

Introduction

As longtime professors and trainers of counselors and psychologists, we find that one of the most satisfying aspects of our work is observing and mentoring the professional growth of students in becoming competent providers of clinical services to their clientele. Therefore, we are pleased to share our model of the supervision and training process with readers involved in this important and enjoyable work.

The integrative developmental model (IDM) as an approach to supervision has progressed for nearly 30 years, beginning with Stoltenberg's (1981) straightforward model that posited counselor growth through four stages of professional development. The influence of this initial presentation on the practice of clinical supervision from a developmental perspective led to an explosion of developmental conceptualizations. Reflective of the heuristic value of such models, at one point, Worthington (1987) compared 16 developmental models, to which Watkins (1995) added six!

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Supervision Essentials for the Integrative Developmental Model, by B. W. McNeill and C. D. Stoltenberg
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Subsequent books (Stoltenberg & Delworth, 1987; Stoltenberg, McNeill, & Delworth, 1998) significantly expanded this view with the integration of research and constructs with empirical investigations, as well as research from related areas of inquiry, leading to our most recent presentation of this IDM (Stoltenberg & McNeill, 2010).

Consequently, the IDM has evolved from its initial beginnings as the counselor complexity model (Stoltenberg, 1981) to the subsequent integration of important clinical activity components (e.g., domains of practice) of the supervisory process first noted by Loganbill, Hardy, and Delworth (1982), resulting in the current conceptualization.

In this brief introduction, we begin by defining *supervision*, offering a quick summary of the IDM, describing our personal journeys toward this conceptualization of supervision, and offering a road map for the rest of the book.

SUPERVISION DEFINITIONS AND GOALS

Definitions of the process of supervision have evolved over time, emphasizing, for the most part, similar aspects with variations in perceived important components. For example, Falender and Shafranske (2004) defined *supervision* as a “distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process” (p. 3) that also involves observation, evaluation, supervisee self-assessment, and the acquisition of knowledge and skills in the form of trainee clinical competencies and outcomes. In their periodically revised comprehensive text on clinical supervision, Bernard and Goodyear (2014) defined *supervision* as “an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of the same profession” (p. 9) and emphasized the evaluative and hierarchical nature of the supervisory relationship that extends over time to enhance the professional functioning of more junior persons, with the supervisor monitoring the quality of services and serving a gatekeeping function for the profession. Hill and Knox (2013) stressed the professional development of the supervisee, as well as client welfare in the supervisory relationship.

We agree with the definition of *supervision* recently adopted by the Board of Educational Affairs Task Force on Supervision Guidelines (American Psychological Association [APA], 2014):

Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. Henceforth, supervision refers to clinical supervision and subsumes supervision conducted by all health service psychologists across the specialties of clinical, counseling, and school psychology. (p. 5)

At the same time, however, we adhere to a more traditional “master–apprentice” definition of *supervision* that highlights the “intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person” (Loganbill et al., 1982, p. 4). These definitions encompass the variety of skills training, interventions, and attention to professional and personal development that are evident in this volume.

In examining the merging of skills, professional development, and personal development as an individual on the journey to therapeutic competence, it is also important to reflect on the goals or endpoint in this journey. These goals, we believe, are best expressed in the research on master therapists first reported by Jennings and Skovholt (1999) and later expanded upon by Skovholt and Jennings (2004). The characteristics of master therapists are listed here.

- Master therapists are voracious learners.
- Accumulated experiences are a major resource for master therapists.
- Master therapists value cognitive complexity and the ambiguity of the human condition.
- Master therapists appear to have emotional receptivity, defined as being self-aware, reflective, nondefensive, and open to feedback.
- Master therapists seem to be mentally healthy and mature individuals who attend to their own emotional well-being.

- Master therapists are aware of how their emotional health affects the quality of their work.
- Master therapists possess strong relationship skills.
- Master therapists hold a number of beliefs about human nature that help to build strong working alliances.
- Master therapists appear to be experts at utilizing their exceptional relationship skills in therapy.

We believe that these characteristics represent crucial therapeutic qualities related to the acquisition of skills or competencies that are often not addressed in approaches to training that conceptualize the process of becoming a therapist (e.g., Falender & Shafranske, 2004). Consequently, our model is designed to focus on the path to competence as a master therapist across domains, accounting for *how* therapeutic skills, knowledge, and attitudes are developed and suggesting best mechanisms for encouraging professional development.

THE IDM IN SUMMARY

In the IDM, we view the growth of therapists as progressing through three developmental stages or levels: Level 1, beginning; Level 2, intermediate; and Level 3, advanced. There is also a fourth level, 3i, in which the supervisee has achieved an integrated level of skills across all domains and structures. The supervisor's attention is focused at each level on the following overriding supervisory structures (see Chapter 1, this volume, for an in-depth look at each structure):

- *motivation* to become an effective psychotherapist,
- *autonomous* functioning in clinical practice, and
- *self- and other* (i.e., client) *awareness* in both cognitive and affective realms.

We also attempt to measure the growth of therapists across the following eight specific domains of clinical practice (see Chapter 2 for an in-depth look at each specific domain):

- intervention skills competence,
- assessment techniques,

- interpersonal assessment,
- client conceptualization/diagnosis,
- attention to individual differences in client work,
- theoretical orientation,
- treatment plans and goals, and
- professional ethics.

Thus, the core aim of the IDM is to provide differing and flexible facilitative supervisory environments and interventions to best enhance developmental progression through the levels.

We note here that the “integrative” aspect of the IDM refers to an integration of recent research, as well as an examination of theory and research beyond the area of clinical supervision (and psychotherapy) to help illuminate processes held in common with other areas of psychology. For instance, in understanding the supervision process, Stoltenberg and McNeill (2010) noted the importance of cognitive models (cognitive and emotional processing; Anderson, 2005; Greenberg, 2002), schema development and refinement (McVee, Dunsmore, & Gavelek, 2005; Schön, 1987) and skill development; development from novice to expert (Anderson, 2005); interpersonal influence (Dixon & Claiborn, 1987; Stoltenberg, McNeill, & Crethar, 1995) and social intelligence (Goleman, 2006); motivation (Petty & Wegener, 1999; Ryan & Deci, 2000); and of course, models of human development (Lerner, 1986).

In the chapters that follow, we investigate each of these interactive elements in more detail.

OUR PATHS AS SUPERVISORS

In both the Counseling Psychology Program and the University Counseling Services (UCS) at the University of Iowa in the early 1980s, there was a hotbed of supervision activity. This activity included classes and other didactic and experiential training with such supervision scientist–practitioners as Ursula Delworth, Emily Hardy, Carol Loganbill, and Gerry Stone. At this time Cal Stoltenberg worked as a graduate assistant under the guidance of Ursula Delworth, which resulted in the publication of the initial developmental

model of clinical supervision (Stoltenberg, 1981). Cal later accepted a position in the Psychology Department at Texas Tech University, where Brian McNeill was a graduate student in the Counseling Psychology Program. During this time, Cal presented a job talk/colloquium on his supervision model, which helped earn him notoriety as a young upstart who dared to tell his elders how to supervise. Brian later completed his degree, with Cal as his advisor, and went on to enroll in his predoctoral internship under UCS Director/Training Director Ursula Delworth, taking advantage of opportunities to coteach beginning practicum, engage in supervision of a less-experienced trainee, attend supervision training seminars, and receive supervision on supervisory activities. Ursula Delworth remained a valued mentor to both of us well into our postgraduate careers, as did Cal for Brian. This lineage has had a significant influence on both of our careers, as we have enjoyed numerous opportunities in the past 30 years to supervise students at various levels of development through our work as professors, including teaching practicum-type courses and developing and teaching courses in supervision. Cal has held academic positions at Texas Tech University and the University of Oklahoma, where he served as director of training for the APA-accredited program in counseling psychology for nearly 20 years. Brian has worked in both academic and practice settings and served as director of doctoral training for two APA-accredited programs in counseling psychology at The University of Kansas and Washington State University. It appears that both the IDM specifically and developmental conceptualizations of the supervision process in general have survived the test of time since Cal presented his initial model.

ROAD MAP OF THE BOOK

In this volume, we present the basic principles related to the theory and practice of IDM, which is fully articulated in *IDM Supervision: An Integrative Developmental Model for Supervising Counselors and Therapists* (Stoltenberg & McNeill, 2010). Although much of the content of this book is derived from that more comprehensive volume, we hope that the current presentation will serve as a solid introduction to our model and spark interest in those who wish to gain more detailed information.

In Chapter 1, we take a deeper look at the foundations of the IDM by examining relevant theory, with an in-depth examination (across all developmental levels) of the three overriding structures by which we view therapist development: self-awareness and awareness of others, motivation, and autonomy. In Chapter 2, we discuss the goals, tasks, and functions of supervision and the primacy of the supervisory relationship and the necessity of supervisee evaluation and feedback. We expand our focus to the eight domains of clinical practice by which trainees are assessed in the IDM. In Chapter 3, we examine various supervisory methods and techniques, including specific supervisory interventions across all developmental levels, always within the context of multicultural and ethical considerations. In Chapter 4, we demonstrate the direct clinical application of the IDM by analyzing a real-life supervisory session documented in the DVD *The Integrative Developmental Model of Supervision*. In Chapter 5, we discuss common challenges that arise at various levels of supervisee development and provide strategies for overcoming them. Finally, in Chapter 6, we briefly examine the empirical support for the IDM and point out directions for future research in the area of clinical supervision.