Institute for Clinical Social Work

The Emergence of the Clinical Self in Supervision

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By

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Abstract

This research describes helpful experiences in psychoanalytically-focused supervision as described by supervisees. Studies on subjective experiences of supervisees are extremely limited. This qualitative study uses three stages of data collection in order to describe the essence of helpful experiences in clinical supervision as described by thirteen clinicians who were in the role of clinical supervisees either in the present or the past. The participants from the study were drawn from four disciplines in the field of mental health and were from the three largest metropolitan areas in California and a small town in Oregon. The findings were broken down into 12 themes. Implications of this study strongly suggest new guidelines for supervisory training.

For my wife, Rosemary, who has always been with me throughout this long process with her generous and loving emotional and intellectual support.

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Chapter I

Introduction

Statement of the Problem

The supervisory relationship is a primary aspect of the training of psychoanalytically oriented clinicians. Given the amount of psychoanalytic literature and research over the past 100 years, the supervisory relationship has received relatively little attention. Sarnat (2016, p. 13) acknowledges the dearth of research in this area by talking about the "…limited supervision research literature." In addition, most of this limited research literature on this relationship has been written from the perspective of the supervisor. Studies on supervisees' subjective experience in the supervisory relationship are rare (Rock, 1997).

The purpose of this study was to study the phenomenon of helpfulness in supervision as described by supervisees. This researcher previously did a pilot phenomenological study on what is and what is not helpful in the supervisory relationship. Based on the results of this study, this researcher decided to pursue the topic on what is helpful in the supervisory relationship. Specifically, the researcher wanted to explore this topic from the supervisee's perspective because there is very little literature on this topic. The essence of the supervisees' responses in this study will contribute to an

understanding of the body of knowledge of the clinical supervisory relationship. In addition, this study may lead to an increased effectiveness in training clinicians.

The researcher's interest in this area is related to the diversity of experience that this researcher had over the years as both a clinical supervisee and as a clinical supervisor. This researcher was struck by the complexity of these relationships, and the researcher has struggled with how to best facilitate a productive learning experience in supervision that ultimately serves those that come to us for treatment.

Research Question

How do supervisees describe helpful experiences in psychoanalytically focused supervision?

Chapter II

Literature Review

The purpose of this literature review on psychoanalytically focused clinical supervision is to survey literature primarily from a conceptual point of view as opposed to a chronological review. This review will de-emphasize historical and theoretical camps. Instead, the review will stress where clinical ideas shift, build on, and/or complement each other. The concepts and ideas mentioned in this review will transcend historical periods and/or theoretical points of view. Because psychoanalytic theory addresses many different professions, in this study, the discipline of psychoanalytic theory and supervision will be more important that the particular profession of the supervisee.

This review will cover 10 areas related to psychoanalytic supervision. These 10 areas were chosen because this research believes that they represent significant developments in psychoanalytically focused supervision. A number of these areas overlap each other. These areas include:

1. an authoritarian point of view of supervision,
2. parallel processes,
3. a relational constructivist viewpoint,
4. the emotional atmosphere in supervision,

5. blind spots in the supervisor,
6. self-disclosure by the supervisor,
7. the reporting of dreams by the supervisee,
8. addressing neurotic issues,
9. Levenson's (1979) creative thoughts on supervision, and
10. studies from the supervisee's perspective.

Authoritarian Point of View of Supervision

Starting in the 1920s, the newly developing psychoanalytic communities in Europe struggled with what structure the supervision of psychoanalytic candidates should take. Views of supervision discussed which person was best qualified to conduct the supervision and the particular form that the supervision should take. For example, one early conception of supervision was that the supervisor would tell the student how she or he would conduct the analysis of a particular case. The expectation was that the student should handle the case in the same manner (Fleming & Benedek, 1966). This model suggests that the supervisor was in the role of an authoritarian instructor.

In the 1930s, there were two significant schools of thought among many European analysts. These two different groups had opposing views as to who should conduct the supervision. These two schools of thought were the Hungarian school and the Berlin-Viennese school. The position of the Hungarian school stated that the candidate's training analyst should also conduct the candidate's supervision. The belief behind this was that the analyst knew the candidate's anxieties, conflicts, and countertransference issues in depth; therefore, the analyst was most qualified to conduct the supervision.

In contrast, the proponents of the Berlin-Viennese school asserted that the training needs of the candidate could best be served by the personal analyst not functioning as the supervisor on treatment cases. Proponents of this school maintained that the candidate could therefore be exposed to different points of view. In addition, it was maintained that supervision should be a *didactic experience* and that countertransferences should be handled in this same didactic manner by the supervisor (Ekstein & Wallerstein, 1958; Fleming & Benedek; 1966; Rock 1997).

Parallel Processes

In the 1950s, Harold Searles (1979) introduced a new perspective on psychoanalytic supervision by introducing the concept of parallel processes. He was the first to state that there are times in supervision in which a parallel process is being enacted by both the therapist and the supervisor that is analogous to the dynamics in the patient/therapist dyad. His term for this process was “the reflective process” (pp. 158–159). In addition, Searles was the first one to present the idea that the supervisor experiences the same wide spectrum of emotions as the therapist, although not as intensely as the therapist. He separated these emotional reactions from what would have been considered classical countertransference reactions that are related to the supervisor’s childhood experiences. Searles’s views were a major theoretical shift in the concept of supervision and the use of countertransference. Searles saw countertransference as a helpful instrument by which to understand the analysand. He did not see countertransference as simply the unconscious reactions of the analyst, based on childhood experiences. Searles (1979, pp. 375–376) says,

> My approach focuses . . . upon the countertransference realm, in the broadest sense of that term, as being of the greatest and most reliable research and therapeutic value. This focus is . . . to be a most sensitive and reliably informative scientific instrument providing data as to what is transpiring, often in areas not verbally articulable by the patient, in the treatment situation.

Thus, Searles's ideas on analysis and supervision moved toward a more collegial model.

Caligor (1981) believed that the parallel process was ubiquitous and little understood in supervision. He believed that the parallel process was probably always present either in the foreground or in the background. He maintained that it occurred in a multiplicity of forms. The patient, supervisee, or supervisor can switch roles of evoker or recipient of unconscious processes related to the parallel process at various times. Caligor asserts:

> If the supervisor is not "inside" and actively participating in the ongoing process of a didactic approach, the focus inevitably falls on the candidate's countertransference to his patient, his 'inability' or 'negative attitude' toward learning in supervision. The supervision becomes a morass. The parallel process occurs more dramatically where the patient, therapist, and supervisor have a junction or crossing of blind spots with resultant heightened disjunctive anxiety and decline in empathy. (p. 22)

While Bromberg (1982) acknowledges that parallel processes happen in the supervisory relationship, he places less emphasis on it than Caligor. In addition, Bromberg conceptualizes the supervisory process as a more dyadic model in the sense of being between the supervisor and supervisee, as opposed to Caligor's triadic process,

which is more inclusive of the patient along with the supervisor and supervisee. Finally, Bromberg places greater emphasis on patterns of unconscious reciprocal activity within the supervisory relationship than Caligor. Bromberg gave an example of this reciprocal process by describing a supervisee who unconsciously leaves out some disavowed aspect of one's self in describing the work with the patient and then projects this aspect onto the supervisor, who takes it in as an introject and then acts out this disowned aspect with the supervisee.

Williams (1997) points out two additional dynamics that she believes may contribute to parallel processes in the supervisory relationship. One dynamic involves the supervisor "unwittingly" modeling behavior that the supervisee then takes and replicates in the therapeutic interaction with the client. Another dynamic Williams believes may contribute to a parallel process involves the vulnerability that a supervisee may naturally feel in relation to the supervisor and the parallel vulnerability that the client may experience as a patient in relation to the therapist.

A Relational Constructivist Viewpoint

Miller and Twomey (1999) assert that the concept of parallel process has been used far too often in the supervisory relationship to explain complex intrapsychic and interpersonal dynamics that occur among the supervisor, the supervisee, and the patient. Miller and Twomey believe that a more relational approach to supervision opens up the myriad possibilities that both the supervisor and the supervisee bring to the dyadic relationship. They maintain that this supervisory dyad influences both the way the patient is viewed by the supervisor and the supervisee. This dyadic process also sheds more light

on how best to address treatment issues. This review will now move into the relational theorists' viewpoints.

A major shift of theory in supervision is the relational constructivist viewpoint of psychoanalytic supervision and treatment. Frawley-O'Dea and Sarnat (2001, p. 3) say that one of the assumptions of relational approaches to psychoanalytic treatment is that, at times, the patient and the therapist enact aspects of the patient's intrapsychic world that are split-off or dissociated: "Relationship and experience are privileged as transformational, while cognitive insight, although still a part of treatment, is deemphasized as the sine qua non of growth and change." Fawley-O'Day and Sarnat stress that the same relational emphasis needs to dominate the supervisory relationship as well as the psychoanalytic treatment dyad.

Frawley-O'Dea and Sarnat say that a similar shift in supervision theory emphasizes "relationship and lived-experience" as opposed to cognitive insight. They believe that the supervisor and supervisee co-construct the supervisory relationship. While they acknowledge that there are other effective models of supervision, they encourage supervisors to look at their own "unconsciously entrenched" ways of doing supervision in order to provide more effective models of supervision that are most conducive to the training and development of supervisees (Frawley-O'Dea & Sarnat, 2009, p. 3).

Ganzer and Ornstein (1999) characterize the supervisory relationship from a relational constructivist viewpoint. Within this model, supervision is viewed "…as less hierarchical and more one of mutual influence, of give and take, in which the issues of both individuals are at play at one time or another . . ." (p. 232). At the same time, Ganzer

and Ornstein (2004) do not advocate a relationship whereby there is equal authority between supervisor and supervisee. Power and authority, however, may be negotiated.

Thus, the review of the literature demonstrates a shift from an authoritarian view of supervision to a more collaborative relational model. This shift seems to articulate the growing theoretical trend in psychoanalytic supervision.

The Emotional Atmosphere in Supervision

Emotional atmosphere is another key concept in psychoanalytic supervision. Berman (2000) places emphasis on the importance of the emotional atmosphere in the supervisory relationship. He believes that this atmosphere in supervisory sessions ultimately has an important impact on the treatment of the patient. Berman specifically draws attention to the following supervisory relationship dynamics: "…the continuous process of mutual evaluation, the reciprocal fears of exposing one's weaknesses, the impact of the institute as a setting and the transferences it arouses, and the inherent conflicts of loyalty for each participant in the analytic/supervisory triad" (p. 273). In order to deal effectively with these potential conflicts, Berman proposes a transitional space where new meanings are free to emerge. These new meanings in turn enhance the progress of the analysis.

One aspect that affects the emotional atmosphere is the level of empathy that the supervisor has for the supervisee. Fleming and Benedek (1966, p. 56) state:

> Just as the analyst's empathic perceptiveness and responsiveness are instrumental in establishing a therapeutic alliance with the patient, so the supervisor's empathic

> perceptiveness and responsiveness are instrumental in establishing and maintaining a learning alliance.

Watkins (2014), in writing a 50-year retrospective of Fleming and Benedek's (1964) term *learning alliance*, adds additional qualities to this term, such as mutuality, collaboration, and others that affect the emotional atmosphere in supervision. Watkins (2014, p. 451) says,

> . . . the learning alliance has evolved across its first 50 years, (a) becoming more democratized, relationally focused, mutual, and collaborative in its implementation, (b) reflecting a far less pathologized and pathologizing perspective on supervisees, and (c) incorporating a far deeper appreciation of difference and diversity across the supervisory triad.

Blind Spots in the Supervisor

Blind spots in the supervisor are also a key concept in supervision. Teitelbaum (1990) maintains that the problems in supervision are typically viewed as shortcomings in the supervisee. Teitelbaum maintains that too often the supervisor's role in the relationship can be a major contributor to supervision not being conducive to the learning environment of the supervisee. Teitilbaum stresses that blind spots, as well as the narcissistic needs related to being a competent supervisor, may potentially adversely affect the supervisory relationship.

Strean (1991), whose theoretical perspective is classical Freudian analysis, echoes Teitelbaum's thoughts regarding focusing too much on the unresolved conflicts in the supervisee, while not addressing the conflicts in the supervisor. Strean says that such

conflicts in the supervisor can ". . . complement and compound the difficulties of the candidate (with) his or her patient" (p. 404). He then states that such supervisory conflicts often result in collusion among supervisor, supervisee, and patient. Strean gives three case examples of such multiple collusions. In each of these situations, Strean shows that when the supervisor was confronted on his or her conflicts by a group of peers, a shift occurred in both the supervisory dyad and the therapist/patient dyad that helped the treatment to progress in significant ways.

Self-Disclosure in Supervision

The issue of self-disclosure on the part of the supervisor is a key concept in psychoanalytic supervision. Farber (2006) addresses the issue of self-disclosure by the supervisor in the supervisory relationship. Farber says that the supervisors he surveyed thought that self-disclosure was especially useful in two areas. The first area related to supervisors disclosing aspects of their own clinical work. Farber believed that the supervisor's disclosures contributed to a collegial atmosphere that encouraged a space for the supervisee to talk more openly about their own clinical work. The second area related to disclosures that "…took the form of emotionally resonant, empathic statements." Such statements include: "Yes, the work is so very hard, so emotionally draining," "I know, progress is so elusive sometimes," and "That kind of thing frustrates me too" (p. 196). Farber believed that the second area of disclosure might foster self-acceptance within supervisees. It was hoped that this self-acceptance led supervisees to more effectively contain their anxiety during difficult sessions with patients. Farber does note, however,

that disclosures in the latter area may make some supervisees more anxious because they realize that their supervisors do not have all the answers.

The Reporting of Dreams in Supervision

Langs (1982) addresses a particular aspect of the supervisory relationship that involves crises as they are manifested in the reporting of dreams by the supervisee. Langs neither encourages nor discourages the reporting of dreams by supervisees. He hypothesizes that when such a dream is reported that is related to a supervisory conflict, it then needs to be addressed in supervision. He makes a qualifying statement that dreams and their associations should not be explored to the extent that they perhaps would be between an analysand and their analyst. Langs maintains that these dreams, as reported by the supervisee, contain ". . . unconscious perceptions and reactive fantasies of the supervisor" (1982, p. 579).

Addressing Neurotic Issues in Supervision

A delicate boundary issue in supervision is addressing neurotic issues in the supervisee. Sarnat (1992) believes that it is possible to address neurotic issues of the supervisee in supervision when it is used to meet the learning needs of the supervisee. Sarnat is extremely careful to point out that supervision that includes what has historically been referred to as treatment as opposed to didactic training needs to meet certain strict criteria. One of these criteria is that there is an acknowledgement by the supervisor that his/her own neurotic anxieties and feelings of inadequacies may easily contribute to and/or interfere with the supervisory dyad and its effective functioning. This

requires a strong commitment to self-examination on the supervisor's part and the willingness and the courage to process aspects of the dyad that may unconsciously be interfering with treatment of the patient. Another important criterion involves the willingness of the supervisee to commit to the same type of openness. Sarnat acknowledges that this combination of dual open processing, along with didactic training, needs to be further developed along the lines of a relational theoretical approach, while taking into consideration the vulnerability that the supervisee faces in an inherent unequal professional relationship.

Levenson's Creative Thoughts on Supervision

Levenson (1982), a seminal analyst in the field, maintains that what may seem like perplexing patient issues to supervisees usually seem exceedingly clear to supervisors. At the same time, Levenson acknowledges that when he is doing therapy, he quite often experiences the same perplexing feelings that supervisees experience. He refers to this common dynamic in the supervisory relationship as ". . . the *infallible* in pursuit of the *ineffable!*" (p. 1).

Levenson explains this clarity of the supervisor verses the confusion of the supervisee in terms of the different levels of abstraction that each brings to the supervision session. Levenson says that the supervisor is dealing with patient/supervisee issues on a higher level of abstraction. Bateson (1979, p. 53) previously had asserted that ". . . conclusions that can be drawn only from multiple cases . . . are of different logical type from conclusion drawn from a single item . . ." In other words, while the supervisor is hearing a category or type of patient/therapist issue, the supervisee is in the mist of

struggling with a very specific constellation of interpersonal/intrapsychic dynamics in the patient/therapist dyad (Levenson, 1982).

Commented [.1]: Should this be "intrapsychic" instead?

Levenson maintains that the central issue of supervision ". . . is not how to get the supervisee to learn what we already know, but how best to facilitate, or at least, not interfere with, some ineffable process of learning by which he settles into professional competence" (1982, p. 5). Before Levenson suggests a framework that he believes helps to tackle this issue of how the supervisee can best learn to become a better therapist, he outlines what he refers to as different approaches that supervisors typically take when doing supervision. He makes the qualifying statement that the following approaches do not make an inclusive list, but is instead a rough list of approaches from which further discussion on the topic of learning in supervision can take place.

In a very insightful and somewhat playful way, Levenson (1982) addresses the various models of psychoanalytic supervision as he sees them. The first supervisory approach Levenson refers to as *holding or confirming* (pp. 3–4). He uses an example from his own supervisee experience as a psychoanalytic candidate at the White Institute with Clara Thompson as his supervisor. During this more than two-year experience in supervision with her, he writes about a supervisor who said nothing and gazed off in space in such a manner that he wondered if she even listened to what he was saying. At the same time, if he felt himself to be floundering or in trouble with a case and asked for advice, she would briefly comment. He then felt contained and he could proceed while feeling less anxious about the problem. He describes his experience of her in this setting in the following manner:

> She was not warm or maternal or benevolent or supportive; nor was she critical, derogating or obstructionistic. She didn't seem to want anything from us—to be reassured that she was a terrific supervisor and theorist, lovable, nurturing—anything. She was like the Matterhorn—simply there. (p. 4)

Levenson described this supervisee experience as providing a playground in which she let him find himself (p. 4). He said that it allowed him "to listen to and gain a feel for the movement of therapy." He also described this as a catalytic experience for him that he highly valued in this supervision (p. 4).

In the second supervisory approach, Levenson (1982, p. 4) refers to as the *Teutonic*, or *by-the-numbers*. The supervisor using this approach believes that there is a correct response for every situation that the therapist is faced with by the patient. Levenson likens this approach to following a manual for doing therapy, and the therapist is expected to follow the preferred metapsychology of the supervisor. According to Levenson, many supervisees find this method very comforting because of the assumed clarity. This method often leads to a certain worshipping of the supervisor. Levenson makes it clear that he has a strong distaste for this approach.

The third supervisory approach Levenson (pp. 4–5) refers to as the *algorithmic*. Superficially, the algorithmic and Teutonic approaches seem like similar approaches. Quite the contrary—there are subtle but extremely important differences. The algorithmic approach starts out having a step-by-step approach. It claims that this approach can lead to a successful outcome. Unlike the by-the-numbers Teutonic approach, the algorithmic approach does not claim that the approach is intrinsically related to the outcome of therapy. On the other hand, the Teutonic approach not only follows a very specific

theoretical framework, but it claims that if the therapy is practiced in accordance with this theory, the outcome is intrinsically related to the outcome of treatment and validates the metapsychology that has been religiously followed throughout this process. The algorithmic approach makes no such claims that the theory is necessarily related to a successful outcome.

In the algorithmic approach, the supervisor tells the supervisee what steps to follow in supervision. Levenson says that it doesn't matter what theoretical framework the supervisee prefers, as long as the supervisee does not push their belief system onto the patient. This method of supervision is Levenson's preferred method, and it will be expanded on a little later in this literature review.

The fourth supervisory approach Levenson (1982, p. 5) refers to as the *metatherapeutic*. This approach focuses on the supervisee's countertransference. When Levenson refers to countertransference, he cites Epstein and Feiner (1979) by describing countertransference in both the interpersonal sense, which means to utilize it, or in the classical sense, which means to minimize it. In this approach, the supervisor feels it is acceptable to address the supervisee's personal issues and act as a catalyst for the candidate's personal analysis. The supervisor is seen as identifying ". . . points of anxiety" as a way of enhancing the candidate's personal growth (p. 5). Levenson's criticism of this approach is not that it does not help the therapy of the patient. He thinks that it does. His main criticism is that it does not facilitate the "ineffable process of learning" by which the supervisee ". . . settles into professional competence" (p. 5).

The fifth supervisory approach Levenson (1979) refers to as *Zen*, or *opening-the-fist supervision*. The purpose of this approach is to help the supervisee adjust to or come

to terms with the indescribable process of doing therapy, or to use Levenson's term, the *ineffable*, by providing an atmosphere of *creative disorganization* (p. 5):

> He harasses, raps, interferes, until the therapist, the supervisee, in the Zen term, "opens the fist," that is, lets go all of his preconceptions and tightness out of a sense of despair. It may appear as if I'm ridiculing this method, but I've been on the receiving end of it, both in psychoanalytic supervision and in learning other activities, and it really works, particularly with tight, obsessional people. If one is screamed at long enough, one gets despairing and suddenly lets go, stops thinking, and to one's absolute amazement, discovers that the activity now seems natural and easy.

As mentioned earlier, Levenson's preferred approach to supervision is the algorithmic approach. It essentially consists of instructing the supervisee to follow three steps. The first step basically involves defining or structuring the contractual commitments related to doing psychoanalysis. This includes such areas as ". . . time, money, frequency, cancellation of sessions, vacations, and so forth" (p. 6). In addition, Levenson includes more subtle structuring by the therapist in this first step. This subtle structuring is related to discerning the patient's motivation for being in therapy, including the patient's goals and their expectations of the therapist within the first few sessions. It is also important for the therapist to address their own limitations and areas of competence. Levenson refers to this step as defining the limits and possibilities of therapy.

The next step involves an inquiry while the patient is telling his story about his life. The therapist is instructed by the supervisor to listen to what is missing from the patient's story that results in a lack of continuity or coherence. It is the therapist's job not

to interpret these gaps but to inquire about them in order for the therapist to have a more complete picture of the patient.

The third step is related to how the transference gets played out from the issues that have been revealed in the process of inquiry. Levenson states, “It is this last step, the use of the transference, the fantasy or real exchange between the patient and the therapist, which distinguishes psychoanalysis from psychotherapy” (p. 7).

As mentioned early in this research dissertation, there is a significant lack of studies that focus on supervisees’ experiences in clinical supervision. This researcher found four studies of supervisees’ reports that are pertinent to this literature review.

Rainey (1997) interviewed supervisees whose population was made up of 28 post-Master of Social Work (MSW) clinicians in supervision. Rainey used a grounded theory methodology for her study. Some of the findings revealed how supervisees used the relationship with their supervisor to delineate their own style, find their own voices, and develop a greater sense of a professional self with responsibilities that went beyond their work with their patients. This evolving professional self, at times, included feeling responsible to contributing to their professional communities.

Rainey’s findings also included supervisees’ experiencing disappointments in their supervisors. Some supervisees were disappointed with the lower than expected quality of their supervisors, who supposedly had excellent reputations in the professional community. Other supervisees were disappointed when they sometimes found out that a current or former supervisor had committed an ethical violation with a patient.

Significantly, Rainey reported that many supervisees who were disappointed in their supervisors’ styles said that they came to appreciate that they could usually find

something that they could learn from most supervisory relationships. Many would learn what the particular supervisor could offer them. They would seek out that aspect from their supervisor that could contribute to their professional development as clinicians. Various supervisees reported valuing numerous as opposed to few supervisory experiences as far as contributing to their professional development as clinicians.

Thomas (2005), using a phenomenological methodology, studied conflict in supervision from the viewpoint of supervisees. Of the eight participants that she studied, seven reported experiencing their supervisors as primarily inflexible and unfriendly. All eight of the participants reported experiencing their supervisors as primarily not committed, not reflective, and not invested in the supervisory relationship. Thomas also found that resolution of interpersonal conflict between supervisor and supervisee was rare. She reported that internal resolution for participants, when it did happen, was accomplished outside of the supervisory sessions and became a transformative dynamic for personal and professional growth.

Lawson, Hein, and Stuart (2009), using a general interview guide approach, conducted a study that focused on supervisees' experiences in triadic supervision. In triadic supervision, there are two supervisees being supervised by a supervisor in the same session. The researchers found benefits, challenges, and limitations to this approach. One limitation was that when a supervisee was reluctant to give negative feedback to a participant, the other supervisee was reluctant to give negative feedback as well. Another limitation was that there was less time and attention for each supervisee within the supervision hour.

The researchers reported many benefits for the supervisees. Most participants valued having the additional feedback from a peer: “Most of the participants valued the feedback they received from their supervisee peer, even when it went beyond areas of strength and dealt with areas of improvement” (p. 452). Supervisees learned from other supervisees’ presentations of their cases and the resulting feedback from the supervisor. In addition, supervisees usually felt much peer support from the other supervisee that extended beyond the supervision hour. The researchers reported that the main challenge to triadic supervision was the matching of pairs of supervisees for compatibility.

The final study is on supervision in a counseling psychology program. This study did not state whether or not psychoanalytically focused supervision was the type of supervision, part of the supervision, or none of the supervision that was used in this study. The methodology used was “. . . multiple regression analyses of the data obtained for thirty-six counseling supervision dyads” (Steward, Breland, & Neil, 2001, p. 131). In this final study, which relied on supervisee reports, Steward, Breland, and Neil (2001) found that supervisees felt better prepared as therapists when they received a combination of both support and confrontation as opposed to just support from their respective supervisors.

In concluding the supervision section of the literature review, this researcher will refer to some incisive comments from Langs (1989). Langs makes a very strong and direct statement about the capacities and limitations of both the supervisor and the supervisee. In a theoretical paper, Langs (1989) reported that some supervisees, as well as some supervisors, are unable to tolerate the extensive anxiety-provoking unconscious

material that patients present in encoded form during their therapy sessions. Langs (1989, p. 576) states:

> Supervisees and their supervisors are capable of tolerating and negotiating selected types and levels of conscious and unconscious meanings, and find it necessary to repudiate those levels of greatest threat.

Langs seems to be saying that psychoanalytic training and a personal psychoanalysis, although extremely important to the endeavor of clinical supervision, may or may not be sufficient to overcome some obstacles presented in the supervisory relationship.

Chapter III

Methodology

In this chapter, an overview of the phenomenological perspective will be given. This will be followed by a definition of terms, the study participants, qualitative verses quantitative research, the data collection, the data analysis, an example of an essence statement, and the assumptions of the researcher. The final three sections of this chapter will be a statement of the protection of human rights, the limitations of this study, and the evaluation of the methods of this study.

Overview of the Phenomenological Perspective

Phenomenology as a philosophy originated with Husserl (1982) in the early part of the twentieth century and continues to develop both as a philosophy and as a tool of scientific research to the present day (Giorgi, 2009; Sokolowski, 2000). Besides Husserl, other prominent phenomenology philosophers include Heidegger (1977), Merleau-Ponty (1962), Giorgi (2009), Moustakas (1994), and Van Manen (1990).

Phenomenology philosophers differ on what phenomenology encompasses as a philosophy. The concept of intentionality is a unifying theme among phenomenology philosophers (Giorgi, 2009; Heidegger, 1977; Husserl, 1982; Merleau-Ponty, 1962; Moustakas, 1994; Sokolowski, 2009; Van Manen, 1990). *Intentionality* refers to consciousness, to the internal experience of being conscious of something. In

intentionality, the mind is directed toward some entity whether the entity exists or not (Moustakes, 1994). Intentionality applies primarily to the theory of knowledge, not to the theory of human action. In light of this statement, the phenomenological use of the word *intentionality* is somewhat awkward because it goes against ordinary usage. Intentionality is a technical term that is used in phenomenology, as well as being a principal concept in phenomenology (Husserl, 1982, p. 199). A phenomenological intending is ". . . the conscious relationship we have to an object" (Sokolowski, 2000, p. 8). In phenomenology, conscious perception of one's internal feelings and thoughts toward objects, others, or self are considered the reliable raw data for exploring the underlying structure of meaning for any given topic of lived experience (Giorgi, 1985; Heidegger, 1977; Husserl, 1982; Merleau-Ponty, 1962; Moustakas, 1994). An individual is not considered apart from its object of intention.

Husserl (1982) describes phenomenology as the study of how people describe things and experiences through their senses. In a phenomenological study, the researcher attempts to understand social phenomena from each participant's own perspective. The participants examine how a particular aspect of their world is experienced. The important reality is what the participants perceive (Patton, 1990).

Phenomenology is different from other sciences in that it attempts to describe human experiences without classifying, theorizing, or abstracting about them. Phenomenology attempts to bring us closer to the world of lived experiences. Phenomenology as a science is relatively new in the sense that it moves away from theoretical and technological concepts, but "it is old in the sense that, over the ages, human beings have invented artistic, philosophic, communal, mimetic and poetic

languages that have sought to (re)unite them with the ground of their lived experience" (Van Manen, 1990, p. 9).

Another important concept in phenomenology is *Epoche* (Husserl, 1962). *Epoche* comes from the "Greek word meaning to stay away from or abstain" (Moustakes, 1994, p. 85). *Epoche* means to stay open to many ways of knowing. *Epoche* refers to approaching the phenomenon under study without suppositions. In order to maintain this stance while doing research, the researcher must maintain awareness and, at the same time, set aside one's biases on the topic under study.

In order to maintain a fresh and open attitude, Husserl (1962) described one aspect of this unbiased stance as *bracketing*. Bracketing means "holding in suspension," keeping attention between the past and the present in order to discern their respective roles (Giorgi, 2009, p. 93). When bracketing, the researcher maintains an awareness of one's biases while staying open to multiple and new perspectives from participants describing their experiences. *Epoche*, of which bracketing is a crucial part, makes it possible for ". . . an understanding of the meanings and essences of experience . . . . In the Epoche, we set aside our prejudgments, biases, and preconceived ideas about things (Moustakes, 1994, pp. 84-85).

Because this study will use a phenomenological research approach, it will not use a particular psychodynamic theory to guide and direct the data collection from the experience of the supervisees. The results of this study, however, may have theoretical relevance in terms of psychodynamic theory. The dialectic among the question being asked, the lived experience of the participants, and the method of this study ". . . requires

a phenomenological sensitivity to (the) lived experience" of supervisees (Van Manem, 1990, p. 2).

The purpose of phenomenological analysis is to bring a heightened sense of the phenomenon being studied. The purpose is not to establish a theoretical cause-effect relationship (Giorgi, 2009). "Phenomenology is the study of essences . . . it also offers an account of space, time and the world as we 'live' them. It tries to give a direct description of our experience as it is, without taking account of its psychological origin and the causal explanations…" (Merleau-Ponty, 1962, p. vii).

Phenomenological research methods use phenomenological philosophy as an underpinning for one of the main qualitative research traditions for exploring and understanding human experience. Within phenomenology, a researcher may choose from a number of methodological approaches to study a particular topic (Giorgi, 1985). While these methodologies all share many basic tenets of phenomenology, they differ in specific ways. This researcher has chosen a specific phenomenological method of analysis that he considers to be the most developed, as well as the most conducive to studying the topic of the clinical supervisory relationship. This form of analysis is based on a descriptive phenomenological method developed by Amedeo Giorgi (2009). This researcher will give an example of a structure that was the result of using this method of analysis. This example is about the structure of "pivotal moments in therapy" and will be included in the methodology section (Giorgi, 2011, p. 72).

Giorgi began studying phenomenology intensively in 1962. He has been working on developing and refining a phenomenological research method over the last 40 years. Before this researcher explains Giorgi's method of analysis, it should be noted that this

researcher used more than one form of data collection with the participants in order to bring more rigor to this study.

Definitions of Terms

Participants.

Clinicians who are currently experiencing or have experienced psychoanalytically focused supervision. The participant must have had at least one year in supervision.

Essence

In *The New Webster Encyclopedic Dictionary* (Thatcher, 1969, p. 299), essence is defined as "That which constitutes the particular nature of a thing, and which distinguishes it from all others; that which makes a thing what it is . . ." (Patton (1970, p. 70.) He further states that "These essences are the core meanings mutually understood though a phenomenon commonly experienced." In phenomenology, essence and the word *structure* are used interchangeably.

Lived experience.

The thoughts, feelings, sensations, and perceptions that an individual experiences during a given moment in time before that individual reflects upon the experience (Van Manen, 1990). Lived experiences are everyday experiences Van Manen (1990, p. 9). Van Manen (1990, p. 9) says,

> Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. Phenomenology asks, "What is this or that kind of experience like?" It differs from almost every other science in that it attempts to

> gain insightful descriptions of the way we experience the world pre-reflectively, without taxonomizing, classifying, or abstracting it. So phenomenology does not offer us the possibility of effective theory with which we can now explain and/or control the world, but rather it offers us the possibility of plausible insights that bring us in more direct contact with the world.

Meaning-units.

Words, phrases, sentences, or paragraphs within a text that are part of a transcript of a participant's interview that seem to have value with respect to contributing to the phenomenon under study. Descriptions from the interviews are usually too long to be dealt with as a whole. It is therefore necessary to break each transcribed interview into parts. Since the goal in phenomenological analysis is the "meaning of experience," each unit contains meaning within the total description of the interview. Finally, each meaning unit needs to be sensitive to a psychological perspective (Giorgi, 2011, p. 129). Giorgi (2011, p. 129) says, ". . . the constitution of parts in the method are based upon the dimension that is most sensitive to the ultimate goal of the task."

Imaginative variation.

A process in which thematic categories are brought to levels of generalization in order to obtain a structure/essence that incorporates the significant psychological meanings of the participants as a whole (Giorgi, 2011).

Triangulation.

Triangulation means that the researcher uses a combination of different methods for cross-data validity checks (Patton, 1990).

Participants

The sample size was 13 participants. Participants had at least one year of psychoanalytically focused supervision. Volunteers were selected from members of various psychoanalytic and psychotherapy organizations in the state of California who have experienced psychoanalytically focused supervision. Supervisees or former supervisees seem to have had a particularly strong interest in the topic of supervision. As a result of their interest in this area, it was generally easier for them to articulate what they found helpful in a relationship with someone who is or who has been in the role of supervisor to them. Supervisees were asked if they would like to participate in a research project utilizing their description of a helpful interaction with a supervisor regarding a patient's case. The identities of the various research participants will remain confidential and anonymous so that this format provided for the greatest level of safety and openness for the participants in the research study.

Qualitative Versus Quantitative Research

This researcher believes that both qualitative and quantitative approaches provide for important but different types of data. In this study, the researcher is choosing a qualitative approach over a quantitative approach. This is because the researcher is

interested in qualitative data that provide a more detailed and descriptive exploration from supervisees' experiences.

The researcher feels that it is important to clarify the purpose of using the small population of 13 participants. Sampling to the "point of redundancy" or the saturation point is an ideal, "one that works best for basic research, unlimited time lines, and unconstrained resources" (Patton, 1990). Quantitative research and qualitative research have different goals, and therefore, they have different purposes and methodologies. They are based on completely different philosophies in approach to a research topic.

Quantitative research is concerned with proving or disproving a hypothesis. Much care is spent on making the methodology and data collection consistent and uniform so that the data will reflect a quantitative proof or disproof of the hypothesis. Qualitative research starts with a research question instead of a hypothesis. The purpose of qualitative research is to produce a more in-depth understanding of a construct, for example, defining what is helpful in psychoanalytic supervision as defined by supervisees in psychoanalytic supervision. The researcher needs to stay attuned to the data as he is accumulating the data. He may make small changes to the methodology if he feels that this would be helpful to attain a better understanding of the phenomenon being studied. This type of research is open to thoughtful, flexible changes as trends and themes emerge during the research process. The point of this research is to record not only the data but also the process of collecting the data. The researcher needs to record and report any changes in the methodology, including the sample size, in the final discussion and results section of the research paper. For example, during the process of gathering data, the researcher might decide that it is important to include another probing question or even to

increase the sample size. The researcher may think that one or more of these alterations in the methodology may further enhance the understanding of some unanticipated aspect of the topic under study. Thus, new data emerges from each research project as to why a certain technique might be more helpful than another technique. It is not sufficient just to record if anything in the methodology is changed, but rather why it was changed, based on informed and thoughtful adherence to the principles of qualitative research—in this case, the tenets of phenomenology.

The final results need to report and discuss not only what the research reports about the research question, but also what was learned through the process of the research design and implementation. The researcher may find that a particular method or technique was helpful or may have been unhelpful. This type of open disclosure and transparency in the research allows other researchers to build on the learning of others. The purpose of qualitative research is not to generalize to the entire population being studied; this would be more the goal of quantitative research. Qualitative research is concerned with purposeful and in-depth understanding of a construct based on sampling to the ideal point of saturation. Both researcher and reviewers—that is, the dissertation committee members—need to consider the parameters of the researcher's goals and resources, which are the aspects that will drive the decision about the sample size. Both researcher and reviewers need to consider how the sample size affected the findings, the strengths and weaknesses of the sampling procedures, and any other design decisions that have been made within the context of the goals and resources of the research study. The researcher and reviewers may even find that a smaller sample would be more efficacious to the design of the research.

Keeping all these concepts in mind will help the researcher in the discussion of the interpretation and understanding of the research results. The purpose of the research is not to overgeneralize but to use to full advantage the strengths of in-depth and purposeful sampling and to report how the research techniques enriched the understanding of the phenomenon being studied. The researcher discussed the strengths and limitations of the research. This included some recommendations for replication of the study and recommendations for similar studies with different designs that might provide for even more useful and valid research findings in the future.

Data Collection

The data for this research were first gathered from 13 interviews. The data were collected in three different phases so as to obtain continuing information for the interviewees throughout the entire research project. Three different contacts with the interviewees provided for triangulation of collection methods to give an opportunity to refine the research questions as the research project progressed. Methodological triangulation means that the researcher uses a combination of different methods to collect data. Using different methods to gather data provides for cross-data validity checks. For example, in this study, some participants may have been more comfortable in expressing their thoughts and feelings verbally during an interview. Other participants may have been more comfortable expressing their thoughts and feelings in the written form. All participants had a chance to review the findings so that they could respond intellectually and emotionally to the content of the collected data (Patton, 1990). The three phases of contact will now be discussed.

Phase 1.

The individual interview was done in person in an office or place that was mutually agreed upon that provided a confidential and quiet space for dialogue and reflection. With permission from the interviewee, the researcher audio-recorded the first interview for 12 of the 13 participants. One participant chose not to be recorded. This researcher took notes in place of taping this one interview. Interviews generally lasted between 60 and 90 minutes in length. The longest interview was approximately two hours and fifteen minutes. The shortest interview was approximately 30 minutes. This researcher set no limit nor set any parameters for the length of time for the interview. Each participant decided how long each interview lasted.

The researcher provided an atmosphere where the interviewees could speak freely and safely about their thoughts and feelings about clinical supervision. In the interview, the researcher gave the following verbal instructions: “Could you describe your thoughts and feelings during personal experiences that you have had with a supervisor or supervisors in your psychoanalytically focused supervision that were helpful for your development as a clinician?”

Each participant was asked to discuss their thoughts and feelings about the question as completely as possible. This researcher and each participant then proceeded dialogically—that is, the interview was an open-ended discussion in response to the interview question.

During the course of the interviews, the researcher used probes when he felt it was necessary to obtain a deeper response or increase the richness of the data. These probes were in the form of a word probe. For example, the researcher asked a follow-up

question in order to elicit more detail or to ask for clarification. The researcher used nonverbal cues directed to the interviewee concerning the level of response that was desired. For instance, if the researcher wanted to encourage the interviewee to continue talking or elaborate, the researcher gently nodded his head. On the other hand, the researcher avoided overenthusiastic head-nodding that might have been perceived as either an endorsement of a particular response or as a cue to stop talking because the researcher had already gotten the point. In general, the researcher kept any interruptions to a minimum in order not to disrupt the flow of the interviewees' speech (Patton, 1990).

Phase 2

After identifying key themes and ideas from the initial interviews, the researcher followed up with three probing questions that stemmed from the data of the original interview question. The three questions were:

1. Could you share any helpful interactions that involved resolving a conflict between you and any clinical supervisor?
2. Could you share any helpful interactions that helped maintain openness with a clinical supervisor who was also an evaluator?
3. Could you share any further helpful interactions that came to mind since our interview?

The participants were emailed these three questions based on the analysis of the initial interviews. The participants were offered the options of either responding or not responding to the three questions by email or by phone. Seven participants answered the three questions and emailed their responses. No participants chose to respond by phone.

This additional material gathered from all the interviewees went through the same process of data analysis as was done with the first phase of the interview material. The interviewees were asked to respond to the three questions within two weeks of receiving the three additional questions so that the interviewees had time to reflect on the questions before responding by phone contact or email.

Phase 3

After all the data were analyzed from the first two methods of data collection, the researcher sent the interviewees a summary of the findings from the first two methods of data collection. The researcher offered the options of responding or not responding to the summary of the findings by either email, phone, or in person, whichever was the most comfortable and/or convenient for the participants.

The researcher wanted to elicit the interviewees' thoughts and feelings about the research summary. The participants received the summary material, and if they chose to respond, were asked to respond within two weeks so that they had time to think about, react to, and reflect on the findings of the research based on the first two phases of data collection. Four participants chose to react to the summary of the findings. All four emailed their responses.

The three different phases of participant contact provided triangulated material from the participants at different points in the process of the research project. The participants were given time to think about and reflect on the data before each of the phases of the research project. This three-fold manner of collecting data generated exploratory and in-depth thoughts about the phenomenon of helpful interactions in the supervisory relationship. Receiving the researcher's summary before the third contact

gave an overview of the material to all the research participants. This exchange of materials germinated new and in-depth thoughts and feelings about what was helpful in the supervisory relationship.

This three-tier phase of data collection provided three different opportunities for the interviewees to respond to the overall research question. By using different phases and three different contact times, the researcher gathered the thoughtful insights on the phenomenon of what it means to be helped in clinical supervision. It took approximately eight months to gather all the data from the three phases.

Data Analysis

The interviews were first transcribed. They were then analyzed according to Giorgio's (2009) method of analysis. Specifically, Giorgio's method of analysis includes the following three stages:

1. read for a sense of the whole (p. 128),
2. determination of meaning-units (p. 129), and
3. transformation of the participant's natural-attitude expressions into phenomenologically sensitive expressions (p. 131).

The above steps of Giorgi's method of analysis will now be described in more detail. The first stage, reading for a sense of a whole, is similar to other qualitative approaches. It is important to get a sense of the entire transcription because any given part fits into the context of the whole description. In this first stage, the researcher takes the raw data as the participant experienced the situation. "No claim is made that the events described really happened as they were described" (Giorgi, 2009, p.99).

The second stage is determination of meaning-units. Each manuscript must be broken down into manageable segments because considering the document only holistically would be impractical for the purpose of analysis. Since phenomenological research is related to discovering meanings of a particular topic, it is important to break down the participant's description of experience into segments within the transcript that are related to meaning. These segments are referred to as meaning-units. Starting from the beginning of the document, the researcher begins by marking off the first unit of meaning contained within the transcript. When there is then a shift in meaning in the transcript, the researcher designates this shift in the data by making a new mark. This process of separating the various shifts in meaning continues until the end of each transcript (Giorgi, 2011, pp. 129–130).

The third stage of Giorgi's (p. 130) analysis of the data is transformation of the participant's natural-attitude expressions into phenomenologically sensitive expressions. Giorgi (2009) describes this stage in the following way:

> . . . each meaning-unit, originally expressed in the participant's own words, is transformed by the researcher by means of a careful descriptive process into psychologically pertinent expressions but without using the jargon of mainstream psychology. (p. 137)

This step is the most labor-intensive of Giorgi's method of analysis. It requires a thorough examination of each psychologically relevant meaning-unit that relates to the phenomenon under study. These relevant meaning-units must be transformed from the description of the participant's (one supervisee) experience and the participants' (all supervisees) experiences to the description that the researcher thinks is the most vivid and

global. It is important that this step be carried out without relying on a priori classifications or theoretical formulations. The researcher's assumptions must be kept in check (Giorgi, 2011, pp. 130–132).

Specifically, in the beginning of the third step, the researcher needs to go back to the previously established meaning-units. Each description must be transformed in such a way as to bring more clarity to the psychological meanings in each participant's narrative. The psychological meanings are not easily apparent to the researcher. In order to achieve this higher level of clarity, the psychological dimension needs to be intensively discovered, examined, developed, and highlighted from the concrete and individualized descriptions (Giorgi, 2011, pp. 130–137).

Additionally, the many incidental or distinct expressions that make up the raw data have to be transformed by the researcher in such a way that they are expressed in a more reliably stable manner. In order to achieve this stability, a certain level of invariance of the many various meanings has to be accomplished. The phenomenological procedure of imaginative variation helps achieve these stable meanings. When using imaginative variation, one must imagine the given data to be different from what they are in order to ultimately achieve a higher level of thematic understanding. This understanding retains the integrity of the psychological meaning-units, although it does not repeat the individual facts that are embedded in the narratives of the participants (Giorgi, 2011, pp. 130–137).

At the same time, it is important that the thematic categories not be pushed to the level of universality whereby psychological characteristics are lost. Instead, thematic categories are brought to the level of generalizations whereby psychological

characteristics are retained in order to obtain a structure/essence that incorporates the significant psychological meanings of the participants as a whole (Giorgi, 2011, pp 130–137).

The individual narratives of the participants will differ from each other. While the narratives differ, the psychological meanings can be identical. The psychological meanings can be sensitive to the individual descriptions and can still be integrated into the structure/essence. As a result, one is not limited to an individual finding from one participant. The structure/essence of the phenomenon being researched can include data from several individuals (Giorgi, 2011, pp. 131–137).

Following the three stages of analysis mentioned above, the researcher rigorously examines what is essential in the various transformed meaning-units that most represent the essence of all the participants' lived experiences of the phenomenon under study. "These transformed meaning-units form the basis for the writing of the general structure of the experience" (Giorgi, 2009, p. 137).

An Example of an Essence Statement

In order to give a more accurate picture of what is the structure/essence of a phenomenological study, this researcher will use an example from another phenomenological study's results. This researcher is Barbro Giorgi (2011). The title is "A Phenomenological Analysis of the Experience of Pivotal Moments in Therapy as Defined by Clients."

Based on her raw data, Giorgi came up with the following essence of a pivotal moment in therapy as experienced by clients:

> One type of pivotal moment in therapy takes place in the context of a therapeutic process and occurs in a situation in which a client will finally allow emotions and perceptions of self as well others and of the world associated with certain familiar, safety promoting but self-handicapping established living patterns to be confronted in a challenging way. The pivotal moment takes place within a therapeutic relationship felt as safe and supporting and is a consequence of a new type of relationship burgeoning within the life of the client. Process-long concomitant contextual constituents necessary for the support of the pivotal moment are: motivation for change; openness; trust and safety; emotional involvement. Proximate contextual constituents are: increased awareness; changed assumptions; increased tension; and challenge to old assumptions. (p. 44)

Giorgi used three participants in her phenomenological study. The analysis of the data resulted in the implications that led her to write the above paragraph. This paragraph became the statement of the essence of the phenomenon in her study.

Assumptions

An important element in phenomenological studies is transparency. It is therefore important for this researcher to reveal his assumptions and beliefs as they pertain to this study.

The researcher believes that there is insufficient understanding of what facilitates helpful learning experiences for supervisees in the supervisory relationship. One assumption is that the research question will begin the process of assessing the nuanced and in-depth aspects of helpfulness as experienced by supervisees. The researcher

believes that the phenomenological method is best suited for this type of inquiry. In this method, narratives of the participants will bring to light important essential underpinnings of what experiences lead to being helpful in this complex and intimate relationship. Subsequent questions based on these initial interviews will continue this process of exploration.

Phenomenological research assumes ". . . that there is such a thing as an essence or essences to shared experiences" (Patton, 1990, p. 70). This is another of the researcher's assumptions. "There is no separate (or objective) reality for people. There is only what they know their experience is and means. The subjective experience incorporates the objective thing and a person's reality" (Patton, 1990, p. 69).

Another assumption is that the phenomenological methodology employed in this study will be able to measure the essential structure of a helpful interaction in the supervisory relationship. The data and analysis of the data will hopefully show whether this methodology did measure what it was intended to measure.

Another assumption is that this researcher believes that the participants should be drawn from different professions within the mental health field as opposed to one profession, such as clinical social work. The focus of the research will be on clinical supervisees in psychoanalytically focused supervision, no matter what their specific profession. Psychoanalytically focused training has increasingly opened itself up to other professions. Interdisciplinary collaboration is also a growing trend in treatment. The researcher also believes that this will provide for richer data. In addition, this interdisciplinary focus will enable the researcher to focus on three clinical organizations.

As a result, psychoanalytically focused supervision will be in the foreground and the profession of any supervisee will be in the background.

This researcher will reveal his thinking and feelings for the purpose of limiting their impact on the phenomenon of helpful experiences in psychoanalytically focused supervision. Starting in the early 1970s, the researcher's main frame of reference for viewing the world has been through a psychoanalytic lens. Although exposed to many other theoretical frameworks and treatment models, this researcher most often gravitates toward the extensive body of psychoanalytic theory to conceptualize issues related to individuals, groups, and organizations. In addition, a major turning point in the researcher's life was the rich experience of being a patient in psychoanalysis for five years. This experience also contributed to a psychoanalytic way of conceptualizing and experiencing life events.

Finally, another one of the researcher's assumptions is related to the many supervisory relationships that he has experienced as either a clinical supervisee or as a clinical supervisor. The clinical supervision experiences that this researcher believes furthered his development as a clinician were the type of supervision where there was mutuality. The supervisor and supervisee learned from each other and worked together in attempting to unravel the extremely complex issues of treating clients. This researcher found this especially helpful when approaching the difficult issues that come up in transference and countertransference, whether between therapist and patient or between therapist and supervisor. In most cases, this researcher assumes that these ubiquitous transference issues are more effectively addressed when the supervisor and supervisee work as a team, albeit an asymmetrical team, with the supervisor having the ultimate

responsibility with respect to addressing critical treatment decisions. This researcher's thinking on this matter may be much more related to his specific personality and may not be how other supervisees learn best.

Statement of the Protection of Human Rights

Written consent will be obtained from each participant. The Institute for Clinical Social Work's Individual Consent for Participation in Research will be used for this purpose. A specific item on the form is for permission to audio-tape the interview. Participants will be informed that they do not have to complete the recording and can stop at any point. The interviews will be transcribed, with names deleted from the transcriptions. Tapes of the interviews will be kept in a locked file cabinet in the researcher's office. Similar to the guidelines in HIPPA, the data will be protected by locked files in a locked work area.

Chapter IV

Research Findings

Participant Demographics: A Composite Sketch

The raw data for this study come from the initial 13 interviews, the 3 follow-up questions, and the participants' reactions to the summary of the data. The participants are from the disciplines of social work, psychology, psychiatry, and marriage and family therapy. Two of these participants were training analysts. All the interviewees were living in one of the metropolitan areas of San Francisco, Los Angeles, San Diego, and a town in Oregon. As stated earlier in this dissertation, all participants had a least one year of psychoanalytically focused supervision. Nine of the 13 participants were currently receiving clinical supervision at the time of the study. These nine participants described interactions with both current and past supervisors. The other four participants, not in supervision at the time of the study, described their interactions with past supervisors. It took several months to locate enough volunteers for the study. Fortunately, almost all of these participants provided rich material for the study of helpful interactions in supervision. This researcher was impressed with the overall sophistication and openness of these 13 participants, whose original educational training spanned four disciplines within the field. Five of the participants had been in the field for over 30 years. Four of the participants had been in the field for less than 10 years. The remaining four had been

in the field between 10 and 30 years. This researcher was also impressed with the value these clinicians placed on continuing supervision, no matter how long they had been in the field.

Introduction to Data

The raw data of approximately 270 pages is distilled and presented in three sections. The first section will include positive experiences that contributed to the clinical development in supervisees. These experiences are presented in 12 themes. In the second section, both negative experiences and positive experiences that did not contribute to the clinical development of supervisees will be identified as part of the findings. In addition, issues with supervisors who are evaluators will also be included in this second section. Finally, the third section will include participants' reactions to the summary of the interviews and the survey.

Data Reflecting Helpful Experiences in Supervision

Positive experiences that contributed to the clinical development in supervisees are included in the following 12 themes: non-judgmental manner, uncovering and understanding dynamic processes, containing anxiety, collaborative relationships, role modeling, sensitivity to major life adjustments, encouraging and helping with development of style, self-disclosure, self-reflective behavior, sensitivity to cultural differences, strong mutual interest, and attention-grabbing feedback. A number of these themes overlap to some degree with each other. This researcher will give examples of each of these themes from the transcripts of the interviews with these supervisees.

Non-Judgmental Manner

An important theme was the importance of the supervisor relating to the supervisee in a non-judgmental manner. One supervisee, after doubting the intervention she had made with a client, described the interaction with her non-judgmental supervisor in the following way:

> Let it be. You did something good. Like, own it and let it stay that way because it's hard sometimes when you see a client shift, like their energy shifts (and) you're like, shit, was that the right thing to do? Especially as a new therapist you're just like, did I handle that correctly? . . . She's just sort of like (says), "Look there's a million different ways you can approach this. Nobody was in the room with you but you, and you have to own what you chose to do." That's really empowering.

Another supervisee described three non-judgmental supervisors by saying:

> So I would say that I've a good experience with three of my supervisors, like really good, and . . . the reason why I really like them and it worked is that there was openness—that's really the key. Like an openness to think about things in lots of different ways and like the humility to not think that they (supervisors) were definitely right. I think that's key.

Another example on the theme of non-judgmental relating is described by a supervisee in his interaction with his supervisor in the following manner:

> So I used a phrase that I knew and I was thinking about it in my mind, should I say this? Should I not say it? Should I say it? Should I not say it because I know that it was a phrase that she (patient) had used, oh, I know a year ago and from

> time to time, I used the same phrase and every time I brought it up, she has taken umbrage with saying that. So I had a feeling that I was going to produce the same result this time. Why not, but yet I still persisted in doing that and I mentioned that and he (supervisor) said, "Well why do you think you did that?" He was very matter-of-fact, but it was extremely helpful and led to a discussion of my feelings towards the patient and why I might have done what I did.

In the same interview, in reference to the above supervisor, the supervisee said, ". . . I guess you would call it confrontational, but he did it in such a way that it was very palatable." He also said:

> [Name of supervisor] is very supportive and he has a way of phrasing things that, I mean, I can see why he's a good therapist because he's a good supervisor . . . Probably there's some correlation there although I've never really thought about it, but my guess is that in that he's very non-judgmental and not critical . . .

Uncovering and Understanding Dynamic Processes

Participants spoke about how they valued supervisors that guided them in how to uncover and understand the dynamic processes in their therapy sessions with clients. In this uncovering process, the supervisors' clinical expertise was used in a manner that was digestible to supervisees. This skill was often related to the types of questions the supervisors asked in reference to the therapy sessions. One example of this type of guidance involved a supervisor asking a supervisee,

> "How is this client seeing you right now? What is going on?" and then unconscious factors like, you know, "What is this client really trying to tell you?" Another was, "Why did this person elicit that response from me (supervisee)?"

Another supervisee described how her supervisor was able to pick up on her countertransference to a woman patient who talked about her depressed spouse:

> And the supervisor said to me well are you thinking she should get a divorce and I sort of said no, because he was picking up something in how I was coming across with his wife and it was one of those situations where it became what I learned from it was that often what people really need is just the opportunity to express all this frustration and everything about this spouse who really was quite mentally ill and she just needed empathic support not like okay the plan will be that you will get rid of him and move on, because they had been married for like, I don't know, ages and that wasn't the option so it was learning about being with the person is kind of the most powerful thing as opposed to offering solutions and plans and you know all that stuff.

While one supervisor was helping a supervisee look at her countertransference issues with a patient, the supervisor in what seemed like a seamless and non-judgmental manner introduced to the supervisee the issue of her going into therapy. This particular supervisee said that she tended to be over accommodating with patients. The supervisee describes this interaction below:

> Well, he encouraged me to get individual therapy for myself so when, if I was doing something where there was clearly a countertransference thing we would get to the point where okay you are overdoing for this woman, that probably has

> something to do with some issues that you could work on in an individual therapy.

The supervisee then proceeded to find a therapist.

In reference to an early childhood transference issue that was interfering with her work with a patient, one supervisee described "supervisory experiences that instigated or initiated some insight or some change in supervision on a really like in-depth level" as being extremely helpful. Another supervisee was able to receive help from her supervisor in understanding how to think about a psychodynamic formulation for a patient. The supervisee described this in the following manner:

> He was supportive and he was warm and he figured out what I was struggling with . . . and helped me understand something in a way I'd never understood before.

Containing of Anxiety

Another dominant theme that supervisees identified as an important part to their supervision and contributed to their growth as clinicians was the containing of anxiety function (Bion, 1961) that they felt from various supervisors. The supervisor absorbed and withstood the anxiety and other intense feelings of the supervisee in a way that permitted the latter to feel secure enough to continue the work of exploration of her patient's dynamics without excessive emotional stress. The interviewees identified this as very useful in contributing to helpful interactions in supervision. The following is an example of containment by the supervisor as described by the supervisee:

> So she would kind of force me to tolerate my own anxiety about not knowing, but not leave me there for too long, and also when it became really apparent that I felt like I didn't know what the fuck I was doing, there was this like very brief reassurance, but without being indulgent, just very brief like, "Of course, you know what you're doing. Next." Like we're not wasting our time on that sort of hand-holding nonsense. So it was not in any way cold or dismissive, but it was just like a very subtle, but clear validation that 'there's no question you're on the right track, we're just refining it here,' which I felt was really affirming in a good way.

Another supervisor helped a supervisee with containing her anxiety in the following case, as well:

> I think it's hard to have words for the place because at that point, it's really focused on whatever that specific issue in the moment and working it out and having that and just knowing that there's somebody there with you. There's somebody there to look at this. You know you're going to get something out of it. You don't know what it is. There's not even any guarantee that it's going to feel good, but moving, knowing that I'm moving my growing edge forward each time.

Collaborative Relationship

Supervisees stated that a collaborative relationship with supervisors contributed to good supervision. One participant described this collaborative process as "working well together." Another participant described this collaboration as a "mutual discovery process." One supervisee said, "It was really an environment where we were both

learning together." Another example of the supervisee and the supervisor working collaboratively was described in the following way while discussing a client:

> The first time I saw her (patient), it was like, I'm so annoyed by this patient. Like I can't sit in my seat. My skin crawls. I've never had an experience like this, and I'm telling her (supervisor) about it and I hadn't written up any transcript and we didn't listen to anything and she was like, "I feel for this girl," like, "This poor girl." I was like she is horrible. Like I hate that I feel this way, but this girl is so annoying. She's like, "I don't get it." Then I brought in a transcript and we listened to it and she said, "I understand" and it felt like so fantastic to feel like, you know, she was getting what I was getting and it wasn't like we were in conflict about this or I was having to justify my (feelings). She totally accepted my countertransference.

One participant specifically stated that he and his supervisor worked well together, but had a difficult time finding the words to express what exactly this "working well together" means. He said, "She (supervisor) and I worked well together. I liked that relationship, but I can't, it's hard to put my hands on actual words that were said or exchanges." Another supervisee said,

> We were able to be comfortable and vulnerable with each other. It was a safe place. Kind of go to that list of items from Dan Siegel about safe, seen, I forgot the other S, something but secure.

Another example of supervisor and supervisee working collaboratively together was described in the following way:

> The ones that have really worked . . . (was when) my supervisor . . . would just kind of sit with it and feel what she was feeling from it (process recording) and we would talk about how we were feeling about it and what dynamics were being played out between us and that was really helpful.

Role Modeling

Many supervisees stated that their supervisors served as good role models for them in interacting with patients. One supervisee described a supervisor's modeling by saying the following:

> So whenever I have a question in regards to a client or patient who's resistant, you know he tells me, "Alright, you know this is an example of my situation where I had a patient who was resistive and this is what I had done." So he kind of provides me with some examples and I love examples. They help me out greatly in regards to what I could do.

Sensitivity to Major Life Adjustments

A number of participants said that they thought that when their supervisor was sensitive to the supervisee's major life adjustments while they were in supervision, this contributed to helpful interactions. One of the supervisees gave the following example of this:

> I was new from [another country] and I was placed in Detroit so it was a huge cultural shock and I remember that he was pretty understanding about the different issues about that . . . At that point I met somebody that, who ultimately

> became my husband and he was an American and so I was struggling with like, "Oh if I really get involved with this guy, what will that mean? You know, will I stay here," this sort of stuff. And I hadn't really communicated it to my parents who I knew would have an absolute fit about this and was their biggest fear actually when I came to America . . . He [supervisor] [was good] at not getting into my business, but he sort of said, "Well [I] think [you] know you must be under a tremendous amount of stress to worrying about what you are going to say to your parents when you are obviously involved with this guy on a deep level, da, da, da." That was good because I thought, yeah maybe that is why I am crazy.

Regarding major life adjustments, another supervisee appreciated her supervisor's sensitivity to her adjusting to chronic back pain.

Encouraging and Helping with Development of Style

Interviewees appreciated their supervisors for encouraging and helping with the development of their own style. An interesting corollary to developing one's on style was the prevalent idea expressed by many supervisees and in describing many of their supervisors was the recognition of many ways of conducting a session with a patient. Where this was not the case—that is, the supervisor felt that the session had to be conducted in a certain manner—this was described as a negative experience for the supervisee. One of the supervisees described part of this process of finding her own way of doing therapy. This was certainly not a prescription by her supervisor for how the supervisee should conduct therapy. She said,

> So I was sort of I think initially seeking approval from the outside—a good pat on the head . . . And her way of being authentic and I think that's one of the best things that she taught me is, you know, I have my own style. I have my own self and how can I bring my best self in to the consulting realm and to keep my third eye active and looking, but be present. It's really complicated and, of course, that's why it's taken me so long. I wanted those answers. I wanted the quick answers, the quick fix for everybody, but like the quote says, it's that "intersubjective edge" with her. You know, she's with you and eventually I got to trust that no matter where I went with it, she was going to bring it back. She had the capacity to track it and bring it back to me and basically look at my process with me.

Another supervisee acknowledged the importance of the supervisor being able to understand her individual style as a clinician by saying:

> I want the smartest one in the room, but I don't want somebody who's going to be rigid and make me feel strange because I already feel like people don't get my work . . .

Self-Disclosure

Self-disclosure**,** another theme, was only used by the supervisor when it was related to developing the clinical skills of the supervisees. One example of this is the following:

> So he (supervisor) provides (me) with a lot of examples of what he has done that has been helpful and some of his mistakes as well. You know he's very, very open to letting me know what worked and what hasn't worked for him.

Another example of self-disclosure is:

> Well, he was very helpful. I had a client who actually committed suicide, which was terrible, and still a bit traumatic and he really helped me through all of that. Very supportive, talked about a client of his who had suicided, said basically made me feel that it's a hazard of the field. (He said), "You know if you are in the field long enough it's going to happen . . . ."

Self-Reflective Behavior

The supervisor's self-reflective behavior was important during the course of the supervision sessions. One supervisee referred to this as her supervisor self-monitoring himself. The following example is given by a supervisee who brought her group co-therapist in with her for some supervision sessions:

> I thought, "Why is he being so hard on this other therapist?" and I never got the answer, but what the supervisor did was he sort of stopped and he said, "Are you guys wondering why I am picking on (him)?" and I thought, hmm, that was powerful because it was an acknowledgement that he was self-monitoring and I have always remembered that too, especially since mostly what I do nowadays is clinical supervision and so I think that is a very good message to, you know, you constantly self-monitor when you are a therapist, or a clinical supervisor or (in) any kind of therapeutic context.

Other examples of this self-reflective behavior were described when supervisees felt that their supervisors recognized that they needed time to vent about frustrating situations, so the supervisors refrained from making any suggestions during these times in supervision.

Sensitivity to Cultural Differences

Some participants said that their supervisor's sensitivity to cultural differences was important and helpful for supervisees, whether supervisees were culturally different or their patients were culturally different from their supervisor. In reference to being of a different race than his supervisor, one supervisee said:

> Yeah, he (supervisor) would bring it up and how I was raised and how it feels to be an Asian social worker in a predominately Caucasian female field, or stuff like that. So I guess . . . very cultured and in tune with what's going on.

Another supervisee said the following:

> . . . because this was a clinic that was right downtown so we mostly dealt with low income people, actually almost completely so that was very useful too, you know understanding how these more esoteric psychoanalytic concepts looked with people of all races. The issues come up. It didn't matter if he were an African-American from downtown Detroit or somebody from Ann Arbor or whatever, resistance was resistance. So that was good.

Strong Mutual Interest

Another theme that came out in the interviews was strong mutual interest in clinical work for both the supervisor and supervisee. One supervisee said, ". . . she (supervisor) somehow figured out that I just really love the work, and that excited her and

she really loved the work." In many other interviews when supervisees described their working with various supervisors, this strong mutual interest was conveyed in their enthusiastic voices and the way they characterized their supervisors' reactions to them as supervisees. For one male supervisee and his male supervisor, this strong mutual interest included talking in an open way about restrictive ways many male clients communicate their feelings in our society.

> So having someone who you feel is human like and genuine, personable makes it easy for you to actually talk to, especially if you're a male . . . you know we as men have difficulty communicating our feelings because of societal restrictions, because of our brain, because of how we're born and raised.

Attention-Grabbing Feedback

Some participants mentioned what could be described as vivid, powerful, and attention-grabbing feedback from their supervisors. They found this type of feedback helpful in supervision. One of these participants described how he had struggled with patients who either talked about leaving therapy or had objections to something he might say. The supervisee brought this dilemma up in supervision. He describes what took place in his supervision below:

> She said to me one time during our supervision, "You know when people tell me that they want to end therapy or they have some objections, I like that. I like that. That doesn't bug me at all," and I (supervisee) said, Oh my God, (name of supervisor), that floors me, and I hate that. She says, well she was actually saying, "I like any kind of objections. I really go with that."

Once again, another supervisee described below this attention-grabbing feedback that her supervisor used in an interaction:

> The thing he (supervisor) did too, which was interesting because I had a young girl client, regular outpatient, I guess adult, and she came in and she had, it was a morning appointment and she had like coffee and a muffin and she proceeded to eat all this in the session. So I was explaining this to the supervisor and he said, "Well what is this, is this you know a chatty coffee klatch or what?" and it was very, very good learning about resistance. Really. And a nice concrete representation so somehow he was able to connect these particular client behaviors with a concept that you could internalize and understand.

In summary, the research question was: How do supervisees describe helpful experiences in psychoanalytically focused supervision? The response to this question in thematic form would be that the supervisors treated their supervisees in a non-judgmental manner, helped them to uncover and understand dynamic processes, helped with containing their anxiety, related to them in a collaborative manner, served as helpful role models, were sensitive to both cultural differences and to major life adjustments, encouraged and helped them with development of their own styles, self-disclosed in a way that was relevant to the patient being discussed, were self-reflective in relation to their supervisees, exhibited interest along with their supervisees, and used attention-grabbing interventions at times with their supervisees in order to make a point that was clinically helpful to their supervisees.

Data Reflecting Negative Experiences in Supervision

With respect to negative experiences, supervisees described supervisory environments where psychological safety was lacking. In these experiences, there was usually a reluctant accommodation to the narcissistic needs of the supervisor. Supervisees described a lack of empathy as well as a lack of self-monitoring in these supervisors. In one instance, lack of self-monitoring took the form of frequent sexist comments. Although the supervisee who experienced these sexist comments was of the same gender as the patients the supervisor talked about, the supervisee noted that she was not the direct recipient of such remarks.

What made the situations described above more untenable was the fact that these supervisees were subject to evaluation by these supervisors in the institutions where the supervisions took place. In some instances, the politics of the institutions involved made it extremely difficult to address these conflicts without facing potential retaliation. For instance, supervisors helped decide whether supervisees successfully completed a particular program. This also made it difficult to switch supervisors after a period of time even though a particular institute officially allowed this. Where retaliation was feared, conflict was not addressed by the supervisees, with the exception of a supervisee confronting a supervisor years after supervision was completed. In another situation, the supervisor did not experience fear of retaliation and was able to bring in a mediator who was a peer of her supervisor and the conflict was able to be addressed to the supervisee's satisfaction. In this last situation, the supervisor had less power than at other programs.

In the most extreme example of a negative experience, one supervisor described her supervisor as having a "narcissistic personality disorder, without a doubt." Years

later, the supervisee talked to others who had been supervised by the same person and they described very similar negative experiences with this same supervisor. In one instance, the supervisee said that a local newspaper wanted to interview her because of her clinical specialty. When the supervisor found out about the interview, he refused to let her name appear in the news article. He also stated that any questions from the newspaper should be addressed by him. The supervisee characterized her supervisor's acting and thinking like the following:

> I am going to have my thumb kind of on what you do and I am going to give you enough to believe that I am proud of you, while at the same time keeping you under my thumb, because I don't want you to excel past my clinical ability. It's too threatening for me.

Another remark describing this supervisor was:

> . . . his supervision was so damaging and so belittling that it was insidious so I, I really didn't know how badly it was affecting my sense of worth, my sense of self-esteem, my confidence and competence as a therapist.

Before her supervision with the above person, she said, "I have always felt really comfortable about my clinical skill, my clinical judgment, my ability to take in the world." Eventually, this supervisor forced her to resign at the clinic. She also said,

> I think he played upon my weaknesses . . . when I was weak from losing my dog. He said, "You are not performing at your abilities." [Name her of dog] died on a Monday. On Friday, he said you are on administrative leave for a week. The following Friday he said, "Here's a sweet severance package . . . We are past the point of no return and here's this, you can benefit for two months and we pay you

> off; we are going to pay you off. It's you sign this, you can't sue us" . . . And I said, "What about like you know, termination with my clients, what about just, can I have two weeks to do this appropriately so that I can be an appropriate clinician?" And he said, "Nope you know that's not something we can offer you right now." So there was a very clear indication [as if he were saying], you are bad and wrong, you are very, very, very bad and wrong and I am going to put you in the basement for you know three years tied to a pole or something and it was so severe.

Ironically, when the supervisee needed a letter of recommendation for her next job, he wrote a glowing letter describing her as the best therapist for the population she worked with at the clinic. It is important to note that at the time she was forced to resign, she thinks that her supervisor had "maybe ten sexual harassment claims, legal claims filed against him, that were swept under the rug." Her supervisor may have also suspected that the supervisee knew that at least one of the therapists he was supervising was having sex with him.

Another supervisee described a negative experience with a supervisor. Although far less egregious than the above example, it was nevertheless quite stressful for the supervisee. In addition, during many negative experiences, such as this one, supervisees often ended up taking care of their supervisor:

> I find that what's not helpful about this specific supervisor is that we review line by line my process recordings and discuss what I should have said and what should have been said and what should have been done and I find that to be really infuriating for many reasons. Mainly, it's not like were editing a script here, the

moment has already passed and I would prefer to work with what I did do as opposed to you should have said. I also find it not helpful to tell me what to say because when I'm in session with somebody if I think what would my supervisor say that usually doesn't produce anything authentic . . . So it's hard for me to even feel like invested in the treatment because I'm just like a puppet. So that doesn't work for me . . . It is helpful to hear sometimes what someone said and it worked for them but not necessarily like by rote, like feed me the line situation. So it's been a real struggle with her going through processed recordings in this way. It's kind of shaming and she very rarely focuses on what I did do right and what my strengths are and she'll often say clearly you're empathic, but you didn't make an interpretation. So it's sort of like that's her basis of the, her scorecard or measurement of how well I'm doing is how insightful my interpretations are. I feel like saying how about the rapport with the client? How about whatever? So I wax and wane with having the confidence to confront her on that or not because she's significantly older than me and I do think that I respect my elders and there's something to be said of people who have been in the field for a while, but if I had to describe her in one sentence it would be out of touch. Not to mention she falls asleep during our supervision sessions, which is problematic, so I'm concerned for her health. Nice lady though, nice as can be, just not giving me what need.

Data Reflecting Positive Experiences without Clinical Development

This researcher will now turn to experiences that supervisees had with supervisors that they described as positive but they didn't not feel that they learned anything that

contributed to their clinical development. One of these supervisees who had just entered the field described two of her supervisors in the following way:

> I had a couple women supervisors who were very supportive and very helpful to me. Did I learn specific things? Not necessarily, but I felt very sort of supported in my development . . . I sought out a lot of them during . . . training . . . I ended up feeling, as I said, supported and like I could become a colleague of theirs you know. That was very helpful self-esteem wise.

Another supervisee described a supervisor that was friendly, non-threatening, and approachable, but never described anything from the experience that contributed to her clinical development. At one point during the interview she said:

> I don't ever remember that feeling of, well, I'm the trainee. I don't know something here and I need to ask you a wise one to impart [something to me]. It was just very informal the way that that all unfolded . . .

Issues with Supervisors Who Are Evaluators

This researcher will discuss issues with supervisors who are evaluators in this section. In addition, since most of the questions in the second phase were related to the above topic, the answers to questions from the second phase of the data collection will be included in this section.

The data from the interviews revealed problematic issues with some supervisors who were also evaluators. It is important to note, however, that most of the supervisees that were interviewed reported positive and helpful experiences with supervisors who also were in the role as evaluators. Once again, because this study asked for volunteers in

order to describe helpful experiences in supervision, the research was not particularly focused on negative experiences where an evaluator was involved. Nevertheless, since these negative experiences with evaluators came out during the first phase of data collection, this researcher, in the nature of phenomenological data gathering, included the following questions to participants during the second phase of data collection:

1. Could you share any helpful interactions that involved resolving a conflict between you and any clinical supervisor?
2. Could you share any helpful interactions that helped maintain openness with a clinical supervisor who was also an evaluator?

These questions stayed within the scope of the study of identifying helpful experiences while still reporting all findings, positive or negative. The primary focus, however, was on what works in supervision.

After this researcher sent out three questions to interviewees for Phase 2 of data collection, 9 of 13 respondents chose to respond via email. One of these respondents said that she intended to respond but she was very sick and couldn't participant in this phase of the study. Another person said that she also intended to answer the questions but that her significant other had to have surgery in the hospital and that she couldn't respond. These two participants, however, did respond to Phase 3 of data collection. A third participant said that due to a heavy workload, she thought she would decline responding to the Phase 2 questions.

With respect to Phase 2 data collection responses, some participants described how they dealt with difficulties that they experienced with particular supervisors. Two participants said that they enlisted the help of a third party that had comparable status to

their supervisor. In one of these situations, the third party was described as respected by both supervisor and supervisee. In both cases, the participants felt that bringing in a third party was helpful. One of these supervisees said the following in response to the question "Could you share any helpful interaction that involved resolving a conflict between you and any clinical supervisor?"

> I think the best example of this situation was probably when my field liaison from my graduate school came in to meet with myself and my direct field supervisor at my internship. I was able to explain to my supervisor, in the presence of my field liaison, that I did not agree with her tendency towards telling me what I "should have" done in a session; that I preferred to conceptualize the case as a whole instead of viewing sessions as instances where I "could have" said X, but I said Y and why that was unhelpful to the client. Being in the presence of my field liaison, who has known me longer than the supervisor at my internship, allowed me to feel supported as I advocated for my supervision needs. Without the support of my field liaison, I don't know that I could have spoken up about this, especially because of our power imbalance—me as graduate student and her as supervisor/a.k.a. the person grading my performance.

In another situation where the supervisee brought in a third party to help resolve a conflict with her supervisor, the supervisee answered the same above question by saying,

> The most difficulty I had with a clinical supervisor was in my first placement as a student where I thought that she did not understand the cultural difficulties (and) shock that I was experiencing. She brought up my distancing in supervision and I was able to discuss those difficulties openly. Also my field liaison was very

> helpful in bringing this about as she was more tuned in to the impact of culture I felt. In brief, the use of a third person trusted by both supervisor and supervisee can be helpful in bridging communication/conflict difficulties.

Again, in response to the question of addressing conflict with a supervisor, a third supervisee said,

> I respected a supervisor for listening empathetically while I voiced a difference of opinion, even though I knew he saw the matter differently. I, of course, acknowledged that I realized that he would get the final say, but that I would have chosen an alternate course of action. I believe it was a satisfactory interaction for both of us.

In two other difficult situations, the participants reflected back on these types of experiences. In one instance, the participant said that she expressed her frustration a number of years later with her supervisor and that her supervisor responded in an understanding manner. In another instance, the supervisee considered her transference to authority figures and thought that she had probably exacerbated an already difficult situation with a difficult supervisor. This participant said,

> I think that I have learned to take a more reflective stance towards my transference towards supervisors and realize how much I project and bring to the table with those that are in a position of authority that comes from my childhood experiences and has very little to do with our personal interactions as supervisor/supervisee. I think that my tendency is to forsake my own needs in order to make the person in authority feel better about themselves. Knowing this, I have to work extra hard to advocate for myself in the supervisory relationship. If

> I get matched with someone who enjoys flexing their muscles in a position of power, then this is especially bad for my growth.

In another conflictual relationship with a supervisor, the supervisee said that she felt there was really nothing that could have been said or done because of the rigidity and lack of empathy of the supervisor. She described this by saying,

> Unfortunately, there has been only one situation I could remember where I had conflict with my clinical supervisor. There was really nothing that could have been said or done as my supervisor was rigid and not empathic. This supervisor was more about meeting more clients [quantity] than the quality of the session. So eventually, other clinicians and I left the job.

In answer to the second question from Phase 2 of data collection, "Could you share any helpful interactions that helped maintain openness with a clinical supervisor who was an evaluator?" the same supervisee as above said,

> I think being humble has helped me maintain openness with my clinical supervisor/evaluator. The whole point of supervision is seeking mentorship/guidance so I come in being humble and willing to listen and be open to whatever is being offered. Fortunately, the majority of my supervisors have been more positive and rational so maintaining openness has been natural.

Another supervisee, in response to the same question from Phase 2 of data collection, said the following:

> I think that my application of humor helped to keep my supervisor and myself on cordial terms while remaining professional. My supervisor had a good sense of humor and so do I, so this was a way that I felt we could join together and create a

> positive relationship together. I feel that her willingness to laugh in the face of stress rendered her more human and relatable.

A third supervisee, responding to the above question concerning maintaining openness with a supervisor who was also an evaluator, said,

> My supervisors were careful [as I am] to relate their experiences which were relevant to my direct needs rather than overwhelming me with general stories of their practice as I have heard sometimes happens.

The third question of phase two of data collection was "Could you share any further helpful interactions that come to mind since our interview?" In answering this question, one supervisee referenced an earlier point in time when she received a type of supervision that she considered a more traditional style among supervisors.

> Actually, what was most helpful was when my supervisors actually taught me and gave me useful and important information for the treatment. So often, their supervising style paralleled the analytic style at that time which involved a lot of silence.

Another supervisee answered this last question concerning afterthoughts about helpful interactions by saying,

> After our interview, I feel like the relational model can also be applied to interacting with mentors/mentees and the concept of empathy, self-disclosure and mutuality all come to play in our interactions.

Participants' Reactions to the Summary of Interviews and Survey

In Phase 3 of data collection, which involved reacting to the summary of findings, 4 of the 13 participants emailed a response. None of the supervisees that responded to the

last phase of data collection identified any inaccuracies in the summary statement this researcher sent out. One respondent in particular remarked in amazement at the variety of what supervisees wanted in terms of helpful interactions with their supervisors.

The following include all of the responses of supervisees that openly reacted to this researcher's summary of the first two phases of this study. One respondent said, "It looks good. I don't have anything else to add." Another respondent said, "Very nice to read this. I sent a copy to my mentor. I've heard of these negative and controlling supervisors and was always glad that was not my experience. Should you work up an article for publication please let us know." The third person who reacted to the summary of findings said, "The excerpts that I'm sure reflected my statements are accurate." The last person said ". . . what a descriptive and informative summary! It seems like every clinician is different in what they seek and how they would like their supervision to be conducted.

Chapter V

Discussion

The discussion section will summarize the study, return to the literature review, and compare this researcher's findings with other research.

The discussion section, in line with the purpose of phenomenological research, will be used to integrate the themes in order to develop an overall structure or essence. First, this integration of the themes will be aided by the use of two constructs. These constructs are emotional atmosphere and attunement. Previous research and theoretical papers on supervision in the literature review provide validation for the importance of these two constructs.

Emotional atmosphere and attunement were chosen as organizing constructs because, in looking back on the descriptions from participants, almost all of what was conveyed could be subsumed under these two constructs. The 12 themes that include non-judgmental manner, uncovering and understanding dynamic processes, containing anxiety, collaborative relationship, role modeling, sensitivity to major life adjustments, encouraging and helping with development of style, self-disclosure, self-reflective behavior, sensitivity to cultural differences, strong mutual interest, and attention-grabbing feedback, are therefore organized around the constructs of emotional atmosphere and attunement.

Second, this integration will combine the insights of the participants' helpful experiences in supervision. In order to convey the whole experience of what it means to be helped in a supervisory relationship, a large part of this discussion section will describe a composite of the supervisees' individual helpful experiences.

In the findings section, it was necessary to break down the 270 pages of raw data into themes. Patton (1990, p. 37) describes "phenomenological inquiry" as "using qualitative and naturalistic approaches to . . . understand human experience in context-specific settings." This is one of the ways the discussion section will differ from the findings section in that the themes will not be discussed in a strictly theme by theme format.

Finally, discussion of the findings will lead to a statement of the essence of helpful experiences in supervision as defined by supervisees.

Comparison of Study's Findings to the Literature Review

In this next section, this researcher will present a comparison of the findings of this research with other research in the literature review.

Emotional Atmosphere

In relation to the supervisory process, similar to this study, Berman (2000) places emphasis on emotional atmosphere in the supervisory relationship. He believes that this atmosphere in the supervisory sessions ultimately has an important impact on the treatment of the patient.

In this researcher's study, an atmosphere of investment and caring about the supervisee's quality of supervision was important to participants. Thomas's (2005) study

was similar to this study's findings on the importance of the supervisor's investment and caring. In Thomas's study, investment and caring were lacking. Thomas (2005, p. 58) says, "Some supervisees felt the supervisor 'just didn't care.' They felt they and their training were inconsequential to the supervisor." Thomas says that this kind of attitude came across

> when the supervisor took liberties with the supervisory frame, or procrastinated completing an evaluation, or discounted the value of a clinical case. These attitudes were experienced as disrespectful and dismissive. Supervisees felt both offended and disappointed. Their enthusiasm for learning waned . . . Unprofessional and inappropriate behaviors also contributed to the supervisee's sense of the supervisor as lacking care not just for the supervisee, but also for the supervisory enterprise in general. Supervisees experienced these supervisors as care-less (p. 58).

Rainey's (1997) study is also similar to this study's findings by emphasizing important aspects of the emotional atmosphere that, in this case, were missing. Rainey says,

> Participants . . . told many stories of disappointments with supervisors, including experiences of feeling neglected, hurt, or not understood, with supervisors, for instance, who seemed disinterested, who fell asleep during sessions, or who were harshly critical. They also reported disappointments with supervisors who seemed inexperienced, incompetent, and unhealthy. At the extreme, participants spoke of huge disappointments when supervisors were involved in serious ethical breaches,

> including sexual and other abuses of power, or financial misconduct. (pp. 210–211)

The supervisees in this researcher's study placed emphasis on an atmosphere that was conducive to presenting therapy material. The emotional atmosphere was the most fundamental and stressed quality that supervisees described in promoting helpful interactions in supervision. What did a conducive atmosphere entail? Participants who experienced their supervisors as invested in their gaining greater clinical understanding was part of this conducive atmosphere. This investment was at first experienced by the participant in seemingly small ways, such as authentic warmth, caring, support, and respect. In addition, participants needed their supervisors to be curious and inquiring with respect to the interventions that they made with clients.

The emotional atmosphere had a direct impact on the more didactic aspects of supervision. Supervisees in the present study did not find it helpful to be told how to do therapy by their supervisors. Rainey's (1997) findings were similar to this study's findings in this area. Rainey (1997, p. 210) says,

> Teaching is not just about transmitting skills and knowledge, but also about offering a new perspective and asking evocative questions. Learning is not just about acquiring skills and knowledge, but also about reaching greater self-knowledge, discovery and acceptance, achieving freedom from reactivity to one's own issues, and finding one's own voice and style, while continuing to seek and to value new opportunities to learn throughout a career.

Levenson (1982), similar to this study's findings, does not advocate for a teaching approach to supervision. Levenson (1982, p. 4) refers to this teaching of a therapy

approach as the “Teutonic approach.” In this researcher’s study, one supervisee described one of her supervisor’s by saying,

> Yeah and so I know that it’s an extremely rigorous program, so for her (supervisor) to get through that, she needed to be really smart, but I, yeah, I was just disappointed in like, it was like her way or the highway kind of thing, it really was, yeah.

In the above example, this particular supervisee did not mention one thing that she took away from this experience that was of clinical value. This was in contrast to three other supervisors that this same supervisee found extremely helpful who did not have this dogmatic style. Levenson (1982), in an article on supervision, states, “One cannot learn to do anything exclusively by being told how to do it, and no one who knows how to do something well can transfer that knowledge by telling the other person how to do it” (p. 2).

The findings of this study, regarding teaching in supervision, were similar to what Ganzer and Ornstein (1999) describe in a relational approach. Ganzer and Ornstein (1999) describe a relational approach to supervision that is opposed to an approach whereby the supervisor tells the supervisor how to do therapy. They characterize the supervisory relationship from a relational constructivist viewpoint. Within this model, supervision is viewed “. . . as less hierarchical and more one of mutual influence, of give and take, in which the issues of both individuals are at play at one time or another . . .” (p. 232).

Attunement

This researcher first wants to comment on the word *attunement* as it is used in the present context. This term is meant in a broader sense than the attunement that is a subset of psychological holding. While not excluding the holding aspect involved with attunement, it is used to describe other aspects of attunement in the supervisory relationship as well.

Participants want supervisors who are interested in understanding the way a therapist thinks about a patient by listening in a highly attuned manner as opposed to jumping to conclusions about how a case should be conducted from their supervisor's point of view. Part of this preferred style among participants recognizes that there are multiple ways of approaching a patient's issues, and the therapist's style has to be taken into consideration, along with how she experiences the client while sitting with him in the room. Being in the room with the patient is quite different from hearing about the patient via the therapist's report. The closeness of the therapist/client interaction often requires a third ear—that is, the supervisor's careful attention to the words and underlying feelings being expressed by the supervisee regarding the therapy session. Participants often describe this quality in various ways that refer to attunement. Specifically, attunement is partially described as the supervisor valuing every word the supervisee spoke along with an intellectual and emotional availability. One supervisee said, ". . . every single word I was saying was being taken in. It was so helpful and so validating . . ." Another supervisee said, ". . . so that's an experience that was strong, but it wasn't particularly anything that she said, just the fact that what I was saying was valuable to her." Similar to

this study's findings, Thomas (2005, p. 66) says, "When the supervisee experiences a lack of attunement on the part of the supervisor, she feels unheard and unseen."

When following the process of therapist/client interactions, a supervisor who is attempting to understand or be attuned often asks the questions that are inquiring and neutral in tone, such as "Where are you going with that intervention?" "How does that serve you?" or "What was the reason you said that?" It is important to note that this inquiring or neutral tone is experienced as non-judgmental. Similar to this study's findings, Rainey (1997, p. 209) says, "The process of establishing an effective learning alliance involves a fostering of openness on the part of the supervisor through adoption of a nonjudgmental attitude." When this non-judgmental attitude is absent in supervisors, this study's findings are also similar to Thomas's (2005) study. Thomas (2005, p.66) describes this in her study by saying,

> Many supervisees experienced their supervisor as judgmental and critical. They felt themselves and their clinical work under constant scrutiny for mistakes and missteps. The supervisee had to be vigilant lest she risk being pounced on, like a cat regarding a mouse. The supervisee felt tormented. She had to dedicate energy and whatever reserves she had to self-protection. Little initiative was available for learning. (p. 57)

The above types of questions, given in a non-judgmental tone, helped participants to be more curious and introspective concerning various interventions with their patients. In addition, within this non-judgmental atmosphere, a supervisor's suggestion that the supervisee take a different direction was experienced as helpful, and participants were generally appreciative of this type of guidance. One interviewee said:

> ". . . she definitely would let me know if I needed to go in a certain direction, but in a way that was respectful and in such a way where if I was going someplace differently, I would be asked to explain where was I going? Not that it was wrong."

Another aspect of this attunement was related to one frequently mentioned concept of containing (Bion, 1961). The more a supervisor was able to psychologically contain the ubiquitous anxiety within the supervisee, as well as her own anxiety as a supervisor, the easier it was for the supervisee to hear relevant feedback. This was especially true regarding containing the anxiety inherent in working with especially challenging patients. The review of the literature on supervision with regards to the supervisor's containment of supervisees is practically non-existent. Farber (2006) comes closest to discussing the supervisor's containment of supervisees when he refers to certain statements that supervisors can make to help foster self-acceptance. These statements can help supervisees more effectively contain their anxiety during difficult sessions with patents. Farber said these comments to the supervisee "took the form of emotionally resonant, empathic statements." Such statements include: "Yes, the work is so very hard, so emotionally draining," "I know, progress is so elusive," and "That kind of thing frustrates me too" (Farber, 2006, p. 196). This quality of empathy that Farber talks about is similar to the findings in this study.

The supervisor's ability to provide psychological holding was also important to supervisees. Levenson (1982, pp. 3–4) described one supervisory approach as "holding or confirming." He gives an example of when Levenson felt himself floundering or in trouble with a case and he asked for advice. The supervisor would briefly comment. He

said that he then felt contained and could proceed while feeling less anxious about the problem. Levenson's description of "holding or confirming" is similar to the findings in this study.

Containing the supervisee's anxiety requires the supervisor to be competent at being perceptive and self-reflective. Perception and self-reflection are two additional supervisory qualities described in helpful interactions. Quotes and examples of all the above forms of attunement were given in the findings section of this study.

When these types of attunement are recognized as being present in the supervisor, the supervisee is then not only ready, but is both receptive to and appreciative of good feedback. Good feedback is a relative term. Generally speaking, the more insightful and perceptive the supervisor is, the better and more helpful the feedback. Participants valued expertise in their supervisors. The way this expertise was conveyed varied among the supervisors. Some feedback was practical and to the point such as telling the therapist to ask about the client's sex life. Other feedback involved teaching the supervisee how to listen more effectively, such as asking the therapist, "What is she trying to tell you here (in this section of your process recording)."

Another form of feedback was mentioned by two participants as especially attention-grabbing and extremely helpful. This type of feedback was characterized as unanticipated reactions from supervisors that were described as insightful remarks that grabbed attention by using demonstrative forms of describing reality as part of feedback. These forms of feedback were initially experienced as norm-deviating or even norm-shattering moments. These thought-provoking remarks, while temporarily experienced as destabilizing, challenged supervisees with an important message to consider regarding

clinical work. After more fully integrating what was said, not only did the supervisees feel enlivened by a new way to conceptualize a patient, but the feedback tended to reinforce their passion for the work. Similar to this study, Levenson (1982, p. 5) refers to a similar destabilizing supervisory approach as "The Zen method." The purpose of this approach is to help the supervisee adjust to or come to terms with the indescribable process of doing therapy or to use Levenson's (1982, p. 1) term, "the ineffable," by providing an atmosphere of "creative disorganization" (p. 5).

Supervisees appreciated supervisors who made an effort to understand the supervisee, as well as the patient being discussed. A number of participants stated that they felt that their supervisor knew them well. As a result, they felt comfortable in revealing more about their countertransference toward patients, along with having more open interactions with their supervisors. This also contributed to open discussions related to client transference and enactments between client and supervisee. In some cases, interactions between the supervisor and the supervisee were related to enactments that were present in the therapy session with the supervisee and the patient. These interactions were also openly processed. Similar to the findings in this study, Harold Searles (1979) said that there are times in supervision in which a parallel process is being enacted by both the therapist and the supervisor that is analogous to the dynamics in the patient/therapist dyad. Caligor (1981), Bromberg (1982), and Williams (1997) also support this study's findings regarding the existence of parallel processes in the supervisory relationship.

Supervisees appreciated supervisors who could hang out with "not knowing." Many participants described interactions where the supervisor would create space for

them to think and even let them dangle for a while with “not knowing,” but would not let them dangle too long by eventually giving feedback. In fact, two participants described this process using identical words. The timing of this dangling was considered important by a number of participants. One participant described her supervisor as a “master of balance” in her timing. Supervisors would often help supervisees tolerate the anxiety of not knowing. It was also described as part of the process of hanging on to the supervisee so that the supervisee could contain the patient. Helping supervisees tolerate the anxiety of not knowing reminded this researcher of Christopher Bollas’s book, *The Shadow of the Object* (1987), where Bollas refers to the months during the beginning of an analysis before he will have “. . . some sense of the person’s private and unconscious use of me as an object within the field of transference” (p. 277). This is one of the periods where supervisees and supervisors have to tolerate the anxiety of not knowing.

Another theme involves mutual interest in clinical work in the supervision hour. One participant in particular described how, when her supervisor picked up on her intense interest for the work, the supervisor apparently was spurred on to invest even more of herself in the contagious stimulation of the emotionally charged atmosphere. There were no other studies or theoretical articles on the supervisory relationship in the review of the literature that addressed the importance of mutual interest.

One interviewee said that having a supervisor of the same gender was important in helpful interactions regarding both modeling and feeling more understood. For this supervisee, he also found it easier to relate to this supervisor. Rainey (1997, p. 200), “. . . strongly suggests that issues of gender . . . will to a large degree reflect the particular

history of the supervisee . . .” Rainey’s remark seems to support the findings of this study.

In good supervision, the supervisor and the supervisee both appreciate the need for boundaries. The type of boundaries set by the supervisor depended on her style and the context in which self-disclosure was practiced during the hour. One remark from a participant was representative of what a number of others expressed in different words. This was that she did not need her supervisor to be a friend. The primary concern was receiving help with treating patients, especially challenging patients. Participants reported that self-disclosure by the supervisor was variable, both in terms of how often it happened and at what point in the supervisory relationship. In all cases when self-disclosure was described, participants felt that it always served a clinical need of the supervisee. One participant stated that she was relieved to know nothing personal about a particular supervisor, especially at first, when she was presenting an extremely challenging case. At that point, it would have been a distraction for her. Some supervisors self-disclosed about previous experiences with patients that were pertinent to the supervisee’s current patient. Supervisees interviewed said that when supervisors gave these relevant examples from their own work as a therapist, the participants found this quite helpful. Similar to this study, Farber (2006) stated that the supervisors he surveyed thought that self-disclosure was especially useful when supervisors disclosed aspects of their own work. Farber believed that the supervisor’s disclosures contributed to a collegial atmosphere that encouraged a space for the supervisee to talk more openly about their own clinical work.

Another example with respect to boundaries is the following example. One participant described a supervisor's style as spending the first session talking about his life in a matter-of-fact "non-conceited" manner and telling the supervisee she could tell about her life in the second session. The participant reported that she found this approach to be very conducive to setting an open atmosphere in which to discuss treatment cases. In reflecting back on the experience during our interview, she speculated that in addition to promoting a more open atmosphere, it may have served the purpose of, ". . . informing his conceptualization of us as supervisees to be able to use that data later when we would have an interaction with the client."

Many participants said that their supervisors required process recordings. Some of these were written out and others were audio-recorded. Except in the cases where the supervisors were either considered not helpful and/or highly critical, participants described the process of reviewing these together as extremely useful. Rainey's (1997) study supports the finding of this study that participants found process recordings to be extremely helpful. Rainey specifically states that "the value of process recordings as a unique and precise tool for focused learning in the work of supervision was strongly affirmed by this study" (p, 209).

Group supervision issues were also discussed by the supervisees. A number of participants mentioned their experience in group supervision. With the exception of one group experience, participants expressed feeling safe to talk about their experiences with their patients because other group members were open with their experiences. These participants felt that helpful feedback came from group members, as well as their supervisors who were leading the groups. Group participants had to feel safe for members

to present cases without filtering and by being open to feedback. The one exception to these safe and helpful experiences was a group in which one participant described the supervisor as highly critical and "way off the mark" with her personal judgements and attacks on group members. The participant described the feeling among the group members as wondering whether it was their turn to be attacked by the supervisor. In both group and individual supervision, it is important for supervisors to be aware of their personal issues and not act them out with supervisees. Teitelbaum (1990) maintains that the problems in supervision are typically viewed as shortcomings in the supervisee. Similar to this study's findings, Teitelbaum maintains that too often the supervisor's role in the relationship can be a major contributor to supervision not being conducive to the learning environment of the supervisee. He further stresses that blind spots, as well as narcissistic needs of being a competent supervisor, may potentially adversely affect the supervisory relationship.

One of the types of groups that was described as highly helpful by participants was geared to the learning of a specific approach to treatment, such as post-traumatic stress disorder treatment. The participants in this type of group described the supervisors as very helpful in giving useful feedback, and they said that it was given in a neutral, non-judgmental manner.

Essence

The essence or structure of the phenomenon of helpful experiences has to do with how the concrete and disparate pieces of the data are related to each other as a whole. While the context-specific findings are necessary in the exploration phase of the

phenomenon, the essence of the findings is necessary to explicate the essential attributes of the phenomenon. Giorgi (2011, p. 200) says,

> The structure is the identification of the constituents that are essential for the phenomenon to manifest itself in this particular way as well as an understanding of how the constituents relate to each other.

The essence is the culmination of all of the efforts of this research project.

This researcher will now return to the research question of this study which is: How do supervisees describe helpful experiences in psychoanalytically focused supervision? The following four paragraphs are a statement of the essence of helpful experiences based on the descriptions of the 13 supervisees' descriptions in psychoanalytically focused supervision.

Although the clinical competence of the supervisor is certainly highly valued, what is even more important is the relationship with the supervisee as defined by attunement to the supervisee's self, as well as her emerging or established style as a therapist. This attunement helps foster an emotional atmosphere that includes safety, self-reflection, empathy, openness, a non-judgmental stance, curiosity, mutuality, critical thinking, and respect for the cultural and unique aspects of the supervisee, as well as the patient. Furthermore, the supervisor's psychological holding and containing of the supervisee enhances a more conducive atmosphere for the exploration of complex issues and complex processes in the relationship between the supervisee and the patient.

An important aspect of this conducive atmosphere is to allow space for thinking and feeling. In one sense, space for thinking allows the supervisee to have more of a chance to put forth her own emerging thoughts related to the issues and processes among

the patient, supervisee, and supervisor. In another sense, space for feeling allows for the toleration and acceptance of the ubiquitous anxiety of "not knowing" that all therapists are often confronted with in their sessions with patients.

This same accepting atmosphere contributes to the taking-in of non-critical and useful feedback. This type of feedback may take many forms, such as metaphorical, "attention-grabbing," didactic, and pragmatic. Self-disclosure by the supervisor is useful as long as it is clinically relevant to the case being discussed. More specifically, examples given from the supervisor's own work that are related to the supervisees' work are especially useful.

Finally, when the supervisor and the supervisee are both highly invested and even enthusiastic for the work, a contagious atmosphere spurs on an even greater investment in making the clinical environment productive. Thus, both the supervisee and the supervisor are engaged in a mutual learning process.

Chapter VI

Limitations of the Study and Evaluation of the Study

The first section of this chapter discusses the limitations of this study. The second section will discuss the evaluation of the study.

Limitations of this Study

The first limitation to this study is that the findings of this research may only hold true for the sample of supervisees in this study. The validity may have been compromised by the fact that this researcher was the only person analyzing the data. The last phase of the research, however, was sharing the findings and conclusions with the supervisees/interviewees to see if this material expressed the essence of the supervisory experience. Comments were elicited to see if supervisees felt that their individual experiences were expressed in the findings and conclusions. Because this researcher has been exposed to numerous supervisory situations, both as a supervisee and a supervisor, this researcher is not devoid of preconceptions regarding varied and complex supervisory experiences. In arriving at the findings, it was important to synthesize the data from all the participants while still maintaining the unique voice of each individual supervisee. A check on the validity of this dual function was enhanced by asking each supervisee to assess the accuracy of the findings. Consultation with committee members to address any

of the researcher's potentially biased statements provided for additional triangulation of the data.

Another limitation is that the supervisees had their own biases influencing their memory of the interactions with their supervisors. These memories were subject to the inevitable distortions of time, cognition, and emotion. Because phenomenological research is concerned with the subjective reality of the participants, an objective depiction of what took place from an outside observer's perspective was not the focus of this study.

Finally, this study focused on a specific type of clinical supervision—that is, participants engaged in psychoanalytically focused psychotherapy or psychoanalytic training. It may be less relevant for supervision related to other forms of therapy. This factor limits generalizations to other forms of clinical supervision.

Evaluation of the Study

This section will first address the evaluation of this study with respect to guidelines from the American Psychological Association (American Psychological Association (APA), 2001, p. 6). This will be followed by some terms that Hays and Singh (2012, pp. 200–203) use in order to evaluate qualitative research studies. These terms will be used to evaluate this study as well.

This researcher reviewed the APA guidelines in the style manual for dissertations and publications (APA, 2001, p. 6). Their guidelines recommend seven questions in order to evaluate the validity, reliability, and ethics of a research project. Each question will be

answered as it relates to this study. These seven questions with answers from this researcher are listed below.

The first question is: “Is the research question significant, and is the work original and important?” The research question is significant because it is asking supervisees to describe their subjective experiences of helpful experiences in clinical supervision, which is mostly lacking in past research studies. The research question is original because few or no research questions have specifically focused primarily on helpful experiences in the clinical supervisory relationship. The research question is important because clinical supervision is an indispensable part of the training of clinicians.

The second question is: “Have the instruments been demonstrated to have satisfactory reliability and validity?” This study did not use any formalized measurements. For instance, there were no psychological tests, no formalized interview protocols, or any other formalized protocols.

The third question is: “Are the outcome measures clearly related to the variables with which the investigation is concerned?” This was a qualitative study, and there were no variables that were stated in a hypothesis at the beginning of the study.

The fourth question is: “Does the research design fully and unambiguously test the hypothesis?” This criterion does not apply to this study because it is not a quantitative study.

The fifth question is: “Are the participants representative of the population to which generalizations are made?” The answer to this criterion is yes, because the participants were drawn from four different disciplines from all over the state of California and one town in Oregon.

The sixth question is: “Did the researcher observe ethical standards in the treatment of participants—for example, if deception was used for humans?” This researcher observed all ethical standards in the treatment of this study’s participants, and no deception was used with the participants.

The seventh question is: “Is the research at an advanced enough stage to make the publication of results meaningful?” All three dissertation committee members, as well as one of the participants in the study, expressed that the results were important enough to merit publication. The participants also expressed that this study was meaningful.

The second half of the evaluation section will use terms that Hays and Sing (2012) use to evaluate qualitative research studies.

One of these terms is *dependability*. Dependability is similar to the concept of reliability, which is used in quantitative research (Hays & Singh, 2012, p. 201). Dependability is evident in this study when it is compared to the studies by Thomas (2005) and Rainey (1997). All three studies depend on supervisees’ report of clinical supervision experiences. Even though the studies vary somewhat in the focus of the supervisory relationship, all three point to the importance of attunement and empathy being present in the supervisor. Thus, “. . . similar findings extend to similar studies . . .,” which is an important part of dependability (Hays & Singh, 2012, p. 201).

Confirmability involves transparency and neutrality on the part of the researcher. When this researcher reported his theoretical orientation, “personal interest,” and “assumptions” regarding clinical supervision, this involved transparency and helped with approaching the supervisees from a position of neutrality (Fischer, 2006, p. xxxix). Most importantly, confirmability was demonstrated by confirmation of the summary of the

findings by participants who responded to Phase 3 of data collection. This last point of confirmability is referred to as *member checking*, which Hays and Singh (2012, p. 206) say may be done by "conducting follow-up data collections to expand participant voices in the findings."

Coherence was adhered to in this study by answering the research question using a phenomenological methodology. The research question in this study looks at the lived experiences of participants' helpful interactions in supervision as perceived by them. In order to describe the essence of these lived experiences, it was necessary to use phenomenology as a foundation for this study. Hays and Singh (2012, p. 50) describe this approach by saying, "Whereas a grounded-theory approach seeks to develop theory, the purpose of phenomenology is to discover and describe the meaning or essence of participants' lived experiences, or knowledge as it appears to consciousness."

Finally, in describing ethical validation, Hays and Singh (2012, p. 202) say that "we should only engage in research that provides insights to practical and meaningful real-world problems." Clinical supervision not only impacts supervisees, but the patients that come to these supervisees for treatment. Thus, this study addresses a practical and meaningful problem in the real world.

A general concept used in evaluating the validity of qualitative research and particularly in phenomenology research is trustworthiness (Hays & Singh, 2012, pp. 200–203). The concepts of dependability, confirmability, coherence and ethical validation that have been mentioned in this section on the evaluation of this study are all included under the concept of trustworthiness (Hays & Singh, 2012, pp. 200–203).

Chapter VII

Implications for Future Research and Recommendations

Given the important role that clinical supervision has in the field, this chapter will address some issues related to clinical supervision that this researcher believes are extremely important. Implications and recommendations for future research will also be addressed in this chapter.

Finding volunteers for this study was a quite a challenge. One can only speculate about possible reasons for the difficulty of finding volunteers to talk about their helpful interactions with supervisors. There were certainly numerous psychoanalytically focused therapists and/or analysts from the organizations that were asked for volunteers. It may be that positive learning experiences with supervisors were far less frequent than their negative experiences. If this were the case, potential participants were less likely to volunteer for this type of study. This is speculative and cannot be verified. If the difficulty of finding volunteers was related to extensive negative experiences, these potentially negative experiences could indicate a similarity to two other studies looking at supervisees' experiences in supervision, which were mostly negative. These two studies were done by Rainey (1997) and Thomas (2005). Difficulty in finding volunteers, however, could be related to other factors, such as many potential participants were either too busy or not interested in the topic.

Fortunately, this researcher had at least three strong advocates for finding volunteers for this research. The advocates either provided a forum for this researcher to talk about the study or they provided this researcher with contacts for locating potential volunteers. Participants were drawn from the three largest metropolitan areas in California, and one participant was interviewed in Oregon. In two large professional organizations, each with over 800 members, only 2 and 3 members, respectively, volunteered to participate in the study.

This researcher suggests that universities and professional institutes may have been lulled into the belief that the quality of clinical supervision is not a serious problem, or at least not a problem to be overly concerned about in the field. The scarce prior research on supervisees' experiences is one indicator that clinical supervision is not given the thoughtfulness that it deserves. Even among the clinicians that have been interviewed for this study of positive experiences in supervision, some clinicians also revealed negative experiences not elicited by this researcher. Universities and professional institutes urgently need to be aware of this apparent huge deficiency. Theoretical papers and studies from the supervisor's perspective, while necessary and important, fall short of going to the heart of the matter—that is, the supervisee's experience. Only the supervisee can say what she has learned, how she has learned, what is a distraction to her learning, what is detrimental to her learning, and what is crucial in helping her to develop her own style as a therapist in the supervision hour. Continued research, specifically from supervisees' own accounts of supervision, hopefully will bring much needed attention to this crucial area of developing more competent and compassionate clinicians.

In this field, there are many professionals who make excellent clinicians, professors, theoreticians, writers, and administrators. One who possesses one or more of these areas of expertise does not necessarily mean that the same individual will also make a competent clinical supervisor. In addition, as so often happens, there is a common assumption that the more experience one has working as a clinician, the more capable one would be as a clinical supervisor. The participants in this study had supervisors with extensive experience in the field. A number of them had extensive name recognition as well. Extensive experience and/or name recognition is not necessarily enough. In fact, one supervisor that possessed both qualities was reported by her supervisee in this study as extremely destructive to her clinical development and her self-esteem. Although this particular supervisee was well-respected by her colleagues as a competent clinician, supervisors like hers can do much damage or much good. Rainey (1997) reports similar findings of disappointments experienced by supervisees with supervisors who were well-respected in the field.

The findings of this study primarily recognize the existence of excellent supervisory skills that supervisees have specifically identified as helpful in their development as clinicians. This study adds to the base of knowledge that is currently available in the area of clinical supervision. At the same time, it appears that some current supervisors, given their personality structure, should not be supervising. Other supervisors could benefit from more extensive training, given what is slowly starting to come out in the relatively recent research on supervisees' experiences, both helpful and not helpful.

Most supervisors have received little or no training before becoming supervisors (Zicht, 2013, p. 9). Clinical experience is not enough. One-day supervision workshops and similar short-term courses that are often given for certification in supervision are not enough. Zicht (2013, p. 9) states the following:

> All supervisors of psychoanalytic treatment have undergone their own experience of supervision in their training to become analysts; yet, very few such supervisors have much or any formal training in the practice of supervision. Consequently, psychoanalytic supervision is practiced primarily, if not exclusively, "by experience", with experience thereby placed at the forefront of conducting psychoanalytic supervision. As psychoanalysts, our experience and training is in conducting clinical psychoanalytic inquiry, making use of our lived experienced, participatory and observatory. As we are not, in fact, typically trained to do supervision (whatever that may be), what then is it that we think we *are* doing, what we call, "supervision"?

Clinical supervision is a specialized area of utmost importance because of the significant role, and maybe the most important role in *the emergence of the clinical self*. One supervisee in this study said that what she learned from supervisors was so much more important than what she learned in graduate school.

When the supervisor is also an evaluator for the supervisee, the problems of receiving unhelpful and/or highly critical supervision are exacerbated. Rainey (1997) and Thomas's (2005) studies support this finding. It would be useful to have a built-in mechanism such as mutual ongoing evaluations from both the supervisee and the supervisor. Following up on this mutual evaluation process, additional studies are needed

to explore the experiences of supervisees under such a system.

In light of all of these supervisory issues, it would be useful to do a replication of this research study because such a study could yield similar or different findings. In addition, it would be useful to explore in greater depth each of the specific themes that emerged in this research.

Other studies could involve interviewing the supervisee, then interviewing their supervisor. This might yield further useful data on what practices are most helpful in supervision. Interviewing both supervisee and supervisor together while they discuss with each other what is helpful and what is not helpful in developing clinical skills could also potentially yield useful data. Another alternative would be to conduct focus groups of supervisees, supervisors, or the combination of both for the purpose of discussing what is helpful in supervision. Given the scarcity of research on clinical supervision, more studies are needed in this crucial aspect of training competent clinicians. In summary, further elucidation of understanding what is helpful in supervision is vital to the mental health field and to the patients that come to us for help. Once professionals in the field acknowledge that crucial supervisory issues need to be addressed, the field can then move forward to take action to design better training for clinical supervisors.

Appendix A

Individual Consent for Participation in Research

INSTITUTE FOR CLINICAL SOCIAL WORK

I, _____, acting for myself, agree to take part in the research entitled: **A Phenomenological Analysis of Helpful Experiences in Psychoanalytically-Focused Supervision as Defined by Supervisees.**
This work will be carried out by Thomas Beller (Principal Researcher) under the supervision of Professor Dennis Shelby Ph.D. (Sponsoring Faculty).
This work is conducted under the auspices of the Institute for Clinical Social Work, Robert Morris Center, 401 South State Street, Suite 822, Chicago, Illinois; (312) 935-4232.

Purpose
The purpose of this study is to explore clinical supervision. This study involves research. The purpose of the work is to meet a research course requirement in the doctoral program at the Institute of Clinical Social Work. This research will become a part of a dissertation. There is the possibility that the findings of this study will have a beneficial impact on the quality of clinical supervision of supervisees.

PROCEDURES USED IN THE STUDY AND THE DURATION
There will be an approximately sixty to ninety-minute interview for each research participant. Later, there will be three follow-up questions to the initial interview. In the last phase of the study, this researcher will ask you to review a statement of the research findings. Feedback to the summary will be encouraged if participants would like to comment.
I agree to be audio-recorded during the interview. Please put your initials next to either "yes" or "no".
Yes _____
No _____

Benefits

Benefits include an opportunity to articulate your views in this area of research. As stated above, there is a possibility that the findings of this study will have a beneficial impact on the quality of clinical supervision of supervisees.

Costs
There are no monetary costs for participants in the research study.

Possible Risks and/or Side Effects
There are no foreseen risks or side effects.

Privacy and Confidentiality
Recordings and transcripts will be kept in a locked filing cabinet located in my locked private work-area. All names will be deleted from the transcripts. Names of interviewees will be coded and kept in a separate location.

Subject Assurances

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Thomas Beller (Principal Researcher) at 202-669-8513 or Professor Dennis Shelby (Sponsoring Faculty), at 312-935-4232 (day).

If I have any questions about my rights as a research subject, I may contact John Ridings, Chair of Institutional Review Board; Institute of Clinical Social Work, Robert Morris Center, 401 South State Street, Suite 822, Chicago, Illinois; (312) 935-4232.

Signatures

I have read this consent form and I agree to take part in this study as it is explained in this consent form.

_____ _____

Signature of Participant Date

I certify that I have explained the research to _____ (Name of subject) and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

_____ _____

Signature of Researcher

Appendix B

Confidentiality Statement for Transcriptionist

CONFIDENTIALITY STATEMENT FOR TRANSCRIPTIONIST

Dissertation Title: A Phenomenological Analysis of Helpful Experiences in Psychoanalytically-Focused Supervision as Defined by Supervisees.

This work will be carried out by Thomas Beller, LICSW, researcher, under the auspices of the **Institute for Clinical Social Work**, Robert Morris Center, 401 South State Street, Suite 822, Chicago, Illinois; (312) 726-8480.

Purpose
The purpose of this study is to explore clinical supervision. This study involves research. The purpose of the work is to meet a research course requirement in the doctoral program at the Institute of Clinical Social Work. This research will become a part of a dissertation.

Procedures Used in the Study and the Duration
There will be an approximately sixty to ninety minute interview for each research participant. Later, there will be three follow-up questions to the initial interview. In the last phase of the study, this researcher will ask participants to review a statement of the research findings.

Privacy and Confidentiality
Digital recordings and transcripts will be kept in a locked filing cabinet located in my locked private work-area. All names will be deleted from the transcripts. Names of interviewees will be coded and kept in a separate location.

Statement of Confidentiality from the Transcriptionist
By signing this consent form, I agree to keep confidential any aspect of this dissertation material that I may have access to in the process of transcribing interviews and summaries. All information will be kept confidential for all time. If I have any questions about the research methods, I can contact Thomas Beller at 202-669-8513.

Signatures
I have read this consent form and I agree to the confidentiality necessary for this position as transcriptionist.

Marcy Throne — Signature of Transcriptionist
10/9/14 — Date

Email: katnip669@hotmail.com
beller@san.rr.com
Phone: (619) 459-4582

I certify that I have explained the transcription duties to _____. I believe that they understand and have agreed to the transcribing of interview material.

Thomas P. Beller — Signature of Researcher
10/11/14 — Date

Appendix C

Approval for Research from San Diego Psychoanalytic Center

Dear SDPC Members:

The Board has approved that I send to our members, the following request for research study participants. If you are willing to participate, please continue reading (see attachment), and contact Tom Beller to get started. Thank you! -Michelle

November 18, 2014

Dear Colleagues,

Did you have a supervisor who was very helpful to you in your professional life?

I would like to hear from you about what was helpful in that relationship.

The training of clinicians could benefit from this lost treasure.

Helpful interactions experienced by supervisees with their supervisors often go undocumented, especially those experienced in the past. This is why I am asking for volunteers to participate in a dissertation that explores helpful interactions that supervisees have experienced at some point in their lives, whether in the recent past or decades ago. A requirement is that participants have had at least one year of experience in psychoanalytic and/or psychodynamic supervision.

Over the course of the research, there will be one interview, a written or verbal three-question follow-up, and finally a verbal or written reaction to a summary of the findings.

If you are interested, please contact Tom Beller, researcher, at tpbeller@aol.com. I have attached an abbreviated version of the proposal for your review if you would like to review it. Thank you.

--
Michelle Spencer
Administrator

SAN DIEGO PSYCHOANALYTIC CENTER

4455 Morena Boulevard, Suite 202 | San Diego, CA 92117
tel (858) 454-3102 | fax (858) 454-0075

Contact Michelle Spencer, Administrator

website | vCard | donate | join | facebook | map | email

Appendix D

Approval for Research at Sanville Institute, Berkeley, CA

Dear Mr. Beller,
Congratulations on a very interesting dissertation theme. I will pass this on to our Faculty and students, as well as our Clinical Consulting Faculty (who serve as supervisors). In addition, I might mention that our Institute will be having our Winter Convocation in Sherman Oaks on January 24 and 25, so some potential subjects might be in the area at that time if that would be more convenient.
My best to you and good luck.
Mario

On Tuesday, January 6, 2015 8:26 PM, "tpbeller@aol.com" <tpbeller@aol.com> wrote:

January 6, 2015

Dear Dr. Mario Starc:

I am writing to you because I am an advanced student at the Institute for Clinical Social Work in Chicago. Our two schools have many aspects in common regarding clinical mission and academics. Because of this commonality, I wanted to approach you about the dissertation research that
am currently conducting on clinical supervision from a supervisee's point of view.

The research is a qualitative study that explores helpful interactions that supervisees have experienced in supervision with present or past supervisors. The study specifically focuses on psychoanalytic or psychodynamic supervision. I am looking for participants who would be interested in being interviewed for this research. Participants will be given the results of the study after it is completed.

I would be interested in engaging any staff and students who would like to be interviewed for this project, and I am willing to travel to Sanville for a few days in order to accomplish these interviews.

I have attached a shortened version of my research proposal that I would send out to all participants. I am also attaching the letter that I have been sending to volunteer-participants in the San Diego area. I would be glad to answer any questions that you may have regarding this study. I can be
reached by email at tpbeller@aol.com or by phone at 202-494-5952.

Thank you for reviewing this request and proposal. I would be very excited about having participants from your faculty and student body.

Respectfully yours,

Thomas Beller, LICSW

Appendix E

Permission from California Clinical Social Work Society

September 29. 2015
Ros Goldstein
California Clinical Social Work Society
Thomas: I look forward to meeting you at our program this Thursday. We usually have a half hour prior to our presentation for attendees to introduce themselves & and make announcements. But, since there are already almost 30 registrants we may only have time for attendees to make job announcements or other programs. at that time. I think it would be appropriate for you to make your appeal to attendees for your research on clinical supervision.

You would have to discuss the use of our member list-serve with the state office, i.e, Luisa Mardones, our executive director, as they send out our local e-letter to all our members (I am cc'ing her). Looking forward to meeting you on Thursday. Ros

On Sep 29, 2014, at 3:25 PM, tpbeller@aol.com wrote:

Dear Ms. Goldstein,

I am sending you another request to use the California Clinical Social Work Society in San Diego as another possible population for my research dissertation on clinical supervision. You may not have received my first request.

I am now a member of the Society and I will be attending the talk this Thursday on Bereaved Military Families. I hope to have a chance to meet you when I am at the talk. I will also bring another copy of my proposal and permission letter that needs signing. I would like to be able to use the list-serve or the news letter to ask for volunteers to participate in this study. I have attached the documents to this email for your review.

I hope to see you on Thursday.

Respectfully yours,

Thomas Beller, LICSW
tpbeller@aol.com
202-669-8513

Appendix F

Letter to Request Volunteers for the Research

November 18, 2014

Dear Colleagues,

Did you have a supervisor who was very helpful to you in your professional life?

I would like to hear from you about what was helpful in that relationship.

The training of clinicians could benefit from this lost treasure.

Helpful interactions experienced by supervisees with their supervisors often go undocumented, especially those experienced in the past. This is why I am asking for volunteers to participate in a dissertation that explores helpful interactions that supervisees have experienced at some point in their lives, whether in the recent past or decades ago. A requirement is that participants have had at least one year of experience in psychoanalytic and/or psychodynamic supervision.

Over the course of the research, there will be one interview, a written or verbal three-question follow-up, and finally a verbal or written reaction to a summary of the findings.

If you are interested, please contact Tom Beller, researcher, at tpbeller@aol.com. I have attached an abbreviated version of the proposal for your review if you would like to review it. Thank you.

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THE INSTITUTE FOR CLINICAL SOCIAL WORK

A PHENOMENOLOGICAL ANALYSIS OF HELPFUL EXPERIENCES IN PSYCHOANALYTICALLY-FOCUSED SUPERVISION AS DEFINED BY SUPERVISEES

A DISSERTATION PROPOSAL SUBMITTED TO THE FACULTY

OF THE INSTITUTE FOR CLINICAL SOCIAL WORK IN PARTIAL

FULFILLMENT OF THE DEGREE OF DOCTOR OF PHILOSOPHY

THOMAS P. BELLER, LICSW
CHICAGO, ILLINOIS
FEBRUARY 2014

Attachment: Research Proposal

Appendix G

Phase 2 Research Questions Mailed to Participants

May 30, 2015

Dear _____,

Here are the three questions that are part of my research study. Answering any or all questions is optional. You may choose the format for your response, that is, email, phone or face-to face. I would appreciate a response within the next two weeks. The questions are:

1. Could you share any helpful interactions that involved resolving a conflict between you and any clinical supervisor?
2. Could you share any helpful interactions that helped maintain openness with a clinical supervisor who was also an evaluator?

3. Could you share any further helpful interactions that came to mind since our interview?

I greatly appreciate your time and effort with this study.

Sincerely yours,

Tom Beller, phone: 202-669-8513; email: tpbeller@aol.com

Appendix H

Phase 3 Summary Sent to Participants for Comments

July 12, 2015

Dear participants,

I first want to state that I consider each person that I have interviewed to be a co-researcher in this study. Each of you, of course, understands your experiences in supervision better than I. I greatly appreciate your sharing with me thoughtful and intimate experiences in your supervision sessions. Please feel free to react or not react to the following summary of findings. The purpose of your reactions is to further refine, add to, correct, or verify the findings. A reaction can be anything from one word to an extensive many-paged reply. Receiving this feedback hopefully will further elucidate the phenomenon of helpful experiences in clinical supervision.
I consistently use the feminine pronoun for participants, even though three of the volunteers were male. I follow the same format when I refer to supervisors. One quote in this summary will be reflective of the actual feminine and masculine pronouns.

According to participants, helpful interactions in supervision more often occur in an environment which is experienced as a haven where uncertainty can safely be explored with a highly focused, insightful, and self-reflecting empathic supervisor. It is helpful if the supervisor and supervisee work collaboratively to explore dynamics of the patients' ingrained intrapsychic and interpersonal issues. The hour is further enhanced, when there is present in the supervisee a highly focused energy, which has been built up from preparation and anticipation of exploration into specific ambiguous areas of patient/therapist interactions. When safety is perceived as lacking, there is often a treading of water with a reluctant accommodation to the supervisor's narcissistic needs, lack of empathy and lack of self-monitoring. In these experiences there is less of knowledge gained, and there may be also an atmosphere of seeming apathy, indifference or sometimes worse—feeling demeaned and marginalized by the behavior of the supervisor. In at least one experience with a supervisor, the participant described a seeming benign silence throughout her sessions with the exception of allowing a request from the supervisee regarding a particular treatment intervention with her patient. With some supervisors, participants experienced a caring and supportive environment which was valued for its acceptance or initiation into the field but that lacked the necessary stimulation of a strong learning experience.
Many participants mentioned holding and containing as an important ingredient for fostering a safe and productive environment for clinical exploration and learning. In this context, participants used the following words to describe the supervisors' approach with them:
warm
caring
kind
inviting
collaborative
respectful

intellectually and emotionally attuned to the supervisee
listening attentively
taking in or valuing every word of the supervisee
subtle validation
appreciation of different styles in working with clients
self-monitoring
trustworthy
compassionate
encouraging
supportive
non-judgmental
accepting
flexible
empathic
authentic
sensitive to supervisee's major life adjustments
very focused
insightful
perceptive
good reality-testers
quality of well-timed and good feedback
creating a space to think
helping supervisee getting unstuck
good at suggesting a change in direction with patient
showing up on time for sessions
clear expectations (e.g. process recordings)
accommodating
capacity to track the process, remember or hold on to it, then to bring it back to the supervisee and process it together

The tone with which the supervisor asked questions or gave feedback was often mentioned by several participants as extremely important. The tone most often expressed was inquiring or neutral, but importantly, experienced as non-judgmental in its effect. With respect to therapist's interactions with patients, question such as "Where are you going," "How does that serve you," What was the reason you said that," were received as helpful questions. These types of questions, in turn, helped participants to be more curious and introspective concerning various interventions with their patients. In addition, within this non-judgmental atmosphere, a supervisor's suggestion that the supervisee take a different direction was experienced as helpful and participants were generally appreciative of this type of guidance.

Many participants described interactions where the supervisor would create space for them to think and even let them dangle for a while with not knowing, but would not let them dangle too long by eventually giving feedback. In fact, two participants describe

this process using identical words. The timing of this dangling was considered important by a number of participants. One participant described her supervisor as a “master of balance” in their timing. Supervisors would often help supervisees tolerate the anxiety of not knowing. It was also described as part of the process of hanging on to the supervisee so that she could contain the patient.

An important aspect of helpful interactions for some supervisees had to do with unanticipated reactions from supervisors that entailed vivid and powerful, but insightful remarks that grabbed attention by using demonstrative, but at the same time accurate forms of describing reality as part of conveying feedback. These forms of feedback were initially experienced as norm-deviating or even norm-shattering moments. These thought-provoking remarks, while temporarily experienced as destabilizing, challenged supervisees with an important message to consider with respect to some patients. After more fully integrating what was said, not only did the supervisee feel enlivened by a new way to conceptualize a patient but it tended to reinforce her passion for the work. The recipient of such expressiveness did not experience this so much as a technique but more as an authentic remark from the supervisor.

Another theme involves mutual interest in clinical work in the supervision hour. One participant in particular described how when her supervisor picked up on her intense interest for the work, the supervisor apparently was spurred on to invest even more of herself in the contagious stimulation of the charged atmosphere.

A number of participants have stated that they felt that their supervisor knew them well. As a result, they felt comfortable in revealing more about their countertransference toward patients along with having more open interactions with their supervisors. This also contributed to open discussions related to client transference and enactments between client and supervisee. In some cases, interactions between the supervisor and the participant that were related to enactments of what went on in the therapy sessions were also freely processed.

Another experience shared by many participants was the feeling that every word they spoke was valued by the supervisor who listened attentively. This seemed to lead to a more focused engagement and investment in the process for the supervisee.
Having a supervisor with the same gender was mentioned, although less often, as important in helpful interactions regarding both modeling of supervisor and feeling more understood and easier to relate to.

The type of boundaries set by the supervisor depended on her style and the context in which self-disclosure was practiced during the hour. One remark from a participant was representative of what others expressed in different words. This was that she did not need her supervisor to be a friend. Their primary concern was receiving help with treating patients, especially difficult patients. Participants reported that self-disclosure by the supervisor was variable, both in terms of how often it happened and at what point in the

supervisory relationship. In all cases when self-disclosure was described, participants felt that it served a clinical need of the supervisee. One participant stated that she was relieved to know nothing personally about a particular supervisor, especially at first, when she was presenting an extremely difficult case. At that point it would have been a distraction for her. Some supervisors self-disclosed about some of their previous experiences with patients which were pertinent to the participant's current patient that they were presenting at the time. One participant described a supervisor's style as spending the first session talking about her life in a matter of fact "non-conceited" manner and telling the supervisee she could tell about her life in the second session. The participant reported that she found this approach to be very conducive to setting an open atmosphere in which to discuss treatment cases. In reflecting back on the experience during our interview, she speculated that in addition to the above reason, it may have served the purpose of "…informing her conceptualization of us as supervisees to be able to use that data later when we would have an interaction with the client."

Many participants said that their supervisors required process recordings. Some of these were written out and others were audio recorded. Except in the exceptional cases where the supervisors were either considered not helpful and/or highly critical, participants described the process of reviewing these together as extremely useful.

Some participants described how they dealt with difficulties that they experienced with particular supervisors. Two participants said that they enlisted the help of a third party that had comparable status to their supervisor. In one of these situations, the third party was described as respected by both supervisor and supervisee. In both cases the participants felt that this was helpful. In another situation the participant said the following: "I respected a supervisor for listening empathetically while I voiced a difference of opinion, even though I knew he saw the matter differently. I, of course, acknowledged that I realized that he would get the final say, but that I would have chosen an alternate course of action. I believe it was a satisfactory interaction for both of us." In two other difficult situations the participants seemed to reflect back on these types of difficult experiences. In one instance, the participant said that she expressed her upset with her supervisor and that she responded in an understanding manner. In the other instance, the participant considered her transference to authority figures and thought that she had probably exacerbated an already difficult situation with a difficult supervisor.

A number of participants mentioned their experience in group supervision. With the exception of one group experience, participants expressed feeling safe to talk about their experiences with their patients because other group members were open with their experiences. These participants felt that helpful feedback came from group members as well as their supervisors who were leading the groups. Group participants had to feel safe for its members to present cases without filtering and to be open to feedback. The one exception to these safe and helpful experiences was a group in which one participant described the supervisor as highly critical and way off the mark with her personal judgements and attacks on group members. The participant described the feeling among

the group members as wondering whether it was their turn to be the next to be attacked by the supervisor. One of the types of groups which was described as highly helpful by participants was geared to the learning of a specific approach to treatment. The participants in this type of group described the supervisors as very helpful in giving useful feedback and they said that it was given in a neutral non-judgmental manner.

Thank you for reviewing this summary.

Tom Beller

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