncan *et al.* 2010).

Competency Profiles

In keeping with the North American trend toward outcome- and competency-based education (Hoge *et al.* 2003), professions have developed competency profiles in psychology (Canadian Psychological Association 2004; Rodolfa *et al.* 2005), MFT (Nelson *et al.* 2007), and counselling (Council for Accreditation of Counseling and Related Educational Programs 2009; Task Group for Counsellor Regulation in British Columbia 2007). Competency profiles specify desired outcomes for entry-level practice. Fouad *et al.* (2009) linked competencies in psychology to stages of professional training (i.e., practicum, internship, postdoctoral supervision and pre-licensure, and continuing competence).

Description of the CFM

The CFM provides a meta-framework for supervisors to organize their supervisory interventions. Experienced supervisors likely already attend to these components, if only implicitly. The CFM provides a heuristic for supervisors to develop their personalized approach to supervision. It is not my intent to prescribe how supervisors should supervise, but rather to invite them to be intentional in considering these six elements in their practice, each of which are supported in the supervision and counsellor development literature. These elements are: the *administrative context* in which supervision takes place; the *culture-infused supervisory working alliance; supervisory functions* – the various "hats" that supervisors wear; the supervisor's and supervisee's *theory of change* (both as it pertains to client change and self-change); isomorphic interactions in the *service delivery system;* and the *phase of counsellor development*. For each component of the CFM, I have suggested an orienting question that supervisors can use to clarify and organize their work, and how to operationalize practices pertaining to each component (Table 1).

Administrative Context

The administrative context in which supervision occurs is the foremost factor to consider. This includes the organization in which services are delivered, regulatory and accrediting bodies, and in the case of practica or internship, the educational institution. Regulatory bodies and

Table 1 Components of the contextual-functional meta-framework for clinical supervision

Component	Administrative context	Culture infused supervisory working alliance	Functions	Theory of change	Service delivery system	Phases of counsellor development
Orienting Question	*"To whom am I accountable?"*	*"Can the supervisory relationship support the intervention?"*	*"When should I do what?"*	*"Is there a clash of ideas, or an ecology of ideas?"*	*"What are the relational patterns that affect the supervision process?"*	*"Where is the supervisee in the journey?"*
Features	AGS Commission Model.	Culture-infused approach:	Clinical educator	How do the supervisee's theory of change and the supervisor's theory of change mesh – or not?	Isomorphism	Skovholt and Ronnestad's (1995) phases of counsellor development.
	With whom have I contracted?	The supervisor's cultural positioning and the supervisee's cultural heritage.	Skill development coach	Typically, supervisor's theory of change is better elaborated.		
	Who is paying the bill?	Supervisory working alliance:	Ethics/risk management consultant	Theoretical pluralism.		
	What do they expect me to do?	Stages of Change	Catalyst	Theory of change as narrative.		
	Does what I am doing fall within my primary commission?	Visitor, Complainant, Customer	Professional gatekeeper Organizational/ administrative supervisor Personal supporter Professional mentor Advocate/system change agent			

educational institutions have specific requirements like supervisor qualifications; a ratio or number of hours of supervision, hours of client contact, and hours on site; and documentation and reporting. Supervisors should ask themselves: "*To whom am I accountable?"*

Holloway (1995), alone among early supervision scholars, emphasized the importance of the context in which supervision occurs. The AGS Commission Model (Salamon *et al.* 1993) provided concrete advice for clarifying organizational dynamics. A family therapy team in Stockholm, Sweden, they asserted that therapy is more effective when therapists are clear about their commission. Clients request services with an idea of what they want, the "presented commission," which may or may not be clear, relevant, or realistic. The therapist presents one or more hypothetical commissions to the clients, on the way to developing a clear commission.

Service delivery improves when stakeholders (funders, the counselling organization, clients, and therapists) are clear about who should be doing what. A primary commission (e.g., an agency that is funded to serve clients who have been referred by child protective services) subsumes any secondary commission (e.g., helping a parent enhance his anger management skills); secondary commissions must fall within the primary commission. Supervisors can be mindful of these questions: *With whom have I contracted? Who is paying the bill? What do they expect me to do? Does what I'm doing fall within my primary commission?*

When developing a supervision contract, supervisors must ensure that the learning objectives are within the mandate of the primary commission. This has implications for informed consent and confidentiality, given that the supervised practice is subject to regulatory and educational bodies, and in alignment with the mission of the service delivery organization. It may be useful to include a disclosure of interest in a supervision contract, in which the supervisor discloses his/her primary obligation, and its implications for the supervisee. While supervisors are concerned with the development of supervisees, we must keep in mind where our accountability lies.

> James began a rotation in forensic psychology in a large regional hospital. He found the mandate of the unit, to assess criminal offenders and report to the Court, uncomfortable. He felt he should be of more help to clients. He told his supervisor, Dr. Law, that he would like to develop his therapy skills with this population. While Dr. Law affirmed that this was indeed a worthy goal, she clearly stated that it could not met in the current rotation, and assisted James to conceive of how he could use his therapeutic skills to engage assessment clients.

The Culture-Infused Supervisory Working Alliance

In the CFM, culture is not a theoretical abstraction. Cultural differences between supervisors and supervisees come alive and, if all goes well, are acknowledged and managed within the relationship between them. Management of cultural differences is a strong contributor to a viable supervisory alliance (Chen and Bernstein 2000; Ladany *et al.* 1997). To orient themselves, supervisors can ask, "*Can our relationship support the supervisory intervention?"*

A Culture-Infused Approach

Arthur and Collins (2010) have proposed an approach that they have called *culture-infused counselling.* They argue for an expansion of culture beyond historical racial and ethnic identities, to gender, disability, and sexual orientation. Rather than approaching those who are different as *the other*, they urge counsellors to acknowledge their cultural positioning and

privilege, and then to appreciate the cultural identity of the supervisee, so as to develop a culturally competent working alliance. "The construct of the working alliance provides an organizational framework for integrating the core multicultural competencies" (p. 52). In the CFM, culture is not a theoretical abstraction; "the rubber meets the road" in the supervisory relationship.

> Dr. Khalil, a Jordanian-Canadian Muslim psychologist, was supervising Lisa, a European Canadian intern. When he first met Lisa, he graciously put his hand over his heart and bowed to her, while explaining his religious practice of not shaking hands with women. He utilized this to open a discussion about their respective cultures and how ethnicity affects the delivery of counselling services.

The Working Alliance in Supervision

The supervisory working alliance can be conceptualized in a parallel fashion to the therapeutic alliance. In line with solution-focused principles (de Jong and Berg 2008), supervisors can conceptualize supervisory relationships in one of three ways: in a *visiting* relationship, a supervisee does not see the need for supervisory input; in a *complainant* relationship, the supervisee may experience difficulty in some aspect of his/her work, but does not see him/herself as able to do anything about it; in a *customer* relationship, the supervisee experiences him/herself as able to take action to advance his/her development. Alternately, Prochaska and di Clemente's Transtheoretical Model of Change (di Clemente 1999; Prochaska *et al.* 2008), applied to supervision, suggests that supervisees can be at different stages of readiness and receptivity to supervisory interventions.

Whether a supervisor uses these or other ways of thinking about the alliance, he or she must match supervisory tasks, goals, and methods to the readiness of the supervisee, when the administrative context permits. However, the supervisor can adopt a collaborative position while developing goals that meet the requirements of the administrative context. Similar to therapy with involuntary clients, supervisors can develop mandatory supervision goals by asking questions like, *"What do we need to do to satisfy the requirements of your academic program?"*

Obtaining feedback about the state of the working alliance improves outcomes in therapy (Miller *et al.* 2006). Logically, it can be argued that it would be beneficial to closely monitor the state of the supervisory alliance. Efstation *et al.* (2004) developed the Supervisory Working Alliance Inventory. Like the therapeutic relationship (Horvath 2004), Efstation, Patton, and Kardesh found that supervisors and supervisees often experience the working alliance differently. Accordingly, it is useful to solicit feedback about the alliance frequently.

Supervisory Functions

Central to the CFM are nine functions of supervision. The CFM is informed by existing approaches that have categorized functions or roles in supervision (Bernard 1997; Holloway 1995; Kadushin 2002; Morgan and Sprenkle 2007). While in North America clinical supervision is emphasized during graduate training and pre-licensure, other English-speaking jurisdictions (e.g., British Association for Counselling and Psychotherapy 2010; Irish Association for Counselling and Psychotherapy, n.d.; Schofield and Pelling 2002) require supervision throughout a counsellor's working life, as a component of lifelong learning. In fact, Grant and Schofield (2007) found that some 96 % of Australian counsellors

received some kind of ongoing supervision. Some North American supervision scholars advocate lifelong supervision as well (Goodyear *et al.* 2003). The functions of supervision described by the CFM assume that supervision extends beyond the student and pre-licensure years. Supervisors can orient themselves with the question: *"When should I do what?"*

Morgan and Sprenkle (2007) distinguished between an idiosyncratic (needs of the supervisee) and general (needs of the profession) approach, suggesting that supervisors are responsible for attending both to the development of supervises and to the interests of the profession. Kadushin (2002) divides social work supervision into administrative, educational, and supportive roles. The CFM provides an inclusive framework for attending to both the needs of the profession and the needs of the individual, and for focusing on administrative, educational, and supportive roles. The nine functions of supervision within the CFM are:

Clinical Educator

This function addresses the supervisee's perceptual and conceptual development (Tomm and Wright 1979). The supervisor teaches concepts and theories. He or she may provide didactic instruction, create learning experiences, or assign reading on an approach to therapy or a particular clinical problem. The goal is to clarify theories of practice, align practice with their theory, and improve clinical knowledge. This may entail challenging supervisees' assumptions, deconstructing supervisees' theories, teaching supervisees perceptual skills (Tomm and Wright 1979) so they *"know what to look for,"* and introducing ideas from outside the psychotherapy literature – e.g., art, literature, philosophy, popular culture – that could help inform clinical thinking. Finally, as a clinical educator function, the supervisor assists the supervisee to integrate this knowledge to develop a coherent treatment plan.

Skill Development Coach

In this function, the supervisor focuses on executive skills (Tomm and Wright 1979) – the behaviors that supervisees perform in sessions. The supervisor demonstrates and/or gives feedback on skills, strategies, and interventions, usually based on direct observation via co-therapy, live supervision, or video or audio recordings. This could include *generic skills* (e.g., attending, questioning, reflecting, summarizing, information-giving, confronting, structuring), *generic sequences,* not strictly related to a particular model or procedure (e.g., history-taking, soliciting a problem description, giving test feedback, conducting a skill training intervention, or delivering didactic content), or *theoretically or procedurally driven strategies* (e.g., systematic desensitization, reframing, questioning about exceptions, or administering a particular psychological test). This includes supporting the supervisee to self-observe his/her skill development.

Ethics/Risk Management Consultant

In this function, the supervisor supports the application of ethical principles in practice, leading and prompting the supervisee's ethical decision-making (EAC, n.d.; Falender and Shafranske 2004; Recupero and Rainey 2007). With novice supervisees, the supervisor supports them to move from conceiving ethics as a theoretical abstraction or set of *"dos and don'ts,"* to developing proactive habits of thought and action. The supervisor warns supervisees of ethically risky situations, drawing the supervisee's attention to larger systemic issues that can drive ethical thinking. The supervisor may explain how agency policies reflect larger ethical or legal imperatives.

Catalyst

In this function, the supervisor attends to, tracks, and if necessary brings the attention of supervisees to their *"blind spots,"* deficiencies, and potential personal issues that might interfere with the supervisee's clinical work – such as issues of "countertransference" (Jordan *et al.* 2008; Shafranske and Falender 2008). When such issues interfere with the supervisee's well-being and/or clinical work, the supervisor can support the supervisee with his/her personal issues, help supervisees develop strategies to manage their interactions with clients, confront the supervisee and, if necessary, refer the supervisee to therapy.

Professional Gatekeeper

When fulfilling this function, the supervisor, on behalf of educational programs and/or regulatory boards, monitors and evaluates supervisees entering the profession (Russell *et al.* 2007). The supervisor is responsible for ensuring that the supervisee obtains the required amount of clinical and supervision hours, evaluating the supervisee's progress according to established entry-level criteria, as described in competency profiles. When necessary, the supervisor may have to out-counsel a supervisee from continuing in the profession. The supervisor protects the integrity of his/her discipline by fulfilling this function.

Organizational/Administrative Supervisor

The organizational/administrative supervisor orients the supervisee to his/her duties, and manages performance. In this function, the supervisor explains the rationale for the organization's procedures, and where relevant, connects them with overarching ethical and legal imperatives. This can include case management procedures, requirements for written documentation, office procedures, and consultation/sign-off processes. The organizational/administrative supervisor supports supervisees with time and workflow management. This is an important area to monitor, as deficiencies in administrative requirements like clinical record-keeping and time management may indicate the first stages of therapist impairment (Thomas 2010).

Personal Supporter

As a personal supporter, the supervisor creates a warm and accepting context. He/she listens respectfully to events and struggles in supervisees' personal lives. The supervisor stays alert to indications that the supervisee's personal struggles could interfere with the supervisee's capacity to perform his/her duties, and/or could decline into an impaired state. If necessary, the supervisor refers the supervisee for therapy. Although the supervisor may use therapy-like skills to support the supervisee, the emphasis must be on supporting the supervisee to perform satisfactorily, making a referral if necessary, taking care to keep the relationship within these parameters (EAC, n.d.; Ladany *et al.* 2005).

> Baldip, a psychologist, was supervising Kisha in Baldip's private practice firm, which conducted parenting assessments for the local child protection authority. Baldip noticed that Kisha was missing deadlines for reports, which was affecting the firm's reputation. In addition, the quality of her reports was declining. He raised these issues in supervision. Kisha tearfully acknowledged her performance problems, and revealed that her husband was having an extramarital affair. Working from a combination of

administrative supervisor and *personal supporter*, Baldip listened supportively. The rest of the session was comprised of planning to get Kisha's outstanding reports completed, reduce her workload, and at Kisha's request, temporarily ceasing to refer to her marital therapy cases. Baldip also had a conversation with Kisha about her preferred type of therapy (individual or marital), and made some suggestions about whom she might see.

Professional Mentor

Following Allanach (2009), the supervisor provides advice, support, and feedback about professional issues and career choices. For example, the supervisor can support the supervisee about his or her career path – for example, whether the supervisee should seek further graduate education or a management or supervisory position, how to exercise self-agency in one's career path, whether and/or how to start or enhance a private practice, and balancing professional and family obligations.

Dr. Moss, a psychologist, had been the administrative and clinical supervisor of Leon, an MFT, for eight years. Leon was ready to return to school for a doctorate. Dr. Moss assisted him to clarify part-time and full-time options, which discipline (MFT or psychology) to pursue, and the prospects for academic and leadership jobs.

Advocate/System Change Agent

In this function, the supervisor advocates for policies, organizational structures, and clinical practices, to improve the context of clinical service delivery (Glosoff *et al.* 2012). In this function, the clinical supervisor thinks systemically and balances the needs of the organization with the needs of the supervisee, striving for improved service delivery and more empowering circumstances for the supervisee.

Leanne was contracted to provide supervision to interns at a nonprofit children's mental health agency. To a person, Leanne's supervisees described how they were burdened by duplicate paperwork and a cumbersome case management process, neither of which increased the quality of the service delivery. It was either affecting their ability to perform other tasks they considered essential (seeing children and consulting with staff), or eating into their personal time. Leanne both contextualized the need for the paperwork to the supervisees in a way that their administrative supervisor had been unable to, and advocated for changes in the forms and clinical reporting systems, resulting in changes that freed more therapy and consultation hours in the interns' calendars.

Some functions will not be used with some supervisees or in some supervisory contexts. For example, when supervising practicum students and licensure interns, supervision is likely to be heavily weighted to skill development coach and clinical educator functions, while a supervisor of an experienced, licensed practitioner would likely function largely, though not exclusively, as a professional mentor. An agency employee who supervises clinicians may not be well positioned to be an advocate/system change agent. On the other hand, while a contracted supervisor may have more leverage and less to risk as an outside expert who has been invited by the senior management of the organization. The gatekeeper function may be entirely irrelevant with a supervisee who is already licensed and seeking supervision to enhance his or her skills.

Theory of Change

In the CFM, *"theory of change"* refers to the supervisor's and supervisee's theory of client change, as well as their respective models of self-change. To orient oneself, the supervisor can ask: *"Is there a clash of ideas, or an ecology of ideas?"* In most cases, the supervisor's theory of client change will be better elaborated and more coherent than the supervisee's. The CFM supports theoretical pluralism – it is not necessary that the supervisor and supervisee share the same theory of client change. In fact, this is relatively uncommon. Practicum students and interns may have little choice about placements, and may end up with supervisors with different theoretical orientations. Accordingly, it is necessary that the supervisor and supervisee view their theories as but one narrative of how change occurs (Gardner and Yasenik 2008). A coherent approach to therapy and a clear belief about mechanisms of change provide a therapist theoretical and procedural coherence. In keeping with a postmodern understanding of knowledge, this is best treated as useful in specific contexts (Amundson 1996), and as not as singular "truth." Effective supervision does not result from colonization of the supervisee.

Although the CFM is not model-dependent, as supervisors it is impossible to escape our theories. Clinical training, whatever its theoretical orientation, induces counsellors to notice, conceptualize, and interact in particular ways. As Gregory Bateson said, *"Your epistemological slip is always showing"* (Keeney 1982). Therefore, while the supervisor's theory of change will usually be better elaborated than that of the supervisee's, the supervisor's goal should not be to indoctrinate or convert, but to support the supervisee's clarification of his/her theory of change, and to deconstruct it in order to explore its implications.

Moreover, no supervisor is competent to supervise every supervisee. The ethical imperative of competence demands that we not supervise those who are performing professional activities in which we are not ourselves competent. Similarly, when theories of change are too divergent, and the supervisor and supervisee are unable to negotiate common ground, a clash of stories, rather than an ecology of ideas, ensues. The latter permits cross-germination, as ideas serve a complementary function, like different elements of an ecosystem. On the other hand, competing or clashing stories undermine collaboration, and may create a context where it is not possible to supervise a supervisee.

> Yvette is an experienced clinician and supervisor who has trained extensively in solution-focused therapy (SFT). She was supervising Kelly, a devotee of emotionally-focused therapy (EFT), in her Master's practicum. Kelly told a classmate of her concerns that Yvette might "ram solution-focused down my throat." However, although Yvette was not an expert in EFT, she had adequate knowledge about the theory underlying it – enough to 'speak the language' knowledgeably, and she refreshed her knowledge by re-reading some EFT literature. When Kelly was flustered about a highly conflictual couple, Yvette first listened as Kelly calmed down, asked her how an EFT approach would help her conceptualize the case, and what she should then do. Consistent with her SFT leanings, Yvette would ask Kelly *what works* in certain situations. At times, Yvette named specific concepts from EFT that she thought were relevant to the case, and invited Kelly to operationalize them. Yvette would sometimes, half-jokingly, comment from an SFT perspective from a one-down position, stating, *"Well you know I only know how to do one thing – SFT – but here is what I would do…."*

Service Delivery System: Isomorphism

It is necessary for the supervisor to consider the interactional patterns within the service delivery system that affect supervision. Here, the orienting question is: *"What are the relational patterns affecting the supervision process?"* "Parallel process" is a term that is sometimes used to describe this; it describes material from the therapeutic relationship that replicates itself in supervision, and is thought to occur when the supervisee unconsciously identifies with the client, and reenacts the client's attitudes or behavior in supervision. On the other hand, "isomorphism" refers to how the supervisee's interactional patterns with the client system are replicated in supervision.

Liddle (1988) suggests that isomorphism can be utilized as an opportunity for intervention. The supervisor can shift the pattern of his/her responses to the supervisee in supervision, which in turn can alter the pattern of the supervisee's in-session behavior.

> Kyle, a Master's counselling student, was working with a chaotic family, in which the adolescent son required structure and the parents appeared powerless to do anything to set limits with him. Kyle's videos showed that he made halting attempts to intervene, but seemed just as overwhelmed with the family as the parents did with their son. Lina, his supervisor, had tried to make some suggestions, but found Kyle had difficulty implementing her suggestions, and was beginning to feel powerless as well. Once she altered her approach to ask him what he was doing when his engagement with the family was better, and how he was able to see the family's strengths, even if only fleetingly, Kyle was able to relax and refrain for trying to push the parents to take charge.

Phases of Counsellor Development

Skovholt and Rønnestad's (1995) landmark grounded theory study of counselors sampled 100 counsellors, from lay helpers to those with 25+ years' experience. They found that counsellors at different stages of development had different learning needs, derived satisfaction differently, and had different sources of influence. Accordingly, supervisors can orient themselves by asking: *"Where is the supervisee in the journey? What are the supervisee's developmental needs?"* They distinguished six phases of counsellor development: the *Lay Helper*, the *Beginning Student*, the *Advanced Student*, the *Novice Professional*, the *Experienced Professional*, and the *Senior Professional*. Rønnestad and Skovholt (2003) provided specific suggestions for how to support counsellors at each phase of development, based on: how practitioners in that phase saw their central task; their predominant affect; their major sources of influence; their description of their function and working style; the conceptual ideas that influenced them, including their allegiance to particular models of psychotherapy; how they approached learning; and how they gauged effectiveness and satisfaction (Skovholt and Rønnestad 1995; Rønnestad and Skovholt 2003; see also Goodyear *et al.* 2003). Accordingly, it is necessary to match supervision with the developmental status of the supervisee (EAC, n.d.)

Integration, Summary, and Future Directions

Utilizing the CFM begins with a clear understanding of the organizational and administrative context in which supervision occurs. The supervisor must be clear about the requirements

and limitations of regulators, educational institutions, and the service delivery organization. He or she and must ensure that the scope of supervisory activities is consistent with these requirements, and that any goals negotiated with the supervisee are within the primary commission permitted in the organizational context. The supervisor must then attend to the supervisory working alliance. After having done the necessary reflection to understand one's own cultural positioning, the supervisor is better prepared to attend to the cultural aspects of the working alliance. The supervisor carefully matches supervisory functions to the supervisee's needs, and consciously and intentionally moves between such functions. The supervisor understands his or her own theory of change, and how it is performed. He/she strives to understand and deconstruct the supervisee's theory of change, and holds both theories of change as narratives of therapy and not one as "the truth." The supervisor observes and tracks how interactional patterns in other parts of the service delivery system isomorphically replicate themselves in supervision. Finally, the supervisor intervenes according to the supervisee's developmental phase.

Applying the supervision research through the lens of 20 years of supervisory experience, the CFM approaches clinical supervision as a practical endeavor that demonstrates its value when supervisees develop professionally and clinically, and service delivery and clinical effectiveness improves. The CFM is a systemic approach to supervision that considers the context of service delivery and supervision, culture, and the interactional patterns in which the client, counsellor, and supervisor participate. The CFM assists supervisors to orient and organize their supervision efforts – reminding supervisors to attend to and weigh multiple aspects of supervision at one time. The meta-framework provides a useful heuristic across theoretical orientations and disciplines, advocates for supervision as a career-long process, and supports supervisors to develop their personal approach to supervision.

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