CORE COMPETENCIES IN SOCIAL CONSTRUCTIONIST SUPERVISION?

Olga Sutherland
Couple and Family Therapy, University of Guelph

Marshall Fine
The Faculty of Social Work, Wilfrid Laurier University

Lynda Ashbourne
Couple and Family Therapy, University of Guelph

Family therapy is moving increasingly toward evidence-based practice and competency-based training. This article explores what might seem to be an unlikely link between social constructionist supervision, which is based on dialogic and fluid processes of meaning-making, and the increasing reliance on discrete core competencies in the education and training of family therapists. We propose an alternate approach to competencies for supervision with therapists in training that, among other things, invites accountability and provides evaluative props. The approach we propose is based on a set of orientations that we hope reflect the dialogic and contextual nature of social constructionist practice and supervision. These orientations consist of reflexivity and attention to power, fostering polyphony and generativity, collaborative stance, and focus on client resourcefulness. Ideas and questions for supervisors and therapists in training to address the orientations are articulated.

The social constructionist ideas currently reshaping the practice of family therapy are also relevant for supervision. However, if, as postmodernists assert, there is no privileged, expert position, how can supervisors evaluate their trainees?

Evidence-based couple and family therapy (CFT) practice is characterized by attempts to identify, typically through empirical investigation based on measurable outcomes, effective ways of providing therapy (e.g., Sexton et al., 2007; Wampold & Bahti, 2004). From a training perspective, there has been a corresponding shift from examining what goes into developing a competent therapist (e.g., coursework, clinical hours) to assessing learning outcomes or core competencies, based on the accumulated knowledge of the profession and demonstrated by students exiting training programs. In 2002, the American Association for Marriage and Family Therapy (AAMFT) formed a task force to delineate core competencies (CC) for the practice of CFT (Chenail, 2009; Gehart, 2009; Nelson et al., 2007). Nelson et al. (2007) and Miller, Todahl, and Platt (2010) described in detail the development of CC in the field of CFT.

Competency-based CFT supervision is a probable, though not unquestionable, wave of the future, particularly in more managerial, evidence-based service environments (Lonne, McDonald, & Fox, 2004; Nelson et al., 2007). It may be argued that the drive to impose a competency-based paradigm on therapist education may signal a challenge to the democratic consensual framework that has guided counseling professions over the years (Dominelli, 1996;
Miller et al., 2010). Despite this and other concerns, like others who have argued for a rapprochement between evidence-based and postmodern practice (e.g., Jacobs, Kissil, Scott, & Davey, 2010; Larner, 1994), we became curious if and how a social constructionist approach to supervision would fit in a competency- and evidence-based professional world. In social constructionist supervision, the evidence-based practice assumption that there are “correct” ways of functioning as a therapist is replaced by a focus on jointly developing or co-constructing meanings with therapists in training that might be useful in their work with families and their professional development (Anderson & Swim, 1995; Flemons et al., 1996; Gardner, Bobele, & Biever, 1997). In constructionist supervision, lived experiences of therapists are privileged through the exploration of their stories and ideas about competent and helpful (to their clients) practice. The dominant knowledge and skills viewed as accounting for effective and ethical practice constitute one possible resource informing supervisory discussions rather than the sole basis of supervision.

In this article, we offer some orienting ideas with respect to “competent” social constructionist practice. Arguably, constructionist practice, similar to other approaches to CFT, needs some “bottom lines” that could be practiced and evaluated in ways specific to the therapeutic setting and community. The general considerations we propose could be applied variably and contextually. We intentionally decided to formulate the constructionist orientation broadly to allow for diverse applications, without a specific community setting up its version of correct practice for all (T. Strong, personal communications). The focus of the article is on competency of therapists in training. The discussion of related topics such as CFT supervisory process and relationship and supervisors’ competency can be found elsewhere (e.g., Todd & Storm, 2002).

We begin the article by reviewing the current literature on professional competence and competency-based supervision followed by social constructionist reconceptualization of competencies. We then articulate some general orientations for competency-informed constructionist supervision and offer some possible questions for supervisors to consider in interacting with therapists in training. We conclude the article by exploring the implications of our discussion for CFT supervision.

COMPETENCE AND COMPETENCY-BASED SUPERVISION

The provision of high-quality mental health care relies on the availability of qualified providers. Indeed, the quality of education providers receive and the quality of service they offer are closely intertwined (Bogo, 2010). Not surprisingly, educators and trainers have been seeking effective and innovative ways to prepare health providers who are competent and well equipped for the substantial changes in health care in the 21st century (Evers, Rush, & Berdeow, 1998). Competency-based education (CBE) and the training of professionals, including family therapists, have been proposed as a viable alternative to more traditional academic approaches (e.g., Celano, Smith, & Kaslow, 2010; Falender & Shafranske, 2007; Gehart, 2009). Distinguishing CBE from these approaches is the assumption that knowledge is acquired in the context of practice rather than preceding it, as in traditional discipline-focused professional education. Graduates who are educated to become practitioners are likely to be better prepared for actual postgraduate practice (Kouwenhoven, 2010). Competence refers to the capacity to accomplish the fundamental occupational tasks of a profession to some standard required in employment; it encompasses core competencies or the set of distinct skills and knowledge associated within a specific profession (Kaslow et al., 2004; Plionis, 2007). The common purpose of CC across health professions is the promotion of service delivery that is evidence-based, ethical, and equitable.

Various organizations including the government, educational institutions, professional associations, and privately funded groups have developed their own lists of CC (e.g., Perosa & Perosa, 2010; Verma, Paterson, & Medves, 2006). In the field of CFT, 128 CC were developed through a collaborative effort of the AAMFT and various stakeholders. Key domains of CFT knowledge (e.g., assessment and diagnosis, interventions, research, and program evaluation) and corresponding skills were identified (American Association for Marriage and Family Therapy, 2004; Gehart, 2009). The AAMFT’s Commission on Accreditation for Marriage and Family Education (2005) requires that accredited CFT programs account for how CC are
incorporated as a part of the educational and training curricula and how students’ demonstration of CC is evaluated.

In professional education, supervision is the key context, aside from the classroom, in which novice professionals acquire competencies (Falender & Shafranske, 2004). Supervision is a process that occurs over time, in which the supervisor participates with trainees to promote trainees’ professional development (Bernard & Goodyear, 2004). Beyond ensuring quality and ethical client care, supervision provides a process and relationship to develop professional competency. Supervisors facilitate processes involved in competency enhancement by sharing and modeling knowledge, skills, and values (e.g., self-reflection, integrity, professionalism, knowledge, interpersonal and clinical skills) and providing a safe place for trainees to reflect on, and experiment with, new ideas and practices (Falender & Shafranske, 2008). The objective of all clinical supervision is supervisee development; however, the extent to which supervisors explicitly adopt the competency-based framework in supervision varies (Falender & Shafranske, 2008). A competency-based model of supervision clearly specifies competencies that trainees need to acquire through the supervisory process at each level of development in each domain of practice (e.g., intervention, assessment and diagnosis, research and program evaluation). Core foundational competencies are also emphasized, such as professionalism, attention to diversity, and ethics. If identified expectations for student learning are not met, a competency-based remediation plan is developed and continuously monitored (Falender & Shafranske, 2004).

CONSTRUCTIONIST CRITIQUE OF COMPETENCIES

A social constructionist perspective on supervision deviates, in some ways, from conventional understandings of competency development. First, constructionists highlight the social, interactive processes involved in competency development. They argue that supervision in CFT and related professions has been largely based on an individualist framework (Sinclair & Monk, 2004; Winslade, Monk, & Drewery, 1997). From this standpoint, individuals can be in charge of their own lives and be free to be self-guided and self-governed in their pursuit of personal development. This perspective locates competence within therapists, presenting it as an intrinsic ability of therapists to adequately perform a role or a task. While supervisors and therapists in any case will regard interactions (both therapeutic and supervisory) as providing observational evidence of competence, what is “noticed” will depend in part on the observer’s theoretical and philosophical commitments. The conception of competence and competency problems as “internal” (i.e., individual achievements or shortcomings) invites the focus on the individual performance in interaction. That is, the therapist’s contributions to discourse are treated as autonomous or relatively independent of contributions of others or the context of interaction, both immediate and more global. Social constructionists, on the other hand, privilege the socio-cultural (macro) and immediate dialogical (micro) contexts shaping therapists’ responses in interaction with clients. They attend to how the context forms and informs interpretations or observations of therapists’ characteristics and abilities (e.g., Anderson & Swim, 1995; Taylor & Gonzales, 2005; Whiting, 2007). While some (micro-oriented) social constructionists endorse individual agency that, for them, helps explain people’s choice and resistance to dominant social practices and forces (Hair & Fine, 2011), constructionists of both micro- and macro-orientations would view competencies as part of a discursive process. They would also highlight that the overall notion of competency is understood as being socially constructed.

Another point of divergence between constructionist and more traditional understandings of competencies is how knowledge and the supervisory relationship are envisioned, as well as the respective roles of supervisor and therapist trainee. Commonly, professional knowledge and competencies are viewed as unilaterally handed down from the supervisor to the trainee, and the former is seen as the ultimate authority or source of knowledge regarding competent practice. From this perspective, the trainee’s task is to recover, by decoding communicative messages, the supervisor’s knowledge. From a social constructionist perspective, on the other hand, the hierarchy between the supervisor and trainee is minimized, and knowledge is viewed as co-constructed, that is shared both ways, negotiated, and jointly developed. As Anderson (2000) remarked,
Knowledge is not imparted by another or a knower who bestows on a no-knower. Rather, knowledge is fluid and communicable, yet personalized. When we share our knowledge with one another, we cannot know what each brings to the sharing; determine how each will interact with the shared knowledge; nor predict what each will create with it (p. 8).

The co-construction of meaning in supervision does not imply that supervisors do not lead. On the contrary, constructionist positioning of supervisors is diverse and fluid. In describing his supervisory role, Ungar (2006) mentioned, “I am never just ‘the supervisor,’ a singular identity determined by my role, but instead I am co-constructed in multiple ways through interaction with the supervisee, depending on what the supervisee wants or needs” (p. 59). Supervisors may fluidly and responsively fulfill multiple roles, such as a supporter, colleague, teacher, coach, and supervisor (Ungar, 2006). They may simultaneously center (i.e., privilege or promote) and decenter (White, 2007) their knowledge in interaction with therapist trainees, attending to trainees’ understandings and preferences.

Dominelli (1996) further critiqued the prevalent understanding of competency as “a set of highly technical, decontextualized practice skills which can be broken down into smaller and smaller constituent parts that can be carried out by personnel trained to a specified level” (p. 163). She went on to suggest that “insofar as competencies separate out various elements of complex social interactions and take frozen snapshots of dynamic processes, they fragment the qualitative nature of social intercourse and abstract it out of existence” (p. 163). In other words, it is possible that complex interactive, ever-fluctuating, and idiosyncratic aspects of therapy that are less readily operationalized and measured are those that are equally significant in fostering the client’s improvement and sense that therapy is helpful (Hubble, Duncan, & Miller, 1999; Lambert & Barley, 2002).

In light of these critiques, we wondered to what extent supervisors who favor constructionist ideas, in many ways incompatible with individualist, objectivist, and reductionist premises, can and should adopt the competency-based framework? Is there a possibility of a friendship between competency-based and constructionist approaches to supervision?

**COMPETENCY IN CONSTRUCTIONIST SUPERVISION**

At the outset of this section, we would like to claim a preference for the term “competency-informed” as opposed to “competency-based” supervision. We offer reasons for our preference forthwith, as the term competency-informed underlies important constructionist ideas for us. The first reason for our preference for the term competency-informed, as opposed to competency-based, is linked to the distinction Bohart (2005) made between evidence-based and evidence-informed practice. He suggested that while therapists need to consider evidence in making therapeutic decisions, the evidence should not dictate the decision, which he saw as more inherent in evidence-based terminology. Thus, he prefers the term evidence-informed practice. We think this logic is applicable to the notion of therapist competency as well—competency without therapeutic wisdom may not lead to effectiveness.

Our second reason has to do with what Larner (1994) termed as a *para-modern* perspective. This perspective embraces modern and postmodern positions as well as recognizes that therapy is both an art (which emphasizes particular, unpredictable, and creative elements of practice) and a science (which focuses more on its generic, predictable, and scientifically rigorous aspects). Specifically, Larner (1994) critiqued some postmodern writing in CFT and called certain depictions of postmodern therapy “an inverted modernism” (p. 13). He argued that post-modernism, when presented as more advanced (“post-”) or opposite to modernism, could become a grand theory or philosophy of privilege in itself by claiming that discourse about reality is more real than the reality itself. Larner consequently proposed to transcend the dichotomy of modern/postmodern, given that it still operates within a modernist binary (either/or) logic, and replace it with a para-modern approach to therapy. According to him, para-modern family therapists do not reject a modernist approach to therapy. Rather, they use their “expert” knowledge playfully and are open to non-professional explanations and metaphors. He described this para-modern approach as follows:
In a para-modern stance we play at being family therapists from a position that is simultaneously inside and outside of family therapy. Standing inside we believe in and respect the truth of a particular therapeutic metaphor, such as structural, strategic, systems, conversation, narrative etc. Standing outside the discourse of family therapy, we believe in the truth of no one particular metaphor at all, open to other possibilities that life presents to both our clients and ourselves. The conversation can then go on in a way that is not family therapy, which paradoxically opens up and enriches the vocabulary and discourse of family therapy (p. 15, italics in the original).

Applying this perspective on CFT practice as a para-modern endeavor to the notion of competency development, we believe that the term “competency-informed” allows for more inclusivity of both modern and postmodern perspectives. We also argue that it fits better with the constructionist emphasis on the collaborative co-construction of helpful knowledge. This process of co-construction incorporates not only the profession’s ideas about what it means to practice competently (CC) but, more importantly, meanings and interpretations related to competent and helpful practice generated by the therapist–supervisor dyad in the immediacies of their dialogue.

Social constructionist supervision is grounded on the assumption that supervisors do not have privileged access to information about therapy (Anderson & Swim, 1995; Prest, Darden, & Keller, 1990). Supervisors prefer to adopt a stance of collaborators or conversational partners (Monk & Gehart, 2003) who have dialogues with therapists in training about therapy, although it needs to be acknowledged that these dialogues are not necessarily “simple,” as they are embedded in relations of power (Fine & Turner, 2011). As persons, therapists have valuable lived experience and knowledge that have contributed to their engagement in the practice of therapy. Often, therapists are educated in foundations of knowledge and practices of various CFT approaches, which serve as the basis of their training (White, 1997). Their personal understandings and skills are often situated outside of, or constrained by, these dominant expert knowledge traditions and, as a consequence, are marginalized. In contrast, constructionist supervision, while recognizing and valuing the profession’s dominant skills and knowledge, also honors the life experiences of therapists and thus leaves space for their presence and influence in the supervision conversation. Therapists as whole persons become integral in the development of therapeutic competence and in ethical, critically reflexive, and generative practice with clients.

To be helpful supervisory dialogue needs to elicit meaningful changes and generate knowledge therapists in training would see as helpful to them and their clients. A dialogic, contextsensitive perspective on competency development we offer here does not focus exclusively on what is communicated to therapists. Supervisors’ initiatives and evaluations are considered alongside the interactional and contextual aspects of a supervisory conversation. It can be argued that a supervisory conversation itself constitutes a valid and valuable source of evidence of learning and competency. Rather than looking beyond supervisory (and therapist–client) conversations to understand how professional knowledge and skills are acquired, we propose to conceptualize competencies as shifts in ways of talking about and responding to clients, co-developed in therapists’ interaction with supervisors and others in their lives. We direct attention to how the details of a supervisory interaction and relationship are a formative part of its outcomes, both immediate (described and practiced competencies) and remote (changes observed in and reported by clients). Thus, in keeping with a constructionist approach to supervision, particularly the co-constructed nature of the endeavor, we refer to a dialogical frame of competency. This view conceives of competency development as a process where knowledge is specifically and contextually applied—transacted with a conversational partner to whom the supervisor is responsive (Strong, Busch, & Couture, 2008).

What we wish to emphasize here is the constructionist challenge to dominant discourse in counselor education that focuses on identification of discrete skills and knowledge and deemphasizes the context of dialogue and relationship. We argue for a more holistic and interaction-focused approach to therapist education and training, wherein therapists are supported in enacting practices in relation to clients in contexts. The focus is on coordinated action and rela-
tional engagement (Gergen, 1994) rather than on cross-contextual application of discrete and universally applicable skills and knowledge. This dialogic perspective on competencies is not meant as a supervision model or a set of tools, but as a heuristic stance for supervisors to assume in supervision.

The argument we have made for competency-informed supervision augments our view of supervisory practice, specifically allowing for the incorporation of notions of accountability and evaluation within the framework of a dialogic perspective on competencies as performed in interaction. This, in turn, informs an alternate approach we are proposing herein. We see the language of competency as ultimately problematic in that it advances a set of presuppositions about an objectively knowable world, the individual mind (with skills and knowledge located within the therapist), and language as carrier of truth. Therefore, rather than relying on use of the word “competency”, we bring forth a social constructionist “orientation” to be adopted in supervision. In the next section, we describe aspects of such an orientation, which could foster therapist development and accountability in the areas of therapeutic and ethical value of constructionist practice while still allowing for variability and diversity in style or approach of individual therapists.

SOCIAL CONSTRUCTIONIST ORIENTATION IN SUPERVISION

Drawing on Hayward’s (2003) distinction between structuralist categories of identity (e.g., characteristics, strengths, qualities) and non-structuralist categories (e.g., principles, commitments, intentions), we prefer the term “orientation” instead of “competencies.” Rather than essentializing competency as a part of an enduring, stable identity and focusing on developments that take place within therapists, the constructionist orientation emphasizes developments in client–therapist (and supervisor–therapist) dialogues. The aspects of this orientation are formulated broadly to allow for variability and diversity in therapists’ styles, assumptions, and contexts. Moreover, a relationally responsible supervisor may abandon these recommendations altogether if the interactional context calls for it. For example, it may be unproductive or unhelpful to continue fostering a generative conversation in some circumstances (one aspect of the constructionist orientation) and propose to “settle” on one particular understanding or course of action instead, such as the need for action to address potential harm.

Current CC identified by the AAMFT (2004) include the primary domains of: admission to treatment; clinical assessment and diagnosis; treatment planning and case management; therapeutic interventions; legal issues, ethics, and standards; and research and program evaluation. The secondary domains of these competencies are: conceptual, perceptual, executive, evaluative, and professional skills and knowledge. While a constructionist lens may apply across all of these domains, the proposed orientation for constructionist practice described herein, for the sake of simplicity and with chief attention to the therapists’ relational and collaborative engagement with clients, lie principally within the primary domains of treatment planning, case management, and therapeutic interventions and the secondary domains of perceptual and executive skills and knowledge.

We initially hesitated to link the constructionist orientation and the CC framework, given the differences in their assumptions. However, we also thought that there may be some pragmatic value in examining constructionist practice in light of the AAMFT domains of competencies, particularly the secondary domains (Tomm & Wright, 1979). For example, reflexivity—one aspect of the social constructionist orientation we propose—may be developed at the conceptual, perceptual, and executive levels. Conceptually, therapists may be asked to demonstrate self-awareness through reflexive writing about their own social location and the ways in which this intersects with specific clients. Perceptually, they may be asked to identify times during therapy when they were able to engage in an inner dialogue and challenge dominant cultural explanations in their own or their client’s discourse. Executively, therapists may display the ability to “repair” specific therapeutic practices in light of their inner dialogue or link their actions and responses with specific hypotheses they may wish to explore in interaction.
The orientation we describe is not comprehensive; however, it is a step in the direction of naming some shared constructionist premises and practices that may be beneficial for therapists in training. These include: (a) reflexivity and attention to power; (b) collaborative stance; (c) fostering generativity and polyphony (including multipartiality and attention to the systemic complexity); and (d) focus on the client’s resources and competencies.

*Reflexivity and Attention to Power*

Of particular concern for constructionist practitioners (and their supervisors) is reflexivity or attention to inter-subjectivity and “working on the self . . . to escape political, social and psychological determinants of identity” (Miehls & Moffatt, 2000, p. 343) in order to open space for possibilities. Because therapists may be viewed as having greater power in the therapeutic relationship and as promoters of professional discourses about the nature of people and relationships (Foucault, 1979), they can influence the way in which clients might see themselves. In other words, they can subject their clients to professional discourses that may not acknowledge or open space for client fulfillment or flourishing (Guilfoyle, 2001; White & Epston, 1990). Therefore, as Rossiter (2007) contended, relationships with clients, given that they involve relations of power, call forth concerns regarding social justice and ethics. These concerns are at the heart of social constructionist therapy and supervision. Supervision practices can open space for therapists not only to scrutinize their own subjectivities but also to virtually step aside their professional subjectivities and power relations (as much as possible) to imagine the subjectivity of the client. This would allow them to speculate together with the supervisor about potentially problematic dynamics within the therapist–client relationship that are not being elucidated or openly hypothesized or acknowledged.

Critical reflection on the interplay of power and subjectivities within the therapeutic relationship could include a therapist’s imagining of the various ways in which his or her subject positions (Davies & Harré, 1990) in therapy are woven with the imagined subject positions of the client. Positioning is similar to the noting of “role” in social psychology; however, it is more fluid and involves multiple “identities” or “selves” of the person and how these are constituted in social interaction (Davies & Harré, 1990). A supervisor witnessing these imaginations would be able, presumably, to comment on whether or not a therapist was demonstrating critical reflexivity in such a thought process (or in recorded and retrospectively reviewed interaction with clients). Rossiter (2007, p. 31) posed a number of questions that have particular pertinence with respect to subjectivity. Some questions relate to power and the influence of professional discourses on the client and the therapist:

1. What is the nature of the language used regarding the client, and how does it constitute power? What stories (discourses) are told about the client, and how does power operate in them?

To this we add the following:

1. What hypotheses are being generated in regard to the client and how are they situated in terms of professional discourses and relations of power?

2. What does the professional’s employer, profession, legislation, and social mandate expect of the therapist and the client, and how do these establishments influence the therapeutic relationship and process? How do they limit, oppress, or increase the possibilities for client flourishing?

3. What relations of power are apparent in the supervision relationship? That is, to what extent do the various relations of power, AAMFT, local preferences, interpersonal preferences, and so on influence supervisory interaction and decisions (Fine & Turner, 2011)?

4. In observing and reflecting on therapeutic interactions, does the therapist demonstrate self-awareness of his or her own standpoints, use of space, and invitation to collaboration, particularly in terms of how these influence the participation of clients? Does the supervisor observe therapist positioning or demonstrated self-awareness as this influences imposition or collaboration in the therapeutic dialogue?

5. To what extent can the therapist in training conceptualize the client’s situation and identity in narrative or discursive terms and resist essentializing descriptions?
Fostering Polyphony and Generativity

Under this heading, we propose constructionist notions such as attention to multiple perspectives, multipartiality, and systemic complexity; fostering of generative and multi-voiced dialogues; maintenance of curiosity; and tolerance for ambiguity. Collaborative language systems practitioners have the most to say about developing dialogue and generative conversation with clients and therapists in training (Anderson, 1997; Anderson & Swim, 1995). We briefly review these ideas, which are articulated prominently in the practice literature and discuss implications for supervision practice and professional development of therapists.

Collaborative therapists in training may be encouraged to stay away from facilitating change in clients or eliciting a particular outcome, direction, or response from the clients. Therapists’ questions arise out of genuine curiosity to know more rather than being used strategically for the purpose of eliciting certain information (Anderson, 2001). Therapists would be assisted in “promoting a process that keeps all voices in motion and contributing” (Anderson, 1997; p. 95). In a multi-voiced or polyphonic interaction, there is no one fixed voice; rather, there are multiple interpreting voices, which continuously intersect with and influence each other (Bakhtin, 1984). Maintaining a position of curiosity and tolerance of ambiguity are important aspects of the therapist’s ability to foster generativity and multiplicity of perspectives in interaction with clients (Anderson, 1997; Cecchin, 1987; Swim, St. George, & Wulff, 2001). As Swim et al. (2001) put it:

As clients privilege us with their dilemmas, confusions, and pains, we must respectfully join in with their telling. This process is by nature unscripted and engenders an uncertainty and ambiguity for the therapist that can be quite distressing. . . We cannot know the nature of the relationship until we are in it and developing it (p. 18)

Thus, constructionist therapists are discouraged from relying on “settled” or universal prescriptions and interpretations and assuming that they would fit all clients. Instead, they are assisted in developing the ability to tolerate uncertainty and not fully know the client’s experience, always seeking to understand further. An underlying assumption is that understanding is ever evolving or unfinalizable (Bakhtin, 1984).

Within the dialogic conversation between client and therapist, the constructionist therapist is simultaneously aligning with multiple family members, therapy outcomes, and perspectives (e.g., Anderson, 1997; Tomm, 1984) while also attending to systemic complexity. This complexity incorporates the client relational system as well as broader social, cultural, and institutional systems intersecting with the clients’ current circumstances. It is important in this intersection for the therapist to attend without partiality or alignment to the relative positions and needs of each client. In addition, the therapist may be called upon to introduce the perspective of, for example, child welfare authorities or court systems when safety and risk to children are identified as potential concerns. The assumption here is one of attending to multiple interpretations and explanations, competing mandates or agendas, balancing safety with autonomy, and maintaining awareness of the different perspectives introduced by various members of the client system.

The supervisor is listening for the therapist’s ability to avoid aligning with only one client in the context of multi-client therapy. In addition, the supervisor is looking for the therapist’s demonstrated ability to, for example, assess for risk in a manner that introduces ideas related to legal and ethical requirements, with language that is often associated with courts or professional discourse, while also inviting the client to bring his or her own language and experience to the therapy dialogue. These principles of practice require, in addition to attention to multiple perspectives, a tolerance for ambiguity.

If the ability to be generative and tolerant of multiple perspectives is viewed as an important ability of a constructionist therapist, in what ways can this be encouraged and nurtured within the supervisory context, and how could it be evaluated? Written projects as well as dialogues during supervision could give “evidence” of the development of these skills. Such reflection demonstrates not only the ease with which the therapist engages in these practices, but also provides an opportunity to give voice to the struggle associated with maintaining positions of multiplicity, transition, ambiguity, and uncertainty.
Tseliou (2010) applied Bakhtin’s (1984) notion of polyphony to the evaluation of therapist learning and development. She described the supervision process in which each student, in pairs, shared his or her reflection on the question: “Which are your resources and which are the parts that need further development in relation to the process of becoming a therapist?” Other students and supervisors then commented on these reflections in a dialogic and iterative way. Tseliou noted, “instead of the trainees being talked about in a context of [supervisors’] monologues, [supervisors] were jointly exchanging voices in a ‘polyphonic meeting in language’” (p. 336). She further argued that although collaboration and transparency may be hard to achieve given structurally or institutionally diverse positions, it may still be helpful to develop more collaborative evaluative processes. Anderson and Swim (1995) similarly wrote about supervision as a collaborative learning community, in which therapists are encouraged to be active shapers of their own learning and to engage in reflection on their learning.

Questions that the supervisor might ask in the area of fostering polyphony and generativity include:

1. How generative or multi-voiced are the therapist’s conversations with families?
2. Is the therapist open to entertaining alternative perspectives or hypotheses in therapeutic and supervisory conversations, considering potential cultural, generational, geographic, socioeconomic, or gender-related discourses or influences? Does he or she bring a range of questions and hypotheses to supervision consultations, or are explanations limited to one or two perspectives across a variety of diverse client situations?
3. How does the therapist negotiate and balance competing or distinct interpretations of complex situations?
4. Is the therapist able to hold onto hypotheses tentatively (Rober, 2002), demonstrating an ability to consider multiple possible explanations or interpretations for the current situation together with an awareness of the contextualized nature of knowledge?
5. When working with couples and families, how does this therapist manage multipartiality? Is he or she more closely aligned or attuned to some family members than others? Is space utilized and negotiated in fair measure during therapy sessions? Does the therapist actively engage in inviting different perspectives and experiences into the therapy dialogue? To what extent can the therapist resist committing to specific outcomes of therapy (e.g., partners staying together)?
6. How does the therapist approach occasions when risk or safety is a concern? Is language associated with various positions of “assessment” introduced in a manner that allows for tentativeness or curiosity to be maintained? Is the client’s voice and language also privileged in such therapeutic dialogues?

Collaborative Stance

The focus of social constructionist practice is on the process of collaborative meaning-making. Constructionist supervisors may attend to and explore, jointly with therapists, these therapists’ participation in conversations with clients. The importance of therapists assuming a collaborative stance in interaction with clients has been extensively discussed and debated in the CFT literature (e.g., Anderson, 1997; Hoffman, 1995; de Shazer, 1994; White, 2007). For some, collaboration means developing conversational partnership with mutually defined membership, boundaries, and roles and therapists adopting a “not-knowing” position to minimize their expert status (Anderson, 1997; Anderson & Goolishian, 1992). For others (e.g., White, 2007), collaboration is about therapists’ assuming a “decentered yet influential” position and privileging the expertise of clients. Still others question whether therapists can step outside of their culturally or institutionally afforded position of power (Golann, 1988; Guilfoyle, 2005) or whether a not-knowing stance can itself be an expression of such power (White, 1991). It has also been noted that from a constructionist perspective, collaboration is not one’s capacity to work together with others or an inherent quality of the therapeutic relationship. Rather, it is a joint, interactive accomplishment—the extent to which all parties in a conversation feel free to contribute ideas and to contest the ideas of others (Weingarten, 1991). Despite these varying positions, the notion of collaboration has been often associated with constructionist
practiced. For this reason, we include a collaborative stance as one aspect of the constructionist orientation.

What does collaborative engagement with clients entail? Arguably, it does not only mean aligning with clients’ familiar understandings but also collaboratively (i.e., in ways that are jointly and mutually preferred) developing alternative possibilities for meaning and action. Strong (2000) offered the notion of discursive flexibility as an aspect of collaboration, which he defined as the therapist’s ability to join the client in his or her current understandings and expand mutually and flexibly on those descriptions. Such expansion may require a set of “skills,” such as wordsmithing (Strong, 2006) or a view on assessment or information gathering as interventive (Tomm, 1987). Strong (2006) maintained that “the wordsmithing counselor is someone at home in varieties and nuances of language, and their inadequacies” who is comfortable with “engaging in improvisational activities . . . where language is ‘played’ within spontaneous ways that suit both client and counselor” (p. 21). Thus, to collaborate means in part to adopt a playful attitude toward language and be able to experiment and improvise with jointly assembling, editing, and re-negotiating descriptions and understandings.

How can a collaborative stance be fostered in the context of therapy? What might evidence the therapist and clients collaboratively developing or co-constructing meaning? Some questions therapists and their supervisors might consider include:

1. To what extent is the therapist responsive to the client’s pace, concerns, goals, and theories of change (Duncan & Miller, 2000)?
2. How does the therapist engage in coordinating actions and intentions with clients (how to proceed in interaction, what to focus on, etc.) (Anderson, 1997)? Does this include checking-in and confirming therapists’ understandings or indicating willingness to go in new directions should this be warranted?
3. To what extent is the therapist able to wordsmith (Strong, 2006) or develop, jointly with clients, a shared language? What might be some indicators of therapists’ improving their participation in wordsmithing activities with clients?
4. How open is the therapist to having his or her understandings and definitions of problems, goals, identities, and so on contested by clients? To what extent does the therapist invite clients to offer alternative perspectives?
5. Is the therapist able to revise his or her responses in light of the client’s feedback that such proposals do not fit?
6. Overall, to what extent is the interaction between the therapist and client characterized by conversational partnership—joint inquiring, interpreting, and constructing of meaning? Is knowledge of both parties shared and incorporated as a part of an ongoing conversation of therapy (Anderson, 1997)?

Attention to Clients’ Resources

Traditional approaches to therapy have emphasized the therapist’s expert status. Within such a framework, the rigor of the therapist is a critical element of successful therapy. A constructionist approach to therapy places more emphasis on client involvement, as described earlier in reference to collaborative interaction, and in doing so highlights client preferences for change and their resources and competencies. Many constructionist therapies place emphasis on therapists’ abilities to maintain this positive orientation to client strengths (Berg & de Shazer, 1993; O’Hanlon & Weiner-Davis, 2003; White & Epston, 1990).

The emphasis in supervision could be on helping the therapist in training link their theoretical training and their practice of therapy, namely to focus on and explore strengths, resources, and skills of clients (Selekman & Todd, 1995; Thomas, 1994). In other words, the therapist is supported—through the supervisor’s questions, observations, reflections, etc.—in orienting to and engaging with the clients’ resourcefulness. The following questions provide ideas about how these aspects of practice might be demonstrated:

1. Is the therapist able to entertain and bring forth the client’s resilience and resourcefulness?
2. How does the therapist invite the client to articulate his or her own meanings on resources?
In situations where violence, trauma, and safety are elements of the clients’ stories and life experiences, to what extent is the therapist able to draw upon his or her own ideas of client strengths and invite these contributions from clients in sessions?

Is the therapist aware of times when it is difficult for any or all participants in the therapeutic dialogue to hold onto ideas of resourcefulness? Does he or she bring these questions to supervision consultations?

Do supervision consultations include attention to inner dialogue regarding resourcefulness and expertise on the part of the therapist as well as on the part of the client?

IMPLICATIONS FOR SUPERVISION

Supervisors not only take a significant portion of responsibility for professional development of therapists in training but also ensure that clients receive competent and ethical services; they “should recognize their legal responsibilities for cases seen by their supervisees” (AAMFT, 1993, p. 12). Supervisors are commonly expected to provide an opinion regarding whether therapists are competent to practice a specific professional activity independently. Many supervisors find it extremely challenging to provide feedback to therapists related to professional concerns (Hoffman, Hill, Holmes, & Freitas, 2005). Presumably, this would be especially difficult for supervisors who prefer to collaborate and co-construct meaning with therapists. How can social constructionist supervisors fulfill gate-keeping and evaluative functions to protect the public yet preserve their preferred politics and ethics of working with people?

In this article, we proposed that one way to address this question is to generate (as an alternative to more specific skill-based CC) descriptions of ways in which a therapist could demonstrate an orientation to social constructionist practice. The presentation of aspects of this orientation provides a guide for decision-making around therapists’ practice and development. While avoiding essentializing “elements” of practice, this presentation suggests possibilities that could be used by constructionist supervisors and therapists in training as heuristics in their supervisory conversations and documents.

The orientation we set forth may inform the constructionist supervisor in two ways. First, the orientation itself can serve in a similar fashion to the CC in that it can direct the supervisor’s attention to specific aspects of therapy practice that reflect constructionist premises and provide a framework of practice for those who are learning to become constructionist therapists. The orientation can be used in conjunction with various methods of supervision including therapists’ self-report, live observation, review of recorded sessions, reflecting teams, co-therapy, and others. Second, the orientation also informs the practice of supervision in order to, for example, engage in collaborative interaction that privileges therapist resources and entertains multiple perspectives. Overall, we conceive of supervision as social construction (Philp, Guy, & Lowe, 2007) and emphasize the process of relational and dialogical engagement with therapists that allows for multiple influences and resources to enter a supervisory conversation. Constructionist supervisors assume that focusing on therapists’ expertise and resourcefulness is potentially more useful than accentuating deficits and unhelpful beliefs (e.g., Selekman & Todd, 1995; Thomas, 1994). In supervision, the therapist takes the lead in developing therapy and training goals and is assumed to have the necessary resources to achieve a learning goal (Selekman & Todd, 1995). Although the supervisor’s ideas regarding the therapist’s learning needs are important, the emphasis is placed on the therapist’s perceptions of what is needed to help the client and to grow professionally (Trientafillou, 1997).

CONCLUSION

A recent development within CFT, and the practice of psychotherapy more generally, has been the delineation of core competencies and assimilation of these as a part of practice and training (Chenail, 2009; Gehart, 2009; Nelson et al., 2007). In 2004, the AAMFT published the list of CC that provides a map for what is required for becoming a competent therapist. Insurance companies and government increasingly use this list to determine what it means to be a licensed and competent CFT provider (Gehart, 2009). The Commission on Accreditation for
Marriage and Family Education (2005) has also shifted its direction to a more outcome-oriented rather than curriculum-based approach to training of therapists, further demonstrating the increased attention to demonstrated outcomes or competencies. These developments have undoubtedly impacted how supervisors work with therapists in training.

In this article, we have explored the topic of competency in social constructionist supervision and discussed a possibility of a linkage between the CC movement and constructionist practice and supervision. Endorsing the overall value of professional accountability and evaluation of practice, we have raised some concerns with basing evaluation solely or predominantly on the discretely and universally formulated competencies. These competencies can privilege essentialism by overlooking contextual and interactional factors shaping therapists’ work and supervisors’ evaluation of such work. Competency-based practice and supervision, as we have discussed, is in some ways incompatible with constructionist premises of multiple truths, co-construction of meaning, focus on strengths, and learning as iterative and ideographic rather than linear and predictable. We have, however, suggested that CC could be used to inform supervisory conversations, among other things, to the benefit of supervisors and therapists and their clients.

As an adjunct to the profession’s ideas about what constitutes competent practice, we have offered some preliminary considerations to be oriented to and developed in the supervisory context. The orientation we have offered involves: reflexivity and attention to power, fostering polyphony and generativity, collaborative stance, and focus on client resourcefulness. Social constructionist practitioners and supervisors may find this orientation more in line with their preferred assumptions about learning and therapy than they would about a more discrete competency-based approach. The description of the orientation we articulated is one perspective on, or approach to, fostering therapist learning and development. It represents our attempt to contribute to the important dialogue on what is involved in promoting helpful and ethical practice of couple and family therapy.

REFERENCES


Miller, J. K., Todahl, J. L., & Platt, J. (2010). The core competency movement in marriage and family therapy: Key considerations from other disciplines. *Journal of Marital and Family Therapy, 36*(1), 59–70.


