Learning Objectives
- Contrast traditional versus strength-based models of supervision.
- Describe the role of the supervisor in strength-based supervision.
- Identify ways to effectively promote a strength-based philosophy in clinical practice and supervision.
- List the similarities and differences among several strength-based models of supervision.
- Develop a strength-based approach to evaluation.

Introduction
- Susan anticipated her afternoon supervision with both relief and dread. Her client was just released from a second hospitalization and she was at a loss for how to help him. She was concerned that she missed signs that led him to seek hospitalization. Worse yet, she felt somewhat responsible, fearful she “pushed” him too much in their last session. Susan relaxed just a bit; her supervisor would have the answers, once she admitted to her own incompetence.
- John prepared for his meeting with his newest clinician. Sometimes he felt overwhelmed by his responsibility. He had to train his staff, keep them motivated and ensure that no harm was done. Other times, he was exhilarated by the interactions with his supervisees. If only it could always feel that way.

What to expect from supervision is often learned on the job. Both Susan and John have expectations of each other, the process of supervision, and themselves. Susan clearly lacks confidence and insight into her strengths. She ignores the fact that she missed signs that led him to seek hospitalization. Worse yet, she felt somewhat responsible, fearful she “pushed” him too much in their last session. Susan relaxed just a bit; her supervisor would have the answers, once she admitted to her own incompetence.

John, though proud of his accomplishments and expertise, is overwhelmed by the responsibility to maintain his role as the expert. What is different about those times when he feels exhilarated after a supervisory session? Is it that he is validated for his wisdom and knowledge or that he and his supervisee communicated openly, collaborated on solutions, and better yet, he had learned something new from a fresh perspective?

Supervision is often seen as a top-down, hierarchical process with little recognition of the responsibilities of both the supervisee and the supervisor in directing outcomes. More often than not, even in systems that promote a strength-based service philosophy, management and supervision is deficit-based. Many supervisors fall into the trap of ferreting out problems, remedying weaknesses and filling gaps, i.e., “You don’t know what you are doing, but never fail. I am here to show you what you are doing and how to do it correctly.” As a result of this mind-set, they fail to see the talents, healthy patterns and strengths of their supervisee as the supervisee fails to connect what they do and what they offer with the successful outcomes of their clients.

In this course, you will explore what it means to have a strength-based philosophy in the practice of clinical supervision.

The impact of practice on supervision
How do we do the work of helping others has constantly evolved over the years, at times rejecting traditional approaches, at other times embracing it. For example, we have seen a re-emergence of family and community – based practice, which builds on the resources of the client and family. While this appears to be a new concept, it really represents a return to earlier days (and to cultures) when people lived in close-knit communities and used the resources of their families and communities to solve social problems.

Typically, though, our history of helping can be characterized as a traditional deficit-based approach. Based on the medical model, therapy and case management focused on the assessment of problems and deficits, the categorization of symptomology, and the implementation of prescriptive interventions by experts. The belief that clients were helpless without us shaped both opinions of our clients and our interventions.

Regarding clinical supervision, “Most traditional supervision has paralleled conventional counseling, looking for what the supervisee was doing incorrectly or not doing enough of mostly in the area of technique and attempting to devise remedial solutions.” (Edwards and Chen, 1999.)

The social services field is a good example. Initially supervision involved the monitoring of work by volunteers. Eventually the field professionalized with more and more services provided by paid staff. As psychoanalytic treatment approaches influenced practice, so too, came a focus on providing therapeutic support for the worker. In the ‘50s, widespread rejection of the psychoanalytic approach resulted in a decreased emphasis on supervision. With each new wave of innovative treatment methodologies and approaches to service, there has been and will continue to be a spillover into how we do the work of supervision.

The impact of society on supervision
In addition to the influence of clinical practice trends, the economics and politics of social services has influenced the nature of supervision. While accountability and outcome management are necessary components of the field, limited resources often leave little time for frequent, quality supervision.

Kadushin (1992) identified three primary functions of social work supervisors: administrative, supportive, and educational. Yet increasingly, supervisors spend more time in the administrative function, which often includes the monitoring and evaluation of processes, rather than client outcomes. For example, case reviews often focus more on ensuring that an adequate number of visits occur or that mandated documents be in place. Supervisors must also focus on utilization management activities where critical time is spent monitoring compliance with eligibility and billing requirements or reviewing lengths of stay.

While politics and economics will continue to influence clinical and supervisory practice, the strength-based movement continues to grow and to even cross over into the “other side” – the private sector. For example, strength-based supervisory approaches are being promoted in a wide range of professions including the probation, nursing, teaching and business fields. “In order to keep pace with the movement toward strength-based counseling, supervision must employ a similar view. As strength-based counseling models become more common practice, supervision practices should follow suit.” (Edwards and Chen, 1999.)

Supervision’s influence on outcomes
While there is more emphasis on practice accountability, there is still little research evaluating the effectiveness of supervision in social services – be it the provision of clinical or general supervision. Still, supported by research in both the public and private sector, there is
strong evidence that supervision impacts many outcomes such as:

- Retention.
- Employee satisfaction.
- Skill acquisition.
- Customer service.
- Client outcomes.
- Employee motivation.

Support from the supervisor is frequently cited as one of the major reasons for job satisfaction, while therapist burnout and turnover can be traced to ineffective and nonsupportive supervision. Csikszentmihalyi (2003) suggests that supervisors can promote joy and innovation by adopting a strength-based approach that creates situations where their skills are engaged and progressively challenged. He feels the best way to supervise is to create a positive, enjoyable environment where one grows in the process of doing their work.

Motivation is another factor that is greatly influenced by style of supervision, and it further affects both productivity and job satisfaction. Sirota, Mischkind and Meltzer (2006) highlight the importance of supervisor behavior and style on employee motivation and suggest that in order to maintain enthusiasm, managers must understand the goals most employees seek from their work, which includes a sense of being treated fairly, being proud of one’s accomplishments and having good, productive relationships with colleagues.

What do therapists want from supervision? Thomas (1996) outlines several themes gleaned from the work of Heath and Tharp (1991) as they explored the needs of therapists in the context of clinical supervision:

- Relationships based on mutual respect.
- Collegial supervisors versus “guru.”
- Supervision and evaluation should be both a cooperative experience based on goals and change.
- Recognition that supervisee is competent, especially given a tendency to view themselves in an overly critical light.
- Tell supervisee what they are doing right: Affirm versus Empower.
- Listen: Make supervision a human experience

### Traditional and strength-based approaches

The traditional model of supervision as described earlier is more problem-focused and hierarchical and parallels clinical practice. The supervisor is in charge of direction, focus and by consequence is viewed as the primary agent of change. Therefore, the supervisor owns the outcome. In this directive and prescriptive approach, the supervisee is viewed as in need of correction and guidance. Individual strengths and abilities, while occasionally recognized, are not sought out and in more extreme scenarios are disregarded altogether.

Since the 1990s, there have been “breakthroughs” in how we look at the helping process that promotes the importance of building on strengths and partnering with our clients. Models such as solution-focused therapy can promote the clinician and client to look for exceptions to the “problem” to identify solutions. This tactic causes a shift in both the clients’ and the clinicians’ view of the problem and more importantly of the person seeking change. When we focus on what has worked and what is working, we begin to see a person who is much more capable than a diagnosis would indicate.

A positive effect on client outcomes. The strength-based supervisor will assess the supervisee’s strengths and culture to help direct the process of supervision.

Change is a collaborative process. The solution-focused supervisor would define the parameters of ethical practice, but would recognize that there is no “right” way to do things. What works for some therapists may not work for others. They promote the supervisee’s first-hand expertise and build on his/her skills to facilitate growth and solve problems.

A strength-based approach to supervision then would be one that sees the supervisee as a partner whose thinking and viewpoint are valued. Viewed less as a subordinate and more as a colleague, the supervisee or employee works together with the supervisor to ensure quality practice. As Edward and Chen (1999) view it: “The nature of supervision thus changes from SUPERvision, where the supervisor is considered the expert with privileged knowledge telling the supervisee how to proceed, to co-vision and co-created-vision, where the co-visee is considered the expert and is expected to know more about what is happening in his or her sessions.”

Keeping in mind that new and even experienced therapists have a tendency to be “self-deprecating and critical” (Briggs and Miller, 2006), it seems logical that creating a context where therapist skills, abilities and actions are appreciated and recognized promotes greater self-confidence. Greater competence ultimately results in more frequent, positive outcomes for the consumer.

“A focus on strengths and successes in supervision creates a climate of comfort and safety which contributes to therapist confidence, and we believe therapist confidence contributes to therapist competence.” (Briggs and Miller, 2006.)

In the next section we will look at the role of the supervisor and how we can change our role so that it both parallels and ultimately supports the strength-based approach in service delivery.

### Role of the supervisor in strength-based practice

One of the challenges of strength-based work is being consistent with the principles of empowerment, self-determination and the strength-based approach throughout the organization. Though we intuitively know that this must be owned and promoted by the supervisors and managers within an organization, there is typically a lack of strength-based training for supervisors.

Some of the roles and tasks of the supervisor in strength-based practice would include:

- Communicating his/her vision and commitment to strength-based practice.
- Providing opportunities for staff to learn and/practice strength-based techniques and interventions.
- Modeling strength-based practice with consumers.
- Developing policies and procedures that support strength-based practices.
- Advocate for strength-based practice from system partners.
- Developing quality management practices that support strength-based philosophy.
- Supervising staff using strength-based strategies.

### Creating a Strength-Based Environment

One of the most important tasks a supervisor faces is that of creating an environment that will allow the supervisee the opportunity to openly communicate both their successes and challenges. You may also need to encourage the supervisee to identify what his/her strengths are. Typically, even the most experienced and self-
confident supervisee will struggle with this, especially when he or she is in a learning context.

There are several ways you can promote a safe environment:

- First, shift the focus away from a deficit-based view of clients. In case reviews, solicit examples of strengths the therapist sees in his/her client. Typically, this is a challenging task with many new and experienced therapists having difficulty identifying much beyond “motivated for treatment.”
- Second, encourage the supervisee to identify what personal qualities and skills make him or her successful.
- Third, when confronted with challenges in practice, solicit supervisee’s ideas about how he/she may have done things differently.

**Strength-based models of supervision**

Since the 1990s a variety of strength-based models have been introduced to clinical practice, and gradually supervision began to evolve in the same direction. For example, Reflective Supervision, described by Johnston (2005), is based on building a partnership between the supervisor and staff. One competency-based approach to supervision advocates for a methodology that “recognizes the personal strengths supervisees bring to their education and clinical training, and drawing on principles of positive psychology, informs the learning process and leads to increased competence and self-efficacy.” (Falendar and Shafranske, 2004.)

Narrative supervisors pioneered the use of reflecting teams, which emphasizes the use of multiple perspectives or “voices” from a team resulting in an open and dynamic process that focuses on the strengths of the therapist and generates multiple ideas, rather than maintaining a critical focus.

To illustrate some of the key assumptions and techniques of strength-based supervision, we will next review several models and methods that illustrate this approach.

**Solution-based supervision**

Solution-based or solution-focused therapy is characterized by a positive and respectful attitude toward the client. Collaboration is achieved because the clinician believes the client wants to do well, has the ability to develop workable goals, and as the expert, has the capacity to make progress with his or her goals. The clinician’s only expertise lies in being curious and asking appropriate questions while mutually maintaining clear boundaries.

Drawn from practice, solution-based supervision uses techniques such as using scaling questions and identifying exceptions to problems to promote a strength – or competency-based approach. This approach can be effective for clinical supervision and also staff supervision. Berg and Kelly (2000) applied this model to public welfare work (2000.) They proposed a new way of working with staff in child welfare that assumes worker competence and a collaborative, empowering approach that assisted workers in developing forward thinking.

Solution-focused supervision is more concerned with what the supervisee is doing, rather than on client issues and what the supervisee does correctly rather than what they may do “wrong”. As defined by O’Connell and Jones (1997), Solution-Focused supervision:

> “Validates the competence and resources of the supervisee, emphasizes the importance of clear incremental goals and identifies pre-existing solutions and exceptions to problems in the supervisee’s work.”

Solution-focused supervision spotlights strengths and solutions rather than problems and mistakes. This better supports the supervisee because problem-focused supervision can maintain supervisee confusion while solution-focused supervision promotes self-confidence as they recognize the positive aspects of their work. (Wetchler, 1990)

Thomas (1996) shares a story taken from an episode of the television series “Northern Exposure” that beautifully illustrates the process of solution-focused supervision. A woodcarver described how he creates a flute from a tree branch. “The branch will tell me how to carve it …. each piece of wood has its own shape, which you must respect…. In each branch lies a flute; my job is to find it!”

One of the principles of solution-focused supervision then is to:

> “Coax and author expertise from the life, experience, education and training of a supervisee/therapist, rather than deliver or teach expertise from a hierarchically superior position.”

(White and Epston, 1990.)

Solution-focused supervision is based on the principles of solution-focused brief therapy (SFBT) and uses the same tools as SFBT as outlined by Waskett (2005) including:

- Eliciting strengths and resources.
- Developing the supervisee’s preferred future or outcome.
- Taking a “not knowing” position and asking appropriate questions.
- Using scales to measure and develop progress.
- Remembering to notice positive movement in small practical steps.
- Offering appropriate evidenced compliments.
- Staying curious, respectful and flexible.

Table 2 compares solution-focused therapy and solution-focused supervision:

<table>
<thead>
<tr>
<th>Solution-focused therapy</th>
<th>Solution-focused supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeks to be helpful to the client in his or her agenda for therapy.</td>
<td>Seeks to be helpful to the supervisee in his or her agenda for work.</td>
</tr>
<tr>
<td>Focuses on history of resources and strengths and the “solution story” rather than the “problem story.”</td>
<td>Focuses on abilities, learning, and strengths that the therapist already has.</td>
</tr>
<tr>
<td>Pragmatic – Helps the client notice what works, their good qualities, abilities in the face of difficulties, etc.</td>
<td>Pragmatic – Helps the therapist notice what works, their skills, abilities, creative ideas, etc. in the service of the client/patient.</td>
</tr>
<tr>
<td>Collaborates with the client on his/her agenda.</td>
<td>Collaborates with the therapist on the agenda for work with clients/patients.</td>
</tr>
<tr>
<td>Listens constructively for client’s unique strengths and resources.</td>
<td>Listens constructively for the therapist’s unique strengths and resources in order to aid clients and his/her practice generally.</td>
</tr>
<tr>
<td>Invites clients to talk about and develop details of their ideas of their preferred future.</td>
<td>Invites and develops therapists preferred future in terms of being as good a therapist as they can possibly be for clients in their working context.</td>
</tr>
<tr>
<td>Uses scales and circular questioning to note and measure progress towards client’s preferred future and goals.</td>
<td>Uses scales and circular questioning to note and measure progress towards the therapist’s best practice.</td>
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</tbody>
</table>
As mentioned earlier, supervisors with a strength-based approach believe that the supervisee has the best interest of their clients in mind and are likely to be doing many things that are helpful to the client. Despite this, supervisors can expect that the supervisees will likely disregard their talents and their effectiveness as clinicians.

Thomas outlined additional guiding principles for the solution-focused supervisor, based mostly on the work of O’Hanlon and Weiner-Davis (1989), as well as Cantwell and Holmes’ (1995), and others. These include:

- It is not necessary to know the cause or function of a complaint in order to resolve it. Not only do therapists typically fall into the trap of having a problem-focused view of the client, but also they will do the same when examining themselves and their performance. Much time may be spent trying to gain “insight” into the origins or nature of the problem and getting nowhere in the process. The supervisor then needs to facilitate the focus to what the therapist was doing when things were progressing. The therapist’s understanding of what he does that “works” will enable him to generalize this to work with other clients with similar issues.

- Therapists know what is best for them. This assumes that the therapist has the resources necessary to solve problems in the therapy context. A frightening thought for many supervisors! The key here is resisting the first impulse to introduce suggestions and advice and learn from the therapist before working to facilitate solutions.

- There is no such thing as “resistance” (deShazer, 1984). The supervisor’s task here is to work with the learning experience and style of the therapist so the therapist is able to generate and choose new options and directions.

- The supervisor’s job is to identify and amplify changes. This concept results in solution talk, not problem talk. The supervisor will bring attention to the occurrence of success and amplify changes the therapist makes.

- A small change is all that is necessary. In this model, the best experience is a small success. Increasing feelings of competence and small successes can lead to a “ripple” or “snowball” effect that will allow the therapist to draw on other resources and in turn lead to additional success.

- Change is constant, and rapid change is possible. The supervisor needs to assume that change will occur and any activity therapy, supervision and life will not follow a prescribed course. As the therapist develops, changes will be progressive or discontinuous. The supervisor needs to allow himself or herself to be surprised and to allow supervisees to change at their own pace and within their own limits. For example, many times work is progressing in a steady, though moderate pace, when suddenly the client or therapist will make a connection and you have the “aha” moment that then propels the process further at a much faster pace.

- Supervision should focus on what is possible and changeable. This means leaving the impossible alone and recognizing capabilities, rather than deficits. The supervisor needs to not spend time on failures – they cannot be undone – but rather move forward with what will be feasible. Again, this is a big departure from the comfort of issue-driven, insight-oriented supervision and may not feel like actual supervision is taking place – at first.

- There is no right way to view things. Different views may be just as valid as others. It is neither necessary nor helpful to try to convince the therapist of the “rightness” or “wrongness” of any particular view or action. Rather, the supervisor’s task is to utilize the language and perceptions of the therapist and empower the therapist with viable alternatives and choices when he or she becomes “stuck.”

- Curiosity is indispensable. (Berg and Miller, 1992.) It is completely necessary to the process of solution-focused supervision that the supervisor has a genuine desire to know the opinions and perspectives of the therapist. Since the therapist is the one working most closely with the client and is the expert, it is more important to learn what the therapist knows to arrive at useful solutions.

### Strength-based wu-wei supervision

This model, presented by Edwards and Chen (1999) was developed in response to an article they read in which a supervisee described the Zenlike “beaten into understanding” approach to supervision she experienced. Wu-wei is a metaphor for action/nonaction. It is less directive, relying more on the natural process of growing and spontaneity to arrive at decisions. In their work with counselor education students, the authors found the following contexts useful:

- **Symmetrical voices** – Rather than the supervisor doing most of the talking or otherwise superseding the “voice” of the therapist, the supervisee (or covisee) is encouraged to “Give voice to their story in a way that expands the options for tackling client problems and highlight their competent behaviors.” Strategies include brainstorming with covisees, giving them the opportunity to teach the supervisor they know or did well, and giving covisees ultimate authority over the direction of the session.

- **A competence focus** – Supervisors must model the same values covisees need to exercise with their clients such as highlighting strengths, looking for good intentions in the face of “mistakes,” and probing for past exceptions. Another important aspect, beyond a focus on supervisee competence, is ensuring that language used regarding clients is competence-based and avoids using pathological labels and diagnoses to describe clients.

- **Client-participated supervision** – To introduce more respect into the way clients are discussed in supervision, clients are invited to join in supervision. If they cannot attend, covisees are encouraged to imagine their clients there.

- **An unassuming transparency** – The supervisor rejects the detached and objective stance by taking advantage of opportunities to share some of the struggle the supervisor may have had in their development or during the process of supervision. This compliments the stance of “not knowing.” As outlined before in solution-focused therapies, the supervisor will also present himself or herself as a curious participant in the process. This allows for doubt, rejection of ideas, and true give and take.

- **Reflecting team model** – The reflecting team is a useful resource for helping beginning group therapists get unstuck from group dynamics.

- **Tag-team supervision process** – During group supervision, the supervisees request input on a client or clients and assigns roles to other supervisees to act as the client(s) and someone who will act as the counselor. All members of the group, including the instructor, play the counselor role for 5-10 minutes at a time. At the conclusion of the “session” there is a postsession discussion, which generates many points of view in a very respectful and curious manner.
Success-enhancing supervision

The success-enhancing supervision of Briggs and Miller (2005) is similar in process to solution-focused therapy and supervision and further addresses the propensity of beginning and experienced therapists to be self-deprecating and critical. The authors believe that “when this becomes reinforced by the supervisor, therapists lose their self-efficacy as a therapist and their competence suffers accordingly.” In order to foster better self-efficacy, the authors apply solution-focused and constructive methods to clinical supervision.

In success-enhancing supervision, as in other solution-focused models, the client is only indirectly involved in supervision. A fundamental belief in this model is the belief that it is the therapist’s job is to serve the client. The supervisor is there to serve the therapist by assisting them to better serve their clients. This is an important distinction, as the following example illustrates:

- Ahmet, a licensed mental health counselor, has been working with his client, Judy, for a few sessions before meeting with his supervisor. As he tries to relate the reasons that brought her to treatment, her goals, and some of the work they have been doing together, his supervisor, Fred, repeatedly interrupts with questions, such as “Did you ask her this? Have you tried that? When I had a case like hers I did this…. Have you tried that?”

  By the end of the session, Ahmet leaves feeling irritated and undervalued.

Notice that in this scenario, Fred had difficulty separating from his other role, that of a therapist, and his eagerness to be involved in the case made it unclear who was in charge of the case! Fred has not only failed in his role as supervisor, but he may also be interfering in the relationship between the therapist and his client, not to mention damaging the supervisory relationship.

The following illustrates the process of success-enhancing supervision as described by Briggs and Miller (2005). In success-enhancing supervision, the therapist may be asked to bring a video or audiotape of the session and be prepared to discuss their work. Other times supervision may also occur in a group or during a live interview.

Goaling questions are used at the beginning of each session that establish the assumption on the part of the supervisor that the therapist wants to accomplish something in supervision. Examples include:

- “What is your goal for coming today?”
- “What would you like to accomplish today?”
- “What are your best hopes for today’s meeting?”

Then the supervisor will look for strengths, successes and exceptions throughout the session. Some questions might be asked include:

- “What are the strengths that you demonstrated in this session we are about to watch?”
- “I appreciate your clear description of times when therapy is not going well. That is useful information for me. Could you also tell me about the times when you are not experiencing those difficulties?”
- “What is different about the times you seem to be having success with this or similar clients?”

Such questions reinforce that the supervisor recognizes the therapist has strengths and successes. To further this belief, the supervisor will compliment the therapist’s description of his/her strengths and even amplify their ability for insight in being able to notice such things.

During the supervisory session, every effort is made to help the supervisee feel in control. For example, when viewing videotapes the supervisee is given the remote control to start and stop, forward, and reverse as he sees fit. Throughout the session, the therapist and supervisor will together continue to identify observable examples of where he or she did well and then amplify them. Initially, the supervisor may need to take the lead in this process, offering affirmative evaluations and praise, with the goal to have that process eventually led by the therapist.

Having a strength-based approach does not mean that the supervisor disapproves a therapist who may be focusing on problems. (which certainly would be counter to the strength-based philosophy.) Initially the supervisor may agree with such an assessment, but then follow up with an exception question. For example, “So how were you and your client able to work yourself out of this temporary impasse?” This is an important point. As discussed, therapists can be self-critical, especially beginning therapists. As confidence builds, therapists realize that difficulties and unanticipated events will arise from time to time and will believe that somehow they and their client will find a way to get beyond them.

When a therapist focuses on the client, rather than what the therapist is doing, the supervisor will redirect him or her by asking about the client’s perspective through the therapist’s lens:

- “What would you have liked to have done instead?”
- “Tell me about the times you don’t have that problem?”
- “What might you have done differently?”
- “When you do that (When that happens), what do you suppose the client is thinking?”
- “What, do you think, would the client like you to do differently?”

Sometimes a therapist may struggle with being able to correctly identify his/her strengths and successes. At these times, the supervisor should periodically pause the tape and ask:

- “What do you think the client thinks you are doing at this point in the session?”
- “What could you do differently (instead)?”
- “How would you do that?”
- “How would the client probably have responded had you done that?”

What do you do when either the therapist or supervisor recognizes a mistake that must be commented on? Being strength-based doesn’t mean you ignore problems. At those times, the tape would be paused or the conversation interrupted, and appropriate questions would be asked, such as:

- “What do you think you did there?”
- “What were you trying to accomplish there?”
- “How would that have been useful?”
- “What would you have liked to have done differently?”
- “How would you have done that?”
- “How do you think the client would have responded if you had done that?”

Keep in mind the importance of not asking the questions in a critical, sarcastic or mocking way. Remember, only ask questions that will generate information for which you are open to the response. Questions such as, “What were you thinking!” for example, are critical and unhelpful to the process.

It is vital that any discussion of problems be concluded with genuine compliments about such real facts as the therapist’s ability to see when problems exist and to participate well in formulating solutions. When a positive change or behavior is seen in the client, Briggs and Miller recommend stopping the tape and asking questions such as “How did you do that?” Questions that reinforce the beneficial
effects of therapy allow the therapist to generalize his or her efforts to other clients or situations in the future.

Other techniques the authors use include versions of scaling and miracle questions that allow the therapist to assess their progress and to project what they will be doing differently when they are closer to their goal of professional “competence.” They recommend that questions be used at the conclusion of every supervisory session. Examples include:
- “On a scale of 1 to 10, where 1 is the worst session you ever had and 10 was the best session you could possibly have, where would you rate that session?”
- “What would have been different if the session were a ________?”
- “How will you do that in the future?”

After the therapist and supervisor discuss the responses, the supervisor will then take a short break to formulate his/her solution-focused feedback for the therapist. Finally, the session ends with bridging statements and tasks, all communicated in the therapist’s language and from his or her frame of reference.”

**Group supervision**

Peer group supervision, in combination with individual supervision, can be an effective learning method. One study of a peer group supervision project demonstrated that it not only reduced confusion and anxiety and clarified goals, but also increased the confidence of supervisees (Starling and Baker, 2000). There are several things the supervisor can do to increase autonomy and self-confidence in supervisees. They include:
- Have all supervisees take a turn sharing a success where they describe a problem solved; make sure everyone has that opportunity.
- Coach individuals to develop a specialty to share.
- Have staff make their own contract about how feedback is solicited and given. An effective model is to have participants offer feedback on what the supervisee is doing well, with the individual him/herself giving the corrective feedback.
- Make sure that people have private venues for seeking feedback and suggestions.
- Seek out those who are likely to be most critical and most sensitive, prepare and make plans to avoid difficult interactions.

**Evaluation in strength-based supervision**

Though strength-based supervision strives to be nonhierarchical, it would be foolish to think that this kind of relationship exists without some power difference between the supervisor and supervisee. No matter how you cut it, the name difference alone – supervisor-supervisee or supervisor-employee – implies a hierarchical relationship. Couple that with the fact that the supervisor is often the individual responsible for formally evaluating the performance of the therapist, and the balance tips further.

This does not mean that all that has been said about strength-based approaches and its purposeful de-emphasis on hierarchy, is misguided. There is, in fact, a much greater effort to lessen this disparate arrangement. In strength-based supervision, the supervisee has much more control, there is more give and take, and more appreciation for and reliance on the skills and talents of the therapist. The supervisor is not the font of all knowledge!

Many organizations and supervisors may believe that a strength-based approach to supervision limits one’s ability to address poor performance and practice. But problems are not ignored. Tools from solution-focused practice can effectively address difficult situations.

But what about evaluation? Evaluation occurs in all the models we reviewed and remains a necessary aspect of the role of supervisor, whether it is formal or informal. Offering praise or illuminating the strengths one sees in a therapist is a form of evaluation, is it not? In addition to reinforcing learning and increasing therapist self-confidence and self-efficacy, such evaluation creates a safer environment for the therapist, especially when constructive feedback is called for.

At those times when constructive feedback is necessary, the supervisor will need to stop the tape or the conversation and interject some thoughtful questions about what is, or has happened. Briggs and Miller (2005) offer a format for a formal evaluation tool that is compatible with their model. It is similar to the 360 feedback evaluations used in many settings, as it allows the supervisee to evaluate himself/herself, as well as other significant persons.

In general, therapists would have little respect for the process if constructive feedback were not given. If we create a safe environment, such feedback will be recognized as well-intended and thus will be taken seriously, though not to the level where one is left feeling incompetent.

Beyond the need to provide periodic constructive feedback, what does one do when a supervisee is behaving in a risky, unethical or potentially harmful manner? Thomas (1996) shares some very useful suggestions:
- Begin every new supervisory relationship with a clear contract about responsibility.
- The supervisor’s comfort level, trust, and ethics should guide the degree of purposeful control. Be more directive regarding behaviors considered dangerous or unethical.
- For extreme clinical situations, discuss the situation openly as a dilemma with the supervisee.
- Always act according to one’s conscience and best judgment.

**Summary**

Clinical supervision continues to evolve and is shaped by clinical practice trends. Whatever specific strength-based approaches and techniques are used, the underlying philosophy remains one of respect and appreciation for the talents of others. Applying models of strength-based therapy to supervision can both alleviate the anxiety therapists and students feel while in an “evaluative” process and lead to greater competence.

**Bibliography**

STRENGTH-BASED SUPERVISION

Final Examination Questions

Choose True or False for questions 1 thru 10 and then proceed to WWW.ELITECME.COM to complete your final exam.

1. Supervision is often a hierarchical process, which recognizes the responsibility of both supervisee and supervisor.
   True False

2. The three major functions of supervision as described by Kadushin are political, educational, and supportive.
   True False

3. Therapist burnout and turnover can be traced to ineffective and nonsupportive supervision.
   True False

4. One of the roles of a strength-based supervisor is to model strength-based practice with consumers.
   True False

5. When confronted with challenges in practice, supervisors should take over and give supervisees ideas on handling them.
   True False

6. Solution-focused supervision is more concerned with what the supervisee is doing, rather than on the client.
   True False

7. Maintaining boundaries and accountability are part of solution-focused supervision.
   True False

8. Clients are often invited to join in clinical supervision in the wu-wei model.
   True False

9. Peer group supervision, in combination with individual supervision, is not an effective learning method in models of strength-based supervision.
   True False

10. Supervisors should always act according to their conscience and best judgment.
    True False