The Relationship Between Critical Thinking and Interpersonal Skills: Guidelines for Clinical Supervision

Kathleen Holtz Deal

ABSTRACT. Research suggests that clinicians who think critically use more effective interpersonal skills. This paper offers clinical supervisors specific guidelines on how to utilize this connection to strengthen supervisees' skills in both areas with an emphasis on how helping supervisees develop greater skill in critical thinking can improve their interpersonal skills of empathy and addressing therapeutic alliance ruptures. Some specific strategies discussed include: modeling, facilitating a supervisory environment that supports exploring different points of view, asking questions that require critical thinking skills, and facilitating supervisees' skills in conceptualizing client communications in thematic terms. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2003 by The Haworth Press, Inc. All rights reserved.]*

Kathleen Holtz Deal, DSW, is Assistant Professor, University of Maryland School of Social Work.

Address correspondence to: Kathleen Holtz Deal, School of Social Work, University of Maryland, 525 West Redwood Street, Baltimore, MD 21201-1777 (E-mail: kdeal@ssw.umaryland.edu).

3

In preparing practitioners for autonomous practice, helping professions such as social work, counseling psychology, and nursing increasingly include skill in critical thinking in their educational standards. The Council on Social Work Education (2003) identifies the ability to think critically, including how to analyze empirically based interventions and evaluate practice effectiveness, as essential for MSW students. The Council of Counseling Psychology Training Programs (1994), in making a commitment to the scientist-practitioner model of education, has emphasized the importance of critical thinking skills. Since 1989, the National League for Nursing has required schools of nursing to quantify critical thinking outcomes (Rapps, Riegel, & Glaser, 2001), resulting in numerous efforts to define, teach, and measure the critical thinking skills essential for nurses (see, for example, Celia & Gordon, 2001; Daly, 2001; Van Eerden, 2001).

Since critical thinking skills focus on evaluating alternatives and forming sound judgments, these skills are frequently treated separately from interpersonal skills, with their focus on forming and maintaining helping relationships. However, studies have found a relationship between these skills, such that persons who think critically are more empathic (Belenky, Clinchy, Goldberger, & Tarule, 1986; Benack, as cited in Kurfiss, 1988; Goldberg, 1974). Understanding how critical thinking and interpersonal skills are related provides useful information to supervisors of clinical graduate students and recent graduates in facilitating their supervisees' development as autonomous professionals.

The purpose of this paper is to offer clinical supervisors specific guidelines on how to utilize the connection between critical thinking and interpersonal skills to strengthen supervisees' skills in both areas. The paper begins with definitions of interpersonal and critical thinking skills and reviews the importance of both sets of skills for clinical practice. This is followed by a discussion on how critical thinking contributes to improved empathy and skill in addressing therapeutic ruptures, including research supporting the relationship between critical thinking and empathy. The third section provides strategies supervisors can use to help supervisees increase their ability to think critically and ways to connect their supervisees' development in critical thinking to improving interpersonal skills, with an emphasis on empathy and addressing therapeutic ruptures. A hypothetical case is used to illustrate these strategies.

INTERPERSONAL SKILLS

Rogers (1957) postulated that therapists should demonstrate genuineness, unconditional positive regard, and empathic understanding during the psychotherapeutic process. Research exploring the relationship between Rogers's facilitative conditions and therapeutic outcome has consistently found that therapist use of these interpersonal skills plays an essential role in forming and maintaining a positive working relationship or alliance with a client (Greenberg, Watson, Elliott, & Bohart, 2001; Lafferty, Beutler, & Crago, 1989; Lambert & Barley, 2001). These interpersonal skills are differentiated from interviewing skills that are more technical in nature, such as asking open-ended questions and paraphrasing client statements, as well as specific therapeutic interventions, such as confrontation or interpretation. The association between a positive therapeutic alliance and positive client outcome is more significant than the specific techniques or theoretical orientation of the clinician (Lambert & Barley, 2001; Horvath, 2001; Orlinsky, Grawe, & Parks, 1994). The therapeutic alliance or bond that is formed between clinician and client appears to lessen client defensiveness so that the client is more open to the impact of the clinician's interventions within the session (Orlinsky et al., 1994). Given the importance of a positive working alliance to client outcome, the ability to reestablish a working alliance when problems or ruptures occur in the helping relationship has also been found to be an important interpersonal skill (Ackerman & Hilsenroth, 2001; Safran, 1993; Safran, Samstag, Muran, & Stevens, 2001).

All of Rogers' (1957) facilitative conditions have been linked to positive therapeutic results (for reviews of the empirical literature on positive regard, see Farber & Lane, 2001; for empathy, see Greenberg et al., 2001; for genuineness, see Klein, Kolden, Michels, & Chisholm-Stockard, 2001). Studies on empathy, however, show a consistently strong effect on therapeutic alliance and client outcome (Greenberg et al., 2001; Orlinsky et al., 1994).

Empathy is an essential, but complex, interpersonal skill defined as "the capacity to project oneself (while remaining separate) into the inner experience of another human being" (Dean, 1984, p. 130). This skill can be envisioned on a continuum ranging from a lack of empathy, to an accurate reflection of the client's surface feelings, meanings or motivations, to a response that accurately hears the client's underlying message (for scales of empathy levels, see Carkhuff, 1969 and Hepworth & Larsen, 1993). Therapists' empathic understanding has been found to

have a positive relationship to client outcome, particularly in studies reflecting the client's perspective, thus emphasizing the importance that clients place on therapist communicated empathy (Orlinsky et al., 1994). In reviewing empirical findings about the role of empathy, Greenberg et al., (2001) summarize that empathy may contribute to client outcome by increasing client compliance, helping clients feel safe to discuss difficult material, providing an experience where clients feel worthwhile and effective in expressing themselves, and helping clients think more productively.

Although empathy is the focus of this section, there is some evidence that clinicians who demonstrate high levels of empathy also exhibit genuineness and positive regard. Lafferty et al. (1989) found that more effective therapists showed greater empathy, patient involvement, and directness than less effective therapists, suggesting a connection between empathy and genuineness. In a qualitative study of master therapists, these expert clinicians were described as having exceptional relationship skills, including skills in the core areas of empathy, authenticity or genuineness, and respect for others (Jennings & Skovholt, 1999).

Ruptures in the therapeutic alliance are "breaches in relatedness" (Safran, 1993, p. 20) that are generally due to clients' negative feelings about some aspect of therapy. Ruptures can generally be seen in situations where clients withdraw through disengagement or confront the clinician with anger or dissatisfaction (Ackerman & Hilsenroth, 2001; Safran et al., 2001). Since ruptures in the therapeutic alliance often lead to premature client drop out, addressing ruptures is crucial through clinicians' use of such interpersonal skills as exploring clients' negative feelings, responding nondefensively, and accepting responsibility for their contribution to the problem (Foreman & Marmar, 1985; Hepworth & Larsen, 1993; Safran, Crocker, McMain, & Murray, 1990; Safran et al., 2001). The process of repairing an alliance rupture may not only improve the alliance, but also contribute to positive therapeutic change (Safran, 1993; Safran et al., 2001).

CRITICAL THINKING

Critical thinking involves identifying problems, obtaining and evaluating information from multiple sources, considering problems from multiple perspectives, and generating, analyzing, and evaluating solutions (Dewey, 1933; Dobrzykowski, 1994; Kurfiss, 1988; Paul, 1992).

In essence, an individual who is thinking critically "gives reasoned consideration to evidence, context, theories, methods, and criteria in order to form a purposeful judgment" (The Critical Thinking Delphi Project, as cited in Gendrop & Eisenhauer, 1996, p. 330). Critical thinking is a vital clinical skill because it contributes to clinicians' ability to evaluate their practice, promotes the transfer of learning across areas, and emphasizes the use of research in decision-making (Gambrill, 1990; Gendrop & Eisenhauer, 1996). The critical thinking process is highly active, disciplined, and purposeful, focusing on making a sound judgment and taking action based on a rationale (Halpern, 1997; King & Kitchener, 1994). In order to form well-reasoned clinical judgments, clinicians must be able to identify and refute fallacies in logic, consider contrary evidence, understand statistical principles, and use research findings, rather than empathy or ideology, to explain client problems (Gambrill, 1990).

Perry's (1999) scheme of intellectual development and King and Kitchener's (1994) reflective judgment model offer complementary views of how individuals learn to think critically through exposure to education and experience. Both models reflect the premise that the process of thinking critically entails changes in understanding the nature of knowledge and in developing the ability to contextualize and evaluate information from various sources. While the models share many similarities, King and Kitchener's model emphasizes the solving of "ill-structured problems," problems frequently encountered by clinicians because a single, definite solution does not exist.

With both models, learners begin with the idea that knowledge is absolute and authorities know the answers (Perry's position of dualism; King and Kitchener's stage of prereflective reasoning). When learners realize that there are some answers that are not yet known and that even authorities can disagree on what is true, learners can conclude that since knowledge is uncertain even for authorities, one's beliefs can be justified through using idiosyncratic evidence and arguments (Perry's position of multiplicity; King and Kitchener's stage of quasi-reflective reasoning). Up to this point, learners are engaging in pre-critical thought because they do not understand the contextual basis of knowledge nor that decision-making requires that evidence be evaluated using relevant criteria. Through the recognition that knowledge is contextual and affected by one's perspective, learners progress to an understanding that some perspectives, arguments, and opinions are better than others, so evidence and opinions can be compared across contexts to arrive at the most reasonable judgment (Perry's position of contextual relativ-

ism; King and Kitchener's stage of reflective thinking). (See Deal, 2004, for a more extensive discussion of these models.)

Research on Perry's model found that few college graduates consistently reason using a contextually relativistic approach (Moore, 2002). Graduate students have been found to regress temporarily from contextual relativism to an earlier position of multiplicity when first exposed to a new learning environment (Knefelkamp, 1999), suggesting that individuals can recycle through Perry's positions when learning unfamiliar material (Moore, 2002). These findings are consistent with Belenky et al.'s (1986) study of women's process of knowledge development that found that few women understand knowledge as constructed, i.e., that answers depend on the perspective of the inquiring individual and the context of the inquiry. Studies using King and Kitchener's Reflective Judgment (2002) model have found that college students typically use late prereflective (Stage 3) or early quasi-reflective reasoning (Stage 4), graduate students tend to use quasi-reflective reasoning (Stages 4 and 5), and advanced doctoral students use reflective reasoning (Stage 6). This research is important for supervisors since it suggests that even students who have completed their graduate training may not consistently consider context, compare alternatives, and evaluate the merits of evidence in making clinical judgments.

Studies evaluating whether or not schools of social work increase their students' critical thinking skills show mixed results. While Harrison and Atherton (1990), using an instrument based on Perry's stages of development, found MSW students were significantly better able than BSW students to view situations in complex ways, Clark (2002) found no differences between the critical thinking skills of BSW and MSW students. Similarly, Kersting and Mumm (2001) found that a course focused on BSW students' critical thinking skills was insufficient to improve this skill. Mixed results have also been found in nursing. Daly (2001) found no increase over 18 months in the critical thinking skills of nursing students; however, Martin (2002) found significant differences between the critical thinking skills of nursing students and expert nurses. The only study located that explored whether experienced clinicians can be taught critical thinking skills found that social work supervisors who participated in a course designed to increase these skills showed a significant increase in their ability to think critically when compared to a control group (Rogers & McDonald, 1992).

The Relationship Between Interpersonal and Critical Thinking Skills

One important link between interpersonal and critical thinking skills is through the interpersonal skill of empathy. Belenky et al. (1986) found that the ability to be empathic was a key aspect in gaining knowledge from the experiences of others and that women who reasoned at the highest cognitive level were the group best able to feel empathically connected to others. In a study using Perry's model, graduate students who operated at the level of contextual relativism were better able to use empathic techniques to understand their client's internal experience and modify their understanding based on client statements, when compared to graduate students at the dualistic level (Benack, as cited in Kurfiss, 1988). Goldberg's (1974) study of master's level counseling students found that students with abstract conceptual systems (highest cognitive level) were able to respond to client feelings and communicate understanding of the client's perspective better than students who were concrete, categorical thinkers. Findings from these studies suggest empathic skills are both cognitive (the student understands the client and their situation in complex ways) and relational (greater understanding leads to accurate and genuine connectedness).

Understanding empathy as having both cognitive and relational aspects illuminates a connection between empathy and critical thinking. Clinicians are better able to make sound clinical judgments when they can consider competing explanations for a client's problems, differentiate relevant from extraneous information, and evaluate different explanations and courses of action (i.e., engage in a process of critical thinking) (Gambrill, 1990). This process requires that a clinician be open-minded about the client's situation, asking questions, exploring possibilities, and listening carefully to the client. Such an exploration allows the clinician to understand the client and their situation in complex ways, facilitating an expression of empathy that is nuanced, accurate, and genuine.

For example, a student who is working with a client with a history of sexual abuse would need to conduct a thoughtful exploration, assessment, and evaluation of the role of this aspect of the client's history in his or her current situation. The ability to consider the client's past sexual abuse without preconception as to its current role or significance allows the student to envision alternative ways to understand the client's situation and facilitates the student's exploring and evaluating those alternatives with the client. The critical thinking skills of differentiating

relevant from extraneous information and evaluating different explanations for the client's current problems, therefore, help the student to truly understand the client, which contributes to developing an accurate empathic connection. By contrast, however, a student who enters the helping relationship with the belief that the trauma of sexual abuse must be responsible for the client's current problems may look for evidence to support this assumption. The student's own preconceptions, coupled with the failure to explore competing hypotheses, are likely to yield a stereotypical, superficial, or incorrect understanding of the client. Empathy and critical thinking both start from a "not knowing" position. Such a position allows the student to explore, assess, and evaluate information, skills that underlie both critical thinking and accurate empathy. The lack of these critical thinking skills hampers the student in developing and implementing an appropriate treatment plan that flows from an accurate assessment.

Critical thinking is similarly related to the interpersonal skill of attending to ruptures in the working alliance. As mentioned earlier, such ruptures are often based on client dissatisfaction with some aspect of treatment and can lead to premature termination if not addressed. When a rupture occurs, clinicians must be able to use such critical thinking skills as considering the situation from both the client's viewpoint and their own, recognizing the "truth" of the encounter as contextual, and evaluating alternative solutions to the problem. Clinicians unable to take the client's perspective may convey, overtly or covertly, that the client is mistaken in their perception of the situation. Clinicians able to see that the client's grievance exists within a relational context, and is not a question of right or wrong, are more likely to explore the client's concerns rather than defend their behavior. Take the example of a client who becomes angry when the clinician is late for their regular appointment due to taking an emergency phone call from a suicidal client. The client's reaction to the clinician's lateness is to cancel her subsequent appointment and notify the clinician that she no longer needs treatment. Through a process of critical thinking the clinician can engage the client in understanding how the client experienced this event (e.g., a loss of importance? abandonment? not getting their money's worth?), examine the relational context of the event (e.g., the dynamics of the client's current relationship with the clinician; the client's relationship history), and assess alternative solutions based on a broader contextual understanding (e.g., explain? apologize for making an error? apologize for the client's distress? accept responsibility? empathize without apology?).

SUPERVISION GUIDELINES

Understanding how critical thinking skills affect interpersonal skills can be useful to clinical supervisors in helping supervisees improve skills in both areas. The guidelines offered here suggest that supervisors begin with strategies to increase supervisees' levels of critical thinking which can facilitate improving the interpersonal skills of empathy and managing ruptures in the therapeutic alliance.

Specific strategies that clinical supervisors can use to encourage their supervisees to think critically include: (1) modeling, (2) facilitating a supervisory environment that supports exploring different points of view, (3) asking questions that require critical thinking skills, e.g., analysis, synthesis, and the formulation and testing of hypotheses, and (4) facilitating supervisees' skill in conceptualizing client communications in thematic terms. Supervisors can best apply these strategies when their own critical thinking skills are well developed, they are comfortable with ambiguity, and do not attempt to expedite the process by oversimplifying it (Potter & East, 2000).

Modeling

One of the most effective ways that supervisors can model critical thinking skills is through approaching a supervisee and their work with an open and inquiring attitude. Locking the supervisee into a category ("uptight ex-military man out of touch with his feelings" or "a know-it-all resistant to supervision" or even "pleasant demeanor liked by everyone") models an undifferentiated understanding of the complex behaviors, attitudes, and qualities of the supervisee. Overgeneralizing supervisees' abilities, in the direction of either competence or incompetence, fails to model the conceptual discrimination necessary for thinking critically. Simplistic categorization of a supervisee can offer a negative model of how to use partial information about another person to confirm one's preferred hypothesis, rather than exploring and evaluating evidence. Supervisors who attempt to understand their supervisees through an open, exploratory process of give-and-take are unlikely to prematurely categorize their supervisees, but instead to provide feedback to them that is individualized, multifaceted, and therefore, more empathically attuned.

By modeling the critical thinking and interpersonal skills involved in attending to ruptures in the supervisory relationship, supervisors offer their supervisees a template for how to handle ruptures in their relationships with clients (Shulman, 1993). Stalemates due to interpersonal

problems with supervisors are common (Nigam, Cameron, & Leverette, as cited in Goodyear & Guzzard, 2000) and are more likely to involve the supervisory relationship, rather than issues of direction or support (Ellis, 1991). Due to the power differential in supervision, supervisors usually need to be the one to raise the topic when problems arise within the supervisory relationship. In doing so, supervisors can model the critical thinking skills of considering both their own and their supervisees' viewpoints, recognizing the relational context within which the problem occurs, and enlisting supervisees in jointly evaluating alternative solutions to the problem. In addressing relational problems in this way supervisors are also modeling interpersonal skills by paying attention to interpersonal dynamics within a helping relationship, acknowledging responsibility for any of their behaviors that are contributing to the problem (interpersonal genuineness), and showing concern for the supervisee's experience of being evaluated (empathy and personal regard).

Both individual and group supervision of cases can provide supervisory and peer-to-peer opportunities to model good clinical judgment. Of particular importance is that supervisors, or more experienced peers, share the rationale for their decision (Dobrzykowski, 1994; Gambrill, 1990). It is the *process* of critical thinking, not just the outcome, that needs to be modeled for less experienced supervisees. Through sharing how they arrive at decisions and how they evaluate their own work, supervisors or group peers can model practice that assumes that critical assessment and evaluation is an ongoing part of the helping process.

A key critical thinking skill supervisors can model is that of metacognition (Gendrop & Eisenhauer, 1996), or critical reflection on the adequacy of their decision-making process. Through showing how they have monitored and critiqued their own practice decisions, supervisors can model not only how they consider evidence, context, and theory in making decisions, but how reflecting on this thinking process can improve it. This type of modeling goes beyond the "I had a similar case and here's what I did" approach or even a "Here's what I'd do differently now" caveat. By reflecting on the adequacy of their entire decision-making process, supervisors model how to monitor and improve clinical judgment. In modeling the process of metacognition, supervisors can "think aloud" their responses to such questions as "What steps did I take to arrive at this decision and were these steps adequate?" and "Why did I exclude certain alternatives from my decision-making and what does this tell me about my own assumptions about this client or the helping process?"

Supervisory Environment

Providing a respectful environment that values and supports thoughtful discussion of different points of view is important in influencing supervisees' critical thinking skills. Supervisors can set the expectation that differences in conceptualizing a case can enrich understanding of the client by showing a willingness to listen to perspectives that differ from their own. Treating disagreements over how to understand or treat a client as opportunities for both supervisors and supervisees to learn helps move supervisees from a reliance on (or resistance toward) the authority of their supervisors. This is not a suggestion that supervisors abdicate their training responsibilities, but rather that they use differences in client conceptualization to model openness to different ideas and to provide a method of evaluating these ideas through critical reflection.

The use of group supervision provides participants with multiple models of how to conceptualize and evaluate practice issues. Having to present and defend their perspective while being exposed to the ideas, observations, and challenges of others forces supervisees to think more critically about their own ideas and compare them to alternative hypotheses (Burman, 2000; Gendrop & Eisenhauer, 1996).

Asking Discriminating Questions

Although discussion of different perspectives is an important beginning, higher levels of critical thinking require not only gathering, but interpreting and evaluating evidence, to arrive at a sound clinical judgment. Supervisees can be helped in the process of conceptual discrimination through their supervisors' use of the types of questions that require critical thought to answer. King (1995) provides a helpful table listing question stems that induce specific thinking skills. For example, to facilitate the critical thinking skill of analysis, a supervisor could ask such questions as, "What are the strengths and weaknesses of being more confrontive with this client at this point in your work together?" or "What is the nature of this client's relationship with you?" To facilitate the ability to compare and contrast ideas, the supervisor might inquire, "What is the difference between the way this client relates to you and to his previous counselor?"

Asking supervisees to explain their rationale for decisions helps supervisors determine where supervisees fit on the developmental continuum of critical thinking skills (see Potter & East, 2000, on using King and Kitchener's (1994) Reflective Judgment Interview for this pur-

pose). Take the example of a supervisor, using King and Kitchener's (1994) reflective judgment model, who concludes that since James, her supervisee, primarily relies on his own experiences and beliefs to justify his judgments, he is exhibiting an early stage in quasi-reflective reasoning (Stage 4). An initial supervisory goal could include James's progressing to a later stage in quasi-reflective reasoning (Stage 5) by helping him develop a contextual understanding of knowledge, i.e., that James's perspective influences how he interprets information about his client and is only one way to understand the client's situation. To accomplish this, his supervisor could encourage James to generate more than one hypothesis about his client and then suggest that he test these alternatives by asking the client questions that explore these different hypotheses (see Erera, 1997, for additional information on using this cognitive approach as a way to increase empathy). The process of identifying alternative explanations for a client's behavior engages James in a process of contextual understanding (moving him toward later stage [Stage 5] quasi-reflective reasoning). Exploring the extent to which his client's history, statements, reactions and interactions during the interview support any of these hypotheses introduces James to the skills of critical comparison and evaluation which are characteristic of reflective reasoning (Stage 6). Exploring and testing the validity of different ways to understand the client can yield complex, evidence-based knowledge that increases the likelihood that James's subsequent expressions of empathic understanding will be accurate.

Supervisors can involve supervisees in seeking relevant research findings and guide them in actively comparing their perspective to this evidence. In such discussions supervisors can encourage supervisees to differentiate between opinions (e.g., preferences and personal theories of causality or change) and data (e.g., facts about clients, relevant research findings), challenging illogical reasoning when necessary. When choosing how to proceed with a case, supervisees may need the thoughtful but discriminating questions of their supervisor to explicitly consider the potential influence of their preferred theories, initial judgments, and personal experience on their decision-making (Gambrill, 1990).

Supervisors can use questions to help supervisees examine recurring patterns in their work. Irving and Williams (1995) suggest conducting a longitudinal meta-analysis of clinical success and failure, for example, by looking at commonalities in supervisees' approaches to their less successful clients over time. Supervisors can facilitate this process by inquiring about what characteristics these problematic clients have in

common, how supervisees decided on their therapeutic approach, and which interventions supervisees tended to use or avoid. This type of analysis can help pinpoint problems or gaps in supervisees' decision-making process that supervisors can address.

Identifying Themes

Finally, supervisors can help their supervisees look for themes and patterns in their clients' words and behaviors. Since themes are at an abstract, rather than concrete, level of thought, the ability to think in thematic terms encourages supervisees' growth in both cognitive complexity and affective empathy. Supervisors can review audiotapes or written recordings of supervisees' interviews to guide supervisees from a focus on clients' concrete words and behaviors (e.g., the client doesn't follow through on joining a parenting group and makes only brief responses during interviews) to recognizing underlying themes (e.g., the client is ashamed of his lack of formal education and afraid that he will reveal it either during an interview or with a group of parents). Supervisees who can understand the conceptual threads that connect the client's specific words and behaviors can be more accurate in their empathic responses.

Case Example

A hypothetical example illustrates how some of the supervisory guidelines work together in practice. Kayla is a clinical social work student placed in an agency that evaluates and treats persons arrested for driving while intoxicated. She is using a supportive approach with these mandated clients because it was moderately successful at her previous internship with psychiatric inpatients, thus it is a comfortable and familiar approach. However, Kayla is having difficulty connecting to some of her current clients who frequently miss sessions and complain about the program. Kayla thinks that her supervisor, Mrs. Darlene Jones, has unrealistic expectations for her performance but is reluctant to raise her concerns.

Mrs. Jones could assist Kayla's growth by recommending that she research and evaluate treatment models for mandated clients, including outcome studies on their efficacy. This process can help Kayla discriminate between her preferred therapeutic approach and which treatments are successful with mandated clients. Mrs. Jones could use questions to facilitate Kayla's analytic ability ("What are the strengths and weak-

nesses of your being primarily supportive with your clients?") and her ability to compare and contrast ("What are the differences between your supportive approach and the treatment models you found in the literature?"). Applying a treatment model developed for involuntary clients, such as Rooney's (1988) socialization model, Kayla can learn to distinguish between negotiable and nonnegotiable requirements, a critical thinking skill.

Mrs. Jones can help Kayla connect her improved ability to discriminate and analyze information with ways to relate to her mandated clients with greater authenticity. For example, Mrs. Jones can use Kayla's understanding of the distinction between the negotiable and nonnegotiable requirements of the court-ordered program to help Kayla consider ways to be more genuine, honest, and direct with her clients about the realistic parameters of their work together. Mrs. Jones can help Kayla think about how each of her mandated clients experiences restrictions on their freedom differently. This discriminatory exercise can enable Kayla to hypothesize ways to offer her clients individuated responses empathically attuned to the specific concerns of each client, in contrast to her current approach of offering undifferentiated support.

In a related effort to help Kayla individuate the characteristics and needs of her clients, Mrs. Jones and Kayla can listen to audiotapes of Kayla's client interviews. During this process Mrs. Jones can model how to form alternative hypotheses about what underlying themes might connect a client's various concerns and how to test these hypotheses by open and objective listening and asking further questions in additional sessions (Erera, 1997). Such discussion allows Kayla to experience how the critical thinking skill of forming and testing alternative hypotheses is related to empathy (greater accuracy in understanding a client's underlying concerns helps Kayla formulate more accurate empathic responses).

Mrs. Jones needs to be alert to tensions within the supervisory relationship, actively initiating a discussion of how supervision is proceeding. Providing a safe opportunity for Kayla to discuss her perception that her supervisor has unrealistic expectations for her allows Mrs. Jones to model a nondefensive response. By sharing her view of the situation, Mrs. Jones shows how a problem can be understood with greater complexity when viewed from different perspectives. By accepting responsibility for any part she played in the problem and showing concern for Kayla's fears of raising a difficult issue, Mrs. Jones is modeling genuineness and empathy. Together, Mrs. Jones and Kayla can generate and evaluate alternatives to solving their problem. Through her combination

of effective critical thinking and interpersonal skills, Mrs. Jones has modeled how Kayla can address the weak or problematic alliances she has encountered with some of her own clients.

The role of the clinical supervisor is critical in assisting students and new graduates in their development as competent and autonomous helping professionals. By utilizing the connection between critical thinking and interpersonal skills, supervisors can help supervisees not only improve their clinical judgment, but also their skill in relating to clients. The strategies offered here provide some specific guidelines on how to put these conceptual-relational connections into action to benefit the developing professional.

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