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Strengths-Based Clinical Supervision Primer

From the Roots of Psychology

Many of our fears are tissue paper thin, and a single courageous step would carry us clear through them.

—Brendan Francis Behan (1923–1964)

Positive Psychology

There are many historic leaders of Positive Psychology such as Abraham Maslow, Carl Rogers, and Albert Bandura, and psychology's emphasis on wellness and strengths seemed to have been center stage up until the late 1940s, when the emphasis shifted to the treatment of "diseases" during World War II, as veterans came back from the war, needing attention. Positive Psychology, as we know it today, was first mentioned in former APA president, Martin E. P. Seligman's, inaugural address (1998). Later Seligman and colleague Csikszentmihalyi wrote an article in the *American Psychologist* called "Positive Psychology: An Introduction" (2000). Thus began the modern-day movement of Positive Psychology.

Positive Psychology Premises

A strengths-based strategy, Positive Psychology is also a scientific study that looks at what goes right in life (Peterson, 2006), as well as a specific protocol for Positive Psychotherapy (Seligman, Rashid, & Parks, 2006). Like some of the other strengths-based models, Positive Psychology challenges the medical model as the only manner to work with mental health issues. But unlike the other strengths-based models, it is not a treatment modality as much as it is a prevention model and a series of well-researched protocols that work to increase the factors associated with happiness and an authentic life. That there has not been an accompanying Positive Psychology supervision will undoubtedly be short lived, and I will give it a beginning try here. As one of the creative researchers and authors of Positive Psychology, Chris Peterson informed me that there is no direct supervision process that is the result of the Positive Psychology movement. He said that it "can inform goals (expanding them), provide assessment beyond the zero point, and suggest some strategies and techniques" (C. Peterson, personal communication, March 1, 2010).

The roots of modern day Positive Psychology began from Seligman's work on optimism, starting with his efforts to understand depression. Seligman's early work on learned helplessness (Seligman, 1975) stemmed from his interest in depression, and it is highly regarded in the profession. It is the basis of a psychological theory that demonstrates how one's perceived inability to control the outcome of a bad situation can lead to the mental illness called clinical depression. Seligman later decided that if helplessness (and thus depression) could be a learned phenomena, one could also learn to be optimistic (Seligman, 1991, 1996), and his book is filled with evidence regarding how optimistic people, as opposed to pessimistic people, have developed the ability to have better, longer, and more successful lives. His call for a positive psychology (Seligman & Csikszentmihalyi, 2000) was followed by an article in *Prevention and Treatment* where he took to task the National Advisory Mental Health Council's report on prevention for its continued overemphasis on the disease model and a lack of commitment to protective factors, which he named a "subset of what I call positive psychology" (Seligman, 2001, p. 2). Next Seligman published his book, *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment* (Seligman, 2002), demonstrating the power of happiness along with the growing research on what effects happiness has on people. This heralded a robust gathering of like-minded researchers who were tired of the medical model as the only way to understand and treat the growing list of *Diagnostic and Statistical Manual of Mental Disorders* (DSM) categorizations (Maddux, 2005) and the status quo of a medical model for understanding human beings (Keys & Lopez, 2005; Wright & Lopez, 2005). A growing list of research efforts aimed at improving human beings began to broaden, as this hearty band began to take back what had been a large part of psychology's original aims of making the lives of people happier, fulfilling, and more productive (Seligman, Parks, & Steen 2004).

Positive Psychology is about living life fully with a good deal of happiness; when it is engaged in human living, Positive Psychology can move mountains of depression, anxiety, alienation, and despair. Knowing that happiness is a subjective phenomenon that has been discussed in many contexts, Positive Psychology proposes to scientifically investigate the components of happiness and what contributes to those components (Seligman et al., 2004). These components are a pleasant life, an engaged life, and a meaningful life. We can, it turns out, increase the pleasantness of our life (positive emotions) through a series of activities (interventions), such as working to recognize and increase our gratitude for those in our life who have been kind or helpful and by entertaining forgiveness for those who have done us harm. The pathways are, however, limited (Seligman et al., 2004). Another path to happiness is through gratifying activities, such as engaging in work we like, or in discussions with others about things that matter to us, or involving ourselves in activities that provide us with a sense of our creativity, perseverance, love of beauty, or other character strengths—those things in life we can readily be fully engaged with and enjoy. They do not necessarily have to be pleasant at the time of their doing, but in retrospect, they give us a sense of accomplishment or enjoyment; training for a sports event or writing a long and well-documented article or book may not give immediate pleasure, but in looking back, the activity provides a sense of great accomplishment. A third path to happiness is to involve ourselves with something that is outside of our local self, connecting us with something greater, such as providing service to others, and it can include learning something new, doing something for someone else or for our family or community, or developing spirituality. All of these are examples of a flow experience that can be larger than ourselves, which can be gratifying (Csikszentmihalyi, 2008). Thus, PP has become a defined, well-researched set of activities that is aimed at increasing human beings' enjoyment of their lives, which can enrich our lives and provide protection against the unhappiness and despair that can become problematic.

It has been no secret that in impoverished areas of the world and individual lives, where despair and alienation live and breed, epidemiological studies show that mental illness thrives (Albee &

Ryan-Finn, 1993). Finding ways to increase the happiness of the average human being is a worthwhile endeavor. Therefore, an emphasis on study and work in areas of people's lives that act as protective factors and lead to a greater focus on what leads to happiness brought about the pillars of Positive Psychology (Peterson, 2006). The pillars, as outlined by Peterson (2006), are as follows:

a. positive subjective experiences (happiness, pleasure, gratification, fulfillment)

b. positive individual traits (strength of character, talents, interests, values), and

c. positive institutions (families, schools, businesses, communities, societies).

(p. 20)

In the beginning paragraph of chapter 4, I quoted Seligman's (2002) battle cry: "I do not believe that you should devote overly much effort to correcting your weaknesses. Rather, I believe that the highest success in living and the deepest emotional satisfaction comes from building and using your signature strengths" (p. 13). So just what are character strengths? Peterson and Seligman (2004) have put forth a classification system they hope will become a companion to the American Psychiatric Association's current edition of the DSM (DSM-IV-TR). The book, *Character Strengths and Virtues: A Handbook and Classification* (Peterson & Seligman, 2004), is a monumental work that documents the well-being of humans by describing and classifying strengths and virtues that enable human thriving. These signature strengths are organized into six virtuous types valued by all of the major moral philosophers, as well as the signature strengths one can have (see Table 5.1). At present, there is a growing research effort, and information can be obtained at any of the university sites with degreed programs for the dissemination and study of Positive Psychology in the United States and Europe. Positive Psychology's grasp grows wider every day. There are several websites where one can obtain further information regarding Positive Psychology (see http://www.positivepsychology.org/, http://www.reflectivehappiness.com). There is also an online Positive Psychology voluntary research site for anyone wanting to participate in this research (see http://www.ppresearch.sas.upenn.edu/). This last site includes activities for participation and reporting. For those interested in how Positive Psychology can be useful for larger venues, such as organizations, see http://www.bus.umich.edu/Positive/. The mother of all their information and ongoing repeatable questionnaires that will measure, among other factors, your signature strengths, can be found at http://www.authentichappiness.sas.upenn.edu/Default.aspx.

The study of Positive Psychology provides information regarding what makes one happy, thus less symptomatic, while Positive Psychotherapy uses the information and interventions to provide an integrated treatment strategy, especially for depression. But as you will see, those who practice Positive Psychology believe it can be generalized to other human problems typically treated with problem-focused therapies.

Positive Psychotherapy

Modern-day Positive Psychology has grown exponentially, and the first aim at having a model of Positive Psychotherapy arrived on the scene in 2005, when Seligman (2005) wrote a chapter entitled, "Positive Psychology, Positive Prevention, and Positive Therapy." This was followed by an article in the *American Psychologist* (Seligman et al., 2006), which outlined the beginnings of this model using interventions aimed at increasing positive emotions and engagement in life, rather than using a deficit-based remediation or repair treatment approach. Their model demonstrates solid evidence for reducing depression, and it is aimed at using the three scientifically researchable components discussed earlier that help to develop happiness. They are a pleasant life, an engaged life, and a meaningful life. The techniques used in Positive Psychotherapy to attend to these areas have solid research behind them aimed at bringing about a happier life, and they outline a treatment plan that progresses through a series of these interventions that are manualized in a protocol (see Table 5.2).

Table 5.1 Classification of 6 Virtues and 24 Character Strengths (Peterson & Seligman, 2004)

Virtue and strength	*Definition*
1. Wisdom and knowledge	Cognitive strengths that entail the acquisition and use of knowledge
Creativity	Thinking of novel and productive ways to do things
Curiosity	Taking an interest in all of ongoing experience
Open-mindedness	Thinking things through and examining them from all sides
Love of learning	Mastering new skills, topics, and bodies of knowledge
Perspective	Being able to provide wise counsel to others
2. Courage	Emotional strengths that involve the exercise of will to accomplish goals in the face of opposition, external or internal
Authenticity	Speaking the truth and presenting oneself in a genuine way
Bravery	*Not* shrinking from threat, challenge, difficulty, or pain
Persistence	Finishing what one starts
Zest	Approaching life with excitement and energy
3. Humanity	Interpersonal strengths that involve "tending and befriending" others
Kindness	Doing favors and good deeds for others
Love	Valuing close relations with others
Social intelligence	Being aware of the motives and feelings of self and others
4. Justice	Civic strengths that underlie healthy community life
Fairness	Treating all people the same according to notions of fairness and justice
Leadership	Organizing group activities and seeing that they happen
Teamwork	Working well as a member of a group or team
5. Temperance	Strengths that protect against excess
Forgiveness	Forgiving those who have done wrong
Modesty	Letting one's accomplishments speak for themselves
Prudence	Being careful about one's choices; *not* saying or doing things that might later be regretted
Self-regulation	Regulating what one feels and does
6. Transcendence	Strengths that forge connections to the larger universe and provide meaning
Appreciation of beauty	Noticing and appreciating beauty, excellence, and/or skilled and excellence performance in all domains of life
Gratitude	Being aware of and thankful for the good things that happen
Hope	Expecting the best and working to achieve it
Humor	Liking to laugh and tease; bringing smiles to other people
Religiousness	Having coherent beliefs about the higher purpose and meaning of life

Table 5.2 Idealized Session-by-Session Description of Positive Psychotherapy (Seligman, Rashid, & Parks, 2006)

Session and theme description	
1. Orientation	*Lack of Positive Resources Maintains Depression* The role of absence or lack of positive emotions, character strengths, and meaning in maintaining depression and empty life is discussed. The framework of PPT, the therapist's role, and the client's responsibilities are discussed. *Homework:* Clients write a one-page (roughly 300-word) positive introduction in which they tell a concrete story illustrating their character strengths.
2. Engagement	*Identifying Signature Strengths* Clients identify their signature strengths from the positive introduction and discuss situations in which these signature strengths have helped previously. Three pathways to happiness (pleasure, engagement, and meaning) are discussed in light of PPTI results. *Homework:* Clients complete the VIA-IS questionnaire online, which identifies clients' signature strengths.
3. Engagement/pleasure	*Cultivation of Signature Strengths and Positive Emotions* Deployment of signature strengths is discussed. Clients are coached to formulate specific, concrete, and achievable behaviors regarding the cultivation of signature strengths. The role of positive emotion in well-being is discussed. *Homework (ongoing):* Clients start a Blessings Journal in which three good things (big or small) that happened during the day are written.
4. Pleasure	*Good Versus Bad Memories* Role of good and bad memories is discussed in terms of maintenance of symptoms of depression. Clients are encouraged to express feelings of anger and bitterness. Effects of holding onto anger and bitterness on depression and well-being are discussed. *Homework:* Clients write about three bad memories, anger associated with them, and their impact in maintaining depression.
5. Pleasure/engagement	*Forgiveness* Forgiveness is introduced as a powerful tool that can transform anger and bitterness into feelings of neutrality or even, for some, positive emotions. *Homework:* Clients write a forgiveness letter describing a transgression and related emotions and pledge to forgive the transgressor (if appropriate) but may not deliver the letter.

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Table 5.2 (Continued)

Session and theme description	
6. Pleasure/engagement	*Gratitude* Gratitude is discussed as enduring thankfulness, and the role of good and bad memories is highlighted again with an emphasis on gratitude. *Homework:* Clients write and present a letter of gratitude to someone they have never properly thanked.
7. Pleasure/engagement	*Midtherapy Check* Both forgiveness and gratitude homework are followed up. This typically takes more than one session. Importance of cultivation of positive emotions is discussed. Clients are encouraged to bring and discuss the effects of the Blessings Journal. Goals regarding using signature strengths are reviewed. The process and progress are discussed in detail. Clients' feedback toward therapeutic gains is elicited and discussed.
8. Meaning/engagement	*Satisficing Instead of Maximizing* Satisficing (good enough) instead of maximizing in the context of the hedonic treadmill is discussed. Satisficing through engagement is encouraged instead of maximizing. *Homework:* Clients write ways to increase satisficing and devise a personal satisficing plan.
9. Pleasure	*Optimism and Hope* Clients are guided to think of times when they lost out at something important, when a big plan collapsed, or when they were rejected by someone. Then clients are asked to consider that when one door closes, another one almost always opens. *Homework:* Clients identify three doors that closed and three doors that then opened.
10. Engagement/meaning	*Love and Attachment* Active-constructive responding is discussed. Clients are invited to recognize signature strengths of a significant other. *Homework 1 (ongoing):* Active-constructive feedback—clients are coached on how to respond actively and constructively to positive events reported by others. *Homework 2:* Clients arrange a date that celebrates their signature strengths and those of their significant other.
11. Meaning	*Family Tree of Strengths* Significance of recognizing the signature strengths of family members is discussed. *Homework:* Clients ask family members to take the VIA-IS online and then draw a tree that includes signature strengths of all members of their family including children. A family gathering is to be arranged to discuss everyone's signature strengths.

Session and theme description	
12. Pleasure	*Savoring* Savoring is introduced as awareness of pleasure and a deliberate attempt to make it last. The hedonic treadmill is reiterated as a possible threat to savoring and how to safeguard against it. *Homework:* Clients plan pleasurable activities and carry them out as planned. Specific savoring techniques are provided.
13. Meaning	*Gift of Time* Regardless of their financial circumstances, clients have the power to give one of the greatest gifts of all, the gift of time. Ways of using signature strengths to offer the gift of time in serving something much larger than the self are discussed. *Homework:* Clients are to give the gift of time by doing something that requires a fair amount of time and whose creation calls on signature strengths, such as mentoring a child or performing community service.
14. Integration	*The Full Life* The concept of a full life that integrates pleasure, engagement, and meaning is discussed. Clients complete PPTI and other depression measures before the final session. Progress is reviewed, and gains and maintenance are discussed.

Note. PPT = Positive Psychotherapy; PPTI = Positive Psychotherapy Inventory; VIA-IS = Values in Action Inventory of Strengths.

Referring to their methodology as it was applied to work with depression, the authors noted that even though the use of PPT produces both "clinical and statistically significant decreases in depression, we view these results as highly preliminary, and we urge caution on several grounds" (Seligman et al. 2006, p. 785). These cautions are related to sample size, even though, as they mentioned, they are in the same ballpark as most outcome studies, to which they concluded, "We doubt that the effects of PPT are specific to depression, and we expect that increasing positive emotion, engagement and meaning promote highly general ways of buffering against a variety of disorders and troubles" (pp. 785–786).

The Positive Psychology method is really not that dissimilar from the social constructivism presented earlier. Mahoney (2005), in comparing the two, made the case that, "Learned optimism, learned resourcefulness, and hope, for example, are expressions of such engagement. Constructivism maintains not only that living systems are active but also that their activity is primarily directed toward self-organization—toward establishing, maintaining, and elaborating a patterned order" (p. 747). He stated that this ordering of patterns that people integrate because they are working become their own personal realities, as they put them to use through actions. As clients begin to use the interventions and act to incorporate parts of Positive Psychotherapy in their lives, they will begin to adapt and create new meanings based on their performance successes.

Gleaning Useful Supervisory Concepts

As Positive Psychotherapy could be applied to clinical supervision, I have used several of the "intervention" components with student interns and in workshops discussing and demonstrating strengths-based supervision. The first exercise I used was one that Peterson (2006) addressed,

where students in their Positive Psychology classes are asked to tell a story about themselves where they describe a time in their lives when they were at their very best. After reading about this exercise, I decided to begin each of my classes with a similar request, first telling a story about my son when I experienced the best of him. I include that story here.

The Best of the Best

My two young teenage sons came to live with me and my second wife during our first year of marriage—actually after three months. I had been single for 5 years after their mother and I divorced, seeing the boys on weekends and long summer breaks. This continued when I remarried, and my sons, who had met several new friends in the neighborhood, asked if they could live with us. There was no honeymoon the first year for us; the events surrounding two high-strung adolescent boys who were not thrilled about their father's recent marriage began with broken windows, paintball gun marks (presents from their mother) around our house when we were at work, and so forth. Their subtle anger and uproarious actions became routine, and yet through it all we survived. Both are now grown men, owners of master's degrees in education, and they are wonderful teachers and wrestling coaches in a high school with wives and children of their own. My wife and I have now been married for 30 years. Is this a miracle? Through it all, my wife graciously took a backseat to many things, but she provided love, nurturance, and food to teenage boys, and she also bought my youngest his letterman's jacket, when I was in my doctoral program with limited funds. The problems did not stop soon, as during their late teens and early adulthood we had many false starts as they left home, only to return months later asking for a second, third, or fourth chance, which were always greeted with love, forgiveness, and a place to eat, sleep, and try their education and launching again.

When my youngest got married in his mid-20s (and here comes the best), during the reception (which was paid for by their mother and my wife and I), he and his wife did their dance together as a newly married couple, and then as is typical, they both went off to ask their respective opposite gender parents to finish the dance. Somewhere in the midst of that, my son escorted his mother back to the edge of the dance floor where all the guests were circled watching, gave her a kiss and said something to her, and then he proceeded directly across the floor to where his stepmother and I were tearfully watching. He stood in front of his stepmother and asked her to finish the dance with him. We were not suspecting this, and we were struck dumb. Even now, as I write this story, tears well. After all those years of trouble, consternation, and heartache we saw before us a humble, loving, grown man who was willing to admit, at least in deed, that his stepmother meant a lot to him. We all cried, knowing that we were family at last.

Whenever I tell this story in class it is met universally with the same sort of emotions, as women cry and men look shaken. But they know what I am asking them to do, and their stories pour out like a cloudburst that has been waiting for the right time to soak and nurture the soil of their beings. The more I tell the story, the more the narrative thickens and creates new, better, and stronger meaning for me and my son.

What is most interesting to me is how we have been conditioned to talk about our problems; we talk about them with almost anyone. On a plane recently, the man in the seat next to me asked me what I did for a living and thus began his life story for the next hour and a half of the flight. But when I ask students or workshop participants to talk about their "Best of the Best," they are shy, stymied, and not ready to push forward. Some think it is bragging; others just mention how different it is to talk about something that was exceptional in their lives. Our culture has indoctrinated us to dwell on the negatives.

I have used this method successfully with supervisees and students in my classes many times over the past few years, but with a twist: I ask them to get into pairs and then tell a story about a time when their clinical work was what they might consider their best. On trial and error, I have found that it is easier for them to do this in pairs first rather than to tell it to the whole class. It puts front and center their ability to do well—their self-worth—during a time when they might not experience themselves as totally competent. By punctuating their best, they are reminded that they are in a process where they are quite capable.

The second Positive Psychology intervention I have used is also from Peterson's (2006) book as well as an activity/intervention from the book, *Character Strengths and Virtues: A Handbook and Classification* (Peterson & Seligman, 2004); it is called savoring. Savoring is an activity that people can cultivate, and those who learn to savor on a regular basis are happier and more satisfied with their lives. It is also a meditative technique to help one become mindful, which is described by Kabat-Zinn (2009). Bryant (2003) stated the following:

> Beliefs about one's capacity to savor have important implications for understanding positive well-being. Just because one experiences positive events does not mean that one feels capable of savoring these events, that is, of generating, intensifying, and prolonging enjoyment through one's own volition. (p. 175)

Savoring is an important part of life that we don't often take the time, or believe to be appropriate, to enjoy. Yet it can be a very important part of making positive meaning of experiences and overcoming challenges in life. I have found it an exciting component of helping supervisees become aware of their own abilities and perhaps add to their own agency.

Savoring

When working with Sue during supervision, we began to talk about her clinical work with a couple who were working on their sexual relationship that was giving her some concerns. The couple had presented with a fairly complicated experience involving their hypo sexual desire, and Sue had done the usual sensate focus training, but the work was going rather slowly, and she had hoped that they might have shown a few signs of rapid recovery. Rather than looking for exceptions as I might have done before I studied Positive Psychotherapy, I asked her to recall a time she had a very good experience working with this couple and to take her time thinking about it, savoring the event in detail, and then to talk about it with me. All of a sudden she beamed and began to chuckle. I commented that her face lit up like a Christmas tree when she started to savor this memory, and we began to talk about the good experiences she has had with them and what made it so good. Of course, it was mostly

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that she liked them and they obviously liked her, and that made a big difference. Rather than wanting to find a speedier outcome that might be short lived, she decided to focus again on their relationship issues, within the context of their sexuality. Again, she beamed and we both could tell that techniques are great but only up to a point. Further strengthening of their relationship might provide a more lasting outcome.

The idea of signature strengths is a positive influence in my life, one that has helped me find better balance. As I discovered that creativity, curiosity, love of learning, wisdom, perseverance, and appreciation of beauty were high on my list of signature strengths, I was able to adjust some of my own thinking. As I did repeated measures of my signature strengths over time, I was able to see that there were also areas—prudence, bravery, leadership, and kindness—that scored lower, and I vowed to work on these even to the extent of running for the office of president of a state branch of the ACA, which I won. As beauty and love of learning are repeatedly high on my list, I have included those as regular parts of my life; playing my guitar and singing with a friend for events also are a regular part of my life, as well as listening to all sorts of music, taking the opportunity to learn new things like taking photography classes, and staying involved in research and writing at a time when I could, academically, slack off. This has made me a better and more engaged professor. I work hard at using my higher signature strengths as part of the way I provide and work in leadership, and I have received high praise from other fellow leaders and members.

I am beginning to ask students to take their own examination of their signature strengths and consider ways that they could use the feedback to enrich their lives. With supervisees I encourage them to use the information to provide a balance in their clinical work and to combat potential burnout. I am positive on Positive Psychology.

I think it will take a while to begin to see how the use of Positive Psychology and Positive Psychotherapy in the context of clinical supervision can be useful. The methods of intervention are so different from what most clinicians perceive as clinical work that there could be dissonance preventing their use. And yet, I find their use to be an interesting and novel adjunct to my work as a supervisor.

Resiliency

Resilience is a well-researched, predictable event in people's lives, when they have come on hard times. Resilience is not something that requires special skills. Resilience has stages and conditions that we all can call upon, if we are willing. We use resilience in the care and therapy of our clients, or in our case, our supervisees. It is not a technique; it is an attitude about life and one I want to talk about here. I have used resilience in my own work, clinically and as a supervisor, but what is more interesting to me is that a lot of folks already know the secret. Following is a ministory about resilience that really surprised me.

I am presenting a workshop on strengths-based supervision at a family therapy conference. We get to the point where I am going to launch into a short piece on resiliency, and I decide to be collaborative and use the existing knowledge and strengths of the group. I ask if anyone has ever studied or worked with Froma Walsh (1996, 1998, 2003b), and three hands shoot up—well, we are in the Chicago metro area, where Froma lives, so I am not surprised, as this is a reasonable question for family therapists. She is, after all, a very well-known family therapy teacher and trainer and she was my

supervisor for a year. I ask them what they learned about resiliency from her, and in unison they say, "It's not a technique; it's an attitude." Of course, they are right; as I said before, Walsh was not the first to study and put forth the ideas of resiliency, even in the field of family therapy studies. As resiliency became a studied and useful concept, not only for individuals but as applied to families, the research began to blossom, reaching out to all sorts of family types and different situations. The discussion of resiliency has taken several different turns over the years until finally we come to an interesting conclusion. As one of the leading researchers on resiliency stated, "Resiliency appears to be a common phenomenon arising from ordinary human adaptive processes" (Masten, 2001, p. 227). No wonder she called it "Ordinary Magic." But if it is not so special, and it is not about techniques or special ways of working with clients—in our case supervisees—what does it take to work from a position of resiliency? Let us take a gander at what the research tells us about resiliency.

Smith (2006) used the work done with at-risk youth as a central piece of her work on a strengths-based counseling model, noting that the concept of at risk can be a bit of a misnomer. Affluence, coming from a good family, doing well in school, and so forth, are not total protections from being involved in risk-taking behavior; in fact, at one time or another most of us are at risk for some type of problem during our lives. The converse is also accurate. Despite living in very problematic families and neighborhoods, doing poorly in school, or engaging other at-risk behaviors, resilience research has found that most children come out the other side having decent adult lives (Benard, 1991, cited in Smith, 2006). Resiliency is such a remarkable human quality that it is hard to pin down exactly who is at risk and who is not. But we can look at the factors and conditions that are involved in resiliency.

Starting in the 1970s, social scientists began to study in earnest resiliency in children and youth who have typically been considered at risk for psychopathology (see, e.g., Rutter, 1979, 1990). The study of resiliency in children has been an upstart process for the deficit-based mentality of how disadvantaged children might grow up, and early studies categorized the resilient as invulnerable and other words setting them apart. Yet, it seems that in most cases, resiliency is a normal adaptive process that, when in good working order, is available to most, "even in the face of severe adversity" (Masten, 2001, p. 227). In one of the earlier studies, Garmezy (1991) showed that the effects of poverty, although horrible in the aggregate, are not necessarily devastating to all who live within it. The same sort of protective factors that are available and normal for others are alive and well here. For instance, the cry that urban schools are hotbeds for gang violence and drug problems fails to recognize that many children succeed with the help of teachers and significant adults who are able to motivate children past their conditions. The problem may not be the schools themselves but the districts' inability to reassign so that there is not an overloading of particular schools with the least able students who may bring others along with them down the slippery slope (Garmezy, 1991). Praising the work of urban schools, Garmezy stated the following:

> What is apparently needed by school personnel is the proud awareness that by putting forth the best effort in their classrooms and schools they are engaged in the most worthy of social enterprises—the enhancement of competence in their children and their tailoring, in part, of a protective shield to help children withstand the multiple vicissitudes that they can expect of a stressful world. (p. 427)

Moving on to other areas, Bonanno (2004) deconstructed our usual assumptions of several intersecting human problems with respect to recovery versus resiliency. He showed that in situations where loss or trauma has occurred, a goodly number of people show signs of resiliency, the ability of humans to weather the storms of life, rather than needing interventions for what clinicians usually consider recovery. In fact, the usual assumption that people need to

have significant interventions postevent is not accurate and cannot be defined as abreactions to the event. Solid research shows that a fairly large portion of people having undergone grief work or trauma counseling actually get worse (Bonanno, 2004). Resiliency to loss or traumatic life-threatening events is common and "does not appear to indicate pathology but rather health adjustment" (Bonanno, 2004, p. 23). Resiliency is a remarkable and underrated human condition that professionals and the population at large tend to dismiss.

Some of the variables that seem to matter most and those we naturally think of as important include being connected with caring, competent adults, having adequate cognitive skills and the ability to self-regulate, and having a positive self-image, as well as the motivation to do well (Masten, 2001). The interventions coming from this research that can enhance protective factors are simple enough, including promoting competencies and prevention of symptoms or risks. The synergy of these conditions is key to producing well-developing children and youth and points to the environmental factors that could be controlled. Investing in the development of self-confidence and educational skills, as well as good parenting and adult support, is key, and working together provides a cumulative effect. And yet, because the human spirit and makeup is such that adaptation to adversity is so great, a youth that lives in a home where there is great distraction and multiple problems can thrive because of a committed significant adult—be that a relative, school counselor or social worker, teacher, or coach.

Masten and Curtis (2000) made the point that our current classification systems for psychopathology "need an overhaul to address more effectively the salient role of competence and adaptive functioning in defining and treating disorder" (p. 234). To begin with, Masten (2001) suggested that all of the research on resiliency point to the central themes of positive psychology, because the traditions of psychology have failed to address specific information regarding the strength of human beings.

Walsh (1996, 1998, 2003b), although not the first to put forth the notion of resiliency as a family affair, was one of the first to write about it in the context of a treatment consideration. By looking at the common traits associated with individuals, and then applying them to families, she offered clinicians a new way of working and viewing the families with which they work. Noting that in many cases families have been seen as potential risk factors, she made the same systemic shift people who use family systems thinking did some decades ago, by suggesting that (and here is the attitudinal shift I spoke about earlier) families can be seen as protective factors, serious influencers of success and promotion of well-being. Her promotion of families suggests that, "In building family resilience, we strengthen the family as a functional unit and enable the family to foster resilience in all its members" (Walsh, 1996, p. 263). Using a systemic view of resilience, Walsh noted that it is a relational event that can influence and create resilient individuals. Children and adolescents learn their views of themselves (self-reliance and efficacy), how to view their outside world (worldview as a struggle or a place that provides sustenance), relationships (affirming or constricting), and resiliency (picking oneself up and moving on or succumbing to adversity) from significant people in their lives. It is these attitudes that they can then bring forward to their own adulthood and then pass on to their own offspring. Relational resilience means a change in how we view families, from damaged to challenged (Walsh, 1996, 1998, 2003b). How we as clinicians and supervisors function also depends on our own views, because our view of family "normal" is usually associated with the typical bell-shaped curve that places normal within the scope of variables between standard deviations. Those families that do not fit within those parameters, but instead are within the tails, can be pathologized when they might be living within cultural norms or personal events that are dictated by their current context. Normality is a social construct that we have come to believe is real and true for all. "The very concept of the

family has been undergoing redefinition as tumultuous social and economic changes of recent decades have altered the landscape of family life" (Walsh, 2003a, p. 4). Our views of family life have been constructed through social political and media events, and as family historian Stephanie Coontz (2000) demonstrated in her book, *The Way We Never Were: American Families and the Nostalgia Trap,* our concepts of the family are not what are projected by any of them, and they never have been. We do not live in a Leave it to Beaver, Cliff Huxtable, or Brady Bunch world. Our families have never really looked like those historically and they certainly do not now.

As Walsh (1998) pointed out, there are several key family processes that are part of a resilient family life, including a shared belief system—an organizing principle or worldview for living one's life and the meanings we ascribe to events, bad or good. Families also provide processes she called "shock absorbers," which include flexibility, connectedness, resources both social and financial, that provide stability as well as efficacy in living. Flexibility during transitions and developmental stages can be extremely important as to whether a family succumbs to stress or the members move on with their lives. Finally, as I mentioned at the beginning of this section, resilience is an attitude about working with and viewing families and individuals. It is important to remember that, "Resiliency does not come from rare and special qualities, but from the everyday magic of ordinary, normative human resources in the minds and brains and bodies of children, in their families and relationships, and in their communities" (Masten, 2001, p. 235). Observing that treatment and healing are different phenomena, as one is applied while the other comes from within, Walsh suggested that many of the newer strengths-based concepts have come about because clinicians have finally recognized that families do have their own sources for healing. So we have come full circle. By the way, Walsh (2006) has an incredible set of resiliency practices that any clinician can use successfully. One of these practices has become commonplace in clinical work. I remember Walsh talking to our supervision group at the Family Institute of Chicago (a part of Northwestern University) and stressing that we should normalize people's stresses, thus putting them in a context of strengths. At first, it made no sense to me and my "pathology" trained epistemology, but she was teaching us to help heal families and their members, not diagnose and label them with irreparable iatrogenic language.

Gleaning Useful Supervisory Concepts

Resilience concepts are a welcome addition to the ideas of strengths-based supervision. Again, I must emphasis that much of the clinical supervision literature is from a medically modeled view, and it is sorely out of date. As the resiliency researchers suggest, the focus on deficits is problematic and not in tune with the reality of those with whom they are working. Supervisees come to us wanting help with cases in which they are feeling stuck or fear they lack the necessary skills. Yet, as I have said before, they are some of the most well-trained, capable people to come out of graduate schools. Resiliency concepts work to empower supervisees to work more effectively and to believe in their own abilities. Just as children and adolescents learn from their families and other significant people in their lives, our adult supervisees learn from us their views of themselves as clinicians, how to view their outside world of colleagues, relationships, and resiliency. They learn that view from gentle collaborative relationships, not from experiences where they are taught to limit their imagination, alternatives, and possibilities.

Sum of gleanings.

The first thing that jumped out at me after writing and rewriting this section was how attitudinal strengths-based supervision purports to be. Even though several of these ideas come from different philosophical positions, they have the common

thread of being against a deficits model and for an agentic perspective as the most important quality with which to work. The status quo of the medical model is intellectually struck down as king, and in its place are put several ideas of how to work with folks from a strengths-based position. Agency, the ability to help empower the people we work with so that they believe that they can succeed, is the most powerful force among humans, other than love. But it is not enough just to believe that you can succeed. People must then be willing, with some sort of social support, to begin the performance; they must step into that belief with everything they have at their disposal to practice, and practice until they know the feelings and behaviors of success—which also includes knowing that there will be times when they need to persevere and to get up when they have been knocked down. This sort of attitude can come from one's family of origin, one's chosen family or group of supporters, or a clinical experience including supervision.

When my daughter Zoë was in kindergarten, she came home one day and as we talked, she told me she couldn't do the monkey bars. She looked sad and said that a lot of the kids could already go hand over hand from the first to the last rung. She could only do one or two and then had to jump to the ground. I asked her what she thought she could do to increase her ability so that some time down the road she might be able to complete the whole set of bars. She pondered this question, as only a 5-year-old can, complete with faces to show she was thinking, and then she said those wonderful words that would last her a lifetime: "I guess I will have to practice, but first I have to believe that I can do it, Dad."

Every day from that point on, I got a report of progress, and every day we celebrated with smiles and encouragement and sometimes a snack, until she had completed the task. She moved from having a goal, to believing she could meet that goal, to moving into the behavior and practice that made her succeed. But she learned something far more important during those weeks—that she can do almost anything she wants, if she puts her mind to it and practices. She learned agency.

Enfolding Strengths-Based Supervision

I have made the case throughout this chapter, and as a central theme of this book, that personal agency is a critical part of what clinical supervisors of any stripe do to help the growth of themselves as supervisors, as well as in their work with their supervisees. Zimmerman and Cleary (2006) reminded us that, "Personal agency refers to one's capability to originate and direct actions for given purposes. It is influenced by the belief in one's effectiveness in performing specific tasks, which is termed self-efficacy, as well as by one's actual skill" (p. 45). Our supervisees need to believe that they can do this very difficult job of working with people who are having difficulties. The different sorts of clients our supervisees see will lead many of them to places they have never experienced before, situations that can be unfathomable—abuse, crisis, violence, and despair. They need to understand that they are not alone in this process and that they can do this work. They need to have the belief in themselves, know that they can originate actions to be helpful, and act on their understandings. Personal agency is more than just believing; it is moving into that unknown space and acting on the belief to succeed and having the resiliency to get back up again when our best intentions do not work.

I will not belabor the point, but one must at least acknowledge that traditionally we have been indoctrinated with the view that supervisors know best and that our job is to make corrections, remediations, and fixes so that they resemble "our perfect" clinical work. Those ideas we may put forth, no matter how kind and gentle, can still have implications for what they can do to perpetuate the system and to make clear that those with whom we work will only come to near perfection with our help, at least in our minds. What a change comes from the narrative in which the hierarchical and egotistical view of an all-knowing supervisor is changed to one of a supervisor who really listens. Jill Freedman, in an interview with Schwarzbaum (2009), answered the question, posed about who were the influential shapers of her work, this way: "I hope that the people I work with as clients influence my practice" (p. 161). This response is the sort of "one-down, not knowing" attitude I would expect from strengths-based supervisors. I hope that all supervisors learn tons from their supervisees.

The next thing that was evident is that there are many roads to good work with people, both in clinical work and supervision. Our traditional lock on listening to tapes to hear if our supervisees are making what *we* believe to be adequate responses is not always the most useful tool in our shed, after all—responses to what? Which model are we using, and what are the circumstances of the client/clinician working relationship at the time? Context and intuition are always important, and listening to a tape provides us with only one variable that constitutes a clinical session. If we only assume that a client-centered response is accurate, we delimit other models. One only has to watch tapes of some of the so-called masters to realize that there are many different possibilities of interaction. And so it is with supervision.

Finally, all seem to imbue an attitude rather than a set of techniques at the metalevel. Oh, yes. There are protocols of activities (Peterson & Seligman, 2004), and formulaic responses (Walter & Peller, 1992), and jargon that, well, I don't know what it does, and techniques (Freedman & Combs, 1996; White & Epston, 2000) that may all have ways of operating, but the soul of them all seems to be to change the prevailing attitude about the people with whom we work, from a deficit-based model to a strength-finding model. I love that and have seen it work wonders, both clinically as well as with supervisees. All of the models presented earlier have an agentic flare, with encouragement to performance so as to enhance and train our neurons in the ability and knowledge of resiliency and perseverance. From the solution-focused mantra of looking for exactions coupled with the request to try more of that, to the simple positive psychology intervention of finding signature strengths and doing more of those and enjoying the moments (flow) we are living, all are agentic, rather than deficit based.

Every form of these new ideas opens up possibilities for also providing multicultural, cross-cultural approaches to supervision. Smith (2006), in her seminal article on strength-based clinical work, suggested the thought that "a core component of the strength-based theory is that culture has a major impact on how people view and evaluate human strengths. All strengths are culturally based" (p. 17). Narrative work with its focus on social justice through a flattening of hierarchical positions (Freedman & Combs, 1996) is certainly an ally of cross-cultural and multicultural perspectives, as are reflecting teams and languaging efforts. In fact, strengths-based supervision is a grand narrative positing equality and understanding at deep levels of difference and similarity of people regardless of who they are or where they come from, figuratively or literally.

I come back to this again, but the issue of evaluation becomes moot when one is looking for and mining strengths in people. The literature throughout this book has statements from several different points of view that are alternative ways of making an assessment, if that needs to be done. But a far more radical approach might be to do what we are supposed to do in our training of group work: split the functions if one must make judgments about others' social

constructions. But of course, I also agree with Turner and Fine (1995), that I can do both quite well with transparency, solid expectations that we both agree on—one for their own growth and potential and another about what administrative expectations are with respect to their work. When I discussed this with one of my colleagues, Andy Young, with whom I do workshops, he said, "When you are telling them what they are doing well, aren't you providing solid evaluation? Where does it state that you have to do otherwise?" (A. Young, personal communication, November 16, 2009). And of course, Andy was right. I have tried to address these issues throughout the book, because they are concerns of us all in today's world.

I have placed these ideas before you in these rather long, and I hope interesting, two chapters, but I would like to end with a few more overarching thoughts, to finally put the nail in the coffin of what has become, in some circles, the way of doing "appropriate" supervision.

The World is Flat and We Are Not

Thomas Friedman's (2005) book, *The World is Flat,* clearly puts forth the notion that because of the changing face of the world's media and technology, there is no longer such a grand need for overseers and managers. At one point in his book he tells the story of accompanying General Richard Myers, chairman of the Joint Chiefs of Staff, on a tour of U.S. military headquarters in Baghdad, Iraq. As they walked around, Friedman was taken by the media technology that is helping our troops. He watched in awe as a soldier monitored the situation from his laptop attached to a camera on a Predator drone that was flying overhead, and Meyers reported that, "technology had "'flattened'" the military hierarchy—by giving so much information to the low-level officer, or even the enlisted man who was operating the computer, and empowering him to make decisions about the information he was gathering" (p. 39).

There are three points that this quote exudes when placed in the context of clinical supervision and clinical work. First, technology has given us the tools to do more, know more, and work smarter than ever before. As I have stated repeatedly throughout this book, in our field of clinical work, our students are taught more, supervised more, and know more about working with clients than ever before. By the time they have graduated from their various programs, they have been taught several different models of counseling, have been recorded via audiotape and videotape for feedback purposes, and have absorbed a number of models to use in their work. Second, the operative word to sum up the previous paragraph is "empowering." Although I am sure that most clinical supervisors believe their work is empowering their supervisees, I have heard many horror stories about clinical supervision gone bad. Many of the models of supervision are reflective of our models of clinical work—mainly problem focused or remediation focused, attempting to solve or correct the problems presented—and it is an attitude we need to rid ourselves of. These models focus on a top-down hierarchical model where the supervisor is supposed to remediate or solve the supervisee's problems and teach the correct way. This is not empowering. According to the Cambridge dictionary online, empowering is (verb) "to give someone official authority or the freedom to do something," or (adjective) "something that is empowering makes you more confident and makes you feel that you are in control of your life" (see http://dictionary.cambridge.org/dictionary/british/empower?q=empower). Nelson and Friedlander (2001), while researching conflicts among supervisors and supervisees, found that conflicts occur on a wide continuum, from the supervisor being too distant and unavailable to being too familiar with supervisees. However, many power struggles between supervisors and supervisees include the disempowering or devaluing of supervisees past clinical experience, as well as supervisors imposing their own model of clinical work on their supervisee, among others. I believe that empowering supervisees is key to excellent supervision. Finally, if the U.S. Army sees the sensibility of giving up the rigidity of a hierarchical organization during war time, what makes clinical supervisors believe

they cannot do this? Historical contexts still inform us, and ancient views and timeworn practices are just that. They are worn thin, and I believe it is time to move to a truly empowering model that shares the same philosophy as the newer clinical models.

Just Try and Make Them

The thought must occur to all supervisors at some time during the course of supervision that when supervisees are alone and not being taped or watched—alone behind closed doors—they probably practice clinically using ideas other than what their supervisor might do or even approve of. Most clinical work occurs with such nuanced differences in each session that to believe one or two models might be enough to help when the client's situation hits a crisis or is seriously wrong headed. We cannot force our supervisees to practice as *we* would like them to, and we should want them to be able to react with grace and transparent therapeutic efforts that are applicable to the moment, rather than on some basis of theory. Those who have practiced clinically and as a supervisor for any length of time have to look back over their career and take stock at the many changes they have had with respect to how best to work with our clients, be they clinical clients or supervisory clients. Cookie cutter counseling just does not work outside of the laboratory.

Wisdom and Truths: Guiding Principles and Systemic Logic

I have been a cook throughout my life. I love to putter around in the kitchen, making good, solid food for my family. My eggplant parmesan was the final straw that convinced my wife to marry me, I think. I love to make bread also, and I will make both loaves of whole wheat and white at the same time. When my oldest son was about 12, he asked me if he could cut a piece of bread to eat, and I said, "Sure; make sure you don't cut your finger off!" Then it hit me; I was telling him what I did not want him to do, rather than what I would like him to do. It is a simple thing; I have heard it before from experts, but we are always more focused on the negative, rather than the positive. So I corrected myself and said, "It works better if you use the bread board, and cut with the bread knife straight down, with a sawing motion, and keep your fingers back and away from the blade." To which he responded, "Got it Dad, I've done this before, you know." But at least it was not the response, "What do you think I am, an idiot?" Now, more times than not, I am clear that the issue of strengths-based ideas is more about an attitude than it is about techniques. As I pointed to earlier in Chapter 1, attitude changes our view when seeing clients who are thought to be "at risk," to see them as "at potential" (Bermeo, 2009). I now come back to reiterate those six elements of strengths-based clinical supervision skills:

- See the glass as half full more times than not.
- See every stakeholder as capable and having unique contributions.
- Help covisees (stakeholders) develop their personal agency (self-efficacy).
- Help stakeholders begin the process of strengths-based forethought.
- Help stakeholders find and use their voice.
- Encourage stakeholders to pass it on to others.

It is, for some, a major stretch to see both supervisor and supervisee on the same level playing field, both with hopes and dreams of what is to come and what the ends are of their journey. But if we truly believe that we are both stakeholders in the process, it changes the way we approach, respect, and treat each other. It is startling for some and comforting to others to realize the scientific fact that our brains can have such a powerful effect over us, to provide us with a top-down view of what has been socially constructed as truths. Our learning from family, culture, and education has provided us with a road map so we do not have to think too critically about much of life, and we can be on auto pilot for much of our life, rather than savoring and paying attention (Kabat-Zinn, 2009; Siegel, 2007). So, if some of the information

I have provided is not according to your epistemological understanding, step back and ask yourself this: "Why am I so set in my ways about this? Where did I learn what I know, and is it still a relevant understanding of life? Why do we look at problems in such a medically oriented set of realities? And what is it about the ideas in this book that affect me so positively or negatively?" And then, after opening yourself to new ideas, ask what fits about these concepts and what does not. That is openness, and we can both be all right with your final conclusions—that our work together here has been a social construction of ideas, out of which you will then make your own meaning. Then we can agree to disagree or add to each other's beliefs in a new way of supervising.