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Therapeutic and supervisory relationships in cognitive-behavioral therapy share the same psychoeducational model and therefore evidence similarities. Nevertheless, these two types of relationships have fundamental differences of the sort that distinguish psychological treatment from professional training. Therapeutic and supervisory relationships share qualities such as (1) a collaborative set; (2) the use of objective criteria to measure progress; (3) the sensitive, mature handling of power imbalances; (4) an atmosphere of optimism, encouragement, and hope; and other similarities. Conversely, therapeutic and supervisory relationships are different in that (1) supervision focuses on the treatment of the client, not the supervisee; (2) multiple supervisors are more advantageous in training than are multiple therapists in treatment, (3) there is some flexibility in supervisory relationships for postsupervision evolution into collegial or personal relationships; and others.

This paper hypothesizes some of the factors that supervision and therapy relationships share in cognitive-behavioral therapy (CBT), as well as factors that make them distinct types of relationships. Some special issues pertinent to supervisory relationships will be addressed to emphasize the important responsibilities that supervisors must fulfill in the service of the training and general well-being of their supervisees.
SIMILARITIES

Collaboration

The supervisory relationship (SR) and therapeutic relationship (TR) are ideally characterized by collaborative teamwork between the participants. In each modality, the parties try to identify and then work toward mutually agreed upon goals. They do not work at cross-purposes, and they respectfully attempt to overcome differences of opinion through constructive dialogue and hypothesis testing. The supervisor, like the therapist, bears the lion’s share of the responsibility in fostering this atmosphere of cooperation, so that the supervisee and client have a safe base from which to express their ideas freely, without fear of condemnation or retribution.

Skills Are Taught

Supervision and therapy in CBT are directive, but not in the sense that the supervisee and client are instructed to act, think, and feel in certain ways out of obedience and blind faith. Rather, the supervisor and therapist teach skills (Newman & Haaga, 1995; Thorne & Dryden, 1991), so that their respective “charges” gain progressively greater degrees of knowledge, independence, and self-efficacy. Examples of skills that are taught include (1) self-monitoring, (2) formulating and testing hypotheses, (3) maintaining hopefulness and adaptability in the face of setbacks and adversity, (4) listening and communicating effectively, (5) systematic problem solving, and (6) establishing, pursuing, achieving, and reevaluating goals. These skills are best learned when they are not merely presented verbally, but when the supervisees practice them experientially, such as via role-playing (Bartlett, 1983).

Progress Is Measured Objectively

Both the client’s and supervisee’s progress is measured objectively. While the therapist and supervisor may have a good, subjective sense about how much the client and supervisee have learned, and how well they are doing, they realize that this alone is insufficient to assess progress adequately. The therapist and supervisor have respect for objective data and therefore measure the client’s and supervisee’s progress systematically over time.

For example, therapists make use of some or all of the following: (1) periodic diagnostic assessments via structured interviews, (2) well validated self-report measures that the client fills out on a regular basis, (3) behavioral observations, via role-plays, home or school visits, and/or interactions with significant others who have been invited to a session, and (4) “single-subject” monitoring, so that true gains can be differentiated from fluctuations in functioning that may be artifacts of chance occurrence, regression to the mean, concurrent life events, and other threats to internal validity.
In similar fashion, a supervisee's progress is best assessed via objective measures (Mead, 1990). Some of these may include: (1) competency rating scales (cf. Beck, Rush, Shaw, & Emery, 1979; Borders & Leddick, 1987; Liese, Barber, & Beck, 1995), (2) behavioral observation, either via cotherapy, one-way mirror, or reviewing audiotapes of supervisees' sessions with their clients, (3) ratings of therapeutic progress of supervisees' clients, (4) written and oral exams that test the supervisees' general knowledge, clinical decision-making skills, and awareness of ethical issues, (5) observation of supervisees' methods of case management, and (6) clients' reports of satisfaction with their treatment.

**Structure and Time-Limits**

In both the TR and the SR, a central goal is for client and supervisee to learn to function more effectively and independently, and to achieve these ends within an optimal time frame. In other words, time is precious and needs to be utilized wisely (cf. Beck, Wright, Newman, & Liese, 1993; Liese et al., 1995). Having a formal structure to supervision helps to achieve this goal, and there is evidence that supervisees appreciate a well organized supervision session, especially if they are early in their careers (Worthington & Roehlke, 1979).

Therefore, both supervision and therapy sessions follow an agenda, focus on high-priority issues, and stay on task. Therapist and supervisor understand from early in the relationship that the TR and the SR will be finite, and that preparation for termination is part of the work. Naturally, in the spirit of collaboration, there is some flexibility here. Some SRs, as some TRs, require more time than others in order to deal effectively with all of the issues involved. Though research protocols in psychotherapy research sometimes dictate that the SR and TR adhere fairly closely to a predetermined length of time, in clinical practice there usually is a much greater range of times that SRs and TRs can last. In the end, however, the CBT approach to both therapy and supervision entails structure and time limits toward the goal of independent and efficacious functioning of the client and supervisee in the near future (if possible).

**Power Imbalance**

In both the TR and the SR, in spite of the fact that an air of collaboration and good will exists, there is an objective power imbalance between the participants. Therapists and supervisors alike need to be mindful of their professional responsibilities, including demonstrating appropriate interpersonal behavior, serving as positive role models, and actively sharing their knowledge and expertise in a way that facilitates clients' and supervisees' growth.
Therapists and supervisors share the burden of setting the tone in the TR and the SR, thereby providing a sense of predictability and direction that creates a safe haven for learning (Shohet & Wilmot, 1991). Therapists and supervisors have the primary responsibility for keeping their work on task, and of making certain that they do not inadvertently give their clients and supervisees misinformation (e.g., when they do not spell out the differences between facts and hypotheses, and when they fail to realize the persuasive impact of offhand remarks that clients and supervisees mistakenly accept as sagely advice). Similarly, therapists and supervisors are ethically obliged not to abuse their power in any way (American Psychological Association, 1992; Kaiser, 1992; Mead, 1990).

An interesting twist on the “power imbalance” issue occurs when therapists and supervisors are threatened by their clients and supervisees, respectively, and thus do not exert sufficient power in the relationship to stimulate learning and change. This can occur when the therapist or supervisor is interpersonally timid or shy in the face of clients and supervisees who are outgoing, bold, hostile, and even bawdy. It likewise can happen when the therapist or supervisor is the younger of the two in their respective dyads. Unfortunately, such power reversals also may take place as a result of the ubiquitous politics of gender, such as when a female therapist or supervisor works with a male client or supervisee who is unaccustomed to being “second in command” to a woman (Brodsky, 1980).

In all of the above cases, therapists and supervisors need to find ways (usually via consultation with colleagues, and direct communication with clients and supervisees) to address and reassert their proper positions in the TR and SR. This is one area where “countertransference” (cf. Layden, Newman, Freeman, & Morse, 1993) truly can be a significant issue, both for the CBT therapist and supervisor.

**Role Definition and Respect for Boundaries**

Both the TR and SR proceed most smoothly when all parties involved have a clear idea of what is required of them by the other member of the dyad (Berger & Buchholz, 1993; Yogev, 1982). Therapists oftentimes do this as part of their process of socializing the client into the work of CBT. Excellent examples of this can be found in the works of Grieger (1989), and Young (1990), who provide clients with written briefings about the process, including respective responsibilities of the therapist and the client.

It is less clear that such a socialization process takes place routinely in CBT supervision, though it certainly would be beneficial. Supervisees are helped when they are provided with a framework that can guide their actions, as well as their decision-making processes, both in session with their clients and in the office with their supervisors.
The Supervisory Relationship

Therapists and supervisors have a similar obligation to respect the personal boundaries of their clients and supervisees. For example, there are ethical guidelines that prohibit romantic involvements in the SR, as is the case in the TR (American Psychological Association, 1992). This is the most extreme example of boundary violation, and therefore is the most obvious and straightforward. A less extreme boundary infringement that both therapists and supervisors must avoid is a tendency toward monopolizing a session with their own issues and stories.

The comparison between boundary issues in the TR and SR becomes a little trickier in some other respects. For example, when clients’ personal problems get in the way of completing therapy homework, it is usually appropriate for the therapist to address this (Newman, 1994). However, suppose that a supervisee’s personal problem (e.g., a recent romantic rift) interferes with his or her performance (e.g., doesn’t complete process notes, cancels appointments with clients, and misses a supervisory meeting). While it is necessary for the supervisor to address and deal with the supervisee’s work problems per se, is it appropriate to discuss the personal reasons for the supervisee’s difficulties?

The answer to the question above is somewhat dependent on the degree to which one subscribes to the notion that supervision entails some therapy in itself, a position that is not uncommon in psychoanalytic orientations (Sarnat, 1992). In CBT, many supervisors choose to stay focused on the supervisee’s professional development and therefore steer clear of addressing psychological issues. In instances when the supervisee is in danger of becoming impaired because of his or her personal problems, the supervisor can utilize options such as (1) encouraging the supervisee to enter therapy with a third party, (2) more closely monitoring the supervisee’s work, or (3) relieving the supervisee of some of his or her duties for a period of time.

A Prevailing Atmosphere of Hopefulness

In CBT, therapists and supervisors similarly model a “can do” approach to their work and foster this attitude in their clients and supervisees. The work of therapy can be difficult, frustrating, and eminently humbling, whether one is a client or a therapist. At times either party may become discouraged and self-doubting. It is difficult to stay hopeful all the time, but this is the spirit that needs to prevail (Beck et al., 1979). This is not to be confused with an endorsement for blind optimism. CBT is not the same thing as “the power of positive thinking.” Rather, it is “the power of objective thinking,” “in synergy with a good work ethic and a healthy sense of self-efficacy” (Newman & Haaga, 1995).

Along these same lines, supervisors need to give encouragement to supervisees, especially if the supervisees are novices at CBT. Further, by
offering such support, supervisors set an example for their supervisees to follow with clients.

Positive Regard Is a Necessary But Not Sufficient Condition

While a facilitative relationship, driven by hopefulness and positive regard, is a necessary condition for both clients and supervisees, it does not substitute for the learning of specific skills (Hutt, Scott, & King, 1983). Therapists and supervisors need to demonstrate benevolence, but must also teach, so that their clients and supervisees gradually learn to operate independently. Supervisees generally want to be supported by their supervisors, but they also feel best about supervision when they receive direct, fair, and constructive criticism (Holloway & Wampold, 1983; Worthington & Roehlke, 1979).

DIFFERENCES

Supervision Does Not "Treat" the Supervisee

In CBT, supervision involves two main priorities: (1) ensuring that the supervisee’s clients are provided with competent care, and (2) facilitating the supervisee’s professional skills and development (Mead, 1990). While it may be beneficial for supervisees to gain some measure of enhanced self-awareness as part of their supervision experience (Thorne & Dryden, 1991), this is a tertiary priority in CBT. This is in contrast with more traditional psychoanalytic models of supervision, where treatment and supervision sometimes occur as one and the same entity during the therapist’s apprenticeship period (Sarnat, 1992).

At times, the SR can be fertile ground for looking at psychological issues that impinge on both the supervisee’s and the supervisor’s approach to a given case (cf. Liese & Beck, 1997). This may lead to personal and professional growth for both the supervisor and supervisee, though it is not to be confused with "treatment" per se (Baudry, 1993).

Different Parameters of Termination

It may be true that supervisees have less power to terminate the SR than clients have to terminate the TR. Well-informed consumers of psychotherapy services know that they have the right to fire their therapists and find someone else to counsel them if they are unhappy with the treatment that they receive. When clients choose to do this, they incur few repercussions, save for the inconvenience and potential additional expenditures involved. In some instances, clients can choose to terminate therapy altogether, with no resultant negative consequences.
By contrast, supervisees sometimes have relatively little power to choose their supervisors and may risk political backlash if they clash with their supervisors or ask for a transfer. This is especially true if the pool of available supervisors is small and cohesive, as it may be in some academic departments. In worst-case scenarios, supervisees may put their academic standings at risk if they show displeasure with their supervisors. At the very least, unlicensed supervisees must continue to seek and receive supervision if they are to continue their careers. They cannot merely "fly solo" if they find their training to be aversive in some way.

The upshot of this observation is that supervisors must be mindful of the power they wield over their supervisees, and how this power can be a deterrent to therapists-in-training exercising their rights to get the supervision they feel they need. Therefore, it is incumbent upon supervisors to spell out the options that their supervisees have if there is a problem in the SR. Further, the supervisors need to be open-minded and nonpunitive if they learn that a supervisee does not wish to continue working with them.

**The SR Entails a Shared Responsibility Toward a Third Party**

The TR involves working as a team on the client’s problems. By contrast, the SR involves a joint, ethical responsibility toward a third party—namely, the supervisee’s client.

When clients focus too much on a third party, this is usually a sign that they are paying insufficient attention to their own issues in treatment (e.g., a man who wants to spend most of his therapy sessions complaining about his wife and wondering how he can convince her to change). On the other hand, supervisees need to pay close attention to a third party (their clients) in the course of their supervisory sessions. This is both necessary and appropriate.

The degree to which an SR will involve focusing on the functioning of the supervisee will depend on the following questions: (1) Is it necessary to examine the supervisee’s behavior in order to ensure that the clients receive appropriate care? (2) Have all of the relevant data about the clients been reviewed first, thus leaving time for monitoring the supervisee’s process? and (3) Will the supervisee be able to learn therapeutic interventions and self-awareness skills simultaneously as each case is reviewed, as this may be the most effective way to provide excellent client care while the supervisee grows as an individual and a professional?

**Implications of Multiple Supervisors vs. Multiple Therapists**

Aside from the usual scenario whereby a psychologist provides the psychosocial treatment while a psychiatrist handles the medications, it is generally a good idea to have no more than one individual therapist at a time (though it is more
common and usually less problematic for clients concurrently to be in couples therapy, group therapy, or 12-step meetings).

It is often a red flag for therapists if they note their new client has had many therapists. Sometimes this is a function of the previous therapists' geographic mobility. On the other hand, it may be a sign of the chronicity of the client's problems, and/or an indicator that the client is still looking for the "right" therapist.

In supervision, on the other hand, it is advantageous for supervisees to have had numerous supervisors during their training (cf. Minnes, 1987). As a reflection of this fact, it is common for CBT departments, internships, and postdoctoral fellowships to provide their trainees with multiple, rotating supervisory experiences.

To some degree, this difference between therapy and supervision is a function of the relative levels of importance placed upon the relationship itself. Another factor is a practical one; it may take many supervisors, perhaps varying in areas of expertise, to help the trainee to manage the breadth and depth of his or her caseloads over time. Therapy is dissimilar in that one competent therapist often is sufficient to help the client. Too many therapists, in fact, may be problematic.

**Greater Flexibility in the Evolution of the SR**

TRs have quite rigid boundaries. Therapists know that they are not to undertake the treatment of someone whom they know socially, are prohibited from having dual relationships with their clients during the course of therapy (including long-term follow-up periods), and only under the most rare and "justifiable" of circumstances do they have friendships or personal relationships with clients long after treatment has definitively concluded (American Psychological Association, 1992).

SRs, too, have prohibitions against dual relationships, in order to maintain the professional integrity and efficacy of the supervisory experience. However, the rules are less rigid and less well defined. For example, it is not uncommon for supervisors and supervisees to have been on friendly terms (e.g., having worked on a publication together, or having fraternized at various departmental social functions) prior to the onset of the SR. Likewise, it is fairly common for supervisors and supervisees to continue a professional (and perhaps a more familiar) relationship after formal supervision has ended. In many cases, SRs have turned into collegial relationships as well as friendships (Gottlieb, 1993). In more than a handful of instances, SRs have ultimately led to marriages.

It may be argued that boundary issues in the TR and the SR show some similarities during the course of the professional relationship. However, after the professional relationship has terminated, the SR, unlike the TR, can more easily evolve into other forms of relationships.
SPECIAL ISSUES

Supervisor "Slacking"

In an ideal world, nobody would ever miss an appointment, all clients would get the therapy sessions they need, and all supervisees would receive the regularly scheduled training that is due them. The reality is that neither therapy nor supervision are immune to interruptions.

Diligent therapists know that they must make every effort to be available for their clients, and to arrive on time for their therapy sessions. Further, owing to concerns about legal liability, therapists know that they need to pursue absentee clients actively, especially if suicidality is an issue.

It is not altogether clear that these same, diligent, competent therapists put forth a commensurate degree of effort in seeing their supervisees regularly and routinely (present company included in this indictment). Anecdotal evidence suggests that therapists have a greater sense of urgency in keeping their appointments with clients than do supervisors in maintaining their supervisory appointments.

Supervisors have at least two important responsibilities: (1) providing supervisees with the guidance and training that they deserve, and (2) making certain that the supervisee’s clients are receiving appropriate treatment. Therefore, it is incumbent upon supervisors to take supervision meetings as seriously as they take their sessions with their clients. It is important and commendable in working with supervisees to (1) be on time, (2) be on standby in case of crises, (3) provide backup supervision during vacation time, (4) act professionally in supervision meetings, (5) promptly contact supervisees who miss appointments, and (6) be ever mindful of, and live up to, the trust that supervisees put into the SR. To do so is to demonstrate a tangible commitment to the supervisee’s training (Mearns, 1991).

Theoretical Differences Between Supervisor and Supervisee

Therapists-in-training are in the process of forming a professional identity, complete with a theory and methodology that reflect this sense of self. When a supervisee with a given theoretical orientation commences work with a supervisor who maintains an alternative orientation, it can be quite unsettling, especially for the supervisee (Kennard, Stewart, & Gluck, 1985; Stoltenberg & Delworth, 1987).

As the data in support of CBT continue to accumulate, an increasing number of therapists trained in other modalities have begun to seek CBT supervision. When motivation to learn is high, as it often is in such cases, paradigm disagreements between supervisor and supervisee can be kept to a minimum.

On the other hand, some supervisees, as part of their assigned training experiences, are thrust involuntarily into situations where they are theoretically
at odds with their supervisors. When this occurs, supervisors are advised not to “proselytize” the merits of CBT to a skeptical audience, but rather to apply the standard, effective, methods of guided discovery and collaborative empiricism that are the hallmark of Beckian cognitive therapy (Beck et al., 1979). Supervisors can minimize conflict, and maximize cooperation by being sensitive to the supervisee’s uneasiness with a new model, and encouraging questions and feedback. In addition, supervisors can use reframing in order to discuss clinical observations that otherwise would be obscured by different sets of theoretical jargon (cf. Goldfried, 1987).

When a “Therapy Agenda” Appears in the SR

Unfortunately, there are times when supervisors have been known to turn supervision into therapy. Unless this transition is agreed upon in advance by both parties, and the parameters of the relationship are well conceived and articulated, the result likely will be a noxious experience for the supervisee. If this situation arises, supervisees would be well advised to consult with another (well-trusted) supervisor or mentor in order to do some problem solving about the matter.

A “therapy agenda” can also occur in supervision when the supervisee pulls for this relationship shift. For example, trainees may begin spontaneously to tell their supervisors about highly stressful events in their lives. If the supervisee frequently makes clinically significant personal disclosures, the CBT supervisor must address the issue directly. Supervisors need to take the lead in addressing the pros and cons of blurring the distinction between a standard SR and an emergent TR. More often than not, it is preferable to assist the supervisee in finding a suitable therapist elsewhere, and thereby keep the supervision and therapy separate. The supervisor can focus on the supervisee’s psychological issues as they impinge upon the trainee’s work, but the line can be drawn there.

Power Struggles

Although cognitive therapy supervision ideally should be a collegial and collaborative process, the appropriate balance of power may, at times, be upset. This may occur when the supervisor is too heavy handed in suggesting interventions, or in focusing on the supervisee’s shortcomings as a therapist, or in threatening the supervisee with broader sanctions if the supervisee does not “comply.” In other instances, it happens when the supervisee covertly or overtly disregards the supervisor’s suggestions and teachings.

To some degree, power struggles in the SR are not unlike power struggles in the TR. In order to work through such conflicts in a productive, healthy manner, both parties in the supervisory dyad need to (1) be willing to inspect the data (e.g., an audiotape of the supervisee’s session, the client’s self-report
inventory scores over time, the client’s track record in doing homework assignments, etc.) in order to make sound, informed, clinical decisions, (2) take stock of their own automatic thoughts surrounding the conflict (e.g., “My supervisor doesn’t understand my client the way that I do,” or “My supervisee doesn’t respect my point of view the way she should!”) in order to generate rational responses that will facilitate cooperation, (3) recognize that a conflict in the SR will be harmful not only to the SR itself but also to the client in question, therefore it is incumbent upon the supervisor and supervisee to discuss the issue and to change their behavior in the spirit of problem solving, and (4) consult with an objective third party if the disagreement proves too difficult to handle on their own.

Learning From the Supervisee

Experienced clinicians know that they grow and learn as a result of their myriad interactions with their diverse lot of clients (Casement, 1991). Similarly, supervisors can learn from their supervisees.

When supervisors maintain a “confident humility” in their supervisory interactions, they set into motion a number of positive processes. First, they show respect for their supervisees’ knowledge and skills, which helps the latter build confidence in their work. Second, the supervisors function as coping models who recognize their limitations but always strive to be competent. This enables supervisors to be more effective instructors than if they present themselves as mastery models who know “everything” (cf. Schunk, Hanson, & Cox, 1987). Third, the supervisors themselves benefit in that their clinical experience broadens as a function of all of the clients whose cases they have supervised. Fourth, since supervisors cannot be expert in all disorders and modalities of treatment, it is educative to supervise someone whose specialty area lies in another realm.

For example, consider the situation where a supervisee treats a marital couple in which the wife has an eating disorder. The supervisor may be an expert in cognitive therapy for couples (Dattilio & Padesky, 1990), but not in cognitive therapy for eating disorders (Fairburn, 1985; Garner & Bemis, 1985). The supervisee may have little training in couples therapy, but a great deal of knowledge about eating disorders. In such a scenario, everybody wins, because the supervisee learns how to perform the couples therapy modality, while the supervisor gains experience with an eating disorder case. In the process, the clients get competent care from both angles.

CONCLUSION

The supervisory relationship (SR) and therapeutic relationship (TR) are distinct entities in CBT, each with its own specific set of goals and parameters. Simply put, clinical supervision is not psychotherapy. Therefore, a supervisee
who wishes to receive CBT generally should seek treatment with someone other than his or her supervisor.

However, as CBT as a whole is a psychoeducational model, the SR and TR share some characteristics and demonstrate some interesting, overlapping processes. For example, both the TR and SR operate most effectively when they involve (1) collaboration between the participants, (2) the teaching of skills, (3) the use of objective criteria to measure progress, (4) a mutual understanding and mature handling of the power imbalances inherent in the respective relationships, (5) clearly defined responsibilities and a respect for boundaries, (6) an atmosphere of optimism, encouragement, and hope, and (7) the recognition that the relationship is a means to an end and not an end unto itself.

Some of the factors that differentiate the TR and SR have been reviewed, including the notions that (1) supervision is not synonymous with personal therapy, (2) supervisees benefit by having many, rotating supervisors, but may have little power to "fire" a supervisor, while clients may fare best with one effective therapist but have more power to "shop around" for the appropriate clinician, (3) supervision is a joint effort on behalf of a third party—the client—to whom both the supervisee and supervisor have a professional responsibility, and (4) the TR rarely, if ever, becomes anything other than a TR, while SRs sometimes involve necessary dualities (e.g., supervisor is also a research adviser, teacher, and casual acquaintance), and may even evolve into various forms of personal relationships once the SR is over and the power differential has balanced somewhat.

Some special issues were discussed as well. These included: (1) the importance of supervisors giving supervisees as much attention and investment as they would give their clients, (2) the manner in which differences in theoretical orientation in the SR may cause difficulties, and how these can be managed, (3) how to keep the SR within appropriate boundaries, even when one of the parties begins to act as they would in therapy, (4) methods for keeping supervisory power struggles within normal, adaptive limits, and (5) the educative benefits of being a supervisor who is open to learning from his or her supervisees.

REFERENCES


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