Journal of Marital & Family Therapy

Journal of Marital and Family Therapy
doi: 10.1111/j.1752-0606.2009.00127.x
October 2009, Vol. 35, No. 4, 395–405

AN INSTRUMENT FOR PERSON-OF-THE-THERAPIST SUPERVISION

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This article introduces a tool that serves as a guide for building an effective bridge between the personal and technical aspects of therapy in supervision. The instrument is based on a model of clinical supervision that emphasizes the purposeful utilization of self—in the moment, with both flaws and strengths—in the therapeutic relationship in combination with the technical interventions with clients. The article also offers some aid to promote a personal integration of the philosophy underlying this supervisory model into a therapist's clinical thinking and practice.

Person-of-the-therapist clinical supervision addresses both the technical and personal components of the therapeutic process. Technically, a therapist works within a model of therapy, fully or partially articulated, that includes a philosophy about therapy, standards for evaluation, and an arsenal of interventions to facilitate change. Personally, all therapists use themselves within the relationship with clients to establish trust with clients, develop empathy for them, and implement their interventions. All therapy is a marriage of the technical with the personal.

PERSON-OF-THE-THERAPIST LITERATURE REVIEW

Historically, the talk therapy that began with Freud (1964) necessarily rested upon some kind of relationship between psychoanalyst and patient. As a consequence, Freud called for analysts to undergo a periodic analysis throughout their careers to prevent their counter transference from distorting their work with patients. Later Bowen (1972), a pioneer in family therapy who himself came out of the psychoanalytic tradition, also addressed the need to prepare therapists for their engagement with client families. His efforts to differentiate himself within his own family became the prototype for training therapists in his school of therapy to achieve differentiation in their own families of origin. Another family therapy innovator, Satir (2000) advocated in her training model that the aspiring therapist work on resolving issues "with his or her own family" (p. 21), aiming for growth "toward a more integrated self" (p. 24). In the Satir and Baldwin (1983) traditions, Kaslow and Schulman (1987) advised family therapists to explore their own genograms and "go home" to resolve issues in multigenerational family therapy for themselves.

In most training and supervision today there is an expectation that therapists "examine . . . how issues (e.g., past and current family roles, unresolved interpersonal conflicts, and coping styles) influence the course and outcomes of therapy and supervision" (Todd & Storm, 1997, p. 206). In the Basic Family Therapy Skills Project that analyzed competencies and basic

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skills of transgenerational family therapists, Nelson et al. (1993) state that ''the most important skills are those that use the self of the therapist to understand and utilize transgenerational family therapy skills for both therapist and clients'' (p. 253).

Deacon (1996, p. 184) reviewed experiential *person-of-the-therapist* training (POTT) and states, ''As we continue to recognize the importance of the development of the self of the therapist, we are finding ways to integrate both the personal and professional training methods.'' In her discussion regarding professionalism of marriage and family therapists, Watson (1993) reinforces this view when she says, ''The supervisory process must address '*person-of-the-therapist*' issues because the clinician interacts with the client to form the therapist-client system'' (p. 22). Watson adds, ''The attention given to *person-of-the-therapist* in the training process today would suggest that the debate over the goal of supervision has been resolved through understanding the interactive nature of personal growth (awareness) and skill development'' (p. 22).

Rober (1999) distinguishes between the therapist's outer therapeutic conversation and the inner conversation. He describes how the inner conversation is between the *person-of-the-therapist* and the professional role of the therapist. This inner conversation is a negotiation between the therapist's personal self and professional role about what aspects of the self can be utilized to create an opening for the unspoken to be operationally applied. Finally, Rober indicates where and why therapeutic impasses occur in this inner conversation, and elucidates the necessity of the work on the self to uncover these blocks.

In *The Therapist's Use of Self in Family Therapy* (2000), Bochner attempts an overview of the use of self among the various schools of family therapy. He judges them on a ''self reflective'' versus ''action'' continuum, ranking the psychoanalytic/object relations perspective as the most reflective, followed by the ''integrationist'' view (which includes Aponte & Winter, 2000). He then cites the ''experiential'' approaches of Satir and Baldwin (1983) and Whitaker and Keith (1981), and ends with the ''self-reflection is unimportant'' position of Minuchin and Haley. Bochner struggles with Aponte's POTT model (as presented in Aponte & Winter, 2000) because he cannot find a theory on change in the client families. What he misses in his understanding of this training model is that it is not tied to any one therapeutic school. The POTT model is meant to cut across the various schools, whatever their theories of change, and facilitate therapists' more conscious, freer, and purposeful use of themselves within their own choice of therapeutic model. The supervisory model in this article is based on the philosophy underlying Aponte's Person-of-the-Therapist Training Model.

THE SPECIAL RELEVANCE FOR TODAY OF TRAINING AND SUPERVISION ON THE USE OF SELF

As noted above, the topical relevance in today's world of the use of self in therapy is not because it has been omitted historically, but because our society has changed, and with it our therapy, and therefore so must our training and supervision. A society of relative cultural consensus allows us to treat culture and its values as a relative constant, a background against which we can judge and evaluate people's issues and how we work with them. At one time, we might have been able to talk about helping people become ''normal,'' which implies conforming to society's norms of healthy functioning. Today, we have a society, at least in the Western world, that is culturally diverse and dynamically so. We argue about lifestyles, when life begins, and people's rights about deciding when and how they die. We also have a society in which freedom of choice is valued over social conformity. Personal freedom is often valued over commitment and obligation in relationships. The ''I'' has priority over the ''us.'' Society has become more democratic and egalitarian.

These changes in society are reflected in changes in our therapy. Therapy models reflect society's diversity of values. Today we have separation among therapies based more on values than on technical tools. We have Christian therapy, Buddhist therapy, feminist therapy, and

therapy based on New Age thinking, social justice, etc. There are therapies that are tailored to particular populations such as the gay community. These differences in philosophy and life values take form not only in mental health institutions but also in the practices of individual therapists. Instead of yesterday's ideal of value-neutral therapists, we increasingly train therapists to embody values that one academic institution or another considers politically or morally correct.

Even so, today therapists are less the authority figures they once were. Therapy is more collaborative. While therapists assume the right to dress their therapy with their values, clients claim ever-greater voice about their options. In the more give-and-take relationship environment between therapists and clients, we also see less anonymity on the part of therapists and more self-disclosure. Our therapies are more active, which translates into therapists bringing more of their personal values and emotions into the mix of their interactions with clients. Therapists are looking for outcomes, and not just allowing the therapeutic process to evolve simply at the client's pace. The therapeutic process is more active on the parts of both therapists and clients.

All these changes in society and in how we conduct our therapies offer a compelling argument for why therapists today need to be more aware and responsible for how they personally participate in and conduct their therapy. This is not just about therapists achieving greater resolution of their personal issues. It is not just about greater self-awareness. We are speaking here of the pursuit of a sophisticated level of mastery of self within the therapeutic relationship and technical process. Yes, this mastery aspires for greater freedom from the restrictiveness of our personal issues; yes, greater emotional and cultural/spiritual self-awareness; but also an elevated level of skill in the conscious and intentional use of the self within the philosophy and technical toolbox of our models. Training and supervision in this use of self, both from emotional and cultural/spiritual perspectives, are lagging. How to use the self in therapy needs conceptual clarity and systematic methodology. The *Person-of-the-Therapist Model* is an offering toward that goal.

APONTE'S *PERSON-OF-THE-THERAPIST* TRAINING MODEL

Aponte (1982) created his *Person-of-the-Therapist Model* for training clinicians in the use of their selves in therapy on the premise that the goal, regardless of therapeutic model, is to develop greater capacity to personally engage with clients in ways that further therapeutic objectives *even as therapists are who they are* at the moment of contact with a client. The essential elements of the goal of this training are (a) mastery of self (self-knowledge with self-command), (b) access to the self (memories, emotions, and values), and (c) the ability to actively and purposefully choose how to use self therapeutically in a therapist–client relationship.

This training is conducted in a combination personal/clinical environment (thus, the *Person/Practice Model* coined by Aponte & Winter [2000]). However, a distinction must first be made between training and supervision within the *Person-of-the-Therapist Model*. The formal training devotes equal time between personal work and the application to clinical practice. Trainees or students learn to identify their *signature themes,* confront their issues, and learn to see and work with and through their personal selves in the context of their clinical work. This training is conducted in a group, usually of six or more, and individual trainees take turns presenting alternately on their personal issues and their clinical practice to the trainer(s). The group functions as a support network to the presenters. The emphasis is on developing the person in the role of therapist to become a more effective clinician both in how he or she engages a client in a therapeutic relationship, and how he or she employs the technical tools of therapy.

An essential element of this training is to help therapists not only to identify their personal issues (signature themes) that are likely to affect their clinical work but also to help them gain a familiarity, comfort with, and command of these issues so that they can turn personal vulnerabilities into clinical assets. These personal themes become means to both identify with and

differentiate themselves from clients. The person-focused presentations also attend to the cultural and spiritual aspects of the trainees' lives that influence their outlooks toward clients and their life challenges. The aim is for the trainees to take responsibility not only for their psychological issues but also for their personal biases about morality, values, and philosophy of life (Aponte, 1994a, 1994b, pp. 168–185). They need to be aware of whether, when, and how they communicate to clients their personal convictions about ideals and moral standards for living.

These person-focused presentations are interlaced with supervised clinical presentations, live and videotaped, that are founded on the use of their selves in the therapeutic process. Over time, the training emphasis evolves from self-work to clinical work (Aponte & Winter, 2000). The bottom-line training environment is clinical practice. Certainly, an assumed goal is for therapists to get out of their own way in doing therapy. However, the preeminent goal is for them to learn to use what they master about themselves in active, constructive ways to assess, set goals, and intervene with clients in the clinical moment and throughout the clinical process.

In Aponte's training model, the secondary but no less integral means to achieve the goals of a more effective use of self is for therapists to strive for growth in self-awareness, self-honesty, and self-mastery in the context of love and empathy for our fellow human. Careful to avoid any semblance of a therapeutic contract (Aponte, 1994a, 1994b), the Aponte model encourages therapists to investigate with the help of their trainers and support of the other trainees their personal issues and family histories. The philosophy of the program assumes that the pursuit of growth and maturity in our emotional lives, sociocultural values, and personal morality is a normal component of the human journey. In the program the personal work is in direct relation to the therapy they conduct. However, they receive encouragement, when appropriate, to seek out for themselves their own personal therapy, as well as their own spiritual resources. The underlying premise about personal change in the POTT model is that the freedom therapists gain in the use of themselves as therapists naturally translates into greater freedom to live their personal lives differently. However, whatever the emotional freedom they attain *outside* the program through their personal resources will contribute to their self-mastery in their conduct of therapy. However, whatever the personal insight, emotional freedom, and self-mastery therapists attain, *within* the training program the ultimate focus is on enhancing the therapist's therapeutic skills.

PERSON-OF-THE-THERAPIST SUPERVISION

In the *Person-of-the-Therapist* supervision model, the exclusive purpose of supervision is to help therapists be more effective with their clients. What supervisees gain personally from the supervision is incidental to the supervisory process. Supervision attends to the case itself, identifying client issues, developing hypotheses about their source, and implementing strategies that will achieve the purpose of the therapy. However, at the heart of this clinical effort is the purposeful use of self in all aspects of the therapeutic process from assessment to intervention. The supervisor bears the responsibility of overseeing the therapist's use of self within the technical aspects of the therapeutic process. The personal depth to which the supervisor will delve and how the supervisor will work these personal components of the therapist's conduct of therapy will depend on the needs of the case and the capacity of the supervisee to deal with all aspects of his or her person in the therapist role. Therapists who have undergone the POTT training are prepared to make fuller use of this kind of supervisory experience. Supervisors who have received training in the use of self in relation to clinical practice will be better positioned to offer a systematic approach to supervising therapists' use of themselves.

As already noted, the *Person-of-the-Therapist Model* is not tied to any one school of therapy. It is an approach to the development of supervisees that holds them accountable for *how* they actively and purposefully use themselves in every aspect of therapy. The self of the therapist in the context of a relationship with a client is treated as an instrument for assessment, as

well as a tool for intervention. Therapists' cultural, philosophical, and spiritual values are treated as contexts for therapists' judgments and choices about how they view clients and their issues. Supervisors guide therapists to assume responsibility not only for their actions but also for their worldviews in the nitty-gritty work of therapy. What follows is a presentation on instruments that can serve as tools for supervision within the *Person-of-the-Therapist* frame.

PERSON-OF-THE-THERAPIST SUPERVISION INSTRUMENT

In this article, the authors propose an instrument that provides concrete structure to this process of working with and supervising within the *Person-of-the-Therapist Model*. Aponte and Winter (2000) in their training program at the Family Institute of Virginia developed a predecessor of the *Person-of-the-Therapist Supervision Instrument*, which served as the starting point in developing our supervision instrument. The proposed supervisory instrument, as it has been tested and revised, seeks first to focus the supervisee on the clinical issue being addressed. Then the trainee looks to identify the links of the technical/clinical challenges of the case to the personal information deduced from the therapist's self in relation to the client and client issue. This personal information is then translated back into therapeutic action—-how to connect with the client and how to use the self in the diagnostic and interventional components of the therapy. The underlying philosophy "concentrates primarily on the *bridge* between the actual conduct of treatment and the therapist's personal life" (Aponte & Winter, 2000, p. 145). The following instrument is the metaphorical blueprint for the bridge in supervision.

The instrument being presented here for the *Person-of-the-Therapist Supervision* was developed by Harry Aponte and J. Carol Carlsen[1] during the period in which Dr. Aponte was mentoring Mrs. Carlsen for her approved supervisor credential. The instrument evolved through several stages prior to and during the course of the supervision before reaching its final form. The instruction sheet and evaluation sheet together comprise the written instrument of the *Person-of-the-Therapist* supervisory form. The supervision instrument is to be completed for each case and updated for every supervisory session. The critical step for our purposes is for therapists to then envision how they will use themselves in working with their client(s) at each stage of the therapy—the formulation of the issue, the reasoning about what comprises the issue with the consequent goals of the therapy, and finally the implementation of the therapeutic strategy with its corresponding technical interventions.

THE INSTRUMENT

Person-of-the-Therapist Supervision Instrument[2]

1. Provide identifying information about the client:

_____

2. Attach the client's genogram.

_____

3. State the agreed upon issue the client is seeking help for in therapy, and note anything in it that carries personal meaning for you:

_____

4. Describe your personal reactions to your clients, and theirs to you:

_____

5. Address whatever cultural or spiritual values may be coloring how you view the issues they are presenting as distinct from your client's perspectives:

_____

6. State the aspect of the issue you aim to deal with in today's supervisory session, and highlight anything in it that carries personal meaning for you:

_____

7. Explicate your hypotheses about the roots and dynamics of the client's issue:

_____

8. Explain your therapeutic strategy with the case, and in particular with the aspects of the case you are to discuss in today's supervision:

_____

9. Detail how you are implementing your strategy's technical interventions:

_____

10. Detail how you use yourself in conjunction with your interventions:

_____

11. Identify your personal challenges working with this client around the focal issue:

_____

12. Discuss your plan for meeting your personal challenges in this case:

_____

INSTRUCTIONS FOR USING PERSON-OF-THE-THERAPIST SUPERVISION INSTRUMENT

General

- The clinical questions are meant to be model-neutral. Supervisees should adapt the instrument to their particular therapeutic model.
- The personal questions aim to elicit only personal information that relates directly to the case under consideration. Supervisors and supervisees should stay within those boundaries.
- The overall goal is to achieve integration between the technical and personal components of the therapeutic process. Clinical observations should be made with the personal in mind, and personal observations should be made within the boundaries of the clinical. The supervisee is always building the bridge between the two.

Specific

- #1 asks for the basic identifying facts about the client (individual or family), not for history or explanation about why the client is requesting therapy.
- #2 refers to a genogram that gives a picture of the family system, only as context to the issue the client is now presenting, not an exhaustively detailed genogram. Supervisees should make a notation about any detail in the genogram that carries special personal significance for them that may be relevant to their work with this case.

- #3 is looking for a brief, specific, summary statement about the issue the client is presenting, along with a note about any way it personally touches the therapist.
- #4 refers to the relationship between client and therapist, its characteristics and potential impact on the work of therapy.
- #5 takes into consideration culture, values, and spirituality of both client and therapist, and how these may influence the relationship and work of therapy, including views about the issue related to personal standards determining salutary functioning and dysfunction, and appropriateness of solutions and goals.
- #6 asks for the immediate, specific circumstances of the issue facing the client today. Identify anything about what the client presents that touches you personally.
- #7 is looking for the therapist's hypotheses, remote and immediate, that will offer at least a tentative understanding about the nature, roots, and dynamics of the issue the client is confronting. This "why" is going to lead directly to the "how" of the therapist's approach to the client's issue.
- #8 calls for the strategy the therapist plans to use to address the issue. This plan of approach should reflect the therapist's therapeutic model and philosophy as applied to this particular client's issue.
- #9 gets down to today's tactic, the specific interventions the therapist is implementing with the case. How these interventions are dealt with here depends on the stage of treatment—the technical process and the therapeutic relationship.
- #10 gets into the use of the self of the therapist in carrying out this work. Again it is treated in relation to the stage of treatment, and directly references the self in the implementation of the therapeutic strategy—its technical interventions and therapeutic relationship.
- #11 gets personal. It is looking for what in the self of the therapist is presenting a problem today for the therapist in working with this client around a particular issue. The problem for the therapist may be in relating to the client as now called for, or may be in implementing a particular technical intervention.
- #12 is looking for solutions to the therapist's personal challenges in this case. The therapist needs to formulate how he or she will attempt to deal with the personal challenges the case presents, including the kind of help he or she will need to do so.

What follows is an abbreviated example of how the instrument may be used. It is based on the seeds of an actual supervisory session. However, it is disguised, and has been embellished as needed for the purpose of illustrating the instrument's use.

PERSON-OF-THE-THERAPIST SUPERVISION: AN ILLUSTRATION

The numbers of each instruction correspond to the numbers on the instrument.

1. (Briefly state the clients' names, ages, ethnicity, and position in the family, as well as their occupations and socioeconomic status.)

Example: *The client is a 17-year-old African American girl in a group home. Her 33-year-old mother is a single parent. My work was exclusively with the youngster.*

2. (Complete your client's genogram, highlighting what in the genogram may trigger an emotional response in you or carries special meaning to your own life experience. Limit your personal information to what you deem relevant here.)

Example: *Her position in her family reminds me of what it felt like to live in my father's home after he remarried, and I found myself with a stepmother.*

3. (Make a brief statement that encapsulates the client's issue, and briefly note any particular personal significance it carries for you that may affect your therapy.)

Example: *The client is uncooperative at home, in school, and with all other authorities, while engaging with her peers in delinquent behavior. The client*'s *mother has ejected her from the*

family, and is looking to have her placed permanently outside the home. I instantly identified with this excluded child.

4. (Address the personal aspects of your interactions and relationship with your client.)

Example: *There was an intense ambivalence on both our parts. I was drawn to "save" her, but was apprehensive about her rejecting me. I sensed she wanted my approval, but was distrustful of all adults.*

5. (Speak to how your and your client's family, cultural, and spiritual values affect how you each think of the issues you are working on in the therapy.)

Example: *I am a 24-year-old female Caucasian from a middle-class family. I believe my client and I both felt the cultural distance between us, but it did not seem unbridgeable. Although from a blended family, I took for granted I had a home. My client could not. Neither did her mother, who was raised in foster homes.*

6. (The issues people deal with manifest themselves in a variety of forms depending on context. Identify what aspect of your client's struggle is calling for your attention today.)

Example: *She will soon be appearing in court for a hearing, and I would like to help her present herself in a cooperative manner that will allow the court to be sensitive to her needs and emotional vulnerabilities. She can be quite uncooperative with anyone in authority, and with me in our private sessions. This task calls for my gaining her trust, but I do not handle the threat of rejection well.*

7. (Given the information you have and what you observe, what do you believe may be behind the issues the client presents?)

Example: *Her mother's abandonment by her mother, and experience with serial foster homes aborted her ability to bond with her own child, my client, who herself grew up expecting abandonment. Her expectation of another rejection by adults prompts her to reject adults first.*

8. (Describe your general plan for working with your client, and in particular with today's issue.)

Example: *Because* the mother *has refused any cooperation with our agency, we must work to create an environment of emotional safety and trust for our client. I will personally try to win her trust as a step toward her viewing the court, her legal guardian, as an ally.*

9. (Detail your proposed technical interventions in her issue today.)

Example: *Work toward getting her to share her fears so that she feels heard and understood, and this step must precede enlisting her active cooperation in formulating what she would like to see come out of her court appearance.*

10. (Consider what you can bring of yourself to the work with this client in this situation to achieve your goal.)

Example: *I need to help this youngster experience me as caring about her and the personal pain in her life. I will need to draw from my personal identification with her, and empathy towards her to make a connection with her. My youth and my gender should help to form a bridge with her.*

11. (What dynamics within you stand in the way of using your *self* more effectively today in the therapeutic approach you are planning?)

Example: *My fear of rejection will make it difficult for me to risk being emotionally open and receptive to her. My need to succeed to guarantee acceptance will put pressure on me to win over this young girl at my pace rather than at hers.*

12. (What are you going to do about the personal obstacles standing in the way of your being effective clinically? Do you believe you can meet the goal you have for yourself with the support of supervision, or will you also need the added help of some personal therapy)?

Example: *I believe I need the support of my supervisor to risk a more personal connection with this youngster. I will be anxious about feeling like a failure if she pushes me away as she has often done in the past. I will need my supervisor to help me keep focused on the process of*

developing the relationship with my client, and not be overtaken by the drive to "succeed" with my client.

The Supervisor's Response: *You have already taken a major stride in recognizing the internal pressure you will be fighting to change this young girl's attitude about trusting an adult authority, as she perceives you. I support you in your goal to be more emotionally present to her in this coming session, leaving it to her to decide whether she wants to and can allow herself a closer emotional connection with you in this very next session. Your challenge is to make yourself more emotionally receptive. You can enter the session more intent on being understanding and responsive to her than to change her. You will consider yourself successful to the extent you can be emotionally present to her. Success will not depend on whether she responds positively to you now. However, this client raises a personal issue for you that you will be facing repeatedly in your work as a therapist. Personal therapy is always a long-range option for you, and something you can consider as you attempt to be consistently emotionally accessible in your clinical work. That is your call.*

We also suggest that therapists maintain a record of their experience with the supervision. Taking the time to write about the case in preparation for supervision and then reflecting on the results of the supervision should help therapists think more clearly about work on a case. Taking the time to formulate one's thoughts should also help therapists develop a discipline about how they think about their therapy, gaining greater mastery of their therapy, and hopefully of how they use their person in the practice of their therapy. The following is an example of an instrument that therapists may wish to use to help them maintain a record of their reflections about their supervisory experience. Such a record can form the basis for ongoing discussion with their supervisors, and for evaluating their supervisory experience.

POSTSUPERVISORY QUESTIONNAIRE[3]

After the supervisory session the supervisee will summarize the basic outcome of the supervision.

1. How my thinking and feelings about the case were influenced:

_____

Example: *I felt more relaxed about risking being more emotionally present in the session with my client, without the pressure of trying to guarantee that she would reciprocate by showing that she trusts me.*

2. How my therapeutic strategy with this case was influenced:

_____

Example: *I was able to think about the relationship as the focus of my next contact with this client, rather than the goal of changing her attitude toward adult authorities.*

3. How my use of self with this case was influenced:

_____

Example: *My supervisor's assurance that I need not guarantee how the client would respond helped me to let up on the pressure I put on myself for changing my client. I was more comfortable being personally present in the session with her.*

4. What questions remain about my conduct of the case:

_____

Example: *In the next session, my client did indeed respond warmly to my approaching her with the intention to be open to a more personal connection. She was able to share about herself, as she had not done before. However, in the following session she refused to even meet with me. I suspect that she became anxious about the closeness she experienced, and had to reject me before risking the possibility of my rejecting her. What disturbed me most about my reaction to her refusal to see me was that I felt relieved. I am ashamed of my reaction, and do not understand it.*

Supervisor's Response: *Your relief at not meeting with her may well help you understand her refusal to see you. You have your own fear of closeness, and were likely anxious about getting together with your client again after that close emotional connection. Your insight about your own fear of rejection will enable you not to react to her avoiding the session as if it were a personal rejection. Consequently, it will leave you emotionally free to both understand her reaction, and to address her fear of rejection when the opportunity presents itself.*

Further Reflections

Referring back to Rober's (1999) internal conversation paradigm, the supervision tool serves as a map for the inner dialogue that leads to the outer intervention. The ongoing evaluation is meant to review with supervisees not only the progress of their cases, but also of their use of self at each stage of treatment. This instrument also aims to aid supervisees in monitoring the growth of their ability to make active use of themselves in therapy in general. Periodic review by means of the instrument can be a rich source of feedback for therapists about their understanding of themselves in the context of conducting therapy, and the development of their skills in utilizing what they bring of themselves to the therapeutic process.

Regarding the evaluation of the supervision, each supervision session ends with reflection by supervisors and the supervisees about what was or was not helpful to the therapist. Because the supervisory process parallels the therapist's work with clients, supervisor and supervisee address not only what the supervisee is learning about the case but also how their relationship is influencing the clinician's learning about the use of self. This presupposes that supervisors also give thought to their use of self in the supervisory process. Supervisors' ability to be in touch with their own use of self in the supervisory role will have a direct relationship to their ability to oversee their supervisees' use of self in therapy. Thus, the supervision of the *person-of-the-supervisor* is an essential element of the training experience. It calls for a focus on the person of the supervisor in the context of supervising.

As layers of relationships are added, the complexity of the review process correspondingly increases regarding the use of self and its analysis. The reader can see that keeping an ongoing *person-of-the-therapist* journal using the supervision instrument as a guide can be most useful in monitoring growth in the professional use of self. It is also worth noting that a *person-of-the-therapist* process journal is the private property of the clinician and is not part of the patient record.

CONCLUSION

The person of the therapist tool attempts to assist supervisors in helping therapists utilize all of themselves in the work of therapy. Because this instrument serves supervision, its priority is the clinical task. The personal development of the therapist is a desirable outcome of the *person-of-the-therapist* supervision, but incidental to it. The personal growth of therapists should always be a goal for all therapists in an effort to free themselves of old hang-ups that impede good therapy, and to grow in personal insight and emotional maturity to bring a more complete self to the therapeutic encounter. However, supervision is above all the venue for overseeing the progress of clinical work and for promoting the maximization of the fullest use of the self by a therapist for the benefit of the case at hand.

That being said, it is important to note that the full use of self in therapy is a very personal endeavor within a technical task. It is a challenge inherent in the nature of the therapeutic process. It is also for the supervisor to be sensitive, perceptive, and astute in this effort to help the supervisee reach deep within himself or herself for that humanity that is necessary to understand people, connect with them, and facilitate change in them. Supervisors themselves will need the training and expertise to use their own person to create a process with their supervisees that makes it possible for therapists to continually risk exploring their personal potential and vulnerabilities in the service of their clients. Our hope is that the instrument and aides we offer here will provide both a structure and a guide to do this challenging work.

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