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Introduction

Students learn psychotherapy primarily through experience and supervision. In large-scale multidisciplinary surveys, clinical supervision is generally rated the second most important contribution to one's professional development, immediately behind direct experience working with patients (e.g., Henry, Sims, & Spray, 1971; Orlinsky & Rønnestad, 2005). Far more than courses and books and theories, hands-on supervision of actual clients constitutes the learning foundation.

Clinical supervision is essential to the education and competence of mental health professionals of all disciplines and orientations. Most mental health professionals will at some point during their career supervise another (Bernard & Goodyear, 2014), and conducting supervision is consistently one of the top five ways in which psychologists spend their professional time (Norcross & Rogan, 2013). More and more, supervision is properly viewed as spanning entire careers of psychologists (Grant & Schofield, 2007).

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Supervision Essentials for Integrative Psychotherapy, by J. C. Norcross and L. M. Popple

Supervision has clearly come of age as can be witnessed by the profusion of professional guidelines, the proliferation of journals and textbooks, and even the establishment of the American Psychological Association's (APA) Clinical Supervision Essentials series to which this book and its companion DVD, *Integrative Psychotherapy Supervision*, belong. By our recent count, there now exist at least a dozen published guidelines on clinical supervision in the English language around the world. In 2014, APA joined the crowd by offering its own guidance to health service psychologists (https://www.apa.org/about/policy/guidelines-supervision.pdf) and promoting quality supervision across competency domains using evidence-based practices of supervision.

Although supervisor competence is now often defined, it is rarely verified. The educational system continues to assume competent practitioners will make competent supervisors and that bright-enough graduate students will make eager, competent supervisees. Folie à deux!

Supervision represents a complex and demanding activity, and the introduction of an integrative perspective does nothing to relieve the pressure on supervisors and supervisees. On the contrary, the supervision of integrative psychotherapy probably requires more from trainees and their mentors than do single-school therapy systems. Not only must the conventional difficulties in producing competent clinicians be resolved, but an integrative approach must also help supervisees to master treatment combinations and to adjust their therapeutic approach to fit the needs of their clients. Nonetheless, if we are to train psychotherapists more broadly than, in Gardner Murphy's (1969) words, "the subspecialized people we turn out today," an intensive apprenticeship with integrative supervisors is needed.

Integrative psychotherapy supervision thus constitutes at once an exciting challenge and a promising opportunity. In this opening chapter, we outline our theoretical underpinnings, trace the history of psychotherapy integration, and define integrative supervision. Moving from these introductory considerations, we then address our personal paths to integrative supervision.

THEORETICAL UNDERPINNINGS

Psychotherapy Integration

Psychotherapy integration is characterized by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see how patients can benefit from other ways of conducting psychotherapy (Norcross & Goldfried, 2005). We attempt to tailor psychological treatments and therapeutic relationships to the specific and varied needs of individual patients as defined by a multitude of diagnostic and particularly transdiagnostic considerations. We do so by systematically drawing on effective methods across theoretical schools (integrative) and by matching those methods to particular clients on the basis of evidence-based principles.

Psychotherapy universally applied as one-size-fits-all is proving impossible and, in some cases, even unethical. Of course, giving every patient the same brand of psychotherapy would simplify treatment selection, but it flies in the face of what we know about individual differences, patient preferences, and disparate cultures.

The clinical reality is that no single psychotherapy proves effective for all patients and situations, no matter how good it is for some. That is the driving force behind integration, the modal theoretical orientation of psychotherapists in Western developed countries. Evidence-based practice has come to demand flexible and individualized, if not integrative, treatment.

Imposing a parallel situation onto other health care professions drives the point home. To take a medical metaphor, would you entrust your health to a physician who prescribed the identical treatment (say, antibiotics or neurosurgery) for every patient and illness encountered? Or, to take an educational analogy, would you prize instructors who employed the same pedagogical method (say, a lecture) for every educational opportunity? Or would you entrust your child to a child-care worker who delivers the identical response (say, a nondirective attitude or a slap on the bottom) to every child and every misbehavior? "No" is probably your resounding answer. Psychotherapy clients deserve no less consideration.

On the face of it, of course, virtually every clinician endorses fitting the therapy to the individual client. After all, who can seriously dispute the notion that psychological treatment should be tailored to the specific needs of the patient? Indeed, treatment manuals are increasingly focusing on ways to be flexible—but they still work within a confined set of theoretical parameters and technical procedures. In contrast, integrative therapy goes beyond this simple acknowledgment of the need for flexibility in several ways:

- Our integrative therapy is derived directly from outcome research rather than from an idiosyncratic theory or seat-of-the-pants syncretism.
- Our therapy embraces the potential contributions of multiple systems of psychotherapy rather than working from within a single theoretical system.
- Our treatment selection is predicated on diagnostic and several transdiagnostic client characteristics, in contrast to relying on patient diagnosis alone.
- Our aim is to offer optimal treatment methods and healing relationships, whereas many focus narrowly on selecting methods. Both interventions and relationships, both the instrumental and the interpersonal—intertwined as they are—are required in effective psychotherapy.
- Our integrative therapy occurs throughout the course of treatment (not only at pretreatment as case formulation), tracks client progress, and evolves with the client through termination. Clients evolve and progress—and their initial complaints are not necessarily their primary disorders or goals at the conclusion of treatment.

In the past, we as well as our colleagues have invoked a plethora of terms to describe our aim to fit the treatment to the patient: prescriptive eclectic, systematic treatment selection, differential therapeutics, responsiveness, aptitude by treatment interaction, customizing, and so on. Here, we employ the term *integrative* throughout. We do so in recognition of (a) the term's more inclusive connotation and representation of psychotherapy integration, (b) its broader acceptance and use in clinical circles than the alternative terms, and (c) its emerging preference among mental

health professionals as their self-identification (Norcross, Karpiak, & Lister, 2005).

In the past, too, integrative supervision was driven by the notion of "different strokes for different folks," but the philosophical pluralism was not concretely translated into sophisticated matching. Typically, that matching was based on a single, static patient characteristic—the presenting problem or diagnosis. Today, by contrast, the matching or fit is driven by multiple client features, especially transdiagnostic characteristics, such as stage of change, reactance level, patient preferences, and culture.

Integrative Supervision

These cardinal principles of integrative therapy similarly apply to integrative supervision and working with trainees. No single supervision theory or method is effective for all supervisees and situations, no matter how good it is for some. Evidence-based supervision has come to demand a flexible, if not integrative, perspective.

There are numerous pathways to the integration of the psychotherapies and thus multiple approaches to integrative supervision. The four predominant pathways are common factors, technical eclecticism, theoretical integration, and assimilative integration. All four are characterized by a desire to look beyond the confines of single theories and the techniques traditionally associated with them, but they do so in rather different ways and at different levels. Below we summarize these four routes to integration and comment on their implications for the supervision enterprise.

Common Factors

The common factors approach seeks to determine the core ingredients that different therapies share, with the eventual goal of creating more parsimonious and efficacious treatments based on those commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than are the unique factors that differentiate among them. The research-informed models of Jerome Frank (1973) and Bruce Wampold (Wampold & Imel, 2015) exemplify the

common factors route. Marvin Goldfried (1980, p. 996), a leader of the integration movement, argued,

> [to] the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases.

In specifying what is common across orientations, we may also be selecting what works best among them.

Judging from experience and the literature (Castonguay, 2000), some psychotherapy supervision is conducted from an explicit common factors perspective. Supervisors enjoin their trainees to cultivate therapeutic commonalities, such as development of a therapeutic alliance, opportunity for validation, acquisition and practice of new behaviors, and fostering positive expectancies (Grencavage & Norcross, 1990; Weinberger, 1995), in their therapy sessions just as supervisors symmetrically do so in supervision sessions. When these common factors operate in "good enough" fashion, they converge to produce favorable supervision outcomes, such as reducing trainee shame and self-doubt, enhancing identity development, and increasing competence development (Watkins, Budge, & Callahan, 2015).

The dilemma is that one cannot function "commonly" or "nonspecifically" in therapy or training (Omer & London, 1988). Hence we must operationalize specific clinical behaviors associated with common factors for purposes of supervision. Until such time, integrative supervision from a common factors perspective will be largely relegated to the prevalent, but still frequently unheeded, reminder that the so-called common factors in psychotherapy—principally the therapeutic relationship—account for more outcome variance than do technical interventions (Norcross & Lambert, 2014).

More than commonalities are evident across the therapies; unique or specific factors are attributable to different therapies as well. One of the seminal achievements of psychotherapy research is demonstration of the differential effectiveness of psychotherapies with a few disorders and with specific types of people. Integrative supervision thus emphasizes those factors

common across therapies while capitalizing on the contributions of specific techniques. The proper use of common *and* specific factors will probably be most effective for clients and most congenial to supervisors (Garfield, 1992; Watkins et al., 2015); that is, we will gradually integrate by combining fundamental similarities and useful differences across the schools.

Technical Eclecticism

Eclectics seek to improve the ability to select the best treatments for the person and the problem on the basis of clinical experience and empirical research. The focus is on predicting for whom interventions will work; the foundation is actuarial rather than theoretical (Lazarus, Beutler, & Norcross, 1992). Proponents of technical eclecticism use procedures drawn from different sources without necessarily subscribing to the theories from which they originated. For technical eclectics, no necessary connection exists between metabeliefs and techniques. As Lazarus (1967, p. 416) described it, "To attempt a theoretical rapprochement is as futile as trying to picture the edge of the universe. But to read through the vast amount of literature on psychotherapy, in search of techniques, can be clinically enriching and therapeutically rewarding."

In practice and in supervision, this integrative approach is widely exemplified in Arnold Lazarus's multimodal therapy and Larry Beutler's (Beutler & Clarkin, 1990) systematic treatment selection. Our approach to psychotherapy supervision and much of this book emanate from the eclectic mandate to customize the technical interventions and the relationship stance to the unique needs of each individual. This customizing or matching, it should be emphasized, applies with equal cogency to trainees assisting their clients and to supervisors assisting their trainees. Integrative supervisors are continually involved in a parallel process of tailoring their supervision to the individual student and enhancing their student's ability to tailor psychological treatment to individual clients.

Theoretical Integration

In this pathway to psychotherapy integration, two or more therapies are synthesized in the hope that the result will be better than the constituent

therapies alone. Theoretical integration aspires to more than a simple combination; it seeks an emergent theory that is more than the sum of its parts, and that leads to new directions for practice and research. As the name implies, there is an emphasis on integrating the underlying theories of psychotherapy—what London (1966) eloquently labeled "theory smushing"—along with the integration of therapy techniques from each—what London has called "technique melding." Theoretical integration represents the most popular variant of integration among clinical and counseling psychologists in the United States (Lichtenberg, Goodyear, Overland, Hutman, & Norcross, 2016).

Paul Wachtel's (1977, 1987) influential efforts to bridge psychoanalytic, behavioral, and interpersonal theories illustrate this direction, as do efforts to blend cognitive and psychoanalytic therapies, notably Anthony Ryle's (1990) cognitive–analytic therapy. Grander schemes have been advanced to meld most of the major systems of psychotherapy, such as the transtheoretical approach (involving the stages of change) of James Prochaska and Carlo DiClemente (1984; Prochaska & Norcross, 2013). All of these stop short, however, of a grand unifying theory of psychotherapy (Magnavita & Anchin, 2014), which may or may not eventually prove possible.

Psychotherapists combine multiple theories in creating their integrations. When 187 self-identified integrative psychologists rated their use of six major theories (behavioral, cognitive, humanistic, interpersonal, psychoanalytic, systems), the resulting 15 dyads were each selected by at least one therapist (Norcross et al., 2005). The most common dyad endorsed in the mid 1970s was psychoanalytic–behavioral (Garfield & Kurtz, 1977); in the mid 1980s, the three most popular hybrids all involved cognitive therapy (Norcross & Prochaska, 1988); and in the early 2000s, cognitive therapy dominated the list of combinations. Cognitive therapy also accounted for 42% of the hybrid combinations in the United States, less so in other countries.

Supervisors combining two theoretical models, say, cognitive–behavioral therapy (CBT) and mindfulness/acceptance therapy, would certainly be recognized as theoretical integrationists. But as soon as another

theoretical model is invoked in supervision, integration seems to merge into eclecticism; that is, in supervision, the distinctions among technical eclecticism and theoretical integration are rarely apparent or functional. Few supervisees receiving broadband supervision could distinguish between them. Moreover, we hasten to add that these integrative strategies are not mutually exclusive. No technical eclectic can totally disregard theory, and no theoretical integrationist can ignore technique.

Assimilative Integration

The fourth route to integration entails a firm grounding in one system of psychotherapy, with a willingness to selectively incorporate (assimilate) practices and views from other systems (Messer, 1992). In doing so, assimilative integration combines the advantages of a single, coherent theoretical system with the flexibility of a broader range of techniques from multiple systems. A cognitive therapist, for example, might use the gestalt two-chair dialogue in an otherwise behavioral course of treatment. In addition to Stanley Messer's (1992, 2001) original explication of it, exemplars of assimilative integration are George Stricker and Jerold Gold's (1996) assimilative psychodynamic therapy and Louis Castonguay and associates' (2004) cognitive–behavioral assimilative therapy.

To its proponents, assimilative integration is a realistic way station to a sophisticated integration; to its detractors, it is more of a waste station of people unwilling to commit to an evidence-based integration. Both sides agree that assimilation is a partial step toward full integration; most therapists have been and continue to be trained in a single approach, and most gradually incorporate parts and methods of other approaches once they discover the limitations of their original approach.

The personal journeys of seasoned psychotherapists (e.g., Dryden & Spurling, 1989; Goldfried, 2001) suggest that this is how therapists actually modify their clinical practices and expand their repertoires. Therapists do not discard original ideas and practices but rework them, add to them, and cast them in new forms. They gradually, inevitably assimilate new methods into their home theory (and life experiences) to formulate an effective treatment.

In assimilative supervision, then, trainees would be taught primarily from a single theoretical tradition with the occasional use of a method aligned with another theoretical system. How often and on what basis supervisees depart from their primary theory remains to be ascertained, but such departure is certainly a frequent and realistic step toward more ambitious integrative supervision.

In our integrative supervision, we heartily embrace three of these routes to integration: common factors, especially for its focus on the therapeutic and supervisory relationship and its emphasis on principles/processes of change; technical eclecticism, which tailors or fits psychotherapy to the unique needs of each client and correspondingly supervision to the individuality of each trainee based on empirical research; and theoretical integration, which demonstrates that theoretical systems are often complementary, not contradictory, when embedded within the diversity of treatment goals, patient preferences, stages of change, and other transdiagnostic features. We do not highlight assimilative integration further in this book as it represents only a cautious half-step toward a full integrative supervision.

HISTORICAL PERSPECTIVE

A novice psychotherapist is faced with a proverbial tower of Babel. He or she is immediately confronted with an overwhelming diversity of theoretical orientations, each represented by articulate and adamant advocates and equally articulate and adamant detractors. The confusion of ideas and admonitions, do's and don'ts, is likely to dampen the enthusiasm of all but the most resilient of students. Integrative approaches to psychotherapy supervision, like integrative psychotherapies themselves, offer hope of reconciliation among diverse orientations and provide an anchor of empiricism in a sea of theory.

Integration as a point of view has probably existed as long as philosophy and psychotherapy. In philosophy, the 3rd-century biographer Diogenes Laertius referred to an eclectic school that flourished in Alexandria in the 2nd century (Lunde, 1974). In psychotherapy, Freud

consciously struggled with the selection and integration of diverse methods. As early as 1919, he introduced psychoanalytic psychotherapy as an alternative to classical psychoanalysis in recognition that the more rarified approach lacked universal applicability (Liff, 1992).

More formal ideas on synthesizing the psychotherapies appeared in the literature as early as the 1930s (Goldfried, Pachankis, & Bell, 2005). For example, Thomas French (1933) stood before the 1932 meeting of the American Psychiatric Association and drew parallels between certain concepts of Freud and of Pavlov. In 1936, Saul Rosenzweig published an article that highlighted commonalities among various systems of psychotherapy (Rosenzweig, 1936). These and other early attempts at integration, however, were largely theory driven and empirically untested.

If not conspiratorially ignored altogether, these precursors to integration appeared only as a latent theme in a field organized around discrete theoretical orientations. Although psychotherapists secretly recognized that their orientations did not adequately assist them in all they encountered in practice, a host of political, social, and economic forces—such as professional organizations, training institutes, and referral networks—kept them penned within their own theoretical school yards and typically led them to avoid clinical contributions from alternative orientations.

Integrative supervision was probably inaugurated in the modern era by Frederick Thorne (1957, 1967) and Arnold Lazarus (1967), who are credited as the grandfathers of eclecticism. Persuasively arguing that any skilled professional should come prepared with more than one tool, Thorne emphasized the need for clinicians to fill their toolboxes with methods drawn from many different theoretical orientations. He likened contemporary psychotherapy to a plumber who used only a screwdriver. Like such a plumber, inveterate therapists applied the same treatment to all people, regardless of individual differences, and expected the patient to adapt to the therapist rather than vice versa. Lazarus's influential multimodal therapy inspired a generation of mental health professionals to think and behave more broadly.

In the late 1970s, several attempts at theoretical integration were introduced. Wachtel authored the classic *Psychoanalysis and Behavior*

Therapy: *Toward an Integration*, which attempted to bridge the chasm between the two systems. His integrative book began, ironically, in an effort to write an article portraying behavior therapy as "foolish, superficial, and possibly even immoral" (Wachtel, 1977, p. xv). But in preparing his article, he was forced for the first time to look closely at what behavior therapy was and to think carefully about the issues. When he observed some of the leading behavior therapists of the day, he was astonished to discover that the particular version of psychodynamic therapy toward which he had been gravitating dovetailed considerably with what a number of behavior therapists were doing. Wachtel's experience serves as a sage reminder that isolated theoretical schools perpetuate caricatures of other schools, thereby foreclosing changes in viewpoint and preventing expansion in practice.

The transtheoretical (across theories) approach of Prochaska and DiClemente was also introduced in the late 1970s with the publication of one of the first integrative textbooks, *Systems of Psychotherapy: A Transtheoretical Analysis* (Prochaska, 1979). This book reviewed different theoretical orientations from the standpoint of common change principles and of the stages of change. The transtheoretical approach in general, and the stages of change in particular, are among the most extensively researched integrative therapies (Schottenbauer, Glass, & Arnkoff, 2005).

Only within the past 40 years, then, has psychotherapy integration developed into a clearly delineated area of interest. The temporal course of interest in psychotherapy integration, as indexed by both the number of publications and the development of organizations and journals (Goldfried et al., 2005), reveals occasional stirrings before 1970, a growing interest during the 1970s, and rapidly accelerating interest from 1980 to the present. To put it differently, integrative psychotherapy has a long past but a short history as a systematic movement. Within that movement, publications on integrative training and supervision began appearing regularly in the 1980s (e.g., Beutler et al., 1987; Norcross, 1988; Norcross et al., 1986). In that sense, explicit integration is a relative newcomer to clinical supervision.

Integration itself represents only the first step: We therapists must widen our therapeutic repertoire and embrace multiple therapeutic

techniques, relationships, and formats. The second and empirical step is to specifically know when and where to use these multiple techniques, relationships, and formats. The early integrative supervisors favored a pragmatic blending (e.g., Halgin, 1985) but did not have the research evidence to specify when and how those multiple theories were to be blended. That robust evidence became available only in the past 2 decades (e.g., Beutler & Harwood, 2000; Norcross, 2011), leading to the systematic and research-informed brand of integrative supervision offered in this book.

DEFINITION OF *SUPERVISION*

Clinical supervision essentially involves a human relationship with the intent of modifying the behaviors, affects, and cognitions of supervisees in ways that enable them to provide more effective (or efficient) services to their patients (Hess, 1980). It is, first and foremost, a relationship. Our insistence on defining supervision as a relationship leads us to eschew characterizations that define it primarily as a "professional practice" or "competence" (APA, 2015). Supervision is assuredly both of those, but the essential foundation, the sine qua non, is the relationship.

The parameters of supervision are fluid and permeable. Supervision extends over a circumscribed period in most instances but extends over decades in others. Supervision requires a distinct set of skills and knowledge, beyond those associated with being a competent practitioner, but clinical skills overlap considerably with supervision skills. Its purposes are multiple and occasionally conflicting: to mentor, to teach, to serve clients being treated by the supervisee and, of course, to evaluate and perhaps to gatekeep by weeding out unqualified professionals (Bernard & Goodyear, 2014).

Teach Versus Treat

Supervision and psychotherapy share numerous features. They both comprise privileged, intimate relationships in which the supervisor/therapist assists supervisees/clients in examining their thoughts, feelings, and behaviors. The typical behaviors of the supervisor and therapist align: listening,

reflecting, empathizing, observing, providing information, offering feedback, and occasionally instructing. Both supervisees and clients are asked to share sensitive, often painful material in regularly scheduled sessions. Supervisees and clients alike desire awareness, skills, and anxiety relief, seeking change and resisting it at the same time. Both seek affirmation and fear judgment from the more powerful supervisor/therapist.

These marked structural similarities raise the legendary temptation to blend teaching and treating, to turn supervision into psychotherapy. Such circumstances rapidly become ethical, legal, and training landmines. For example, when discussing their countertransference to a particular client, supervisees may divulge too much personal information regarding the origin of their positive or negative feelings about their clients. Or supervisors may subtly pull or overtly demand such detailed information.

Supervisors can remain vigilant and remember that, although supervisees have the opportunity and right to seek therapy, they rarely have a choice regarding whether to seek supervision. Supervision and the particular supervisor are frequently mandated. Supervisors may slip into their preferred mode of conducting therapy, or supervisees may attempt to use supervision (knowingly or unknowingly) as their personal therapy. Supervisors need to mentor and maintain appropriate boundaries for their supervisees.

Despite the structural similarities of supervision and therapy, their goals differ substantively. The goals of supervision are to help the trainee develop his or her skills, model boundaries, offer support, and ensure client welfare. Clients seek treatment to enhance life satisfaction and work on specific behavioral disorders (Page & Wosket, 2001); in contrast, supervisees work toward an academic degree and often seek to become more advanced clinicians. This supervisory relationship is not a place to offer personal therapy to the supervisee (Watkins, 1997).

Some models of supervision suggest blurring the boundaries between supervision and therapy as long as it enables the supervisee to learn from the experience and become a more advanced clinician (Sarnat, 1992, 2015). We do not blur those boundaries. In integrative supervision, we conscientiously do not cross the boundaries between supervision and therapy.

Although one hopes that supervisees are mentally healthy and fit for their profession, there are times when their personal problems interfere with their ability to treat clients properly. When such difficulties arise, we as supervisors acknowledge what has occurred, discuss it openly with the supervisee, arrive at a mini remediation plan to avoid a reoccurrence, make a mental note to watch for it again, and then move on from the specific incident. Should the single incident prove a regular occurrence or constitute a serious breach, then integrative supervisors strongly recommend personal therapy. A referral for therapy can gently nudge supervisees into an appropriate therapeutic environment. When we recognize that supervisees' recurrent problems prevent them from providing good therapy, we do not attempt to treat the supervisee directly.

Evidence-Based Practice and Competencies

The international juggernaut of evidence-based practice (EBP) lends increased urgency to the task of using the best available research and clinician expertise to tailor psychological treatment to the client's culture, personality, and goal (Norcross, Beutler, & Levant, 2006). In corresponding fashion, evidence-based supervision will leverage the best available research and supervisor expertise to tailor supervision to the unique trainee. Data-based clinical decision making will become the norm for conducting psychotherapy and for conducting supervision.

EBP has sped the breakdown of traditional schools and the escalation of informed pluralism (Norcross, Hogan, Koocher, & Maggio, 2017). EBP reflects a pragmatic commitment to "what works for whom." The clear emphasis is on what works, not on what theory the supervisor prefers. Integrative supervision is simpatico with EBP properly defined.

At the same time, our integrative supervision reflects and reinforces the growing movement toward competency education in mental health. The APA (2015) guidelines, for a recent exemplar, are organized under seven competency domains: supervisor competence; diversity; relationships; professionalism; assessment/evaluation/feedback; problems of professional competence; and ethical, legal, and regulatory considerations.

Although supervisor competence is often assumed, only recently has there been a shift by training programs to value competency-based supervision (Kaslow, Falender, & Grus, 2012). At the least, supervisors are expected to have informed and contemporary knowledge of research on supervision and the professional activities being supervised. Supervisors are expected to complete continued education in supervision via seminars and/or reaching out to another supervisor for their own supervision. In addition, supervisors should prioritize communication with other professionals responsible for the supervisee's continued learning and growth process and enable a direct line of contact between all supervisors.

However, competencies are not for the supervisor alone. Competency benchmarks can be usefully incorporated into the trainee's learning goals and into the criteria for the supervisor's evaluation of the trainee's performance. As detailed in later chapters, we adopt APA's competency benchmarks for different levels of training (Fouad et al., 2009) in completing written evaluations of the supervisee. For now, the take-home point is that our integrative supervision values and employs competencies for all parties involved.

AUTHORS' PATHS

John C. Norcross (Supervisor)

For 30-plus years, I have been supervising students and colleagues. My earliest flirtations with clinical supervision involved brief episodes of supervising less experienced doctoral students in a "vertical team" during my graduate studies. My primary lessons from that experience? First, I enjoyed the relational and clinical immediacy of supervision, and second, I learned to never arrange for two supervisors holding discordant theoretical orientations to supervise the same beginning student. Confusion reigns, and clients probably suffer.

In receiving graduate and postgraduate supervision, I was fortunate in many respects. I did not experience any awful or traumatizing supervisors. One supervisor was warm, supportive, but probably otherwise benign (teaching me the valuable lesson that quality supervision may

require a strong supervisory relationship, but more than that). Another clinical supervisor was wise, scholarly, but preferred to speak only of my research (teaching me that not all licensed professionals are interested or skilled in psychotherapy supervision). Otherwise, I obtained excellent and responsive supervision. In addition, I emerged as one of the lucky ones in that I completed a graduate course in supervision (actually, consultation and supervision), joining the 20% of psychologists serving as supervisors who received formal training in supervision (Peake, Nussbaum, & Tindell, 2002).

As well, I had the good fortune to be integratively trained by my family of origin and in my formal education, which obviated the need to take a circuitous and necessarily assimilative approach (Norcross, 2006). In some ways, my integrative perspective was overdetermined by my family of origin. I am the second of four children, all boys. Consistent with that ordinal position and the cumulative research (Sulloway, 1996), I was born to both mediate and rebel—an apt summary of integration. Reliable adult observers concur that I served as the go-between for my brothers and as the bridge between my older, domineering brother and my two younger siblings—a familiar pattern (or reconstruction) among psychotherapists in general (Dryden & Spurling, 1989; Henry et al., 1971). More than that, my birth order and family dynamics led to an openness to scientific innovation, along with a propensity to rebel against conventional wisdom.

Additionally and concurrently, I was a product of the synthesis of diverse religions and cultures. My parents hailed from different parts of the country: one from the urban northeast and another from the rural Smoky Mountains. Gentile and Jew, white collar and blue collar alike, populated our neighborhood and friendships. It was natural and easy to accommodate several religions in my extended family; for example, I attended a Jewish nursery school and kindergarten, a private Lutheran elementary school, a public high school, an originally Dutch Reform college, and a state university for graduate studies. (Continuing the theme, I married a woman raised as a Baptist, we attend a Methodist church, my stepdaughter and son attended private Catholic schools, and for the past 30 years, I have taught at a Jesuit university.)

These multiple traditions flowed naturally, like a seamless mosaic. A favorite family story is illustrative: When a young boy, I was asked if I was Jewish. Reflecting my multireligious heritage (or confusion), I replied, "No, but I think my brother is."

The occupational and political positions of my parents also profoundly influenced my worldview. My father was a labor organizer in his early years, when it was a radical—and potentially dangerous—profession, especially in the south where he met my mother. It was made clear to me that orthodoxy, dogma, and business were not to be trusted. My mother was one of the first female employees of the National Park Service, an adventuresome and unconventional position in the 1950s. Mistrust of the establishment and advocacy for the common people were leitmotifs.

In retrospect, my family shaped my personality in three directions that Robertson (1979) identified as facilitating integration among psychotherapists. First is an obsessive–compulsive drive to pull together all of the interventions of the therapeutic universe. Second is a maverick or rebellious temperament to move beyond theoretical monism. And third is a skeptical attitude toward the status quo. To these I would add being predisposed toward pragmatic considerations as opposed to theoretical doctrines—a variable also supported by the nascent research on integrative therapists.

Integrative leanings evident in childhood were crystallized by multiple undergraduate experiences. Undergraduate mentors modeled and demonstrated the integrative spirit. My three Rutgers mentors hailed from different orientations: Andrew Bondy was a staunch behaviorist; Michael Wogan was an interpersonal psychodynamicist (and a student of Hans Strupp); and Winnie Lennoix was a client-centered and multicultural therapist. Although strongly prizing their own orientations, they were uniformly respectful of the contributions of disparate traditions. All repeatedly emphasized that I would learn from complementary ways of researching and conducting psychotherapy. And, in applying to graduate school, Rutgers's Arnie Lazarus—one of the grandparents of eclecticism—guided my path.

The PhD program in clinical psychology at the University of Rhode Island (URI) cemented the integrative "deal." Jim Prochaska, with a recently relocated Carlo DiClemente in Texas, had just secured his first

multi-million-dollar grant for self-change and was building an impressive research program at URI. He had published *Systems of Psychotherapy: A Transtheoretical Analysis*, one of the first integrative texts on psychotherapy, taught couples therapy, and maintained a private practice. Here was a scientist–practitioner in action.

The URI clinical program provided unsystematic training in multiple theoretical traditions, but Jim's transtheoretical model brought it to a harmonious whole. The systematic synthesis of theoretical orientations was guided by the stages of change model, which was emerging in the research and then applied to clinical practice. The integration of research and practice was never explicitly presented as the scientist–practitioner or Boulder model—it simply occurred. Individual psychotherapy in the clinic was naturally blended with population-based interventions in the lab. Self-change was integrated with formal psychotherapy. These proved not contradictory but complementary.

Jim also supported my research expansion into the person of the therapist. We conducted several studies on the personal and professional characteristics of clinical psychologists and continue to chronicle the evolution of the field every few years. This work frequently highlighted that integration or eclecticism was the modal orientation of mental health professionals in the United States. Some of our most exciting projects examined the self-change experiences of psychotherapists. We discovered that psychotherapists' theories exert considerable influence on their treatment of clients but virtually none on the treatment of themselves (Prochaska & Norcross, 1983). This pattern of results has now been replicated in five studies with different populations and diverse disorders (Norcross & Aboyoun, 1994) and supports the notion that psychotherapists are quite secular, pragmatic, and integrative in their own self-change.

Regarding integration per se, a formal course on the topic was not offered in the URI clinical psychology program (until years after graduation, when I returned to teach it during a summer session). Nor did we employ the self-characterization of *integrative* until years later. More important, however, was the research-informed pluralism and the absence of the demeaning rivalry of paradigms.

Like most psychotherapists (Geller, Norcross, & Orlinsky, 2005), my personal therapy was personally rewarding and professionally instrumental. During graduate training, I undertook individual therapy with a psychodynamic therapist who was integrative and practical. I experienced little conflict in his being a psychoanalytic therapist or his being a psychiatrist. Instead, I warmly recall his interpersonal generosity—reducing session fees, seeing me at an earlier time—and his gentle directness. Toward the end of therapy, he supported my decision to decline attractive employment offers from doctorate-granting, research-intensive institutions. The fit would have been disastrous in the long run: They were principally interested in my writing articles, securing grants, and continually publishing but would have largely neglected my abiding interests in teaching, supervision, and practice. My therapist helped me see and secure what I wanted: a midsized institution that would allow me to teach, supervise, research multiple areas, edit, and practice minus the preoccupation with grant procurement.

My path toward becoming an integrative supervisor surely was nurtured in graduate training but rooted in my family of origin and undergraduate years. One's professional motives are less academic and more personal in origin than one may wish to consciously concede (Demorest, 2004). The personal is the professional, and this role fusion—the personal as the professional—runs throughout my career and my life.

Now, 30-plus years postdoctorate, I supervise 4.5 hours per week: 1.5 hours of group supervision with advanced undergraduates undertaking their first clinical fieldwork and 3 hours of individual supervision with postdoctoral psychologists and other mental health professionals interested in integrative psychotherapy. The latter, I immediately concede, is a privileged position; I determine how much to supervise and select whom I will supervise. That's my strong recommendation to other supervisors, but one not realistically available to most who labor in the vineyard.

Leah M. Popple (Supervisee)

Although my path to integration is still in its infancy, and albeit a shorter version than that of JCN, it begins with my family of origin. I am the

second born, first daughter, in a family of four preceded by a brother and followed by my sister and then younger brother. I was born to working-class parents and the first in my family to complete a bachelor's degree. I attended Catholic grade school, public high school, and a large state university. This was followed by a Catholic graduate school and then internship, postdoc, and a position at a Jesuit university.

My undergraduate training at Pennsylvania State University offered me endless research opportunities in which I gladly indulged. I served as a research assistant in developmental psychology, clinical psychology, sociology, and gerontology. Wandering around the great university filled with rich research opportunities and those who aspired to advance their field, I soon realized my desired goal was clinical psychology and that I, too, might one day find my niche. Although I minored in gerontology and hoped to focus more on the aging population in graduate school, it was not to be. Fate would intervene and soon determine my future path and clinical interest.

I began my graduate training at a small Catholic institution in clinical psychology. As part of the curriculum, I learned the different schools of psychotherapy (e.g., CBT, psychodynamic, experiential), and then as a practicum student I learned how to apply them to my first clients. CBT emerged as my early favorite, and it seemed initially that each client, regardless of diagnosis or personality, was suited for it. I remember using technical words like *cognitive restructuring* and *thought stopping* but never words to describe the clients' needs and preferences. I do not even recall asking clients what *they* wanted out of therapy. I assumed after a lengthy intake (three to five sessions) that I (or my supervisor) knew best. I would ask clients what they wanted in terms of treatment goals but most were unsure how to *operationally define* (another term my graduate program loved) them. I never asked clients if they thought therapy was working for them nor did I ask if they were happy with the treatment they were receiving. It never occurred to me and was never mentioned by my supervisors. How unfortunate for them and for me.

I got married and had back-to-back girls 13 months apart, at which point I changed my status to a half-time PsyD student. After considering

only community placements within a 30-mile radius of home, I landed my first practicum at the counseling center at my institution. Never before had I considered working with a college student population, but I found a true passion once I began. This was also the first time I received supervision outside my graduate program. After taking 4.5 years off to be with my children, I was fortunate to find a local, half-time internship at the University of Scranton counseling center and again worked with college students. I stayed on as a part-time postdoctoral resident and was offered a position upon completion.

During the fourth year of my doctoral program, I completed a course in clinical supervision. The course acquainted me with the fundamentals of the enterprise, and I even co-supervised a couple of graduate students in their first and second years of study. Alas, the course also left me feeling lost and alone, lacking any meaningful structure for conducting supervision or, for that matter, performing psychotherapy.

With clinical experience and a change to an integrative supervisor, I began to realize that CBT or any monotherapy was not the way to go. In fact, I needed and desired systematic integration. The more freedom I had to be myself and to systemically tailor therapy to the entire client, the more skilled and comfortable I became. And once I found the integrative path, there was no turning back.

The process of integration was transparent for both my clients and me. I found that using the stages of change was indispensable during treatment planning and a much better alternative to expressing my frustration with certain clients during supervision. JCN encouraged me to treat each client individually using multiple methods adapted to his or her stages and preferences for session frequency, therapist directiveness, outside-therapy work, and the like. Although in the beginning, the process felt as though I was checking off a list of questions, it quickly became part of my intake session. Most important, it worked! I began to rely on the research evidence in selecting clinical methods and in constructing a personalized therapeutic relationship. JCN taught me to conduct serial assessments to track clients' progress and to obtain feedback from them to ensure they were satisfied with our work. I was

empowered by JCN to be my own advocate and, likewise, encourage my clients to advocate on their own behalf. Integration simultaneously fit me and my clients.

Integrative supervision has catapulted my own desire to supervise. As someone at the end of her "official" training, I find myself conflicted. I am ready to leave the nest yet afraid to take that first leap. Supervision goes quickly, and I find myself wishing I could go back in time to restart the experience (of course, knowing what I know now!).

ROAD MAP FOR THIS BOOK

In this opening chapter, we have introduced psychotherapy integration, broadly defined *supervision*, and provided historical background on integrative supervision. We outlined a personal and professional path to becoming an expert integrative supervisor.

In Chapter 2, we focus on essential dimensions of integrative supervision: its critical goals, unique functions, and the supervisory relationship. We briefly touch on the negative effects of a poor supervisory relationship, as it accounts for the majority of damaging supervision experiences. Without a trusting, respectful, and caring relationship, not much of value seems to transpire in supervision. We discuss the need for routine bilateral evaluation of both the supervisee and the supervisor.

Chapter 3 leads you through the multiple methods of integrative supervision, such as video recording, process notes, documentation, and parallel process. The distinctive aspect of integrative supervision is its tailoring supervision to the unique supervisee just as that supervisee is simultaneously tailoring treatment to his or her unique client. We review the meta-analytic evidence for doing so and its documented success for all parties in the supervisory triad (supervisor, supervisee, patient).

Chapter 4 gets to the nuts and bolts of integrative supervision. We offer an insider's look into what actually transpires in our typical supervision sessions via verbatim transcripts from multiple sessions. We selected excerpts that best represent integrative supervision and what distinguishes it from other types of supervision.

Chapter 5 takes you through some common supervisory dilemmas. These include supervisory conflicts and their resolution, difficult supervisees, supervisee deficits, power differentials, multicultural conflicts, and legal and ethical conflicts. Psychotherapists suffer from high levels of brownout and burnout, so in the following chapter we focus on self-care for both the supervisor and the supervisee.

In Chapter 7, we barrage you with the research support for integrative supervision. Exciting research suggests that integrative supervision outperforms supervision as usual. In the final chapter, we consider probable future directions for clinical supervision in general and the integrative approach in particular. The book concludes with our recommended readings on integrative supervision.

We have genuinely enjoyed working on the APA supervision video series and this book, *Supervision Essentials for Integrative Psychotherapy.* Our fervent goals are to broaden the scope of typical supervision, demonstrate the documented benefits of integrative supervision, help diffuse any fears that it is "too damn hard," and encourage others to join the integrative path. Although integration does not prove easy or useful for all contexts, one soon discovers its numerous advantages for supervisees and supervisors alike. And, in the end of course, it's all about improved care, and integrative supervision appears to be producing improved outcomes for clients. In the words of one sagacious trainee, "The benefits of integration far outweigh any struggles in learning the approach."