Evaluating Therapists' Practices in a Postmodern World: A Discussion and a Scheme*

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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? This question—a most pertinent one for university-based supervision, where evaluation is necessary and constant—is addressed both theoretically and pragmatically in this article. Ethical issues are explored, and an evaluation form, developed by the authors for use in a family therapy doctoral program, is presented and discussed.

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A few years ago, Harry Goolishian and Harlene Anderson of the Houston-Galveston Institute, and the faculty of Our Lady of the Lake University, invited approximately 100 therapists, teachers, and supervisors from North America, Europe, Australia, and New Zealand to meet for a few days in San Antonio, Texas. The participants were invited to converse with each other in break-out groups about various therapeutic implications of the ideas of social constructionism and postmodernism. During a session on supervision, many of the participants spoke eloquently about their nonhierarchical relationships with their supervisees, about how they considered all ideas equally valid, and about how there is, from a social constructionist perspective, no objective place to stand and judge another therapist's work as either good or bad. Anderson and Goolishian (1990) have, in another context, characterized such ideas as a *collaborative language systems approach* to training:

> The training system, like the therapy system, is one kind of meaning-generating or language system. In such a language or learning system, the teacher and the student create meaning with each other. In this sense, both are learners. The teacher (the supervisor) and student (the therapist) create narratives and stories with each other around which they organize the learning task. Implicit in

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> this learning system description is the idea that it is a collaborative, egalitarian, and horizontal system in which their expertise (teacher's and student's) is shared. [p. 1]

In the midst of the discussion at that conference, one of us (S.G.) spoke about her struggles with the issue of evaluation. She noted that many of the other participants worked in institutes or agencies, and thus their supervision was not directly connected with the granting of graduate degrees. She contrasted this to her own supervisory context. As a faculty member in a university therapy program, she, along with her colleagues, was responsible for determining who did and who did not graduate. She made the point that the university context is such that a supervisor cannot *not* pass judgment because the decision to graduate a student from an academically oriented, clinical training program sends a message to the general public that the individual has been declared sufficiently competent to receive a graduate degree. Thus, she felt the responsibility to give careful consideration to students' clinical abilities. The conference participants responded with a prolonged silence.

In this article, we attempt to speak to that silence, to describe how we as supervisors and teachers in an academic program pay respectful heed both to the postmodern ideas of social constructionism and to the setting in which we work. It explains how we participate with our students and each other in the supervisory process, a process that entails detailed, ongoing evaluations of each student's clinical work. We have developed an assessment form as a means of presenting these evaluations to the students, which we will describe in the latter half of the article, following a discussion of the contextual, ethical, and practical implications of evaluating in a postmodern world.

THERAPY AND SUPERVISION

Lynn Hoffman (1990) has called for a shift in the field of family therapy from a cybernetic/systems metaphor to a postmodern, anthropological one. Parry (1991) has suggested that family therapy's move into postmodernism was ushered in when theorists and therapists began to embrace the reflexive implications of cybernetics-of-cybernetics. The most marked difference in therapeutic practice accompanying such a shift is the loss of certainty, the loss of the idea that there can be one privileged (correct) understanding of problem situations (Andersen, 1990; Anderson & Goolishian, 1988; Gergen, 1985; Gergen & Kaye, 1992; Hoffman, 1993; Lax, 1992). Hoffman (1993) explains that social constructionist theorists, locating their ideas in the postmodern tradition, view all knowledge and ideas as evolving through language and taking shape in the realm of the "common world" or "common dance" (p. 116). Instead of one truth, the question then becomes, "Whose truth?" (p. 150). This, in turn, challenges the traditional hierarchical relationship between therapist and client, where the former is thought to cure the latter with his or her expert knowledge (Anderson & Goolishian, 1988; Hargens, Grau, & Leeds, 1994). From a postmodern perspective, the therapist begins each session from a position of "not-knowing," with the realization that he or she must learn from the expertise of the client (Goolishian & Anderson, 1992).

Given the isomorphic relationship between the processes of therapy and supervision (Haley, 1980; Liddle & Saba, 1983), it is clear that the ramifications of these ideas affect not only therapy, but also its supervision. If there is no one right way to converse with a client, what grounds can the supervisor have for taking a particular position or asserting a specific perspective? Put differently, if the only knowledge is that which is created in a common dance,

how can the supervisor claim to know which steps should emerge as most significant?

As therapists, we are intrigued by, and comfortable with, many of the changes that postmodern ideas bring to the practice of therapy; however, as supervisors training therapists in a university context, we find ourselves challenged by how to make an analogous shift in our supervisory practice. This challenge is made even more daunting by the diverse clinical perspectives of our faculty. However, while the seven clinical faculty members presently supervising in our program operate quite differently, we consistently agree on which students seem to us to be doing well, and which students are having difficulty in their clinical work. It was this general consensus that led us to believe that it would be possible, and advisable, to develop a method of evaluating our students in a way that would attend to our diversity as clinicians, our desire to graduate systemically sensitive therapists from our program, and our agreement on basic clinical and ethical concerns.

THE QUESTION OF EVALUATION

If therapists have "no privileged position or neutral vantage point from which to observe or practice" (Parry, 1991, p. 39), then the same is true for supervisors: we cannot possibly provide an objective evaluation of trainees. Turner and Fine (1995), who have also grappled with constructionist challenges to evaluation, put it this way: "As supervisors we are in a seemingly contradictory position[:] having the power to make evaluation judgments but recognizing that these are based on partial and subjective knowledges" (p. 58). Nevertheless, as Atkinson and Heath (1990) observe, an evaluation need *not* be objective to be valuable: "[T]here are some things that happen between people that should be evaluated in a 'better/worse' fashion by those who recognize the subjectivity (but importance) of their evaluations. Opinions and judgments in these situations are helpful" (p. 166). Not only are such evaluations *helpful,* they are also *ethical,* and, as such, necessary: "[T]here is no way to escape the responsibility of making moral decisions" (Epstein & Loos, 1989, p. 418).

If, in this postmodern world, it is no longer possible to bolster an ethical stance by appealing to some outside or universal standard, neither is it necessary to discount such a stance as inadequately subjective. Making a moral decision or taking an ethical stand are each ways of establishing a *relationship*—they locate the observer in the observed. Keeney (1983) considers the notion of *ethics* to be a way out of the oscillation between objectivist and subjectivist positions:

> It is apparent that we need to look beyond the gestalt of objectivity and subjectivity. . . . [T]he alternative is *ethics.* From an ethical perspective we do not ask whether we are "objective" or "subjective." Instead, we recognize the necessary connection of the observer with the observed, which leads to examining *how* the observer participates in the observed. [p. 80; original emphasis]

Ethical decisions, therefore, are neither subjective nor objective, but *relational*—they have to do with taking a clear stand and, in so doing, defining a relationship between self and other. As supervisors, we take stands in relation to our students and their clients, our colleagues, and our profession.

When we supervise and assess our students, we define our relationship with them and to the ideas informing our teaching and evaluation. To the degree that we stay in touch with other supervisory colleagues as to how we go about supervision, we also demarcate our relationship with each other. And, when we are able to state a particular

set of shared values and ideas clearly, we distinguish our relationship with those colleagues who taught us—with that network of teaching therapists, past and present, whose work informs our own.

As previously noted, our faculty reflects considerable clinical diversity; we identify variously with brief problem-solving and solution-focused, Milan, Ericksonian, reflecting, narrative, languaging, and Bowenian approaches. In keeping with a postmodernist position, we have not tried to minimize or diminish the range of our clinical differences, nor have we attempted to develop an integrated supervisory position. We do, however, recognize the importance of marking therapeutic assumptions that we share in common. These assumptions could be categorized in any number of ways; for the purposes of this article, we have organized them in terms of three ideas or values:

1. *Individual behavior is usefully considered in an interpersonal context.* This leads in practice to respect for contexts, ours as well as the clients', and open discussion of how they inform our relationships. For example, we all, in our own way, ask our students to enter into the logic of their clients' dilemmas and, thereby, respectfully appreciate how such situations could both arise *and* dissipate.

2. *The therapist shares responsibility with the client for the therapeutic reality created.* This concept of the co-responsible therapist leads in practice to two ethical imperatives: a) respect for individual, biological, gender, ethnic, and cultural difference; and b) respect for the unique experiences, strengths, and resources of clients. Without such respect, the therapist runs the risk of creating realities that limit, rather than expand, the clients' possibilities.

3. *Sensitivity to and dexterity with the complexities and subtleties of language are important therapeutic tools.* Whether one's use of language takes the form of Hoffman's (1993) "more active listening" (p. 158), White and Epston's (1991) active search for unique outcomes, or Erickson's indirect suggestions (Erickson & Rossi, 1980), the therapist must continually attend to and actively participate in the interplay of various levels of meaning in what is heard and spoken.

These notions, which serve as a point of departure for each of our individual approaches to therapy and supervision, have helped us to distinguish clinical commonalities between us. Additionally, they have allowed us to evaluate in a way that we hope is simultaneously respectful of the unique work of each of us and our students, the tradition of systemic family therapy, and current developments in the field.

In addition to the these commonalities, we must also consider the *contextual* relationships within which decisions regarding evaluation are made. Thus, the sorts of choices and decisions we make as faculty members, including the evaluations we make of our students, must be understood in terms of: a) our relation to the students; b) our relation to the university context of which we both are a part; c) our relation to a public that trusts clinicians holding advanced degrees; and d) our relation to the community of family therapy. We attend carefully to each of these relationships, and to the multiple ways in which they interconnect. These contextual relationships necessarily define what we are able and willing to do, and such definition is a necessary part of any interaction.

Many in our society accord special status and heightened respect to professionals who hold graduate degrees, and state licensure boards and the AAMFT place faith in the training offered and the degrees conferred by universities. In addition, university, institute, clinic, or hospital administra-

tors who hire our graduates to teach and supervise *their* students, treat a job applicant's Ph.D. as an indication of high competency, as a message from us that we consider our former student to be a colleague. We thus feel a responsibility to the public to engage in an evaluation process with our students, to ensure to the best of our ability that the therapists and supervisors we graduate from our program, and on whom we confer graduate degrees, will "first do no harm" (Becvar, Becvar, & Bender, 1982, p. 385) as they respectfully and effectively participate in therapeutic contexts.

The evaluative component of our supervision, detailed in the following discussion, precludes the sort of egalitarian, horizontal system advocated by Anderson and Goolishian (1990). Nevertheless, we view our relationship with our students as a collaboration, one in which both supervisor and supervisee are able to learn from each other. We thus seek collaborative relationships which avoid the danger that "therapeutic practice might slide and fade into innocuous relativism of both teaching and praxis where no one dares be more of an expert on anything than anyone else" (Cantwell & Holmes, 1994, p. 25). In such supervisory endeavors, we are informed by Efran and Clarfield's (1992) view that a constructionist perspective does not "necessitate being neutral, avoiding hierarchy, or waiting for change to happen of its own accord" (p. 215).

THE PRACTICE OF EVALUATION

Evaluation can be considered a two-step process. The first entails the supervisor distinguishing between "good" and "bad" therapy—if only to say, "This fits for me, but that does not." This is perhaps as far as any supervisor in a nonacademic training facility or workshop setting would need or want to go. Harry Goolishian exemplified such clarity in the way he defined his personal stance. Following a live demonstration of his and Harlene Anderson's therapy at our university, he responded to a student's derogatory comment about a client in the following way:

> Take this couple. It would be fairly easy in traditional psychological language to think of her as being demanding or to think of him as being stubborn, or you could think of a whole bunch of adjectives, diagnostic adjectives, to call them if you wanted. You might even go back to the old hysterical-paranoid axis of the 1950s, the early 1950s. But if I was in the room and a thought like that hit me in terms of my idea or my theory about what they were, . . . if, for instance, I thought "my God he's being pushy," I would consider that a very dangerous idea, and I'd have to find some way not to have it. [Goolishian, 1989]

The second step in supervisory evaluation entails the supervisor deciding whether or not a therapist who engages in practices that concern or unsettle the supervisor in some significant way should obtain a credential that is taken by the public to be evidence of expertise. This second step may be taken by supervisors in nonacademic settings, but it is a given for supervisors in university-based training programs, for reasons elucidated above.

Because our supervision is undertaken within the context of a university, we involve ourselves in both steps of the evaluation process. Following Tomm and Wright (1979), we have attempted to define a set of skills that we consider necessary for the effective practice of family therapy, and we have defined them in terms of "instructional objectives." However, unlike Tomm and Wright, we have not tried to develop a *model* of family therapy; rather, we have tried to define the objectives in such a way that they can be relevant to a variety of models of therapy.

A SCHEME FOR EVALUATION

Over the last 7 years, we, in conjunction with our colleagues and the students in our program, have evolved a means of evaluation that reflects and respects both values held in common and our individual differences as supervisors. Integral to such an assessment method has been the identification of a set of clinical abilities that we consider important to the practice of family therapy. In this, our efforts both coincide with, and diverge from, those of Figley and Nelson with their Basic Family Therapy Skills Project. We too are interested in the notion of "family therapy competencies" (Figley & Nelson, 1989, p. 354); however, we did not derive our list of skills and attributes with empirical survey methods, and we have not attempted to be exhaustive so much as encompassing.

Figley and Nelson have, to date, differentiated a total of 336 separate therapist attributes nominated by supervisors and trainers in the field (100 generic family therapy skills [Figley & Nelson, 1989], and 100, 14, 45, and 77 skills for Structural [Figley & Nelson, 1990], Brief [Nelson & Figley, 1990], Strategic [Nelson & Figley, 1990], and Transgenerational [Nelson, Heilbrun, & Figley, 1993] approaches, respectively). We, however, have evolved and adapted a list of 32 skills, and this has been accomplished not by surveying other supervisors, but through ongoing conversation with ourselves and our students, and through the recursive process of evaluating our evaluations.

In our development of an evaluation form, we sought to describe skills with enough behavioral specificity to ensure consistency across supervisory evaluators, yet enough abstractness to allow for individual interpretation and application by supervisors and supervisees alike. Then, whenever a trainee would do (or not do) something that could not be adequately categorized within the existing version of the form, we would, through discussion, find a way to refine one or more of the categories in order to accommodate the observation or idea. The version we are presenting here can thus be understood as a trial-and-error artifact of the recursive interaction between our shared values, the supervisors' observations, and the students' performances with clients.

Typically, the development of an evaluation tool would include an assessment of the reliability and validity of the instrument (for example, Anastasi, 1988; Ghiselli, Campbell, & Zedeck, 1981). In this case, however, such efforts, informed by positivist assumptions about measurement, would be inconsistent with our approach.

Instead, we have adopted and adapted the ideas of constructivist, qualitative research methodologists Lincoln and Guba (1985) to help us in the ongoing process of assessing the *trustworthiness* of our evaluation method. Following Lincoln and Guba (p. 300), we have attempted to make our evaluation method more *credible, transferable, dependable,* and *confirmable.* This has been done through activities such as (Lincoln & Guba, pp. 289–331): (a) *prolonged engagement* and *persistent observation*—we have continued to evolve the categories of the form and their utilization in practica for the last 7 years; (b) *peer debriefing*—faculty have stayed in conversation about the form and its applicability to their supervisory needs; (c) *negative case analysis*—when we have been unable to categorize the particularities of a student's skill or struggle within the existing version of the form, we have adapted it accordingly; (d) *member checking*—each major revision to the form has been piloted for a semester so that student and faculty responses can be incorporated in the new version before being formally implemented; and (e) the maintenance of an *audit trail*—we have documented our various

versions of the form and the process and rationale for making changes.

What follows is a description of the current version of the form we use to guide the assessment procedure with our doctoral students. A modified version is used with our master's students. We have received encouraging comments from students regarding the specificity of the format—they find that it demystifies their supervision experience and provides them with a means of orienting to the learning of therapeutic skills.

Our doctoral students are continuously enrolled in practica for 2 years (six trimesters). Inherent in doctoral studies is the gradual dissolution of the distinction between teacher and student. Hence, the practicum evaluation form marks the various phases of this transformation. It differentiates three levels of advancement over the six practica, each of which requires progressively more sophistication in systemic conceptualization and practice, and less reliance on the supervisor. As noted above, there are a total of 32 skills arrayed over these three levels; each, in some way, makes reference to one or more of the values we all share—to respect for clients, colleagues, and context; to the notion of shared responsibility; and/or to an appreciation for the potential uses and abuses of language.

Beginning Students (Practica I and II) must consistently be able to:

1. **Introduce themselves and the clinic (policies, procedures, videotaping, etc.) to clients in a warm and professional manner**

   At times, we all encourage students to videotape their sessions, while the supervisor and team observe behind a one-way mirror and/or on a video monitor. These arrangements are sometimes disconcerting to clients when they walk into the therapy room, even when they have been explained in advance over the phone. Effectively handling clients' concerns about such issues is often an initial and important first step in establishing a good working relationship with them.

2. **Follow clinic policy (paperwork, followup, confidentiality, legal, and/or referral issues, etc.)**

   Many of our referrals come from the courts, the state social service agency, and various schools; it is thus essential that the students attend with great care to case management details to ensure that clients and documents do not fall through bureaucratic cracks.

3. **Conduct themselves in a professional and effective manner (attendance, punctuality, presentation of self)**

   It is expected that all trainees, including beginning therapists who have never been in the room with a client, should consistently behave in a professional manner with everyone in the work setting. It should be clear by the way students participate in such relationships—their reliability, what they say, how they say it, and how they visually present themselves (clothing, hair, nonverbal behavior)—that clients, colleagues, and staff are not being mistaken as friends or family, nor as strangers. The therapist's presentation of self is considered professional when it does not draw the client's attention away from the therapeutic process.

4. **Maintain an active case load, including clients from a wide variety of contexts**

   Although much can be learned from observing cases as team members, students learn most from being in the therapy room themselves, actively seeing a variety of clients both in and out of practicum. As Shilts, Filipino, and Nau

(1994) note, clients can be our best teachers.

5. **Sensitively vary voice (tone, volume, rate, inflection) and nonverbal behavior (posture, gestures, facial expressions) to connect with clients**

Supervisors encourage students to match respectfully the verbal and nonverbal behavior of their clients, and to become acutely attentive to clients' responses to their questions and interventions. Focusing the students' attention on such microskills has made a significant difference in their ability to achieve communicational flexibility.

6. **Empathically communicate an understanding of and respect for the experience of clients**

Students who are in the throes of reading and learning about a multitude of clinical models may be so eager to try out new ideas with clients that they overlook the basics of effective interpersonal interaction. We stress that trainees focus on developing respectful relationships with clients, and not privilege an illusory effectiveness over affiliation, affirmation, and respect (Hoffman, 1993; Lipchik, 1994).

7. **Ask questions in a conversational and interactive (as opposed to interrogational) way**

Students new to family therapy often concentrate their efforts on understanding ideas and theories *about* questions, about circular and miracle and open and interactional and positively framed questions. It is not uncommon, then, for them to become so engaged in asking the "right" sort of question that they forget they are actually in conversation with a human being who may feel put on the spot, or barraged with queries. We thus attempt to guide beginning therapists away from the technical or systemic wizardry of their questions and toward a sensitivity to the comfort of the clients.

8. **Avoid offering simplistic advice and personal opinions**

Despite their best intentions and in spite of what they are taught in their didactic courses, some students find themselves offering instantaneous reframes and what we sometimes call "Ann Landers" advice. We encourage therapists not to begin to formulate, let alone offer, ideas about how client dilemmas might be different until they have a richly detailed understanding of what the clients are experiencing and what they are asking for in terms of help.

9. **Limit self-disclosure to occasions of therapeutic utility**

Self-disclosure can be helpful, but it can also redirect the focus of the conversation away from the clients' story. We ask that students give careful consideration to placing the needs of the clients first.

10. **Explore client stories with curiosity and demonstrate patience in developing possible interventions**

Sometimes brief therapists attempt to be too brief (Lipchik, 1994). Just as MRI (Mental Research Institute) therapists encourage their clients to go slow (Watzlawick, Weakland, & Fisch, 1974), we encourage our students to take the necessary time to be curious about the contextual complexity of their clients' lives. Only when the therapist can appreciate how the clients and the problem(s) fit together is it possible to offer suggestions that don't breach the relational integrity of the client system.

11. Attend to larger-system issues and access appropriate resources for clients

The complexity of, and multiagency involvement in, many of the referrals our clinic receives ensures that our students have numerous opportunities to interface with multiple systems. As Anderson and Goolishian (1988) point out, problems give rise to systems whose participants are organized by the defined problem at hand. Therapists learn how to work not only with clients, but with other mental health providers, many of whom hold different assumptions about change. And although we generally differentiate therapy and social work, there are times when the most therapeutic response in a situation is to arrange respite care or find alternative schooling opportunities, or help someone negotiate their way through the maze of the state human services agency.

12. Deliver supervisor/team communications with poise and sensitivity

It is not uncommon for beginning students to experience phone messages and intersession conferences as distracting. However, we believe it is important for trainees to become adept at managing various forms of communications from supervisors and colleagues. Since we ascribe to the belief that the client family is the responsibility of the team rather than just the individual therapist, the relationship and communication between supervisor, team, and therapist becomes of utmost importance.

13. Actively solicit and implement supervision as an opportunity for learning, regardless of model

Fisch, Weakland, and Segal (1982), as well as de Shazer (1988), have written about the necessity of determining whether or not a client is a customer for the therapist's services. Similarly, we recognize that supervision can go nowhere if supervisees are not in some way customers for what is being offered.

We believe that the diversity of perspectives and approaches our group of supervisors offer is a positive contribution to the students' learning, and we ask them to make the most of each supervisory situation, just as we, in turn, attempt to appreciate and affirm the uniqueness of each student.

14. Challenge their own premises and biases, and expand their awareness and appreciation of cultural, gender, spiritual, and sexual diversity

We ask our students not to handle their discomfort with culturally different clients by simply dismissing them as Other, or by imposing their own beliefs and values. We encourage dialogue rather than censorship, understanding rather than judgment.

15. Actively participate in practicum, offering and requesting constructive feedback, when appropriate

Students are expected to engage actively in team discussions and to provide both challenges and support for their colleagues. In addition, it is important that trainees are receptive to feedback and strive to incorporate that feedback into their clinical work.

16. Demonstrate an understanding of and respect for multiple perspectives (clients, team, supervisor)

We are sensitive to the isomorphic relationship between therapist-family, and supervisor-therapist interac-

tions (Haley, 1980; Liddle & Saba, 1983). That is, the therapist, as a co-responsible participant in client, team, and supervisory interactions, is encouraged to respond to team- and supervisor-generated ideas with the same orientation to understanding and respect that he or she accords clients and that the team and supervisor accord him or her.

17. Conceptualize and describe client conundrums in systemic, nonpathologizing ways

It is not uncommon for trainees to assess individuals negatively within a family, or to characterize the whole family as dysfunctional. We encourage the students to become curious about the strengths and resources of family members, and to strive to understand how the clients' situation makes sense.

In addition to the above, Intermediate Students (Practica III and IV) must be consistently able to:

18. Develop and maintain themes across sessions

We expect trainees to gradually increase their ability to conceptualize cases thematically, and to categorize new information into previously developed (and/or revised) themes. Students develop their ability to open sessions with previous themes in mind, to use those themes as long as they are therapeutic, and to modify them effectively when necessary.

19. Spontaneously generate relational questions and comments in the therapy room

The goal at the intermediate level is for the therapists to understand the relational *logic* informing their questions. Once they can do so, it is possible for them to begin exercising what we might call relational curiosity, to go in unanticipated, but potentially fruitful directions.

20. Distinguish relevant information—in relation to model, client(s), goals, previous sessions, etc.—and organize the conversation accordingly

Although models vary in terms of *what* about a client situation is considered pertinent, all provide guidelines for distinguishing relevant from irrelevant information. Because context determines relevance, we encourage students to develop rich understandings of their clients' context and to use this understanding to help them determine what is relevant in the therapeutic conversation.

21. Weave supervisor/team communications into the conversation in a smooth manner

Intermediate students should be able to incorporate the supervisor's ideas and suggestions into the session in a seamless way, folding them into the therapeutic conversation with a sensitivity to timing and delivery.

22. Contribute systemic ideas to team discussions

Pre- mid- and post-sessions are excellent times for the students to cut their systemic teeth, to try out ideas and offer suggestions that both contribute to the understanding and direction of the team as a whole, and give them opportunities to experiment with new ways of conceptualizing.

23. Appropriately generalize from supervision on a particular case to other analogous situations

At this point, trainees should be able to apply supervisory guidance on a specific issue to other similar therapeutic situations in a way that demonstrates an appreciation for both the commonalities between the instances

and the unique nature of each situation. This demands that they be able to attend to the complexities not only of the therapeutic context, but of the supervisory context as well.

24. Discuss and describe cases concisely within a systemic framework

Midway through their training, students should begin to be able to describe their cases systemically, and to avoid pathologizing, normative, and/or linear descriptions of client relationships. This entails not getting lost in the specifics of case content and being able to explore clients' difficulties contextually.

25. Require less detailed direction from the supervisor

As noted earlier, a developmental approach to supervision (Liddle, 1991) recognizes that the context of the supervisory relationship changes over the course of the student's tenure in a training setting. Heavy reliance on the supervisor is expected and acceptable at first, but by the time therapists reach their third practicum, we believe they should be more proactive in setting the direction of their cases and less reliant on the supervisor for specific suggestions and questions, or for rescuing them from difficult situations (see #28, below).

26. Identify what they wish to obtain from supervision

Ideally, the more students learn, the more they can recognize what they have yet to grasp or master. As our students move through the program, we expect them to assume more and more responsibility for requesting specific guidance or ideas from their supervisors.

Advanced Students (Practica V and VI) must be able to integrate the beginning and intermediate skills in a smooth and compelling manner. In addition, they must be consistently able to:

27. Take calculated risks to expand their interpersonal repertoire (with humor, creativity, play, etc.)

As students move into the final phases of their training, we ask that they strive to develop their own way of working with clients. This requires that they go beyond the basics of model-specific, technique-driven work, and, in a sense, bring more of *themselves* into the therapy room. Each student approaches this task differently, and it is expected that such risk-taking will be conducted in a professional and respectful manner that enhances relationships with clients.

28. Handle unexpected and crisis situations with poise and skill

It is relatively easy to fly an airplane in good weather and when all the instruments and engines are working as anticipated. The mark of a good pilot is the ability to manage situations effectively, including relationships with co-workers and passengers, when something surprising or threatening transpires. The same is true for therapists.

29. Describe cases and interact with clients using a variety of therapeutic models

We expect advanced trainees to demonstrate the flexibility to work within various different therapeutic modalities and to be able to articulate the implicit and explicit assumptions of these models in an organized fashion.

30. Move toward a collegial relationship with supervisors

As noted above, over the course of their practicum training, therapists

are expected to take on increasing responsibility for their cases, both conceptually and pragmatically. As this occurs, the supervisory relationship becomes more collegial, and it is hoped that trainees will access and benefit from a more egalitarian relationship.

31. Articulate a coherent therapeutic orientation

In the spirit of collegiality, we ask of our students at this juncture in their education the same thing we ask of ourselves: the ability to be clear about what they do and why they do it. This will enable them to work consistently and creatively, and move beyond the safety and constraints of the supervisory relationship.

32. Demonstrate their orientation in practice (in team discussions, invention of ideas and/or interventions, delivery of ideas, etc.)

Although we recognize the importance of flexibility of ideas, we also consider consistency to be useful. Therapists participate in all aspects of team cases, and their participation should now demonstrate an ability to carry their understandings and abilities into a variety of different conversations—with clients, with their colleagues, and with their supervisors. In order to do this well, they must know the assumptions of their orientation very well indeed.

SOME PRELIMINARY CONCLUSIONS

As mentioned above, the approach to evaluation presented here is a work in progress. The story of its evolution is too involved to include; suffice it to say that its present form reflects much spirited discussion among the faculty, pointed (mostly constructive) criticism from our students, many major and minor revisions, and a recognition that we haven't, and won't get it "right." We continue to tinker. The diverse opinions among faculty and students help ensure that we will continue to question our assumptions and methods. We have not achieved balance so much as a means of utilizing multiplicity and difference.

We and our colleagues have found the method helpful in both predictable and unpredictable ways. As we expected, it has provided a shared language for a variety of supervisors, each working from a different model, to give specific, in-depth feedback to the students in our program. It has also allowed us to pay respectful heed to our differences as supervisors, to the differences among our students, to the field as a whole, and to the ethical responsibilities that attend our positions as university-based teachers.

What we didn't anticipate was the extent to which the students would begin to use the evaluation form proactively to organize their own learning. One of our students commented to us that the present version of our form provided her with her first written introduction to the sorts of skills that constitute good therapy. This proved to be most helpful for her: it gave her specific ideas about "what good therapists are able to do," as well as "what to shoot for" in future practica. Her ideas have been echoed by a number of other students.

We have also been surprised by the usefulness of the form in bridging theory and practice during clinical and classroom discussions. Faculty have used the form to describe and illustrate how abstract notions—such as the three therapeutic assumptions we described earlier—get translated into conversations with clients. In this regard, it has provided a more specific and less mystical way for us, as faculty and students, to develop a shared language regarding theory and clinical work.

It is important for us to underscore that

our evaluation form isn't everything, and it isn't universally embraced by the students. One student we talked with noted that the two most helpful things her supervisors had done—calling into the therapy room with detailed comments and suggestions, and explaining their conceptualizations of cases—had nothing to do with the form. However, this same student appreciated the way the form encouraged the faculty to provide specific, rather than vague, feedback. Another student criticized the very thing that others found helpful. She preferred our earlier version of the form, as it gave her "more of an overall feeling" about herself, as opposed to a point-by-point analysis. She also recommended that we retain our earlier practice of providing a formal place for students to comment on their evaluation. We are in the process of implementing this last suggestion.

Our practicum evaluation form serves as a kind of socialization into our shared therapeutic values. This is true not only for new students, but for new supervisors as well. Recently hired full-time and adjunct faculty have found that it accommodates their need to meet the double demand of becoming a part of a new community—fitting in with the consensual view and not losing their unique perspective. At its best, then, the form allows new supervisors to become part of and enrich our familiar conversations.

The development of this evaluation method has helped us clarify for ourselves some of the more pressing questions surrounding assessment in a postmodern world. This article serves not so much as an answer to the dilemmas, but as a position from which to act and to ask more interesting questions. Given the many discussions the evaluation method has helped generate within our school, we would now like to extend the conversations to the broader family therapy community.

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