Institute for Clinical Social Work

# MODULATING SUPERVISORY TECHNIQUE WITH PSYCHOLOGICALLY IMPAIRED SUPERVISEES

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By

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# ABSTRACT

Twenty-five clinical social work supervisors were interviewed to explore how they modulated their responses to psychologically impaired supervisees. For the purposes of this study, a psychologically impaired supervisee was defined as a supervisee whose unresolved emotional issues impaired his or her ability to engage in the supervisory or therapeutic task. The supervisors interviewed had been practicing and supervising for an average of 29 and 20 years, respectively.

The supervisors in this study described three types of psychological impairments: transient, normative parts of the clinical learning process; temporary impairments due to a crisis or personal problem; and ongoing substance abuse, psychiatric, or characterological issues. Each category had a range of severity and there was overlap between categories. Supervisors found working with supervisees in all three categories challenging. It was only in the last category that supervisors described supervisees who "shouldn't be in the field," who often were "counseled out" or terminated.

The supervisors articulated that they modulated their responses to psychologically impaired supervisees to best meet their individualized learning needs, as they did with supervisees who were not psychologically impaired. The supervisors articulated a model of supervision that stressed the importance of tailoring goals and methods to the individual supervisee.

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# CHAPTER I

## INTRODUCTION

Clinical social work supervisors expect to attend to the emotional life of their supervisees as a normal part of supervision. This expectation is related to the nature of clinical social work and to the nature of the training required to develop this type of clinician. At times, however, supervisees may bring to supervision unresolved emotional issues that interfere with their ability to do the work and to engage in the supervisory process. They may be aware, partially aware, or not aware of these issues and their impact. Such unresolved emotional issues are referred to in this study as psychological impairments.

These psychological impairments range in type and intensity from normative parts of the learning process to severe threats to the supervisee's ability to function in the field. The supervisee may experience clinical "growing pains," countertransference reactions, or an enactment. They may have a trauma or disruption in their personal life. Or they may struggle with profound characterological, psychiatric, or substance abuse issues. The severity of each of these types may range from minor to acute.

To protect the client, the supervisory process, and the supervisee's development, a supervisor must formulate a response to this psychological impairment. This may happen

before the supervisor, the supervisory dyad, and/or the supervisees come to an understanding of the psychological impairment, let alone a resolution. The supervisor may or may not be aware of this process.

When the supervisor realizes that the supervisee's work or supervision are being affected, they might suggest that the clinician begin or return to personal psychotherapeutic treatment in order to resolve these issues and thus reduce their impact. The acknowledgement that there is a problem that needs attention may be sufficient in itself to get the work or the supervision back on track. Also, the supervisee may respond to treatment quickly.

However, referring a supervisee to treatment is not, in many cases, sufficient to address the problem the supervisor has observed or experienced. The supervisee may be in treatment concurrently with supervision. The supervisee may begin treatment. Some may refuse. If a supervisee does begin their own therapeutic work, results are not necessarily instantaneous. Furthermore, it may be more common for a social work supervisee to enter non-intensive therapy, rather than intensive psychodynamic psychotherapy or psychoanalysis. For some types of impairment, this may reduce the intensity, and perhaps efficacy, of a treatment. A referral to treatment may not in itself be a sufficient response in many cases.

Whether treatment is sought or not, the immediate impact on the supervision or the work remains threatened by the supervisee's unresolved issues. The supervisor must decide how to respond to best support the supervision and the supervisee's work.

No clear guidelines or protocols exist to help the supervisor make such decisions. Supervision is rarely offered as a course in Masters of Social Work (MSW) or

PhD/Doctorate of Social Work (DSW) programs or in Continuing Education Units (CEU) courses (see Appendix C). It is not sufficiently attended to in the literature and it is not standard practice for clinical social workers to form study groups on the issue of supervision. Agency supervisors often are not trained except in technical or managerial aspects of the job. (Shulman, 1993, Gardiner, 1995) This study sought to understand supervisors' responses to psychologically impaired supervisees and the process by which they developed these responses. This study contributes to our field's increasing interest in this issue and suggests areas for further study. This effort serves to improve our field and to protect the general public as consumers.

# CHAPTER II

## REVIEW OF THE RELEVANT LITERATURE

Literature that addresses the general topic of modulation of supervisory technique with psychologically impaired supervisees within clinical social work does not exist. Work on supervising supervisees with characterological issues is minimal. (Gill, 2001, Brightman, 1984, Glickauf-Hughes, 1994) This absence is but one example of the lack of attention to supervision that the field of clinical social work should begin to address in a fuller way. Few training programs offer programs or courses on supervision on the masters or doctoral level or for continuing education credits (see Appendix C). The necessity for the examination of this topic, as well as of supervision issues on the whole, assumes paramount importance when one examines the following: the nature of the tasks of clinical social workers; similarities among those who enter the field of social work; the need for treatment for social workers; the inherent difficulties in the role of supervisee; the complexity of supervision; and the teach/treat conundrum within the history of psychoanalysis and within current practice.

The work of clinical social workers[1] is complex, demanding, subtle and profound. In addition to concrete skills, the work requires a high level of intra-psychic

[1] In the discussion that follows, authors discussing the training, theories, and experiences of therapists from other disciplines will be referenced. While each discipline has unique traits, it is assumed that clinical social work shares with them certain fundamental properties.

sophistication. (Sharaf and Levinson, 1964) Safran and Murran explain that therapists must posses a variety of skills, stating:

> The relevant skills are not just narrowly defined technical skills: they are also complex, multifaceted inner and interpersonal skills. In order to disembed [sic] from enactments, therapists require a basic capacity for self-acceptance (or at least the ability to work toward it), as well as the willingness and courage to face their own demons and to engage in an ongoing process of self-exploration and personal growth. They also require certain basic skills, including interpersonal sensitivity, perceptiveness, and tact, as well as the capacity for intersubjectivity (in the sense of being able to apprehend the patient's perspective and of being able to experience the patient as a subject rather than as an object. Related to this is the capacity to engage in genuine dialogue with the patient, through which therapists are willing to challenge their own preconceptions. (2000, p. 205)

To achieve this level of competency, it is clear that clinical social workers must be self-aware, must have worked through emotional issues, and must be committed to intra-psychic growth and health.

However, a significant body of literature asserts that many clinical social workers and psychotherapists choose the profession because of unresolved emotional issues. Studies have documented that a significant percentage of clinical social workers choose the profession because of trauma and loss histories of their own. (Black, Jeffreys, and Hartley, 1993) Master's level social work practitioners and social work students reported being "overresponsible" and "good or parentified children." (Black, Jeffreys, and Hartley, 1993, p. 172) One third of all U.S. social workers came from families in which alcohol abuse played a role. (Black, Jeffreys, and Hartley, 1993, p. 177)

A recent edition of the National Association of Social Workers (NASW) *Social Work Networker* included a standard column "Student's Stand." In it, Christina Petersen, a BSW student, asserted that she chose to become a social worker as a result of

witnessing what she labeled as her father's verbal abuse of her mother and witnessing a friend's experience of domestic violence. (Petersen, 2004) While we do not know what meanings she made from what she witnessed, Ms. Peterson choose to explain her career choice as based on her experiences with family dysfunction.

Even popular culture can reflect this phenomenon. The popular Home Box Office series *Six Feet Under* charts the career development of one of the central characters. Brenda, a massage therapist, explains her decision to enter a social work program, stating, "I just figured that no one knows more about crazy people than I do. I was raised by them. I am one of them, and I'm way too old to be rubbing on strangers.[2]" Both her parents are famous psychotherapists, and her mother was once a patient of Brenda's father. This scenario demonstrates the phenomenon in question.

Numerous authors have written about the way in which the career choice of psychotherapists is affected by problematic families of origin. A. Miller asserts that many psychotherapists come from backgrounds with narcissistically impaired caretakers. (1987) Other authors have asserted that the choice of becoming a psychotherapist points to early family trauma or parental failures more generally. (Brightman, 1984, p. 295) Chudnof, in his unpublished dissertation, extensively interviewed twelve "helping professionals." He found that they all came from dysfunctional families. He noted common themes, including being burdened at a young age with responsibility, acting in an emotional parentified manner, not being able to fully develop a sense of self, and making meaning of early traumas by choosing a career in the helping professions. (1988)

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[2] Episode 2, season 4, "In Case of Rapture"

Other authors have studied more specific aspects of family dysfunction which impact career choice in psychotherapists. Lackie explores the childhood role played by those who later became social workers. He asserts that "a plurality" of social workers come from families of origin in which they were "the parentified child, the overresponsible member, the mediator or go-between, the "good" child, the burden bearer." (1983, p. 310) His dissertation, an empirical study of 1,577 social workers found that "over two-thirds described themselves in such terms vis-à-vis their families of origin." (1982, p. 310) Lackie then explores the impact of such a role on psychic development. He asserts, "The overly parentified child is expected to specialize in meeting the needs of others, and is, paradoxically, simultaneously infantilized in other aspects of his or her development. Empathy for others takes precedence over empathy for the self." (1983, p. 312) Thus, these children are left insufficiently psychically developed.

Lackie suggests that these parentified children, suffering from low self esteem, (1983, p. 313) may choose the career of social work in an attempt to alleviate their own intra-psychic issues. These issues include "healing other families, as one can never resolve the impossible bind of healing one's own," (1983, p. 315) avoiding loneliness, experiencing human contact, defending against the desire to narcissistically exploit others, exercising power and control, being an important object for someone else, (1983, p. 316) and integrating externalized "bad" parts as represented by the clients. (1983, p. 318) In addition, Lackie suggests that:

> Professional caretaking . . . may be an attempt to make symbolically one's own parents, or our parental introjects, more capable of parenting. It is an attempt to distort history. It can be a trade-off, a compromise, an attempt at individuation from the specialized role of parents to the parents. It can

> be an attempt to put to rest an impossible legacy through more limited, more manageable caretaking. (1983, p. 317)

An individual's unexplored response to dysfunctional family functioning or trauma may propel them into a career in clinical social work.

Other authors explore the more general intra-psychic motivations for choosing a career as a psychotherapist, while not exploring family of origin issues specifically. They assert that career choice provides information about the individual, specifically about their intra-psychic reality. (Henry, Sims, and Spray, 1973) Racker states, ". . . the psychoanalyst's choice of profession, like all such choices, is itself based upon the object relations of infancy." (1968, p. 106) He continues:

> For neither is the analyst free of neurosis. Part of his libido remains fixated in fantasy—to the introjected objects—and so apt to be transferred. Part of his psychic conflicts remain unsolved and strive after a solution by means of relations with external objects. His profession, too, and his resulting social and financial situation are subject to the transference of central inner situations. (1968, p, 105)

Thus, the choice of psychotherapy as a career is an expression of early object relationships. Being a psychotherapist may serve a defensive role. (Austin, 1952) Arkowitz states, "It is likely that those of us who choose this profession enjoy the kind of protection that comes with the role of therapist, for varying dynamic reasons." (2000, p. 38) Narcissism may be one of them, as A. Miller has suggested. (1987) Brightman suggests that "narcissistic issues may be assumed to occupy some position of prominence in the personal psychology of the psychotherapist." (1984, p. 295) Clearly, intra-psychic issues affect the choice to become a psychotherapist and a clinical social worker.

The implications are concerning. Numerous authors have written on the possible problems that may result. These problems all interfere with the ability to be a good

clinical social worker. Austin states, "People whose early life experiences have been too damaging and who have not had subsequent corrective experiences will be vulnerable . . . and may not make good social workers." (1952, p. 67) Black, Jeffreys, and Hartley are more specific, stating:

> . . . failure to resolve a problematic background may result in a "wounded healer" (Maeder, 1989), with countertransference biases that can be harmful to the therapeutic relationship. Internal pressure from unresolved personal needs may prevent the therapist from appropriately attending to the needs of the client. (1993, pp. 177-78)

Caplan and Caplan describe caregivers drawn not only to the helping professions, but to specific types of cases. They state, ". . . caregivers compulsively hunt out cases that link onto unresolved themes or conflicts in their own lives, manipulating clients so as to reenact the caregiver's own unconscious inner drama." (2001, p. 40) This allows the caregiver to unconsciously defensively address his or her unresolved emotional issue. They explain what they term a "theme interference:"

> [It] is an irrational, unconscious maneuver engaged in by the caregiver in order to solve an unresolved problem in his or her mind or life. The caregiver projects onto a current work situation his or her own unconscious or preconscious issue that is triggered by an evocative cue in the characteristics of a client or in a feature of a client's case. Theme interference is a psychic defense, whereby, to use psychoanalytic terminology, a displacement is effected so that the caregiver confronts and struggles with his or her own problem 'out there," where it is relatively unthreatening because it is supposedly taking place at a safe distance in someone else's life and not, obviously, within the life of the caregiver. (2001, p. 41)

Therefore, therapeutic relationships may be geared towards meeting the clinician's, not the client's, needs. (Black, Jeffreys, and Hartley, 1993, p. 179)

Woititz asserts that adult children of alcoholics (ACOAs) replay family dynamics in the workplace. This is of special concern as Black, Jeffreys, and Hartley found that a

third of social workers come from family backgrounds in which alcohol abuse played a role. (1993, p. 177) Woititz explores the specific challenges these ACOA "counselors" face, which she asserts are: problems with boundaries, burnout, a high level of stress and poor stress management skills, fear of conflict with clients, need to be liked by clients, fears of referring or not accepting clients and managing case load size, need to predict and control treatment progress and discomfort with countertransference. These challenges would have a severe impact on a social workers ability to practice, especially to practice as a clinician.

Wood explores further problems faced by the ACOA social worker. Wood asserts that ACOAs "sacrifice a substantial portion of their selfhood in order to minister to the physical and psychic needs of their parents or parent-surrogates." (1987, p. 145) They employ splitting and utilize the helper role to avoid feeling helpless and to maintain a false sense of family harmony. They may choose to enter the mental health field to continue this process. If they do not examine their own functioning, they will act-out in an unconscious, defensive manner. This will lead them to be unavailable to their clients and unable to tolerate necessary parts of the treatment, such as a lengthy treatment and the patient's appropriate expressions of difficult affect. (1987) Clearly, these challenges would impact negatively on ACOA clinical social workers' ability to practice psychotherapy.

Therapy for social workers who enter the field as a way to respond to unresolved family problems or personal trauma is clearly necessary. It is also necessary for less obviously burdened social workers. Whether suffering from unresolved issues based in a traumatic background or not, all therapists remain affected by their archaic objects and

their psychic realities. Symington asserts the necessity of a therapist's comfort with his or her own internal world, stating:

> It is the analyst's task to help the patient bear these feelings, to be there with the patient. But if the analyst also has feelings that he cannot bear, he will repudiate those same feelings in the patient. He will do this unconsciously. It is when these proto-feelings in the analyst have not reached the status of feelings, and no transformation has occurred, that there is trouble. (1996, p. 31)

It is crucial that clinical social workers be aware of and comfortable with their own intra-psychic world. Ekstein and Wallerstein assert, "One can only work with the unconscious of another person when he has learned to work with his own, has relived his infantile neurosis, freed himself from its terrors, and has resolved his basic conflicts." (1958, p. 248) Working through also prevents impairment in the learning process Austin asserts that a supervisee must be able to form a relationship with the supervisor and that this ability is dependent on the supervisee's appropriate resolution of developmental tasks. (1952) Clearly, it is imperative that clinical social workers engage in his or her own psychodynamic treatment, no matter the level of dysfunction or trauma in one's history.

While many clinicians, degree programs, and training institutes may recommend treatment, (Ekstein and Wallerstein, 1958, p. 247) it is not required in this field. Further, many mental health practitioners do not pursue their own psychotherapy. (Koenig and Spano, 2003) Treatment is, however, crucial to the development of the clinical social worker. Ekstein and Wallerstein state: ". . . the personal psychotherapeutic experience is, with but few exceptions, essential for the psychotherapeutic practitioner, and should be highly recommended to him." (1958, p. 251)

Over and above the pressures brought on the supervisee due to his or her potential trauma history and the pressure of his or her archaic objects, being a supervisee has inherent difficulties, no matter on what level one is functioning. (Austin, 1952) Supervisees must expose themselves, through their descriptions of their work. At times, supervisees reveal mistakes they have made or their mishandling of a situation. For some supervisees, the pressure is increased if his or her supervisor also plays an evaluative role and assures that the standards of the program, institute, or agency are maintained.

Being a supervisee makes one narcissistically vulnerable for a number of reasons. Gill (2001) provides a review of the body of literature that explores the inherent narcissistic vulnerability of the role of supervisee. Part of this narcissistic vulnerability is related to the process of learning and training. Fuqua defines learning as, "a potential disruption of a stable, cohesive self because it is an attempt to incorporate something new." (1993, p. 16) Learning to be a clinical social worker may be even more disruptive to the learner as it involves developing the ability to use the self in the work. Towle states that in social work, "learning and growth are synonymous." (1948, p. 22)

Although speaking of psychoanalytic students, Fleming's assertion that the development of the self is of paramount importance in training is applicable to clinical social workers. She states "the principal learning objective for any psychoanalytic student is the development of his self-awareness and his skills as an instrument in the psychoanalytic process." (Weiss, 1987, p. 147) This aspect of clinical social work training adds a further challenge to the already narcissistically taxing task of learning. Cozzarelli asserts that, "Professional and personal self-esteem are less differentiated for those in the helping professions because the instrument of practice is the self. Success or

failure is often viewed as a reflection of one's own character and level of functioning." (1993, p. 231) Just as learning itself is challenging to the self, training is fraught with inherent difficulties. (Lauro et al., 2003)

Authors have examined the stresses inherent in the training of psychiatric residents. While their process carries with it particular difficulties, it is possible to infer that they share some similar challenges with social work trainees. Sharaf and Levinson, discussing the training of psychiatric residents, state: ". . . more primitive wishes are often activated in the training situation; and, depending upon their strength and role in the individual personality, they serve both to intensify and to complicate the resident's professional learning. (1964, p. 137) Mehlman (1974) reviews the narcissistic challenges inherent in each step of the process of training psychiatrists. Thus, such training arouses various challenges.

Towle (1948) explores a number of specific aspects of social work training that make it potentially even more narcissistically challenging to the learner. Social work trainees begin field work before they have the expertise to do what they are asked to do. Trainees are faced with client contact long before they have had the opportunity to learn the academic and technical knowledge of the profession. This may be even more the case if a trainee is practicing psychotherapy as part of the internship. In discussing learning the practice of psychotherapy, Mollon notes that "one cannot learn it without doing it. There is no avoiding being thrown in at the deep end and beginning from a position of ignorance and naivety. Trainees inevitably suffer injuries to their self-esteem and self-image when finding that they are floundering." (1989, p. 113) In this way, learning by doing, especially clinical work, is more of a narcissistic challenge.

The clinical social work profession challenges its members to rid themselves of biases and prejudices. Many social work programs have increasingly focused on issues of diversity. Because the pressure, from both within and without, can be strong, social work students may not have the opportunity to fully work through their own biases and prejudices. Thus, they may be subject to denial and repression until the time that they can do so. (Towle, 1948) This may be further exacerbated if the trainee is working with clients who are from populations about which he or she may have biases and prejudices.

Towle continues laying out the particulars of social work training which challenges the trainee, noting that social work demands a unique form of thought. The learner must develop a way of thinking that is both "dispassionate thinking and intuitive feeling, precise thinking, well supported by evidence, along with speculative thinking, imaginative consideration. . . ." (1948, p. 24) This is an often times unexpected part of the profession, causing the learner to feel even less knowledgeable and capable.

Further, working with emotionally disturbed clients can be traumatic for social work trainees. They are exposed to the difficult emotions of the clients. The trainee may also struggle to deal with their own difficult feelings, such as frustration, helplessness, and pain, generated by attempting to help such clients. (1948) This may be confusing because the desire to help may not achieve the expected results. The trainee must deal with this often unexpected aspect of entering the "helping profession." While Towle focuses on the experience of trainees working with emotionally disturbed clients, it might be equally troubling to work with less disturbed clients.

Last, Towle notes that the trainees are encountering all these stressors at an early age. Because of this, they may lack the life experience and maturity which might make it

easier to handle all these stressors. In addition, this is made more difficult because they are negotiating normative, age-based developmental challenges. (Towle, 1948) Since training may provoke issues from previous developmental stages, (Brightman, 1984) it can be especially difficult for students negotiating normative developmental issues. This particular issue may be an ever increasing one for the social work profession as students entering master's levels programs are increasingly younger. Thus, Towle articulates how the particulars of social work training add additional challenges to the development of a student's sense of self.

Over and above these challenges presented by the learning and training processes, specifically being a supervisee offers challenges of its own. This is the case for many reasons. Some supervisees are leaving the comfortable, familiar, autonomous, and potentially protective role of therapist for the more vulnerable role of supervisee. The supervisory relationship is a crucial part of the clinical social work process for workers at any stage of development. However, it in itself may confuse supervisees, and provoke regression leading to a repetition of archaic object relations. Arkowitz states, "The supervisory relationship, while intended to augment learning in a safe context, itself stimulates uncertainty, vulnerability, and regression." (2000, p. 38) This may be even more acute an issue for psychologically impaired supervisees. Lewis asserts that, "Intense transference projections and displacements, both positive and negative, are triggered in the supervision process as they are in analysis." (2001, p. 75) Therapists may struggle against identifying with the patient (Arlow, 1963) and might be confused about the role of the supervisor. (Berger and Buchholz, 1993) The supervisor may come to serve as a professional analog to the idealized parent (Brightman, 1984, p, 307) adding

more conscious or unconscious material with which the supervisee must struggle. The somewhat hierarchical structure of the supervisory relationship for the beginning student may provoke regression, awakening early developmental challenges. (Levy, 2001) Finally, some of the tasks best worked on in the supervisory relationship, such as developing a sense of self as a therapist, are often challenging and unsettling in and of themselves. (Brightman, 1984) Therefore, the supervisory relationship is even more burdened. Thus, being a supervisee, no mater at what stage of the profession one is practicing, carries with it its own narcissistic challenges.

While potentially of immense value, parallel process may produce an additional challenge to the supervisory process. Patterns, conflicts, or problems within one dyad of the patient-supervisee-supervisor-training institute/community network will often be repeated in another dyad. (Ekstein and Wallerstein 1958; Arkowitz, 2000) It may travel in any and multiple directions from dyad to dyad. Unchecked, it may turn into an increasingly virulent spiral. (Ekstein and Wallerstein, 1958) Frawley-O'Dea and Sarnat explain that parallel process functions as ". . . an interdyadic transference-countertransference situation based on sequential enactment of identifications, often, projective identifications." (2001, p. 174) This is an unconscious process and often happens if there are "conflicts and difficulties that have arisen [in one dyad that] have not been fully understood in that situation." (Miller and Twomey, 1999, p. 558) This includes the acting-out of identifications, including defenses and resistances. (Arlow, 1963) A supervisee may recreate in supervision the dynamic between him or herself and the patient, unconsciously arranging for the supervisor to experience what it feels like to

be with that patient. (Arlow, 1963) This process can complicate the already difficult supervisory relationship, thus adding an additional challenge.

To make the situation more challenging, supervision is a complex task meant to address difficult goals. Expectations for supervision are based on the training, theoretical backgrounds, previous supervision experiences, and the intra-psychic make-up of both the supervisee and the supervisor, as well as its context, including institute, agency, and state licensing requirements. Fundamentally, supervision is intended to develop the supervisee's skills. However, the array of skills required by clinical social workers is varied. In addition to academic knowledge, the profession and its demands include the use of a specially developed self. Thus, the task of supervision for clinical social workers, and for other professions that produce psychotherapists, is in itself complicated and far reaching. The needs of clinical social supervisees are varied, profound, and subtle.

Ekstein and Wallerstein define supervision as being much more than a way to teach concrete information. They state that they understand supervision:

> . . . . not simply as the transmission of knowledge and skills, but rather as a complex process that goes on between the supervisor and his student. This process is a helping process in which the student is being helped to discover his problems as a psychotherapist, to resolve them with the help of the supervisor, and to develop toward higher integrations as a learner and as a psychotherapist. This process includes affective problems, interpersonal conflicts, problems in being helped, as well as in helping, as is therefore truly itself a helping process. (1958, p. 251)

Clearly, supervision is more than a didactic process.

In fact, supervision must teach a new way of knowing. Yershalmi asserts that supervision is an interpersonal process: "intended to broaden, deepen, and enrich supervisees' constructions and the knowledge they have acquired about their patients and

their experiences, or about themselves as humans and therapists." (1999, p. 424) Thus, this type of supervision is radically different than what is meant by the term in common parlance, i.e., the supervision of electricians, phlebotomists, or clerks.

Numerous authors assert that supervision must focus on the development of the trainee's self. This is one similarity supervision shares with the psychotherapy itself. (Austin, 1952) Wolf asserts that, "The purpose of so-called supervision in psychoanalytic education should be to facilitate the emergence of those psychological skills and talents as well as to strengthen of those [sic] personality traits that will enable the student-analyst to perform and to improve his psychoanalytic work." (1995, p. 4) Gardner asserts that clinical supervision "includes among its fundamental aims the development, consolidation, and maintenance of a cohesive professional self." (1995, p. 271)

To achieve the task of the development of the trainee's self, a supervisor must do more than transmit information. Sloane asserts that,

> The supervisor's functions, then, include not only didactic elements, but also selfobject functions, mediated by empathy, of mirroring responsiveness, idealizable calmness, and strength despite his own "not knowing," as well as idealizable empathic understanding and knowledgeability when needed. (1986, p. 208)

Part of this includes helping the supervisee feel safe and cohesive enough to learn. Brightman asserts that the supervisory situation must provide a "holding environment for the trainee during a period of extreme narcissistic vulnerability." (1984, p. 297) Clearly, supervision is not a cut and dried endeavor.

Further complicating the task of supervision is that it proceeds best when it is tailor-made for the particular needs of the supervisee. Austin suggests that successful

supervision requires the supervisor to make an individualized plan for supervision based on a sophisticated diagnostic evaluation of the supervisee's educational abilities and deficiencies. This includes the supervisee's relational abilities and personality. (1952) Furthermore, the needs of the supervisee change as they develop or as they are faced with particular traumas or challenges. Teitelbaum (2001) suggests that the supervision must change in response to the supervisee's development and new learning needs. Thus, supervision must be an individualized, fluid endeavor.

Such a complex and difficult task would seem to require training, supervision, and on-going support. However, this is rare within clinical social work. Jacobs, David, and Meyer summarize the paucity of training and support for supervisors:

> Yet in the field of supervision, there is still no agreed-upon theory of learning, no recognized technique, and often no clearly stated goals by which to measure failure or success. Each supervisor has been left to her own resources, forced to piece together a patchwork of ideas and theories regarding supervision from reading when she has time and from informal discussions with colleagues. Despite a sizable literature and the contributions of skilled clinicians like Wallerstein and Dewald, the theory, practice, and goals of supervision remain for a good many supervisors and teaching institutions poorly defined. Although clinicians are trained to think about theory and technique in psychotherapy, they are not expected to do the same for supervision. Supervisors often apply what they know of the psychodynamics of psychotherapy to the supervisory situation. Thus they may tend to use the vocabulary developed to describe patients and their pathology in their descriptions of the learning situation in supervision. (1995, p. 26)

Many clinical social workers never receive training in supervision. Instead, as stated above, they use their own experiences as supervisee and as supervisor to develop their supervisory techniques. However, learning supervision by modeling is an insufficient way to learn it. (VandeCreek and Harrar, 1998)

The field is just beginning to examine and address this lack. For example, some states are now requiring that social workers who want to provide supervision for advanced licensure receive certification. (Catherine Clancy, American Board of Social Work Examiners, personal communication, November, 2004) Texas, for example, requires a forty hour course. Illinois does not require such certification at this time. (Cheryl Fox, Illinois Department of Professional Regulation, personal communication, March, 2005)

While clinical social work has drawn its fundamental methods and tenets from psychoanalysis, (Strean, 1996) it has not taken the training structure developed by it through trial and error to address the special needs of this demanding work. The training structure in psychoanalysis was developed to address the difficult nature of supervision, the many narcissistic challenges facing the learner, and the facts of who seeks to become this very special type of practitioner.

To provide a historical context, it is notable that Sigmund Freud of course had no formal training in psychoanalysis and relied on his self-analysis and peer consultation. The next generation of psychoanalysts had little formal or academic training and benefited only from a brief analysis with Freud himself. (Ekstein and Wallerstein, 1958, p. 242) Freud and this generation developed the earliest conceptions of roles and boundaries, rife with violation. (Gabbard, 1995) It was within these early generations that the triadic structure of analytic training was established consisting of didactic learning, supervision, and the personal analysis.

Freud recognized the importance of supervision and the personal analysis, stating:

> At the same time it is clear that the psychoanalyst can dispense entirely with the University without any loss to himself. For what he needs in the

> matter of theory can be obtained from the literature of the subject and, going more deeply, at the scientific meetings of the psycho-analytic societies as well as by personal contact with their more experienced members. As regards practical experience, apart from what he gains from his own personal analysis, he can acquire it by carrying out treatments, provided that he can get supervision and guidance from recognized psycho-analysts. (1918, p. 171)

Thus, early on supervision was an integral aspect of psychoanalytic training.

Freud initially viewed a personal analysis for an analyst in training as an optional, brief type of professional development. (Weiss, 1987, p. 24) It was only after the field had begun to wrestle with the issue of countertransference did analysis become a necessary component of the development of an analyst. Freud viewed countertransference as an indication that the analyst had unresolved issues which needed to be addressed by self-analysis. (1910, p. p. 144) Soon after, he realized limitations to self-analysis and began to view a personal analysis as vital. He warned:

> But anyone who has scorned to take the precaution of being analysed himself will not merely be punished by being incapable of learning more than a certain amount from his patients, he will risk a more serious danger and one which may become a danger to others. He will easily fall into the temptation of projecting outwards some of the peculiarities of his own personality, which he has dimly perceived, into the field of science, as a theory having universal validity; he will bring the psycho-analytic method into discredit, and lead the inexperienced astray. (1912, p. 117)

Thus, almost from the beginning of the field, personal analysis was the cornerstone of preparation to become an analyst. Indeed, Wolf asserts, “The inescapable implication is that healing, that is, being analyzed, must precede learning.” (1995, p. 1)

While the field of clinical social work has not inherited from psychoanalysis the personal analysis as part of its training requirements, it has inherited the supervisory “dichotomy to treat versus to teach.” (Weiss, 1987, p. 63) From the earliest beginnings of psychoanalysis, there has been disagreement as to where to draw the boundaries in

what material is appropriate for supervision. Supervisory topics range from the patient, to the supervisee's countertransference, to the supervisee's psychic makeup which make him or her vulnerable to certain types of enactments. Yet focusing on the therapist-supervisee's early objects may begin to blur the distinction between supervision and psychotherapy.

Both supervision and psychotherapy concern themselves with making the unconscious conscious; there are other similarities between these processes as well. (Weiss, 1987) For example, Gardner states, "The method by which the goals of the supervisory process are achieved is fundamentally the same as the method by which therapists achieve their treatment goals: the unwavering use of an empathic mode of observation." (1995, p. 276) In a psychoanalytic training program, while a candidate's supervisor and training analyst have different jobs, each must struggle with balancing the tasks of treating and teaching. This becomes a complex challenge. Fleming states:

> A supervisor is a teacher, a clinical teacher. As such, his task is very complex. He is called upon for creative, growth-promoting work that involves both treating and learning. A supervisor treats as he analyzes the patient's problems, and he teaches as he evaluates his student's competence and assists him in mastering the obstacles to learning the skills of his profession. Helen Ross, at a Chicago Training Analysts' Seminar in March of 1956, emphasized the Janus job of teacher and therapist with which a supervisor is confronted. Miss Ross said, "It is very difficult to remain a teacher when he [the supervisor] sees the emotional flounderings, not just of the patient, but of the student as well. How to keep the balance so that the supervisor can continue to be a teacher; to help the patient and to help the student deal with his own emotional problems is the most difficult task I know." (Weiss, 1987, p. 144)

She continues:

> Even many of the techniques of teacher and therapist are similar, attempting as they do to continue to extend along productive lines the

> developmental, educative process set in motion at birth and initially guided for better or for worse by the child's first educator and first therapist, his mother. (Weiss, 1987, p. 23)

The lack of training and support for supervisors may contribute to the problem of differentiating the roles of therapist and teacher. A supervisor might be more comfortable with the role of therapist and therefore tend to treat the supervisee. (Shulman, 1993) Ekstein and Wallerstein state, "If a supervisor feels more comfortable with their [sic] role as psychotherapist, they may feel more comfortable treating rather than teaching their students." (1958, p. xi) This may be especially true with less experienced supervisors. They state:

> The one confronted with something new will try at first to reduce the new to the familiar. The Psychotherapist who becomes a teacher of psychotherapy will frequently be tempted to fall back to skills that represent prior acquisitions. He will thus try to convert the teaching relationship into a therapeutic relationship. (1958, p. 255)

Even an experienced supervisor must attend to maintaining a safe and comfortable balance. Due to the nature of the task and the population entering supervision, this balance is constantly tested and the boundaries risked, requiring a high level of skill and awareness on the part of the supervisor. Many useful supervisory techniques carry with them the risk of shifting the teach/treat boundary.

Empathy, the process by which one can profoundly understand the emotional experience of another, can be used to illustrate this. Supervisors empathizing with their supervisees can be useful. Chernus and Livingston state, "The empathic stance by the supervisor can be said to have enhanced the therapist's capacity for empathic responsiveness with the patient, so that the 'therapeutic self' of the supervisee became more firmly integrated." (1996, p. 388) Thus, the use of empathy by the supervisor has

defined another task to which supervision should attend, that of the development and integration of the supervisee. (Sloane 1986; Wolf 1995; Gardner 1995)

Another example is found in focusing on the supervisee's affect. Jacobs, David, and Meyer state: "While it is not our intention here to suggest that the trainee's affect should be the primary focus of his or her education and supervision, the trainee's affect will at times be the central concern of supervision." (1995, 142) Wolf states, "The goal of education is not to affect the deep structures of the personality, as in psychoanalysis, but the more toward-the-surface structures that determine a person's skills and cognitive capacities." (1995, p. 6) While of immense importance, these supervisory foci, if improperly handled, threaten to shift supervision into psychotherapy. Each supervisor must assure that an appropriate supervisory boundary is maintained. To do so, it is necessary to explore the teach/treat conundrum.

The teach/treat conundrum has existed since the beginnings of psychoanalysis. It originated in the early 1920s when the first attempts were made to develop institutes with standardized training models. (Jacobs, Davis and Meyer, 1995, p. 19) This became a necessity when the number of people interested in becoming psycho-analysts increased beyond the previous system, that of personal apprenticeships. (p. 18) Soon, two schools of thought emerged, the Hungarian and the Viennese.

The Hungarian view of supervision posited that the person best suited to supervise an analytic candidate working with his or her first client was the person who knew his or her inner workings best, the candidate's analyst. This was based on the assertion that the problems in a case grew out of the student analyst's own unresolved issues. Thus, the distinction between an analyst in training's own treatment and his or her struggles with

his or her work was blurry indeed. (Ekstein and Wallerstein 1958; Jacobs, David, and Meyer 1995) Wolf (1995) asserts that the Hungarian school is also characterized by viewing the analyst as someone who works to heal people with psychic disturbances. This would influence the conceptualization of the role of the supervisor, with more emphasis on the psychic effect of the supervisor and on the management of the multiple dyads in the candidate's experience (patient-candidate, candidate-analyst, candidate-supervisor). (1995)

In contrast, the Viennese School contended that candidates benefited from working with a variety of analysts and thus should seek supervision on the control analysis from an analyst with whom they were not in treatment. (Ekstein and Wallerstein, 1958) Whenever personal problems arose in the candidate's work, the candidate would be referred back to his or her own analyst to address it. This reflected the Viennese view of the analyst as scientist, investigating phenomena and creating theories to explain them. This view of the analyst as supervisor asserted the primacy of didactic teaching of clearly defined knowledge. The relationships were less important than the material studied. (Wolf, 1995)

Thus, the two major schools differed in their opinions on the very definition of an analyst and on who should provide supervision to candidates, his or her analyst or another instructor. Although it is more frequent for American psychoanalytic institutes to have a separate supervisor and analyst for a candidate, the discussion as to what constitutes appropriate material for supervision remains.

This issue may be seen as further complicated by the fact that there has been an overall shift over time in the conception of what is appropriate in supervision.

Teitelbaum explains that supervision used to be considered a one way process. A more knowledgeable and experienced supervisor helped a more inexperienced supervisee develop. (2001) The focus of supervision was based on the supervisor's or institute's conceptualization of the purpose of supervision. As the field over all has developed, supervision has increasingly come to be viewed as a two way, interactive process. What this looks like in practice also varies depending on the particular supervisory situation. Frawley-O'Dea and Sarnat (2001) explain that the range of supervisory styles on one end is represented by a supervisor who refuses even to comment on countertransference issues and on the other end to the relational model of supervision in which the boundaries between teaching and treating must be blurred.

More conservative or traditional supervisors will maintain the strictest teach/treat boundary. They will focus almost exclusively on didactic teaching, leaving the supervisee's personal development to their own treatment. They might only identify the issues that the supervisee needs to address in his or her psychotherapy or psychoanalysis, but explore them no further. (Lauro et al., 2003) This position may be based on many issues and concerns, including the view of the clinician as scientist, the frequently time-limited nature of supervision, and the difference in power between the supervisor and supervisee that may result in the potential for harm for the supervisee. (Frawley-O'Dea, 1997)

Further along the teach/treat boundary spectrum are found supervisors who attend more directly to the supervisee's internal needs. Sloane (1986) charges the supervisor with providing selfobject functioning, including being idealizable. The purpose of this stance is explained by Wolf who asserts: "Unless we make sure that the student's sense

of self is secure, that there is a minimum of self-esteem, he or she will not learn well. A steady supply of selfobject responsiveness, the "psychological oxygen," is in order for the self to be cohesive and functioning well [sic]." (1995, p. 5) Supervisors who keep in mind the selfobject functioning of the supervisor are clearly further along the spectrum of how supervisors negotiate the teach/treat boundary.

Glickauf-Hughes (1994) could be seen as going even further along the continuum. She suggests that the supervisor must attend to characterological problems in their supervisees by changing the supervisory style. She identifies specific techniques to work with different types of characterological resistances that interfere with learning which she lists as: issues of autonomy and control; insufficiently developed sense of self or identity; basic trust; shame; and narcissism. To do this, a supervisor must make a sophisticated diagnosis of the supervisee and change the supervisory technique. These supervisors are negotiating less clear teach/treat boundaries in supervision.

On the other end of the spectrum are supervisors whose teach/treat boundaries are permeable and changing in varying degree. Some may not maintain their boundaries because of lack of experience. Others may not be comfortable with the role of supervisor, or may experience psychological impairments themselves. However, some supervisors make a conscious decision to violate the teach/treat boundary. For example, Frawley-O'Dea and Sarnat (2001) support the idea of supervisors providing time limited periods of clearly defined psychotherapeutic treatment to supervisees. This is done at a particular point to best serve the supervisee's development. Clearly, it must be done carefully and with great deliberation to protect the supervision.

This examination of the teach/treat boundary leads to the question of concurrent psychotherapeutic treatment for supervisees. When a supervisee is in concurrent treatment, such as in the psychoanalytic training model, it may help the supervisory pair to do more effective and profound work. A personal treatment takes some pressure off the supervisory dyad by providing a separate space in which the supervisee can process the myriad of phenomena experienced during the process of work and supervision. In addition, the goal of treatment is personal development, while that of supervision is professional development, which of course includes personal development.

However, a concurrent treatment does not necessarily suggest a more conservatively drawn teach/treat boundary. Some supervisory dyads will choose to examine issues considered as falling into the "treat" category in supervision. In addition, there may be specific occasions when a dyad chooses to explore issues in supervision that would otherwise be taken to treatment. This may be the case when an issue arises in supervision and the supervisee and his or her own therapist are working intensely in an unrelated area. The supervisee might be resistant to bringing a new issue to his or her therapist at the time but see the value of working it through for the treatment. An example of the former is found in Frawley-O'Dea and Sarnat's comment on Marion, a supervisee. It also serves as an example of a supervisory dyad with flexible teach/treat boundaries. They state:

> Verbatim transcripts of some supervisory sessions would be hard to differentiate from transcripts of some therapy sessions. At the same time, the focus of the analytic process taking place in supervision remained fixed on Marion's growing freedom and effectiveness as an analytic practitioner, specifically, in her clinical work not only with the supervised patient but also with other patients. In her analysis, Marion eventually revisited this dynamic even more broadly and deeply, with a full complement of transference and countertransference manifestations alive

> between herself and her analyst. Yet it is inescapably true that the analytic exploration of Marion's relational themes in supervision resulted in significant personal growth for the supervisee that was indistinguishable from her professional development. (2001, p. 152)

This triad negotiated the supervisory boundaries in a particularly fluid and creative way.

Although perhaps an extreme example, the above cited case is an example of the situation when a supervisee is engaged in his or her psychotherapy at the same time he or she is engaged in supervision. It is significantly different than the teach/treat boundary when the supervisee is not also in treatment. Whether the supervisee has terminated a treatment or has never been in treatment, negotiating the boundary may be more complicated without the containing, exploratory process of treatment.

When the supervisee has terminated a personal treatment, whether successfully or prematurely, there is at least the chance that the supervisee has developed some of the emotional skills to manage being a supervisee. These include self-awareness, understanding of transference/countertransference phenomena, curiosity about latent meaning, etc. Thus, the supervisee may be better able to engage in the supervisory process and may be more amenable to hearing a recommendation to return to treatment if warranted. (Frawley-O'Dea and Sarnat, 2001)

When the supervisee has never been in treatment, there is a higher chance that the supervisee will be unprepared, both intellectually and emotionally, for the myriad of emotions and psychic events provoked by his or her work and by the supervisory process. The supervisee may be amenable to being referred to treatment or may experience the recommendation as an injury, an empathic break. It is possible in such supervisions that the supervisor may need to limit the focus of supervision to didactic matters (Frawley-

O'Dea and Sarnat, 2001) or to the facilitation of a supervisee's beginning treatment. (Lauro et al., 2003, p. 419)

As has been explored above, supervision for clinical social workers is crucial and fraught with multiple difficulties. The task of supervision is made more complex by the limitations in training requirements for social workers. Supervisors are faced with a variety of challenges from their supervisees, based on everything from the supervisee's experience to his or her internal functioning. To be successful, supervisors have to change the focus, style, and process of supervision according to the needs of the supervisee. Therefore, supervisors have to change their techniques based on the learning needs of the supervisee. Because supervisors are therapists, and therapists change technique for different patients based on their needs (Freud, 1910, Lombardi, 2003), it is reasonable to assume that this is possible in supervision. This will be explored further below. This study will explore how a sample of supervisors modulate their technique in response to psychologically impaired supervisees.

# CHAPTER III

## THEORETICAL AND CONCEPTUAL FRAMEWORK

Relational theory provides the theoretical and conceptual framework of this study. It offers a psychological foundation for understanding the way in which the supervisee's impairment may impact the supervisory relationship. In addition, it explores how the nature of the supervisory process itself makes it vulnerable to the supervisee's impairment.

Relational theory emerged from the interpersonal and object relations traditions, affected also by psychoanalytic feminism, constructionism, and self psychology, (Mitchell and Aron, 1999) as well as by co-constructionism and intersubjectivity. Greenberg and Mitchell (1983) first used the term in 1983 to describe a psychoanalytic alternative to previously existing theoretical schools. It was not until the mid-1990's, however, that there existed a school of thought that has referred to itself as relational theory. (Mitchell and Aron, 1999)

Interpersonal psychoanalysis, which had its heyday in the 1930s and 1940s, focused greater attention on the individual within their social world, rather than focusing solely on intra-psychic realities. Practitioners pursued interests in social and humanitarian causes and participated in political activism in an effort to improve the real life experiences of individuals. Interpersonal psychoanalytic theoreticians such as Clara

Thompson, Harry Stack Sullivan, and Erich Fromm were often dismissed by the more classic psychoanalytic academy. However, their work founded both the Washington School of Psychiatry and the William Alanson White Institute, both of which continue to function. These concepts contributed to the development of relational theory. (Mitchell and Aron, 1999)

Object Relations Theory, which began in 1940s Europe and came to the United States in the 1960s, continues to influence psychotherapeutic practice. Melanie Klein linked intra-psychic events to those in the exterior world. Others such as Winnicott, Kernberg, and Fairbairn focused on psychological concepts differentiating internalized mental representations of objects from their external counterparts and an individual's real relationships with others. This tradition also provided a foundation for relational theory.

Because of their relevance to the topic being studied, it is worth speaking of two of the schools of thought that affected the development of relational theory, co-constructionism and intersubjectivity. Vygotsky initially developed a theory of co-constructionism to explain how children develop cognition. (Wertsch, 1985) He asserted that the capacity for all thought originates in the social interaction before being internalized. Psychodynamic psychotherapy took this concept to explore the production of meaning in the treatment. Stark asserts in her Model three of psychodynamic theory that all "reality" is co-constructed by the patient and the therapist, including transference and countertransference. (1999, p. 63) This is in contrast to classical drive theory's positioning of the therapist as a blank screen onto which the patient projects his or her transference.

Intersubjectivity has a similar focus on the interconnection on the creation of meaning. Stolorow and Atwood posit that the intrapsychic is created through interactions with important others, stating:

> The concept of an intersubjective system brings to focus both the individual's world of inner experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence. In this vision, the gap between the intrapsychic and interpersonal realms in closed, and, indeed, the old dichotomy between them is rendered obsolete . . . . (1992, p. 18)

Benjamin (1995) focuses on the necessity for one to be able to see others as having a separate subjective experience in order to fully realize one's own subjectivity, instead of unconsciously manipulating others to fulfill internal fantasies. Both intersubjectivity and co-constructionism brought the importance of the mutual, reciprocal relationship between individuals into focus.

Relational theory characterizes dyadic relationships as mutual, interactive, and co-created. As in other dynamic theories, countertransference is valued on par with intellectual knowledge as a means of knowing and may be used openly as material in sessions. While both parties participate as complete, authentic people, each responds, both consciously and unconsciously, to the reciprocal pressure evoked by the other. This approach implies a "two-person" psychology. (Aron, 1991, p. 248)

As early relationships set the templates for all later relationships, early neglect and trauma result in bad internalized mental representations of objects. In an attempt to maintain a sense of connection with these internalized objects, an individual will unconsciously seek out and create with others familiar unhealthy or pathological relationships. Doing so provides the unconscious opportunity to rework these early losses, albeit in the displacement. Thus, inevitable enactments of these object relations

will occur. In the context of a therapeutic relationship, an individual has a greater chance at success in creating healthier future relationships. If the therapist is able to tolerate these difficult and unpleasant enactments, the dyad has the potential to explore the patient's subjective experiences and reality. (Stark, 1999) Interpretation and identification may provide the opportunity for internal growth.

Relational theory also influences modes of supervision which have shifted and developed throughout the history of clinical social work and its precursors. (Teitelbaum, 2001) Instead of a didactic process in which the knowledgeable supervisor imparts the details of the craft to the supervisee, relational supervision views the process as a reciprocal process, a two-person endeavor. Each supervisory dyad creates its own mode of working and mutually influencing each other. The modes of working are tailored to the learning needs of the supervisee, and are informed by the supervisor's basic tenets.

The supervisory relationship itself increasingly has come to be viewed as "a central dimension of the supervisory process." (Teitelbaum 2001; p. 6; Austin, 1952) This focus, including discussion when there is tension or conflict, provides the supervisee the experience of working through "relational impasses." (Safran and Muran, 2000, p. 215) Indeed, the supervisor models aspects of the psychotherapeutic process in supervision, i.e., a not knowing stance, self-awareness, the ability to tolerate being wrong, empathy.

Safran and Muran assert that within a relational framework, "Good supervisors are experienced by their trainees as attuned to their emotional and learning needs. They invite their trainees to identify with them, to take them as mentors, and yet at the same time they encourage autonomy." (2000, p. 213) It is important for supervisors "to create

a safe environment or a type of transitional space that encourages therapists to play with the subtle edges of their experience." (p. 216)

In addition to being a safe and supportive space, for relational theorists, the supervision must also be a reciprocal process, creative and interactive. Yerushalmi describes relational supervision as playing, as "brainstorming," suggesting the process be "as open as possible." (1999, p. 421) He suggests that it, "Involves ongoing negotiation over the clash of different subjectivities, leading to the evolution of new and joint meanings. The participants work together to create new constructions, after first individually deconstructing their old ones." (p. 421) He continues, stating:

> It is an ongoing process of probing for newer, richer, more pertinent formulations that offer ever greater freedom of action. Every new spiral involves subsidiary processes of deconstruction and reconstruction, each of which enhances the meanings that the participants can attribute to the supervision and to the nature of their relationship. (p. 424)

Thus, the supervisory process, and supervisory relationships are mutual, co-created, and interactive.

Due to its interactive and mutually influential nature, relational supervision may be more vulnerable to influence by a supervisee's psychological impairments. Although a supervisee is consciously using supervision to further his or her own professional development, he or she will unconsciously pressure the supervisor to engage in relational enactments because of the transference. In some instances a supervisor can use the transference to strengthen the work. For example, for a particular dyad, a parental/child dynamic might evoke the image of an object who would encourage a useful interest and concern. For another dyad, however, a parental/child dynamic might provoke a punishing, persecutory object re-experienced in the relationship. With an impaired

supervisee, the danger is that he or she will be unable to use the supervisor to mediate countertransference in the treatment or in the supervision. Supervisees may then pressure the supervisor, via projections, introjections, and projective identifications, to engage in enactments which impair the supervision.

The transference in the supervisory situation has some basis in the present, actual relationship. However, a supervisee's propensity to experience others in a particular way will cause him or her to see only certain aspects of the supervisor, aspects that will confirm the supervisee's expectations of all relationships. (Hoffman, 1983) Thus, once again the supervisor will have to negotiate the supervisee's pathological, frequently counter-productive, supervisory transferences.

For relational psychotherapists, individuals, in and outside of treatment situations are always constructing the reality that they experience. (Hoffman, 1983) Since this applies to supervisors as well as supervisees, the supervisor should be aware of his or her own relational dynamics. This will allow him or her to utilize his or her transference and countertransference towards the supervisee in order to help facilitate the supervisee's learning process.

# CHAPTER IV

## STRUCTURE OF THE STUDY

### Theoretical and Operational Definitions of Major Concepts

Psychologically impaired supervisee: a supervisee whose unresolved emotional issues impair his or her ability to engage in the supervisory task or the therapeutic one. This impairment ranges in severity from a fundamentally emotionally intact person with some unresolved issues or engaging in normative learning challenges, to someone with a more global characterological, psychiatric, or substance abuse disorder that makes him or her unsuitable for the field.

At times, supervisors may realize that the supervisee's psychological impairments have resulted in actions that require reporting, to state licensure agencies, academic institutions, the police, etc. The reporting may lead to the termination of the supervisee's licensure, participation in a training program etc., which may lead to the termination of supervision. This type of response by the supervisor is not the type that was studied herein as it does not constitute a modulation of technique.

Supervision: the regular or sporadic process sought by a less experienced clinician with a more experienced, or more highly licensed or accredited clinician. The supervisee's goals may range from agency or licensure requirements, to assistance with

problems in a case or practice, to professional development. This may take place in an individual or group setting. This includes what some might term "consultation." It does not, however, include peer supervision or consultation. While a valid method of working, its structure provides different relational opportunities than those offered in supervision as defined above.

## Statement of Assumptions

1. It will be assumed that a clinician's unresolved psychological issues can negatively impact his or her clinical work and his or her ability to engage in the supervision process. A clinician may not be consciously aware of the issues or of the impact.

2. It will be assumed that supervisors become aware of this impact and modulate their supervision in a way to best facilitate change and to protect the supervisory process and the supervisee's patients. Supervisors may or may not be aware of the process by which they decide how to respond. Their individual responses will vary not only on the particular presentation of the supervisee, but on the supervisor's own personality and history, training, theoretical stance, participation in the development of the field, personal psychotherapeutic treatment, and supervision history.

3. It is a requirement for participation that supervisors in this study will have engaged in their own intensive psychodynamic psychotherapy or psychoanalysis. It will thus be assumed that they therefore are reasonably emotionally intact. By this it is meant that they have an investment in self-awareness and self-analysis. They may still

experience, at times, intense counter-transference reactions to patients and supervisees and engage in enactments, and have issues that remain not completely resolved. They will, however, be committed to working through their emotional experiences to best serve their clients, their supervisees, and the field.

4. It will be assumed that aspects of the supervisory relationship will function in a similar way to the psychotherapeutic one. For example, the supervisory relationship will be affected by the transference and countertransference of both the supervisee and the supervisor.

5. It will be assumed that although clinical social work is different from other fields that train therapists, it shares characteristics with them. Thus, much that has been written about other fields is applicable to clinical social work.

6. It will be assumed that supervisees seeking supervision to fulfill requirements, for licensure, for an agency, or for a program, and those seeking supervision independently, solely to focus on their professional development, have the same potential to experience psychological impairments and pathological relational dynamics with their supervisors.

## Methodology

### *Research Question to Be Explored*

The research question of this study is, “In what way do supervisors modulate their response to an impaired supervisee?” Supervisors do so to reduce the negative impact of

the supervisee's impairment on the work, and to facilitate and strengthen the supervisory process.

### *Type of Study and Design*

This is an exploratory study (Tashakkori and Teddlie, 1998, p. 53) to develop a better understanding of the nature of how supervisors modulate their technique with psychologically impaired supervisees. It utilizes qualitative methods to, as Strauss and Corbin state, "obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods." (1998, p. 11) Each of the 25 subjects who were interviewed read and signed a consent form for participation in research before proceeding with the interview (see Appendix A). Once they did so, demographic information was obtained using closed-ended questions to elicit background information (see Appendix B). Then, a semi-structured interview was completed using a variation on a "funnel interview," (Tashakkori and Teddlie, 1998, p. 102) each of the three sections beginning with broad questions and becoming ever more focused (see Appendix C).

### *Scope of Study, Population and Sampling, Sources and Nature of Data*

A sample of highly educated and trained supervisors involved in the development of the clinical social work field was recruited (see Appendix D). This sample is more likely to have studied, thought about, and struggled with the issue in a meaningful way. Further, any suggestions offered by the results of this study will be stronger as they are derived from a sample drawn from the pinnacle of the profession. Thus, "purposive

sampling—the selection of individuals. . . based on specific questions/purposes of the research" (Tashakkori and Teddlie, 1998, p. 76) and "sampling for homogeneity—[selection of cases] such that they have the same quality and/or magnitude of the attribute" (Tashakkori and Teddlie, 1998, p. 56) were utilized. Thus, the subjects have differences of age, gender, training, experience, class, health status, theoretical orientation, etc., (see Appendix A), but they are more alike than unlike in terms of being practitioners of depth psychotherapy.

Snow-ball sampling (Tashakkori and Teddlie, 1998, p. 76) was utilized to produce subjects. No students, advanced students, alumni, board members, faculty, or staff of the Institute for Clinical Social Work (ICSW) were utilized as subjects, per the requirements of ICSW's Institutional Review Board. However, an email sent by the Dean of ICSW to the clinical faculty requesting names of colleagues, and an email sent by the researcher to other students, produced subjects who provided introductions to other subjects.

Contacting the deans of local Universities and training programs, and the presidents or board members of local chapters of professional clinical organizations requesting that the study's flyer be sent to the clinical social work faculty, students, or members did not produce subjects. Contacting individual members of local clinical organizations yielded two subjects, one directly, and one through another social work who did not meet criteria.

Only persons who fit the criteria laid out in Appendix D were used as subjects. There were no monetary rewards for participation in the study. Due to the chosen sampling techniques, the external validity (Tashakkori and Teddlie, 1998, p. 65), the

ability to generalize the results of this study to all clinical social work supervisors, are low.

### *Data Collection Methods and Instruments*

There were 25 one-on-one interviews that were completed. Originally, the researcher planned to conduct 30 interviews. However, data saturation was achieved with fewer interviews and so the number of required interviews was reduced. The interviews were approximately one hour in length. Subjects were requested to contact the interviewer to share any further thoughts. Although it was offered, no one requested an additional hour long interview. Only one subject left a message with a further thought for the researcher. The right to contact them for further clarification was also requested, but was not needed.

The sessions were audio-taped with two simultaneously running tape recorders, one digital and one with a traditional cassette tape. The digital recorder allowed files to be emailed to the professional transciptionist for transcription. The other recorder made back-up tapes in case there was a problem with the digital recorder. This occurred in one case. In that instance, the researcher transcribed the session from the cassette.

### *Data Analysis*

The data was coded, a process by which raw data is labeled, sorted, and organized in a way to answer questions and demonstrate results. (Straus and Corbin, 1988) “A

priori" themes, (Tashakkori and Teddlie, 1998, p. 119) or categories, were drawn from the literature and from the semi-structured interview and prepared prior to coding (see Appendix E). This labeled the "manifest content" of the data. (p. 121) As expected, this accounted for the majority of the categories.

However, during the data analysis other themes become clear. Thus "emerging themes" (Tashakkori and Teddlie, 1998, p. 117) were created during that process and were used to label the "latent content" of the data. (p. 121)

Strauss and Corbin suggest "open" and "axial" coding to code the latent content of the data. "Open coding" is "the analytic process through which concepts are identified and their properties and dimensions are discovered in data." (1988, p. 101) In other words, interview transcripts were reviewed and each idea, however minor, that was found was given a label, i.e., supervisee assessment, parallel process, need for treatment. (p. 106) Labels were taken from the respondents' responses to the demographic survey, the interview questions, and from any other comments they made, and from the researcher's observations of the interview process and associations. The data was then reviewed in larger segments, i.e., sentence, paragraph, or document, until no new categories were discovered. This stage of the open coding process went beyond labeling into memo writing.

Writing memos is the process of documenting the research process in writing. A memo contains the researcher's reaction to data, thoughts, plans, feelings, questions, ideas, and concerns. Rather than being only descriptive, memos are "analytic and conceptual." (p. 217) Writing memos suggests new concepts and categories for the

researcher, i.e., supervisor resistance to the interview process. Concepts with which to organize the latent content of the data arise from labeling and writing memos.

Strauss and Corbin's second stage of coding, "axial coding," is a process by which data that has been previously labeled and about which memos have been written are grouped together into more general categories. This process synthesizes data after splitting it apart in the open coding process. Large numbers of categories are grouped together in manageable groups. (p. 123-24) Thus the data was analyzed through these steps.

### *Statement on Protecting the Rights of Human Subjects*

Before any subjects were recruited, the Institute for Clinical Social Work's Institutional Review Board reviewed the plans to use human subjects to assure that no ethical violations would inadvertently take place. All participation was entirely voluntary. The subjects were informed of the purpose and scope of the study and signed a consent form (see Appendix A). All identifying data for supervisors, supervisees, and presented case material was deeply disguised. Subjects were informed of potential risks they may incur by participating in the study. These included becoming upset by thinking about and revealing potentially unsettling material, for example, how they handled supervision challenges in the past or aspects of their own supervision experiences.

If painful or troubling issues had been raised for the subject by the interview experience, and this was either apparent to the researcher or articulated to the researcher, the researcher was prepared to suggest subjects seek or return to mental health services.

If a subject did not plan to seek assistance from a current psychotherapist, it would have been suggested that a referral be sought from the dean or a senior member of their institute, university, or training center, a former professor or supervisor, or colleague. This did not happen.

To protect the confidentiality of the subjects and of the supervisees who were discussed, and in the service of clarity, all supervisors are referred to using the feminine pronoun, and all supervisees are referred to using the masculine pronoun. In addition, both parties will be deeply disguised and all potentially identifying details removed.

# CHAPTER V

# FINDINGS

## Demographic Information

The average age of the subjects was 58, with the youngest being in her mid 30s and the oldest in her late 70s. Of the subjects, 20 were females and five males. Subjects self-identified as White in 13 cases, six as White and Jewish, two as Jewish, one as other, and three did not answer.

MSWs had been completed by 24 subjects, while one had her Master of Arts (AM) in clinical social work. Additionally, one had a PhD in social work and two were currently in PhD social work programs. Five had certificates from a psychoanalytic training program and one had a doctorate in Psychoanalysis. Two had completed another therapeutic training program and one had a doctorate in a field outside of the human services.

Of the subjects, 15, or three-fifths, live and work in the suburbs of Chicago; six live and work in the city of Chicago; three work in the suburbs and live in the city while one lives in the suburbs and works in the city. No subjects either lived or worked in a rural area.

Subjects each were in practice for an average of 29 years, with the least being 11 and the greatest being 41. On average, they had been supervising for 20, with the least

being 5 and the longest being 36. Length in practice did not necessarily correspond to length of time supervising.

All subjects have supervised master's level social work students. Most have supervised MSW staff. Four supervised students in psychoanalytic training programs. A small number also supervised psychiatric residents, and psychology, DSW, and marriage and family therapy (MFT) students. Additionally, a few provided supervision or consultation for the following professionals: psychiatrists; psychologists (MA and PhD); counselors; BSWs; MFTs; clergy; child care workers; teachers; administrators in education; doctors; and nurses. One supervised foster parents. This work occurred within the auspices of training programs, agencies, and private practices.

A personal psychoanalysis was reported by 14 of the subjects. Of the others, 11 reported that they had been treated in in-depth psychodynamic psychotherapy. In addition, subjects reported participating in couples, group, and family treatment and twelve-step programming. Multiple subjects reported multiple treatments which they described as "rewarding," "deep," "intense," "successful," "long-term," and "constant." Many were currently in treatment.

All subjects described themselves as working from a psychodynamic background. Of the subjects, five labeled themselves solely as "psychodynamic." The rest labeled themselves as working from multiple theory schools, such as self-psychology, relational, object relations, family systems, cognitive/behavioral. The majority stated they work "eclectically."

Subjects reported teaching and doing presentations, writing and presenting papers, participating in national social work organizations and study groups, running intern

programs, and leading consultation groups. Supervision was currently sought by seven subjects, two reported seeking supervision as needed, and ten reported engaging in peer supervision and group supervision. The remaining five said they were not in supervision at this time.

No supervisory training was reported by eight subjects. Attendance at seminars was reported by six subjects, two attended field instructor trainings, three received a year of supervision on their supervision, two participated in supervision as part of a training program, and four reported their agencies offered supervisory training.

## Background

The twenty-five supervisors interviewed for this study have worked with psychologically impaired supervisees at times throughout their supervisory careers. For the purpose of this study, a psychologically impaired supervisee is defined as a supervisee experiencing unresolved emotional issues that interfere with their ability to do their clinical work and to engage in the supervisory process. The supervisor's response to psychologically impaired supervisees is understood within the context of how they think about supervision, their own experiences in supervision, the ways in which they learned to supervise, and the boundaries between teaching and treating supervisees. After this background information is presented, the experiences with and actual responses to psychologically impaired supervisees will be exemplified. Concluding remarks about supervisors' experiences with the interview process will provide additional implications for this study. To protect confidentiality and to increase clarity, all supervisors are referred to with the feminine pronoun and all supervisees with the masculine one.

The supervisors interviewed felt passionately about supervision. They saw it as a fundamental tool of the social work profession in developing clinicians. One supervisor noted, "[supervision] is how people learn and evolve." In addition, some noted that it is an important "quality control" mechanism for the field, a way to "guarantee good treatment." A few noted that it is a way to assure the continuation of a high quality clinical social work field. One noted, "It's a wonderful opportunity to be able to contribute to the field of psychotherapy. It's a privilege that one has to be able to work with people who are learning and growing and developing. I think that it is a special position to be in. It's an honor." With one exception, they all very much enjoyed supervising and made it a regular part of their practice. The one exception self-selected out of supervising as she felt that MSW students did not share her passion for psychodynamic theory and instead began teaching in a psychodynamic post-MSW program.

Those who enjoyed supervising expressed gratification in seeing their supervisees grow and develop. Supervisors enjoyed being seen as a mentor and even as an idealized figure. Several reported that it had a positive impact, finding it "energizing" and clinically stimulating. One stated, "It keeps me sharp." Another observed that it facilitates a continual examination of one's practice. She said, "It makes me think, well, why do I do it that way?" Another noted that as a supervisor you are constantly learning from your supervisees. One subject observed,

> I really enjoy supervising. I really enjoy thinking about learning, what a creative process it is. I like exploring how we get in the way of that process, and how we can promote it. I like working with students around these issues. I feel that it deepens my work and my own personal growth.

Another supervisor observed,

> Sometimes I've learned more about the work we do and the clients by supervising because you are one step removed and you can hear someone else talking about it. It is much clearer than when you are doing the work yourself. Whether it's because of your own issues, or because when you are sitting with a patient it is so much harder to see, but it is so much clearer when you are the supervisor.

Many supervisors enjoyed supervising for a range of reason, as exemplified by the following comment:

> It feels like teaching and I have always loved teaching. I love watching people grow. I love being part of what I hope is going to be. I feel like there are sixty professionals out there that I have piece in. I feel like it is a way for me to prepare the next generation. It humbles me because it just takes me back to my own not knowing. It also keeps me on my toes because they are always going to ask me something like well why do you do that? And, I will think to myself well, why in the hell do you do that? So, I really have to think about things. It also keeps me up-to-date. I don't always have time to take classes but they are learning such new stuff so I'm learning too.

Another, who works solely with post-MSW students who are working on an advanced level stated:

> It is always delightful to pass on things that you have learned with people. It is different from the therapeutic relationship because you can be more real. You are not just an object of transference and you can say, 'Well I had a case like that 10 years ago and here's what happened.' So there is an opportunity to be more of who you are. Which I think in this business is a wonderful refreshing break from just letting someone's emotions wash over you all the time. It is more mutual and you instantly have something in common with the person because you are in the same profession and you are both reaching for the same thing, which is to understand people better and to help them more effectively. That's exciting and fun.

One noted that supervising reminds her of what she does know, while another explained, "You get to feel really smart because you don't have all the encumbrances that go on when you are being the therapist."

These supervisors took supervising seriously. They felt that supervisors have a lot of power and can be of great use to a supervisee, can be indifferent, or at worst, can be

damaging. They felt that it was an important job requiring a great deal of work and energy. One subject expressed concern because, "This is not talked about much in our field. It's isolating and overwhelming. It's a huge responsibility. There's something up in our field that training is non-existent. The support is not out there." This same supervisor noted that in her experience supervising is a greater "burden" than providing psychotherapy and problems that arise in supervision are more challenging than problems that arise during the treatment process. A few supervisors felt that agencies that provide clinical services without providing clinical supervision are violating ethical standards.

A number of supervisors benefited from working, currently or at some point in their careers, at agencies where they received on-going high quality supervision themselves. For some, this included participating in regular groups for supervisors to talk about supervising. In addition, some received on-going supervision on their supervision cases. Some subjects received a year of supervision on their supervision as part of a licensure program. A few supervisors had taken useful courses on supervision as part of training programs. Others had attended field instructor or supervision seminars which provided some useful information, or read useful books and articles.

The majority of the subjects, however, reported that they trained themselves to supervise, patching together things they had learned from their own experiences in supervision, their own psychotherapy, and by trial and error while actually supervising. One noted, "You take a little from all of your experience and kind of meld it all together in a way that makes sense to you." Multiple supervisors made a connection between their clinical skills and their supervisory ones. One noted, "If you are going to be a good supervisor you really need to be a good clinician, because it's all the same stuff." One

noted that she learned to supervise by providing psychotherapy to patients, noting, “It’s a modified form of therapy.” In addition, multiple supervisors stressed the importance of their own treatment on their ability as a supervisor. One described “an enhanced capacity for empathy and understanding of other people.” Another noted, “I feel like it widened and deepened my compassion for understanding other people’s pain in life.” Another noted, “It taught me how to learn” while another noted, “Your work is only as healthy as you are.” A number reported using time in their own treatment to elicit supervision on both client cases and supervision cases from their therapists.

Numerous subjects reported that they had internalized good supervisors and even experienced bad and good “supervisor imagoes” which helped steer their own supervisory work. One supervisor spoke of when she first entered the field almost forty years earlier, noting, “I had a very bad experience with my supervisor. I promised myself that I would never do it like she did.” A few supervisors noted that during the internalization process, they unconsciously parroted their supervisors’ methods. They said this was unsuccessful, one noting that “it went over like a lead balloon.” Over time each was able to adapt their supervisor’s techniques and use them naturally and successfully. A few subjects reported that they modeled themselves as therapists and as supervisors on their own therapists.

Supervisors reported a wide range of personal experiences as supervisees themselves. There was general agreement that the qualities of a good supervisor included being good clinicians, compassionate human beings, intense, challenging and trustworthy. The good supervisor was present, emotionally and practically available, “with an open door policy.” The capacity to listen, model behaviors, give useful

information about cases, express concepts clearly, and to view mistakes as opportunities for learning were essential attributes. They also provided a holding environment, could tolerate being idealized, facilitated the exploration of feelings, and advocated for the supervisee when necessary. One supervisor noted that she especially appreciated her supervisor's "healthy sense of himself" and "see right to the heart of the issue." Another noted that being flexible and having a sense of humor helped enormously.

One subject noted that, "good supervision like with therapy is hard to come by." Many subjects spoke of experiencing poor supervision. They noted that poor supervisors tended to focus on their own needs. They did not teach anything "beyond where the fax machine was" and "couldn't be bothered," not "spending the time." In addition, these supervisors did not make the supervisees "sweat too much," and one even was sexually inappropriate. One supervisor reported a personal experience in which a former supervisor regularly fell asleep and blamed it on the material, without discussion or further exploration. A number of supervisors reported that they had especially struggled with "neutral" supervisors who based their stance on "classical psychoanalytic theory." These "classical" supervisors were experienced as cold, not present, uninvolved, and unhelpful. One supervisor noted that some of these supervisors were trained during the fifties and sixties when "the whole practice of psychoanalysis was like fraternity hazing." These supervisors felt that it was appropriate to focus on analyzing the supervisee as a regular part of the supervision which this supervisee found unhelpful, inappropriate, and undermining. A few subjects reported later learning that their supervisors had significant personal problems during the time of the supervision which may have contributed to their

poor performance. Also, some supervisees were able to diagnose their supervisors with a psychological problem which impaired their supervision.

The subjects observed that as supervisees, they learned how to elicit what they needed from supervisors, and learned to assess what could be gotten from a particular supervisor. One subject stated,

> As a supervisee I began to learn that as I am very good at taking care of people, so I can learn how to take care of my supervisor in order to get what I need. Still, with consultants that I use today, I know that certain consultants won't go there, won't talk about anything other than analytical treatment, and that's fine. But, if I need something different, I don't go to them. You learn to draw things from different people.

Another subject reported that she realized that her behavior as a supervisee contributed to the positive supervision she received. She said, "I do think that I like to please and I do all the stuff that students are supposed to do, keep good notes, show up on time, and I'd read anything that they tell me to read." Numerous subjects observed that supervisors are different from each other based on their personalities and on how much psychotherapeutic work they had done themselves.

These supervisors noted that they have experienced a wide range of supervisees. One acknowledged, "There is a big learning curve." The supervisors clarified that the structure of the supervision impacts how they proceed. They noted a difference between supervision that is required, for students, those seeking their licensure hours, or those adhering to agency protocol, and supervisions that are independently sought. A number of supervisors referred to the later as consultation, which they noted had ethical and legal differences from supervision. One supervisor noted that for independently sought supervision, in contrast to required supervision, "I am just there for whatever the person wants me to be there for." Another supervisor stated, "I am going to start with whatever

they think they need, but I am also going to give them feedback about things that I hear as we go along that I think would be helpful." This contrasts with required supervision in which, one supervisor clarified, "It is incumbent on them to put into action my feedback. They could disagree, and they could come and they could talk to me. But, because I have a legal and an ethical obligation, there is an expectation built in there."

In many instances, that which some defined as supervision took place in an agency setting, while consultation took place in private practices. Training programs, social work programs, and agency settings often had requirements for supervision. In addition, supervisors differentiated between working with supervisees who were assigned to them versus supervisees with whom they chose to work. Some supervisors who also held administrative posts tried to hire only people they felt would be productive to supervise. A few supervisors spoke of unofficially requiring people they agreed to work with to be in treatment in an effort to improve the quality of clinical work and the ability to engage in the supervisory process.

Other supervisors worked within the structure of a program and not only were able to interview prospective supervisees, but might also have had access to information about them from the program. One reported that she asks her supervisees to see their genograms which they do for a particular course taught in her program. Some agencies provide a protocol to follow which structures the process of supervision. For example, one agency had a formalized, many month orientation process in which the supervision was only one part.

Many supervisors commented that outside forces can make the supervisory process could be made more difficult. An example of this included the conflict implicit

in having a dual administrative and supervisory role with a supervisee. Gender differences can create problems, as can having "different values," for example generational differences resulting in different opinions, for example, of appropriate dress. Crises in the life of the supervisee may also cause problems. The relationship could also be stressed by forces internal to the supervisee, i.e., lack of understanding of the supervisory role and process, vulnerability, anxiety, empathic breaks, and the fundamental truth that, "It's hard being a supervisee."

These supervisors had as their goal the development of the supervisee. This includes wide ranging issues like skill development, an increase in grasp of theory and general knowledge, development of the use of self, and deepening of the treatment. These supervisors focus on both the personal and the professional development of the supervisee. One supervisor explained,

> [For newer supervisees] I want them to understand what it is about to be a therapist. . . what that requires of us and what that is like. . . . As people progress, I think what really the supervision is about is what is going on in the therapeutic system, where people are getting hung up because of their own issues with the clients.

Another noted that with more advanced supervisees, the focus will be on their work with clients and the theories that they incorporate. They felt that this could best be done with in a positive, supportive supervisory relationship.

All of the supervisors spoke of initially assessing the supervisee. Even before meeting with the supervisee, the supervisor may try to garner information about the supervisee. Some institutions allow access to a student's files, and merely knowing the type, level, and specific institution provides some information. Some institutions allow supervisors to review student files. One supervisor noted, "I take into account the school

that they go to. And really what their program is about." Another supervisor noted that she will not take students from a program if she considers it poor. If a supervisee is a new hire at an agency, the supervisor may review files, references, and transcripts. If the supervisee has been at the agency, the supervisor may have access to their files and may even have personal information about the supervisee if they two have worked as colleagues. Many supervisors will not work with a supervisee without first interviewing them. This not only allows an initial assessment about concrete issues such as experience and theoretical compatibility, but allows a "gut reaction" as to the appropriateness of the dyad.

A number of supervisors reported that they will only take supervisees if they feel that they will be appropriate for the particular supervisor. For example, one supervisor stated that she would not accept a supervisee who wants to focus on a theoretical model that the supervisor does not practice and in which she is not interested. Some noted they will not accept supervisees who display "excessive anxiety" or "blatant unresolved issues." Another supervisor stated that she only picks supervisees who have a sense of humor and "then it is more of a how I feel we are going to work together personality-wise." One noted that she always observes how the potential supervisee interacts with the receptionist at the front door which she has found indicates important information about him.

Many supervisors spoke of the similarity of this assessment process in their work with both with supervisees and with clients. One supervisor noted about this assessment process, "That's the same as working with a client, a patient. They come and you just establish a connection, a relationship, and through that process you make a learning

diagnosis." Another noted, "I consider this more an art than a science. And I am going to call upon every sense that I have to learn what's going to be helpful to the supervisee." Another stated,

> It's just like I do with my cases. I try to get to know who they are, try to understanding how they think about the work that they do. I try to get a sense of their strengths their weaknesses. Talk with them in terms of what it is that they expect from me. How are they expecting this to be delivered? And, basically talk about our relationship and how our relationship impacts the work that they do.

The goal of the initial assessment is to find out how to be most helpful to the learning process of the supervisee based on their functioning, needs, and learning style. Supervisors wanted to know the supervisee well enough to tailor-make a learning plan. Preferably, this plan would be co-created by the supervisor and the supervisee and would represent both the supervisee's and the supervisor's agenda, including format and goals. This plan would allow the supervisor to tailor the supervision for the particular learning needs of the supervisee.

One supervisor said, "I start where they are at and it [what I do] depends on who I get." Another supervisor noted that this also depends on the type of work the supervisee is doing. For supervisees in a program, their institution might have a particular form, a learning contract or agreement that needs to be completed to facilitate this process. A few supervisors specified that theoretical compatibility was important. For the one supervisor mentioned above, this was so important that in fact she stopped supervising because "I had religion [psychodynamic theory] and so sometimes when you are in that position you don't have that much tolerance for people who don't share your belief system."

Many spoke of wanting to know early in the process the level of experience, sophistication, and maturity of the supervisee, their training and supervision history, and how they approach the work. One supervisor said that she wants to know "what they know, what they want to know, how smart they are and if they are open to things." Another stated, "I try to figure out where they are in terms of their professional development and in terms of their personal development, their personal evolution, whether they are self-aware, whether they get it." Less experienced and sophisticated supervisees will most likely have less insight about these types of information.

Supervisors wanted to know at the very least what the supervisees felt worked and did not work for them in past situations, even non-social work ones. One supervisor explained that analogous situations will provide useful information, "Even with the newest social work students, they've had a boss at a restaurant, or their parents at the very least. They know at least what they liked and what they didn't." Supervisors want to know the hopes and expectations of supervisees for supervision on every level.

Some thought of this evaluation of the supervisee as an organized process. The "learning diagnostic" included an evaluation of learning style, availability to the learning process, growth potential, "workability," growth potential, and knowledge and use of theory. One supervisor reported that she had students fill out a form describing their learning style. For most supervisors, however, this evaluation was not usually made explicit to the supervisee, although it was noted that supervisees "knew where they stood." Another noted that she requires students to have taken certain courses to assure a certain level of knowledge about the particular type of work the agency does and the population it serves. One supervisor stated,

> I try to get a handle on, a sense of how they best learn and what obstacles might get in the way. I use that as an overarching way of then approaching my supervisory meetings with them and then that diagnostic obviously changes and gets more complex over time. I try to get a read on how they take in your information, how they use the supervisory relationship, how that might parallel what happens with their clients.

Some consciously sought to understand the psychological makeup of the supervisee in the service of the supervision. One supervisor stated that she tries "to get a sense of who they are and what 'the market' will bear psychologically." These supervisors want to know the extent to which a supervisee is available to or defended against the learning process and the supervisory relationship.

The supervisors made an effort to evaluate the supervisee's level of anxiety and their ability to manage the anxiety produced by the clinical and supervisory task. This might be demonstrated by resistance to openly discussing their work and their feelings or by being inflexibly wedded to ideas or certain theories. Anxiety may be evidenced by the response to feedback and how the supervisee handled not knowing. One supervisor tried to determine the supervisee's ability to "play with ideas." Other concerns included the degree to which the supervisee could be in touch with feelings, self-awareness, and shame, as well as major problems in the supervisee's current life and difficulties in early years. The "natural talent," or "sensitivity towards the emotions of others," and "awareness of the sort of impact they have on others and others have on them" indicates a supervisee's empathic potential.

One supervisor noted, "You have to get to know them to see where they are comfortable and where they are not comfortable, and then you make your decisions about how you intervene." Another observed that she seeks to understand "what they need in a supervisory relationship, what they need in a personal way that is going to make them

able to be open to supervision." One supervisor made an important distinction. She said, "It is not my business to diagnose someone. My business is to find the best way to work with someone and to be aware of the dynamic in that process." In addition, many supervisors noted that they quickly became aware of narcissistic issues of their supervisees. This provided unique challenges to the supervision.

Supervisors are looking for a wide range and significant quantity of information about their supervisees as they begin to work together. Some of this information is elicited directly, i.e., supervision and work history. Other information is determined using the clinical skills of the supervisor. Some described the use of their countertransference experiences. Many supervisors commented that the process is not significantly different from that used with patients. One said, "You push them a little bit and see what happens." Numerous supervisors stated that they learned a lot of information by listening to their supervisees talk about cases.

The majority of these supervisors spoke of taking a supportive stance with supervisees to build a positive framework for the supervision. "I'm not here to be critical" one noted while another observed that most people do not learn when feeling shame or embarrassment. Another observed that people need to feel "safe and respected." Some supervisors wanted to make it clear both that the supervisor had something to offer and that the supervisee had something to learn.

With new therapists, many noted they worked to build their confidence, pointing out to them "that they knew some stuff and could so some things." Many asserted the importance of a non-confrontational stance. One marked exception was a supervisor who worked exclusively with high level supervisees in a training program. These supervisees

explicitly sought her out, knowing her confrontational method of working. She said "I have kind of a no pain no gain mentality. Because it is mostly without judgment, they actually, after a bit of a hiccup, can hang in and really start chewing on the stuff that we are talking about."

The majority of these supervisors felt that it was important to develop a collaborative, supportive relationship with the supervisee. One said, "I express that if you are willing to go through this process it is not going to be painless, but I will be right behind you." Another noted that she tried to teach the supervisee to think about what he is doing right, oftentimes asking, "Why aren't I hearing about your 'good' cases?"

Supervisors sought to be patient and empathic. One noted that, "People don't learn through shame." Others spoke of wanting to avoid the supervisee feeling embarrassed, or as if he was not good enough. Supervisors wanted to empower supervisees, to help them figure out how to do something, rather than merely telling them how to do it.

Numerous supervisors commented that they taught their supervisees by giving them the experience the supervisors were trying to teach. For example, a supervisor might help a supervisee develop empathy by providing the supervisee with an empathic experience. Another supervisor said that she teaches the need to attend to the process in treatment by exploring the process within the supervision. Attention is also paid to parallel process. Supervisors work to help supervisees to understand about themselves "what they heard and why they said that." To this end, supervisors will speak of their own cases and experiences. In addition, the majority of the supervisors spoke of seeking

to help increase the self-awareness of the supervisee. One said of this process, "If we can name it, I can give them support."

## Psychologically Impaired Supervisees

All the supervisors spoke of having worked with psychologically impaired supervisees, as defined by this study. These supervisors expressed that psychologically impaired supervisees present a serious problem, for the supervisory dyad, for the supervisee's patients and agencies, and for the field. One noted,

> I guarantee that [psychologically impaired supervisees] will at best just be pretty crappy social workers. They will not be particularly good at the job. At the worst, they are going to end up in front of ethics groups or in a lawsuit or they are going to lose their license. They are going to screw up. And they are going to hurt people. Maybe they won't lose their license or anything, but they are going to do damage.

The supervisors are aware of and concerned about this issue. This section will describe how the supervisors categorized the impairments and explore their assessment and response.

Supervisors described three types of psychological impairments: transient, normative, and expected parts of the clinical learning process; temporary impairments due to a crisis or problems in the supervisee's personal life; and ongoing substance abuse, psychiatric, or characterological issues. Each category had a range of severity and there was overlap between categories. Supervisors found working with supervisees in all three categories challenging. It was only in the last category, however, that supervisors described supervisees who "shouldn't be in the field," who often were "counseled out" or had their internships or jobs terminated. Although many supervisors did not consider the

first category, the normal parts of the clinical learning process, to be a psychological impairment, it is included for the purposes of this study.

Supervisors spoke of supervisees who experienced emotional reactions to patients and to the supervisor. These might include countertransference experiences, enactments, and experiencing feelings generated by memories, consciously or unconsciously, of one's own experiences or dynamics. One supervisor said, "People's buttons get pushed." Many supervisees, especially those who have not had treatment, who are newer to the field, or who are less psychologically sophisticated, may not realize or understand the deeper meaning and potentials of their own internal experiences. Some of these supervisees are understandably upset or reactive as they attempt to deal with their internal experiences.

Although these experiences are a normal part of the developmental process for a supervisee, they exemplify the way in which a psychological event can be impair their ability to do their work or engage in supervision. Supervisors must respond to these impairments to prevent damage to the supervisee's patients and to the supervisory relationship. Further, supervisors, as part of the teaching process, need to help supervisees learn to understand, manage, and utilize these challenging and potentially useful reactions.

Multiple supervisors noted that many supervisees enter the field, or enter into a supervisory relationship with them, not expecting these kinds of events and may be initially surprised and distressed by them. Some supervisees are very open about their internal experiences and share them easily with supervisors, especially after a solid

supervisory alliance was formed. The supervisees were able to engage in a learning process around these issues.

Other supervisees, especially those who were less self-aware and open, were hesitant to share their internal experiences with their supervisors. Supervisors spoke of noticing "patterns" of reactions by supervisees, to patients and to the supervisor, which signaled such an event was occurring. Multiple supervisors used these patterns as a technique to educate supervisees about these phenomena. One supervisor reported, "If I feel like they are still not learning a particular thing, often they are still getting caught up in something. I'll say, you know, I think there are still some issues here, or I still think that you are having a problem with that." Another reported that she might say, "I think there is something else getting in the way here. Might this have to do with what is going on in your life? So, sometimes I will inquire about their own current situation, a personal thing that is going on in their life." This is one way to help the supervisee learn that there are connections between their personal and professional lives.

Another indication reported by multiple supervisors was the supervisee's overreaction. One noted,

> The situation occurs when I think there might be an over reaction to a patient, or when obviously they are having a reaction working with me and I have no idea where that is coming from. It doesn't fit with what I am experiencing, or what I know to be true about myself or about the current situation. Sometimes I see something in a hall way with a patient or another staff person. It's when you observe something that doesn't quite fit. That's when I go there.

Another supervisor noted that she would use her own internal experience to notice when these types of events were occurring outside of the supervisee's awareness, stating:

> When I am not hearing something, when I am not understanding something, when I'm sensing something wrong, then I try to go about it in

> a different way. It is basically when it is not happening between us, or when I am not hearing something, like it doesn't make sense or we are not getting anywhere or they are still stuck.

A number of supervisors noted that they were alerted that there was an issue if the supervisee spoke more about themselves than about the cases.

Many supervisors reported that they used these events to suggest treatment to those supervisees who were not yet in treatment. In many cases, supervisors presented treatment as a normative part of the training process for clinical social workers. For supervisees who were in treatment, supervisors might suggest they explore some of issues in their treatment. This type of psychological impairment is not considered problematic unless it is severe, unchanging, and intractable or indicative of a deeper problem.

The second type of psychologically impaired supervisees described by subjects was the supervisee who was experiencing transient psychological impairments due to a crisis or a problem in their personal life. Most common was the supervisee who was struggling to maintain normal functioning in the face of a significant illness, relationship problem, loss, etc.

One supervisor spoke of a supervisee who developed severe financial problems, who began having health problems, and whose spouse unexpectedly left him. As the supervisee became increasingly ill, both physically and psychologically, he began missing meetings, not doing his work, and taking increasing amounts of time off. The supervisee's supervisees began coming to the supervisor, who was also an administrator, to express their concerns about their supervisor (her supervisee), including his discussion about himself during their supervision. The senior supervisor attempted to provide

support to the supervisee, who was already in treatment. She made the choice to excuse him from meetings and from some duties in an attempt to provide some relief. However, the supervisee's performance continued to decline until he met the agency's criteria for termination. The supervisor added that she later learned that the supervisee stabilized, changed the type of work he did and was able to be professionally successful. Although acute and damaging, this supervisee's psychological impairment was reactive and temporary. Supervisors noted that this type of situation often puts a lot of stress on a supervisor and an agency. One supervisor noted, "Nobody wants to fire anybody in social work."

Another type of situation is illustrated by the following in which the intervention was successful and allowed the supervisee to continue with work. This supervisor spoke of a supervisee "who was having trouble keeping it together," resulting in job performance problems. He reported that the program in which he worked had become too disturbing for the supervisee when a family member entered the same stage of life as the people in the program in which he worked. The supervisee sought medication management and therapeutic services on his own. He approached his supervisor and shared his situation. In response, the agency was able to transfer him to a program within the agency that he found less activating and stressful. He was able not only to feel better, but also to function satisfactorily at his job.

One subject noted in a joking manner that as a supervisor, "I'm not there for their psychological needs. I'm there to exploit their labor!" The bottom line for many supervisors is that a supervisee must meet minimum performance standards. This is sometimes made more difficult by the intense type of relationship supervisors have with

their supervisees, by their understanding of what is contributing to the supervisee's problems, and by the profession's desire to help people. In other words, the supervisor's compassion for their supervisee has the potential to complicate their responsibility to maintain standards.

A few supervisors noted that problems arose when a supervisee had more responsibilities than he could manage. An example of this occurred when a student in a part time social work masters' program also worked full time outside of the field placement. He did not seem to be taking the internship seriously and it seemed to be "last on his list." He was frequently late, did not complete tasks and assignments, and demonstrated poor performance with clients. The supervisor confronted the student and informed his program. He was able to respond well, and by reprioritizing, engaged fully in the internship and the supervision. He finished his internship successfully.

Another type of impingement occurred when supervisees had a problem with some specific, localized issue. These people were able to manage acceptably or even perform well when not affected by the transference. One example given was a supervisee who had a family member with a particular psychiatric diagnosis. Whenever he was assigned a client with that diagnosis, he would become over-involved and not able to provide appropriate treatment, in contrast to the rest of his work. His own treatment was not sufficient in helping him manage this issue. His agency decided to not assign this supervisee clients known to suffer from the particular diagnosis with which he had trouble working. Instead, they filled his caseload with clients suffering from other types of psychiatric problems.

Another supervisee experienced abuse as a child. During his internship, he shared with his supervisor the difficulty he had in working with children. He struggled to work through this issue and to manage his feelings, but ultimately it was decided that he would not work with children for the rest of the internship. He worked successfully with other populations and finished his internship successfully. These supervisees had specific areas in which transference issues created impingements, although they were able to work successfully with other populations and supervisors. In interviews, supervisors generally felt that this issue in supervision was amenable to intervention and could often be resolved. Sometimes resolution could not take place until after the supervisee had left the placement or job. In the event that such situations seemed irresolvable, a supervisor might become concerned that the person might fall into the third, potentially more serious category of psychological impairment.

The subjects described the psychological impairment of supervisees in this third category as being a substance abuse, psychiatric, or characterological problem. In most, but not all cases, these problems were more global, acute, and intractable, causing at times greater difficulties for the supervisor. At times supervisors had to struggle not to engage in enactments with these supervisees, working to maintain their objectivity in order to provide the best supervision possible.

It was in this category where supervisors described supervisees as unfit for the field. One said,

> Some people don't belong in social work. I really have only seen a handful of people in my life that I felt that it applied to. Everybody else, I felt given the right support, they could get past whatever it was.

Examples of supervisors' descriptions of supervisees with substance abuse, psychiatric, and characterological impairments illustrates that there can be significant overlap between these three categories. Perhaps because the supervisors often do not have a complete knowledge of their supervisees internal functioning, which would be more appropriate to treatment, at times, supervisors did not know enough about the supervisee to be able to fully understand their presentation diagnostically.

Addictions were mentioned by a number of supervisors as a serious impairment to therapeutic functioning. One presented an example of a man who had a serious problem with alcohol abuse. After being at the agency for some time, he began missing sessions and days of work. When it was discovered that he phoned patients and other staff while intoxicated, the agency decided to terminate him.

Another supervisor spoke of a student supervisee who began coming to placement hung over and with alcohol on his breath. The placement provided substance abuse programming for adolescents. The supervisor, placement personnel, and school worked with him to salvage his placement. As part of this plan he agreed to enter a twelve step program. He was able to complete the minimal requirements of his placement.

The theft of agency money to pay for drugs by a supervisee was described by another supervisor. This person was a long term employee with whom the supervisor had a close and good working relationship. The theft took place in a way that the agency could not fail to notice. She remarked that although he had not displayed any overt problems that threatened his job until this point, she had sensed that something was amiss. Because he was a valued long term employee who was committed to his recovery, the agency was willing to work with him. They developed a plan for him to attend a

substance abuse problem without losing his job. Once he was stabilized, he returned to work, with a verifiable plan for his continued sobriety. Sometimes supervisees with substance abuse problems can be helped, while sometimes they are too impaired to continue their work.

The same is true for supervisees suffering from psychiatric problems. One supervisor spoke of a supervisee who began decompensating at work. Initially, he demonstrated boundary problems with clients. Over time, however, he became severely inappropriate with clients and began provoking other staff in a paranoid, attacking manner. Medication was prescribed but was not properly managed and resulted in him falling asleep at work. The supervisor knew that this person had marital problems and had recently left his religious community. Although the supervisor and the agency tried to work with him and support his efforts towards better mental health, he was unable to function well enough and was terminated.

Another illustration was that of a supervisee whose supervisor felt was "spilling a psychological problem." This situation is a good example of one that could be understood as either a psychiatric or as a characterological impairment. The supervisee shared with the supervisor that he had had a difficult childhood and had a serious psychiatric and substance abuse history including inpatient treatments. The supervisor noted that in the course of supervision,

> When we talked about relationships and feelings, he literally didn't understand what I was talking about. He literally couldn't understand why it kept coming back to how could we begin to think about how he might have been feeling, or how the client was feeling.

The supervisee began missing supervision sessions, claiming illness or without providing an explanation. Although the supervisor questioned his capacities to be a

therapist, she noted that the supervisee had a tremendous amount of compassion for his clients and tried hard at placement. Although both the supervisor and the agency personnel had concerns, he managed to finish the placement.

Another supervisor described a situation in which the supervisee's learning impairment paralleled his psychological impairment. She observed that because he suffered from an unresolved eating disorder he:

> . . . was very protective and guarded. He would come in and talk very rapidly and any time that I would say something he would nod his head and say "oh, yeah, yeah, okay," and then keep going. There was a way in which things moved too quickly. I felt like I couldn't hang onto an idea, let alone convey ideas. I couldn't understand him. There was something happening in the room that made it really hard to learn from each other. He was moving so quickly and needed to be so agreeable all the time, always saying, "yeah, yeah, yeah, okay, okay, great, great, great." But he would forget things, that often happened, and I think because he was moving so quickly he wasn't absorbing anything. He wouldn't let himself struggle in the moment at all. There was no direct interaction outside of this needing to quickly please me, which kind of drowned me out. I spent time trying to understand what was happening and then also to try to articulate that to him. The thing that he was doing made it hard to share anything with him. I would start to say, "I am noticing this. . . ." and he'd jump in, "yeah, yeah, oh yeah, yeah, yeah, okay I'll do that." He was somebody who kept his composure and was very careful not to say, "I am scared shitless. I feel like I am way over my head with my clients." So after not taking anything in in supervision, he'd go home and read volumes and volumes of [psychodynamic theory] and just be up all night long and so he would just be gorging over here but couldn't really take it in in supervision.

This supervisor worked hard to avoid engaging in an enactment with this supervisee. In other words, she attempted to understand and to process, rather than automatically reacting to his unconscious interpersonal pressure. This would have prevented progress by reinforcing his relational expectations. Her response helped him engage more fully in supervision and enter into effective treatment for his eating disorder.

While problems remained, his treatment made a noticeable difference and had a positive effect on his work and on his ability to engage in the supervisory relationship.

Another supervisor spoke of a supervisee who also struggled with an eating disorder. While this supervisee did not display such acute problems as the previous example, the supervisor described him as "a perfectionist and kind of judgmental, and he pathologized his clients a little more than I was comfortable with." She noted that she became critical with this supervise and felt unable to empathize with him. He confronted her, which led to successfully processing this dynamic which could be understood as an enactment. The two were able to more fully engage in a supervisory process and he successfully completed his internship.

Characterological problems formed the final type of impairment in this category. This category also overlapped with the former categories. Impairments in this category differed in type, severity, and level of impairment. Symptoms of characterological impairments in this category included "just not getting it," narcissistic organizations, fear of being open and available, and general, unspecified personality issues.

A number of supervisors spoke of supervisees who "just didn't get it." These supervisees did not display any discrete psychiatric or psychological problems, but lacked a fundamental understanding of the work. Efforts at education, training, and supervision made little or no impact. In fact, the lack of progress over time was the hallmark of this group.

One supervisor spoke about such a supervisee who was "in over his head" and "kept getting in the way of his patients." He lacked attunement, was unable to empathize,

and felt attacked and criticized. He demonstrated no progress over time. The supervisor said,

> I could see it in his writing and I could hear by how he answered questions that he was consistently not tuning in to what people were saying. He was not empathizing where he needed to be. He was not picking up on various key pieces of information. He wasn't linking one session to another and even though I did a lot of interventions to try to help him tune into that he wasn't doing it. He wasn't picking up the cues. And he wasn't integrating the input to try to help him be more sensitive to that. And he wasn't getting it. This is months going by. There should have been progress. He should have been picking up more and he wasn't. The thing that made me feel that he shouldn't be in the field, versus maybe that he just needed to go more slowly, was that he really didn't seem to grasp what he wasn't getting.

This supervisee was typical of a group of characterologically impaired supervisees who supervisors described as "just not getting it."

Multiple supervisors spoke of supervisees being unwilling to openly explore themselves and the work. This type of impairment had many permutations. One worked with a student supervisee who stated at his interview that he wanted to work within a cognitive behavioral framework. When he was informed that the agency worked psychodynamically, he decided to pursue the placement anyway. However, in supervision, he repeatedly refused to "delve into it," both about his clients and about his own process. At the same time, he repeatedly acted out with the supervisor, for example, pretending he did not notice knocking things off her shelves. When this was pointed out to him, he was very resistant to exploring it also.

Another supervisor spoke of supervisee who seemed very anxious and highly defended. She noted,

> He came in from the beginning very rigid, very anxious, he came late, too. He kept getting lost. The resistance was quite clear from the beginning. If, as we looked at process recording, I might suggest that there are a

> variety of ways to do things. You don't have to say what I say, but it is a matter of trying to understand what someone is communicating and then realizing that there are a variety of responses one might make. He would get very defensive, he would feel criticized and I would have to say I am not criticizing you, but I need to know what you were thinking and why you decided to say that. What was it that you heard? It was a rough year. I guess that I am used to my students kind of idolizing me and I tend to stay connected with them long after they leave. I know about their babies, I know what they are doing professionally. But he was having none of me.

Another remembered working with a supervisee who, right when she was going to begin speaking about a dynamic in the room, would begin talking theory. She noted that he would " . . . talk around me. He was much more intellectual than I am. He would start spouting theory and research finding." Another spoke of her experience with supervisees who were:

> . . . very anxious, very concerned, they've had a previous experience whether in terms of their own family or a supervisory experience where they have been really criticized, really made to feel incompetent. And so they come into the supervisory experience kind of expecting to have that happen again and then being very closed or guarded, very careful about what they reveal and then it becomes difficult to really access the learning process for them or how to begin to understand what they are looking for or what they need some help with.

Another supervisor routinely experienced supervisees who feared being wrong and feared that she would judge them. She noted that they:

> . . . can't get through their head that what they are doing is practice and that it is not to be perfect. So every time that we try to focus on what is a mistake there is a defensiveness, they have to justify or rationalize or explain in a way that is motivated by a defensive stance to not be judged as being wrong.

These supervisees have a deep fear of exposing themselves and therefore defend against it in a number of ways and to differing extents.

A number of supervisors spoke about the difficulties of working with a narcissistically impaired supervisee. Commonly, they noted that the supervisee "couldn't take it in," "always had to do things his way," "didn't want to learn anything," "didn't want anything from me," "insisted it was his way or no way," and was defensive and unavailable. One supervisor noted that her supervisee's narcissistic impairment surprised her as he had made it through her program's rigorous application and screening process. One supervisor described her struggles working with a narcissistically impaired supervisee, reporting,

> He was very narcissistic so it was very, very hard for him to learn from me. It was very hard for him to trust me. It was very hard for him to believe me. It was very hard for me to feel engaged with him. I felt diminished often, and from the beginning this was someone I was a little bit intimidated by and didn't particularly think that I could supervise. I knew that some of that was my own business, I had to keep reminding myself I knew what I was doing, I knew what I was about. It was a challenge because he would often misconstrue things that I said. He would accuse me of taking too much personal time in a session to talk about things. If I would get interrupted, I was also an administrator, he would be very injured. There was this atmosphere within our agency that, that would be okay. But, it wasn't okay with him. So, I supervised him for [a number of years] and it was rough the whole time.

It is possible to understand part of this supervisor's struggle as working to avoid engaging in an enactment and instead working to maintain a productive supervisory stance. The supervisor went on to note that this supervisee was very bright, did good work with clients, and has gone on to have a successful clinical career.

A few supervisors noted difficulties in working with supervisees who had successful careers in other fields and switched professions mid-life. For some of these supervisees, switching from successful functioning professional to the challenging role of inexperienced, novice student was narcissistically challenging. Some responded by

"battling for control" of the supervision. Others had trouble accepting that they could not change agency policy or functioning, wanting to do things as they saw best. One supervisor said, "He couldn't understand why he alone couldn't dictate treatment for his clients, why it was a treatment team decision. He also didn't like agency protocol and did not understand why he had to follow those rules he didn't like."

A few supervisors noted that their supervisee seemed injured by the fact that the supervisor "wasn't a star" or did not present in a certain way. One supervisor commented,

> It really had more to do with how he saw me. I am not sure he saw me as what he thought he should have gotten as a supervisor, who would have been someone fancier. I always dress like I'm dressed now. He was very fashion conscious and so I think he wondered, 'How did I get this person who really doesn't match my expectations of what somebody in the field who would supervise me would look like and act like and be like?' I sensed that I didn't meet his standards and so consequently, I wasn't someone who he could look at and say, 'I respect what this person can offer me.'

Supervisors spoke about supervisees who displayed general characterological problems that ranged in severity. One supervisee was an intern at a large, multi-service agency and was having a relationship with someone in another department. The supervisee did good work and the supervisor felt that the relationship itself was appropriate. However, the supervisee violated confidentiality perpetrating a major ethical breech by sharing a non-clinical issue with his lover, causing significant damage to his department. He could not understand what he had done wrong. The supervisor understood this breech as a pathological loyalty issue, noting that this relationship fulfilled several unfilled and unexplored needs for the supervisee which she feels caused him to act so inappropriately. Although he was not terminated, he was put on probation

with increased and more rigorous supervision and monitoring, including videotaping his sessions.

One supervisor reported that in retrospect, if she were to diagnose the following supervisee, she would consider Borderline Personality Disorder. She commented on how she noticed the problem, reporting:

> I experienced it personally because at first things seemed to be going fine between us and in fact I could do no wrong. Then, out of the blue, there was nothing that I could do that was right. Nothing I could say that was right. I couldn't even look at him right. It just became apparent that there was some kind of a switch that twisted and I just became the dirt on the bottom of his shoe.

This supervisee was in a school program and the liaison reported to the supervisor that the exact situation was happening with a professor in the program. The student appeared to have problems with those he perceived as authority figures, while relationships with peers, patients, and those he did not perceive as authority figures were not affected. The school and the supervisor worked together and the student agreed to begin treatment. At this point in his placement, the student had been focusing on group work. Co-therapists reported to the supervisor that the supervisee was performing adequately in group and was not displaying any of the problematic behaviors. The student, with treatment and monitoring by the supervisor and the school, was able to finish the program.

In another reported situation, the student raged against school personnel while developing and maintaining a close working relationship with his supervisor. She understood him as struggling with a characterological mistrust of authority figures. This caused him to be angry and mistrustful of teachers and administrators at his program. He

was able to form a good working relationship with her and was able to helped to begin treatment which reduced his rage and his acting out at school.

Another subject described a supervisee who "at a characterological level, was very intellectualized." The intellectualization prevented him from deepening his work resulting in superficial treatment. He was an extreme example of a more common pattern which this subject described as supervisees:

> ...who are limited in terms of not being able to go deeply enough within themselves or with their clients. So treatments stay supportive and superficial and they can't get beneath that surface. Because, in a way, they haven't gotten that much beneath the surface in their own selves.

Another supervisor agreed to supervise a student who was known in his program to be very difficult to work with. He had "blind spots" that led him to be overwhelming, anxious, and controlling, which caused him to have problems with patients as well as with supervisors. This supervisee had some awareness of the issue but had limited ability to manage it. He was able to provide acceptable treatment to some types of clients and was able to meet minimum requirements for supervision.

At the most impaired level, supervisors spoke of supervisees who were not suited for the field due. One described such a supervisee as follows:

> It was clear from the very beginning that he had no interest in insight. He had no interest in insight into himself. No ability to open himself up to that. He was very defensive. Either he'd be argumentative or he would just shut down and not say anything, not say that he had an issue with anything or a problem, no questions, no nothing. And, I tried talking to him, tried to understand, and mercifully he quit the program. He was just totally not suited to it.

Another spoke of a supervisee who began a training program and was assigned to her for supervision. At an orientation meeting, he responded to a small issue by becoming hysterical, and acted in a bizarre and inappropriate, manner. The other

supervisors and the students noted his strange reactions. He attended a few supervisory sessions, but presented as panicked, in crisis, and therefore unable to discuss clients. He stopped scheduling sessions as required and became agitated when informed he did not met the program requirements. As a result, he dropped out of the program. The supervisor did not become sufficiently involved with this person and did not understand his internal dynamics leading to his behavior.

In one instance, a subject described how her initial troubling impression of a supervisee was validated through their year together. She said:

> In his first meeting with me I asked him what he did before he started graduate school. He basically told me that it was none of my business, that it was irrelevant information and he would rather not talk about it. I was so taken aback, I didn't even know how, because this is kind of a nice meeting where you try to get to know each other and I didn't know where to begin with him. How do you work with somebody who doesn't understand at all what the supervisory relationship is, or any part of that? So, that was a very hard situation and so I talked to the liaison from the school who really encouraged me to try to help this student through, which I really didn't like doing.

In a different situation, a supervisee initially presented well. However, he resisted providing required video-taped sessions of his work. When he finally did provide them, they illustrated behaviors with the client that were extremely inappropriate. In the opinion of the supervisor, he was in fact "abusive." Later, when it was revealed that the supervisee had lied on his resume, the supervisor confronted him. When his attempted at manipulating her failed, he began to attempt to intimidate her, bullying her with his large size. When that too was ineffective, he began to rage, screaming at her. This resulted in termination.

A different supervisor spoke of a supervisee who presented well but was revealed to be a chronic liar. His clinical work, too, came to be understood as disingenuous and

shallow. She had serious ethical concerns about his performance. Before he could be fired, he left the agency to open a private practice, leaving her with grave concerns. One more supervisor spoke of a supervisee who also presented well but could not maintain consistent work standards. Over time, it became clear that he was pathologically shallow, never taking "anybody in as a whole separate person." He used case conferences to share how he felt about other workers and never demonstrated interest in self-awareness or his internal functioning. When presenting his own cases, he shared elaborate fantasies about the patients that he never used clinically or explored further. Eventually, he violated a boundary with a client by giving an inappropriate holiday gift. When the supervisor reacted critically, she said he "became enraged with me in a way I had never experienced before. He became insulting in a sexualized way." This severe violation was easily documented and allowed her to put him on probation resulting in termination.

All of these supervisees were clearly inappropriate for the field. They often presented grave problems for their supervisors and for the agencies or programs with which they were affiliated. Supervisees with other types of characterological impairments also presented unique challenges to their supervisors. Supervisors responded to the psychological impairments of their supervisees in a variety of ways which will be discussed below.

## Response to Psychologically Impaired Supervisee

Supervisors responded to psychologically impaired supervisees in an attempt to be most helpful to the supervisee. The responses were based on the specific supervisee,

the supervisor's experience of their impairment, and the personality and mode of working of the supervisor. As with supervision itself, the goal of the response was to help the supervisee be successful at their placement or job and to continue the learning process. This was not always successful. It was also frequently a difficult, stressful, unpleasant, and taxing process for the supervisor, one that remained with them for years after the supervision was over.

These responses illuminate how the character of the clinical social work supervisory process differs from that of non-clinical fields. Within clinical social work, supervisors report that they respond to psychologically impaired supervisees by dedicating enormous amounts of time, energy, and resources to help the supervisee, sometimes at an enormous emotional cost to the supervisors themselves. It is reasonable to postulate that in a non-clinical field, such supervisees would be reprimanded, terminated, or labeled as a problematic employee. Their presentation might indelibly harm their reputation at a job or in a field.

Subjects presented examples in which psychologically impaired supervisees were able to work through their impairments and, in the cases where functioning was impaired, return to adequate levels of functioning. In some cases, the supervisees went onto career success. It is possible to imagine, however, that severe characterological impairments which impact relationships outside of the supervisory one might have an on-going detrimental impact of the supervisee's position in the agency or field. Even with the most severely disturbed supervisees, however, there is attention to the psychological functioning, health, and development of the clinical social work supervisee.

The responses of these clinical social work supervisors indicated that they used techniques with impaired supervisees that were similar to those they used to work with their patients. They felt they were being therapeutic with their supervisees. In an effort to maintain the teach/treat boundary, they sought to individualize supervision by the avoidance of being reactive, by being empathic, and by helping the supervisee identify problems that interfered with the work. They used themselves to contain and confront the supervisees while trying to reduce anxiety, and not encouraging inappropriate personal exploration in supervision. All subjects spoke of encouraging concurrent treatment.

As discussed above, these supervisors spoke of tailoring the supervision to the particular needs of the supervisee. While each supervisor had their own particular mode of working and set of standards defined by themselves or by an agency or training program, they all made the assessment of the needs of the student a priority. Subjects clearly stated that the needs of the supervisor must not form the basis of the supervision. One subject spoke about the pacing of expectations within supervision. An emphasis for this supervisor was on being patient with the supervisee.

The supervisors observed the need to monitor their internal experiences so they would not be overly reactive the supervisee. One supervisor noted, “I think the more I did not respond to his defensiveness, the more I contained it. I maintained my cool, and the more I did that the more he could control and manage his anxiety.” Instead of acting out of anger with a supervisee who behaved in a hostile manner, another subject described allowing herself to be aware of her angry and insulted feelings. She was then

able to raise the issue of the supervisee's interaction with her in a calm, cooperative, and productive manner.

Even as intense countertransference experiences occur, supervisors attempted to empathize with their supervisees. One noted,

> I tried to understand how he perceives things, and tried to use it to establish some sort of relationship, when in fact he wanted nothing more than to just get out of here. I tried to start out where he was. I tried to include his experience with the clients, and experiences he had shared with me in bits and pieces from his own life.

Not only can empathy help the supervisor to better understand the situation from the supervisee's perspective, but it can also facilitate the development the optimal response and a better process for exploration. Sometimes the result might be a resolution of the situation itself. Although supervisors did not describe the specific processes, it is possible to hypothesize that these responses created positive experiences in a variety of ways. For some supervisees, the experience of empathy may be curative in and of itself. The experience of feeling understood may provide a context in which it is possible to better organize internally and to manage anxiety. An environment that is accepting and less critical may relieve the need for defensiveness and open the way for the development and deepening of the supervisory alliance. A greater trust in the supervisor might make it easier to address sensitive, problematic areas. In addition, supervisors spoke of the importance of being compassionate and expressing concern. Many supervisees responded well to supervisors asking about their feelings and offering to make themselves more available or providing more time when needed, all of which supervisees may experience empathically.

Supervisors spoke of the value of helping the supervisee to identify the problem. For some, identifying the problem seemed to alleviate it. For others it was just the beginning of a process. One supervisor noted,

> I would say things to this person like, 'Why do you think that you had that reaction? What did the client or the patient say that made you think that? Why did you choose to pay attention to that instead?' That was beginning to try to get him to think about the fact that maybe not everybody would do it how you did. It was the first crack, the first thing without hitting them over the head. Then you make comments like, 'Much of the time this stuff stirs our own things up.'

Other supervisors described being more aggressive in identifying the issue to help supervisees develop a better understanding of them.

One technique used for this purpose was talking about what was going on in the supervisory relationship. This offered a "here and now" relational view to help the supervisee begin to recognize problematic issues. One noted, "I stick with the supervisee. I don't just let things get swept under rug." As an example, one supervisor reported saying to a supervisee, "My brain just went out the window. Yet when you leave, I'm fine. Let's think about what this might tell us about what is going on between us." Another shared that she reacted, "By being very honest with him about his impact on me and the struggle I was having with him." Multiple supervisors identified the importance of talking about "what's going on in the room." For some supervisors, this involved courage, and the ability to tolerate a great deal of anxiety and/or other difficult affects in themselves or their supervisees.

Limit setting in order to maintain standards for the task, position, or program was often necessary. In some situations this served to contain the supervisee. At other times it was necessary to confront the supervisee about his behaviors. One subject described a

supervisory relationship in which "I really had to pull rank. He would say that he wanted a particular thing to go into the record, which just could not be included. I would say to him that it would be totally inappropriate. You just cannot do so." Sometimes confrontation involved sharing concerns about a supervisee's appropriateness for the field.

At other times, this limit setting involved helping the supervisee to remain focused on the task. One supervisor noted, "I try to make them susceptible to the fundamentals of the work so they'll be able to understand something about relationships, feelings, their past, how they see things, what works for them and what doesn't and why they see things the way they do." He kept returning to this goal as a fundamental part of his work with supervisees. Multiple supervisors spoke about trying to help contain a supervisee by setting up structures to help them. For clinical social work students, this might involve contacting and meeting with school personnel, and requiring treatment and additional supervision.

A number of subjects noted that they frequently modified expectations and responsibilities for the impaired supervisee, while maintaining minimum standards. One supervisor realized that, while she normally required process recordings, insisting with a particular supervisee would merely result in a power struggle. Her assessment was that the damage done by such a struggle would far out weigh any benefits the supervisee might gain by doing the process recordings. Some of the modifications other subjects made included allowing supervisees to miss meetings, relieving them of some responsibilities, and assigning them to work with populations they found less unsettling.

Whatever the psychological impairment, all supervisors talked about working to avoid raising the anxiety of supervisees. For some, this involved changing usual practices, making alterations facilitating the best learning experience for the supervisee. Describing examples of these modifications, supervisors made statements like, "I stayed away from interpretations," "I allowed her to feel in control," and, "I'm going through the backdoor." One spoke about focusing on aspects of the work in which the supervisee felt competent. Many said they "gave him more rope," "backed off and let him stumble around a bit," "gave him a lot of latitude to make his own decisions and not make as many suggestions." One more specific example was provided by the comment, "He was very much interested in the academic view of someone so I let him tell me what that was a lot." These responses intended to tailor the supervision to the supervisee. They were attempts to avoid raising anxiety levels that threatened to worsen psychological impairments.

Another method supervisors used to reduce supervisees' anxiety was to share their own experiences. Many shared their own difficult clinical situations and their own clinical mistakes. Some offered vignettes of experiences at comparable stages of learning, like internships, launching a career, starting a private practice, teaching, etc. Some supervisors described exposing their own shortcomings. One said,

> With her I made a point of letting her know that I didn't know everything, that I wasn't neat. I never made it messy for her but I didn't hide it. With other students I might have tried to at least look more organized, but with her I let it hang out because she was so constrained by her need to be perfect and I said, "Hey I'm not perfect, and I think that I'm a really good therapist."

Another subject explained, "I model the struggle." Only one supervisor, known for her confrontational style, reported that she did not work to avoid

anxiety. She acknowledged that her teaching techniques at times resulted in increased anxiety that she felt could be useful with some supervisees.

The majority of supervisors interviewed reported that they routinely recommend treatment for their supervisees. Many did not wait until they noted any psychological impairment as it was an important part of the learning process. A number reported that they mention it during interviews with perspective intern supervisees. One reported, "I say it as part of my introduction. I say it to everyone I work with. I normalize being in therapy for a therapist. I say a little bit about my background and that I have been in therapy." Another tells perspective intern supervisees that, "the internships are for the art of therapy. Sometimes the colors get muddled because of our own stuff and so we just need to be clear on whom it belongs to. So, as part of our training, we need out own treatment. It's part of the process."

A number of supervisors mentioned the need for treatment as a matter of course at some point during their work with supervisees. One noted, "I always say that I really feel like it would be very difficult to be a clinician without having ones own treatment." Another commented, "I am clear about saying that I think it is important for people doing clinical work to have their own therapy." A third reflected, "I don't want to be intrusive, but it is necessary."

This was also true with group supervision. A group supervisor notes that she routinely tells her group:

> It is essential for people to experience therapy from the point of view of the client. And we all need to go into therapy, not because therapy is going to iron out all of our kinks and then we are going to have no issues. We hope that it at least gets the major ones so that we don't react in automatic ways that are harmful to our clients.

Another group supervisor suggests personal therapy to her students at the end of the course she teaches.

Other supervisors tended not to raise treatment as a regular part of supervision, rather they addressed it "as it came up." Several subjects gave the example of discussing treatment when a supervisee displayed a problem, or when the supervisor felt some pressure to do therapy in the supervision. Another declared, "I certainly will not hesitate at some point with supervisees suggesting treatment when it's clear that their own issues are complicating their work in ways that looks that treatment will be helpful to them." One supervisor said,

> I would say that this is the stuff sometimes we have to think about with our own therapist and I know that you have never been to therapy. Have you thought about therapy? I made it very clear we weren't going to go there, but we would identify those issues. And, I would say that directly. Because he would start to get into some things and I would say, I could tell those are old things that linger around and that its normal. If they are not resolved and even if they are resolved you have to have a great deal of self awareness in order to not get pulled in. To keep clear what's yours, what's theirs. We are always going to have our self. It's reason enough because you are doing therapy because this person is pulling you in. So, it is very delicate but I think it is part of our work that we know about ourselves.

Another supervisor described how she might raise the issue, stating:

> I worked with some people that have been really, really struggling and I have felt a responsibility to say pretty point blank, 'I think you got some things you really need to address and you need to address them now as you continue to do this work.' I have met with somebody who I even suggested should wait and do some years of therapy before pursuing more work more work as a clinician. At times, in the room, I feel like I need to say there are some things that you need to address that are really going to get in the way of being able to do the work that you say you want to do.

When the supervisor feels pressed to provide treatment, they often report finding a direct or indirect means of suggesting the need for personal therapy. For example, a subject explained,

> Sometimes somebody will say, 'Wow, I wish that I could talk to you about more than just my work,' or, 'A lot is coming up in my work,' or, 'This almost feels like therapy. I wish we could get into those kinds of things.' That has been a common time that I would jump in.

Some noted that with a more serious psychologically impaired supervisee, it is especially important to maintain the boundary between supervision and therapy. To this end, supervisors are careful not to pursue the root of a supervisee's personal problems. Holding the focus in supervision on how personal problems impacted the supervisee's work is primary. In fact, supervisors attempt to help supervisees make their own connections between personal problems and the work they do. One supervisor noted,

> He revealed some things, personal things. I responded to them so that he knew that I was responsive, but I did not pursue it in anyway or try to make any connections. I tried to help him make the connections himself as to how he was treating this particular child and what it had to do with his own background, which he was able to do.

Another supervisor described:

> It was tricky, because his personal issues seemed paramount in the moment. They were the issue at times. It felt like I could be doing therapy with him if I was not careful. I would continue to bring things back to and discuss things in terms of his learning, discuss things in terms his work with his clients. I would wrap things around those ideas. It took a long time for him to trust me. He would get into some personal material and some dynamics happening inside. I wouldn't introduce it. I would bring us back over to how that impacts what is happening in the room and his learning and his presentation of his [psychological impairment]. At times it was difficult though because I could tell he would want to go more into it, to pull it out of the learning focus and more into how he is struggling in these ways more generally. I would make space for that, somewhat, but I would not comment or interpret or get into that. If I was going to comment and interpret, it was about what it had to do with this stuff he was learning, his work with his clients, what is happening in the

> supervision relationship. I would just repeatedly encourage him to go get treatment.

The distinction between supervision and therapy was an absolute for the supervisors interviewed. They spoke about the importance of making this clear to the supervisee as well. One noted, "I think identifying somebody's issue, and how it affects the case is for supervision. If it is something that they have to work through in terms of their own issues, that is for their therapy. That is not to me for supervision."

The majority of supervisors noted that while making this boundary clear was of paramount importance, it was often "fuzzy," "gray," and changeable. One supervisor said, "If you do supervision you want to have a feel for what the boundaries are. The boundaries are somewhat different in different cases and I think that one needs to approach it with an open minded." Another expressed her feeling that it can be useful if she is used therapeutically by supervisees, asserting:

> It doesn't bother me if a person uses me therapeutically or if issues of attachment come up in the relationship, if they talk about themselves or about their feelings about me, that doesn't bother me at all. In fact, I kind of like that. I feel like if a person is willing to be that vulnerable in their supervision they can really use it to help their clients' treatment. And if they are not in therapy, they need to have that experience. But I've learned over the years, especially with one supervisee who is not in therapy, how to define it for him. Like if an issue comes up, I'll say if I was your therapist, we might go down this path. But since I'm your consultant, I think what we need to talk about is X, Y, and Z. And I love working with this supervisee who is not in therapy so I'm willing to find all sorts of ways to do that

Thus, supervisors respond therapeutically to their psychologically impaired supervisees while maintaining clear boundaries between supervision and therapy. Many drew parallels between how they work with supervisees and how they work with patients. Supervisors used themselves and became involved in the relationship. It was never a

purely didactic process for the supervisors interviewed. This required great personal effort and commitment on the part of the supervisor.

Multiple subjects spoke of seeking help with challenging supervisory situations ranging from getting the school or program personnel involved, to seeking supervision for themselves, to discussing it in their own treatment. Many spoke of seeking support from colleagues, both from within or without the agency or program. These subjects worked proactively to achieve the best response. One noted:

> I got a lot of support in that way to say you are doing a good job. The biggest thing for any supervisor is that you have to stay grounded and keep your boundaries clear. You have to know yourself. If you don't know what you are doing, you have to go get help to get grounded.

## Interview Process

The majority of subjects participated enthusiastically in the interview process. They appeared to enjoy thinking and talking about supervision. One noted, "I don't usually think about this," while another said, "It was nice to reflect and to go back to the beginning and to be able to think about it all." One subject noted that she found it "fun" when she had not anticipated the questions. A few subjects commented that it was a pleasant change to be asked questions and to "be the one talking the whole time."

It appeared that many had not thought about these issues and had not conceptualized how they understand and respond to psychologically impaired supervisees. The interview process seemed to spark productive thinking which the supervisors appeared to find gratifying and stimulating. At times the process felt exciting as the subjects appeared to be engaging in rich, productive thinking.

The interview process allowed some subjects to revisit experiences, both positive and negative. Both types were often fresh in their minds, even if they had happened years ago. It was clear that they carried strong feelings about both supervisors and supervisees. Their fondness and affection, as well as their hurt and disappointment, were palatable. It was also interesting to listen to descriptions of how the field has changed over the past four decades.

Some shared recent occurrences which were not always completely processed or resolved. They re-experienced and communicated the emotions generated by the memories. For some, these were painful incidents. They made themselves vulnerable during the interview and shared a lot of personal information about themselves and their experiences.

Numerous subjects expressed their hopes that they had been useful. They were almost all curious about the results and wanted to read the finished project. Some were curious about whether their experiences were common and wanted to hear what the other supervisors said. Others were curious about how the topic was developed. One noted that she felt some envy that the researcher had the liberty to complete this project when she also felt such passion about and interest in supervision, but was not able to pursue it at this time.

Some experienced anxiety around the interview process. One subject reported that she had feared that she would not be able to remember information. She noted that she knew that just like with treatment, she would remember what was important and what she did not remember, she would not remember for a reason. Another reported feeling anxious about being interviewed. Over the course of the interview, this subject seemed to

become progressively more comfortable and gave richer information. Only one commented that she found it awkward to be recorded by two recording devices.

Many appreciated the open ended nature of the questions. One noted, "I feel like they gave me an opportunity to launch in 25,000 different directions and I feel like I could have gone on and on. Your questions do elicit a lot of associations and thoughts." Another subject commented, "I appreciated that you just sort of let me ramble and it felt easy to do."

Some subjects, however, at times found the broadness of the questions challenging. One noted, "It lets me go anywhere I want to go, on the one hand, and on the other hand, it's hard to know where to go." The subject who reported feeling anxious noted that more specific questions may have helped her feel less anxious. One commented that she had begun to prepare herself by filling out the demographic survey in advance. Another noted that she found the request on the demographic survey for specifics about the subjects' experiences of treatment, i.e., frequency and length, intrusive, and it was subsequently changed.

# CHAPTER VI

# DISCUSSION

The research question of this study is, “In what way do supervisors modulate their response to a psychologically impaired supervisee?” The subjects described the many ways that they had modulated their responses to psychologically impaired supervisees over the course of their supervisory careers. Although the specific ways that they modulated their responses varied widely, the purpose and origin of the modulations were the same. Supervisors attempted to protect clients and to help supervisees function well and to develop as clinicians.

The subjects supervised psychologically impaired supervisees in the same way they supervised all of their supervisees, by tailoring the supervision to best attend to the needs of each particular supervisee. Supervisors reported that they did not modulate their supervisory technique specifically in response to psychologically impaired supervisees. Working with psychologically impaired supervisees might be more challenging. It might require more modulation of technique to help these supervisees succeed. It might demand a higher emotional toll from the supervisor. It might focus more on the supervisory relationship and on the identification of the impact of the supervisee’s issues

on the work than on discussing case material directly. However, the fundamental tenets of the supervisory technique was the same.

The purpose of this study is to explore how a sample of specialized clinicians modulates their supervisory techniques in response to psychologically impaired supervisees. Modulate is defined as:

> To adjust or adapt to certain proportion; regulate or temper; to change or vary the pitch intensity of tone; to vary the frequency, amplitude, phase, of electromagnetic waves; . . . [or] to move from one key or tonality to another by means of a melody or chord progression. (*The American Heritage Dictionary of the English Language*, 2000, on line)

Synonyms for modulate include, "attune, balance, do up, fine tune, harmonize, inflect, regulate, restrain, revamp, switch, temper, tone, transmogrify, tune, tweak, vary, yo-yo." (Thesaurus.com) Modulate is thus the term used in this research to denote how supervisors change their supervisory techniques. For the purpose of this study a psychologically impaired supervisee was defined as one whose unresolved emotional issues impaired their ability to do the work or to engage in the supervisory process.

Strict criteria were set for supervisors chosen to participate in order to assure a high quality sample. Subjects were found via the process of snow-ball sampling. Over half of the subjects were referred by other subjects. Local chapters of clinical organizations produced two subjects. The rest were referred by faculty and students of the Institute for Clinical Social Work.

These subjects represented a small and highly specialized sample, a particular segment of the clinical social work supervisory population in a particular geographical area. Although there were differences, the subjects were a fairly homogenous group. In addition, they self-selected for the study. The study does not represent a racially,

ethnically, or economically diverse group of supervisors. This may suggest that only limited conclusions may be drawn from this study. However, the subjects were among the highest functioning practitioners in one of the major centers for clinical social work in the country. The insight and experiences of this rarified sample might have implications for the average clinical social work supervisor and for the field itself.

Before scheduling an interview, potential subjects confirmed that they met all of the criteria. Before participating, subjects read and signed a consent form. This included another listing of the criteria for participation to confirm the appropriateness of the subject. Information was solicited from the subjects through a demographic survey followed by a semi-structured interview. Surveying the demographic information from the 25 subjects confirmed that the desired specialized sample had been achieved. The subjects had been in practice for an average of 29 years and had been supervising for an average of 20 years. They all reported engaging in long-term personal psychotherapy and considered themselves psychodynamic practitioners. While all engaged in continuing education events, 11 had engaged in post-master's training. All subjects participated in activities that served to further the field. These factors suggest that these clinicians have thought deeply about the issues and are committed to the field.

The semi-structured interview explored four areas of information about the subjects: their experience with psychologically impaired supervisees; their own experience as a supervisee; their views on how supervisors should be trained; and the process of this researcher's interview. The first group of questions sought to elicit information about how each characterized psychologically impaired supervisees and how she modulated her techniques in response to them. The second group of questions sought

to understand the subjects' own experiences in supervision. This served to approach the question from a different angle. It was thought that supervisors may be aware of the affects of their own psychological impairments on the supervisory experience. In this reversal of position, the subject might be able to discuss the experience of supervisors modulating responses to them. The next section sought information on how they thought supervision should be taught in the field. Any additional thoughts about the subject and about the process of the interview were requested, as well as referrals to potential subjects.

Psychological impairments present a unique challenge for clinical social work training due to the nature of the profession. Unlike many other fields, clinical social work requires far more than technical skill. An interest in self-awareness and continual personal growth, as well as interpersonal sensitivity and skills, such as empathic attunement, are critical. It is therefore troubling that the literature suggests a significant percentage of those who enter the field of clinical social work come from traumatic or dysfunctional backgrounds. This in itself would not necessarily be of concern, but the literature suggests that many in fact enter the field in an attempt to rework these experiences and to respond to their unresolved issues. They may or may not be aware of this motivation and many have not had sufficient, or even any, psychotherapeutic treatment. Therefore, a greater proportion of those entering the field of clinical social work may have psychological impairments than in other fields, although the need for stability, reliability, and good mental health is paramount in the work.

The dilemma may be worsened by the clinical social work supervisory situation itself. Research shows the difficulties inherent in learning, and specifically, in being a

clinical social work supervisee. Learning in and of itself may entail a disruption of one's sense of self while one incorporates new material. Being a clinical social work supervisee offers additional challenges. Because the self is an important component in the work, a clinical social work student has to expose and examine himself in a way that can be disruptive. With his supervisor, he is vulnerable and may potentially have less power. This is especially true if the supervisor also evaluates him. For social work students, it may be challenging to be expected to do the work at placement without having any experience, knowledge, or familiarity with the tasks. Being exposed to traumatized or non-compliant patients might be upsetting and unexpected. For more experienced clinicians, being expected to change roles from the comfortable, familiar and potentially protective role of therapist to the more vulnerable role of supervisee may be narcissistically challenging. For supervisees of every level, the supervisory relationship may prompt confusion and regression.

In addition, there are many situations in which a supervisee cannot choose whether or not to participate in supervision because it is required for participation in a training program, a school, or for licensure. The sense of being forced may increase the potential for problems with some people. In few of these positions does the supervisee have any choice about the supervisor with whom they will work. These supervisors also often have a role in evaluating the supervisee. Supervisees know that in addition to aiding professional development, their supervisors will be grading and evaluating them with potentially major consequences. Factors like these have the potential to contribute to or even incite feelings such as rage, infantilization, powerlessness, and anxiety.

While subjects identified similar issues in instances of both required and chosen supervision, there is a fundamental difference in the power differential. In chosen supervision, the supervisee is also the consumer. He is scheduling and paying for the supervision and may fire the supervisor at will, a circumstance that may affect the supervisor's approach. He is not dependent on the supervisor for help completing assigned tasks or program requirements. In many ways, the supervisee has control of the supervisory process. This may lessen the chances of the most pathological processes from developing. If such intense interpersonal dynamics develop, either party may terminate the relationship without involving third parties. It is possible to hypothesize that if a severely psychologically impaired supervisee chose supervision, he might assess the supervisor to assure that it was an appropriate match for his expectations. Even so, he would remain in more powerful position than someone assigned to or required to be in supervision. The impact of required or chosen supervision was not fully explored in this study.

Whether required or chosen, the task of supervision itself is complicated, multifaceted, and wide-ranging. While didactic knowledge and skill acquisition remain a central focus of supervision, the development of the self is increasingly valued as a central goal. However, little training and support is provided to supervisors who are expected to facilitate, mediate and monitor the progress between learning and use of self therapeutically. A dearth of guidance is especially significant in working with psychologically impaired supervisees. The difficulty of this situation is exacerbated by the fact that clinical social work does not attempt to mitigate the issue by imposing requirements for treatment during training, as do psychoanalytic training programs.

All subjects have worked with psychologically impaired supervisees and observed the range of severity and the impact of the impairments. Many subjects did not consider the challenging moments that are expected, normative parts of the learning process to be psychological impairments, as they were defined for the purpose of this study. This specialized sample has, over time, incorporated a personal and professional understanding about the developmental process for clinical social workers. They understand that the process of experiencing and attending to transient psychological impairments is necessary to the development of a reflective self. Furthermore, supervisors were usually able to respond without any difficult personal process or in interpersonal struggles. Thus, although for the purposes of this study this type of supervisee was understood to have a psychological impairment, they did not present the same supervisory challenge as did the more severe categories.

While in most cases temporary, the second category of impairments had a greater impact on the work and on the supervision and was thus considered more severe. While undergoing a personal crisis, the supervisee was having trouble performing adequately. Supervisors working in agencies had what could be considered an administrative problem; one of their workers was not doing their job adequately and the supervisor had to make sure the work got done. They had to figure out whether the supervisee could be helped, and in what way, to return to previous or at least acceptable levels of functioning.

Subjects reported that it was often difficult to witness a supervisee's struggles. Such situations often had a negative impact on agencies as a whole. At times, the problems of one worker caused problems for other workers. For example, some types of psychological impairments led supervisees to act out with the other employees. Even if

they did not, it was often times be upsetting and stressful to observe a colleague's disintegration or struggles. Colleagues might have to take on additional responsibilities to make sure the job is done adequately. If the impaired supervisee is a supervisor or manager, their supervisees or employees might lack appropriate support. Last, such situations at times might require a great deal of agency resources, financial and otherwise, which would in other cases be spent on the other employees. However damaging and difficult this type of impairment was for the subjects, it did not pose the greatest challenge to them.

While working with the most severely psychologically impaired supervisees, subjects experienced dynamics best explained by relational theory. The most difficult types of interactions generated the most intense countertransference. Projections and projective identifications from the supervisee create a pressure to engage in enactments that in some cases challenged or even threatened the supervision.

Although no subject identified their supervisory style as relational, and only two out of 25 identified relational theory as one on which they based their work, the findings demonstrate that the subjects are practicing relational techniques in supervision. The basic tenants as laid out in the theoretical foundations section parallel the subjects' descriptions of their work. All these supervisors viewed the supervisory relationship as an important part of the learning process. They described their relationships as dynamic, co-constructed, and mutual, with each party affecting the other. Each dyad creates a particular way of working, tailored to the needs of the supervisee though informed by the supervisor's basic tenets. The development of a safe space in which the supervisee felt understood and responded to by the supervisor was an important goal of the subjects.

While becoming intimately involved with supervisees, the supervisors encourage autonomous functioning. Supervisors thus seek to help supervisees to feel competent and to develop a deeper understanding of themselves and their work independently. The subjects reported using themselves, including their countertransference experiences, as a vital part of the methodology for learning about their supervisees and the supervisory process.

One subject explicitly used the concept of transference to explain a supervisee's behavior, stating:

> They've had a previous experience whether in terms of their own family or a supervisory experience where they have been really criticized, really made to feel incompetent. And so they come into the supervisory experience kind of expecting to have that happen again and then being very closed or guarded. . . .

In addition to being explained by transference, this example also demonstrates the application of relational templates as discussed by relational theory. Other subjects also referred to the repetition of early relational dynamics. For example, subjects noted that a psychologically impaired supervisee would develop a similar pattern of relating to the supervisor as to other authority figures. This suggests the possibility of a repetition of a relational dynamics from early important relationships.

Although not made explicit, it is worth hypothesizing that an investment in a relationship with an available and responsive supervisor could be partially founded on and could generate transference. In one example presented in the findings section, a supervisor described herself as a good supervisee, always doing assignments, etc. She explained that because of her efforts, she is able to elicit good supervision. This positive connection with the supervisor in a relationship characterized by productivity could be a

transference in which the good daughter performs competently for the pleasure of a caring parent. Many other subjects spoke of idealizing their supervisors and incorporating some of their traits and attributes. This too might suggest some re-enactment of earlier important relationships. Subjects considered the transference as a way to better understand the supervisee and the supervisory relationship. They did not, however, report interpreting the transference to the supervisee. Interpreting the transference was described as potentially intrusive and threatening to the appropriate teach/treat boundary.

As discussed earlier, subjects tolerated challenging and sometimes unpleasant experiences with their supervisees. Wary of being caught in entangling enactments, subjects maintained a consistent self-reflective attitude. This allowed them to provide supervisees with an environment creating the potential for them to grow and develop and to explore and understand themselves and their work all within the context of a new relational experience. Even though these were not treatment relationships, supervisory relationships provided supervisees a chance to create healthier and more productive future clinical, and even personal, relationships.

The subjects were aware of the need to maintain the teach/treat boundary. While the importance of this boundary was observed by all, they reported that “the line” was often unclear, changeable, and unique to each supervisory dyad.

While the central assumption of this study was not validated, others were borne out by the findings. Subjects clearly felt that supervisees’ unresolved issues did have an impact on their work and their ability to engage in supervision. They described supervisees who were aware of these issues and dynamics as well as those who were not.

With supervisees who were unaware, the development of the capacity to reflect becomes the focus. All subjects demonstrated an interest in their own psychological functioning and values self-awareness and continual self-development and study. This of course did not guarantee that each was herself an emotionally healthy person, but that was not an area researched by this study. Subjects spoke of the similarities between psychotherapy and supervision and about the similarities of techniques. And while discussing supervisory experiences as both supervisors and supervisees, they used examples from a variety of disciplines. These characteristics were consistently true for required and chosen supervision.

While the subjects are a homogenous group, implications from the study may be applicable to the field of clinical social work as a whole. Since these subjects represent a sample taken from among the best trained and most experienced group of clinical social workers, then we must wonder about the average clinical social work supervisor working in the field. We may postulate that the average supervisor has not engaged in long-term depth psychotherapy, nor have they pursued additional training or extensive supervision. Without these professional enrichments the majority of clinical social work supervisors will not have crafted their psychotherapeutic and supervisory techniques to the same extent as the subjects.

The researcher felt that the subjects' discussion of their emotional experiences, both positive and the negative, were, in the majority of the cases, fresh, vivid, and powerful. It was moving to hear them talk about cherished supervisors. It was at times painful to hear them reveal their struggles with a psychologically impaired supervisee. In many instances, the impact of their experiences had not lessened over time, even after

decades. The strength and longevity of these feelings speaks to the deep and abiding effects of such experiences.

Because these experiences were common among the subjects, we may assume that the average clinical social work supervisor has also experienced a range of intense positive and negative experiences with supervisees. It is experience in personal treatment, the undergoing of advanced supervision, and the kind of adjunctive supports sought by the subjects interviewed, that made it possible to process and work through the effects of these types of interactions. Without insight and understanding the residual strong feelings may affect the average supervisor's ability to supervise effectively in the present and future.

It appeared that many of the subjects had not thought through the issue of working with psychologically impaired supervisees before the research interview. Yet all devised and used clinical methodology in automatic ways, demonstrating technical and theoretical sophistication. The average clinical social work supervisor, with a less considered and less sophisticated method of working, may not be providing a high enough caliber of service. It may be inferred, therefore, that criteria need to be set for establishing an acceptable standard of supervisory expertise.

The subjects seemed to enjoy the interview process and found it useful to articulate and conceptualize their methods and experiences. The subjects' reactions confirm that there is interest in the area and an awareness of the need for more attention. The greater majority of clinical social workers acting in supervisory roles could benefit from the availability of resources to train supervisors. Such resources might be didactic courses, supervision for supervisors, and personal therapy. The results of this study all

seem to lead to the questions of whether the profession requires established criteria for training in clinical supervision and consultation and whether there should be ongoing requirements for continuing education in supervision and consultation.

This study also has implications for the discipline of clinical social work. Currently, in the state of Illinois, the only distinction between clinical social workers and non-clinical social workers is the Licensed Clinical Social Worker designation. This is earned by working a certain number of hours in direct service while receiving supervision from a licensed supervisor. Considering the challenges inherent in clinical social work, it is worth considering if clinical social work should consider becoming a separate discipline. Again, this would include separate training and licensure requirements as well as procedures for supervisors. As an independent discipline, clinical social work might be in a better position to require personal psychotherapy as part of training and licensure. This would be similar to many psychoanalytic training programs that follow the tripartite approach for training, requiring concurrent didactic coursework, supervision, and personal treatment.

Agencies should provide individual and group supervision for every worker regardless of the length of employment, how long they have been in practice, their level of education or clinical role at the agency. The subjects reported the usefulness of this type of supervision and quantitative studies have proven its efficacy. An example of such an in-service resource is the Zero to Three Center for Program Excellence. This program provides resources for child welfare agencies to implement “reflective supervision,” a supervision method that has been shown to improve not only client care, but outcomes.

Follow-up studies have indicated that it resulted in a reduction in staff turnover as well as an increase in staff knowledge, effectiveness, and productivity. (Parlakian, 2002)

Clinical social work needs to consider increasing requirements for supervisors. Some states, though not Illinois, require that social workers who provide supervision hours for advanced licensing engage in many hours of specific programming. While a basic level of knowledge should be required, advancement in knowledge and technique is possible via attendance at courses, workshops and seminars. However, the advanced clinicians participating in this study felt that the greatest impact on their work was the experience of supervision on their supervisory work. Perhaps clinical social work might consider a training program like the one required for MFTs which includes a year of supervision on supervision to be a licensed supervisor.

On-going support and training on supervision should be available to supervisors and they should be encouraged to participate. Supervisors need to be provided with the opportunity to process their supervision with a variety of resources. They may receive supervision on their supervision, or they may participate in a supervision group. Some agencies may decide to have supervisors who work with students and who work with professionals participate in separate groups. In any case, it is crucial that supervisors be provided an opportunity to discuss their experiences supervising. For supervisors in private practice, this may require more initiative to access or arrange such services.

This study suggests further research to deepen the understanding of the phenomenon of psychologically impaired supervisees within clinical social work. Quantitative, as well as additional qualitative data, could be gathered to increase knowledge and to develop best practices.

Research on a larger scale could investigate whether the findings would be replicated. Samples of supervisors could be recruited with similar training, treatment experiences, and theoretical background as in this study, but with greater diversity in terms of economics, race, culture, class, and geographical location. This would explore the potential effects of those variables on the findings. Of perhaps greater relevance to the field would be a study designed to explore how the average clinical social work supervisor, as opposed to the highly specialized supervisor in this sample, conceptualizes and responds to psychologically impaired supervisees. Preliminary work would have to be done to define the term "average clinical social work supervisor." This study would increase understanding on the realities of supervisory experience in the field at large, rather than within this more specialized sample.

A quantitative study could be done to better determine incident rates for the different categories of psychologically impaired supervisees. Studies correlating impairment categories with impact on supervisors, clients, agencies, and training programs could provide rich data for understanding and planning. While some impacts, such as that which is experienced by clients, might be difficult to measure, others, such as work performance could be tabulated. It could explore whether it would be possible to correlate categories of impairments with the manner in which the situation is resolved. Possible resolution could include the supervisee returning to adequate levels of functioning, taking time off, entering psychotherapy, and leaving the agency, program, or field. Information on the number of impaired supervisees seeking personal psychotherapy while in supervision might also enrich data for understanding their needs. All such types of information could help supervisors, agencies, and programs develop

guidelines for working with these types of supervisees and knowledge about education and support for supervisors.

It would also be useful to understand if there is a connection between certain types of psychological impairments and improper supervisee actions resulting in criminal or civil proceedings, and ethics violation reports and findings. It might then be possible to measure the financial costs generated by psychologically impaired supervisees. These costs might include supervisory and administrative hours, legal proceedings, and professional hearings. A survey of the kinds of complaints made to regulatory bodies, and the resultant repercussions or sanctions to supervisors, supervisees, and agencies would provide significant information. In some cases, it might be impossible to identify that a psychological impairment played a role. When possible, however, the identification of the role played by psychological impairment in additional cost might motivate improvements in training and supervisory training requirements. Studies like these would provide information on the scope and impact of the problem of psychologically impaired supervisees within clinical social work.

It would be of additional value to interview the supervisees categorized by supervisors as psychologically impaired. This could determine whether they agreed with the supervisor's assessment, their understanding of the supervisory dynamics, and their own plans for addressing the issue. This would serve to deepen the understanding of the subjective experience of the psychologically impaired supervisee. Such an understanding might have implications for working with supervisees in supervision and beyond. Recruiting subjects for this study due to the sensitive nature of this material might be

difficult. It would, however, be useful to deepen the field's understanding of the complexities inherent in the process of supervision.

Numerous subjects reported that they had "patched together" a way to supervise because they had not received formal or sufficient training in supervision. This included methods for responding to psychologically impaired supervisees. It is unclear whether the resulting supervisory methods constitute techniques. In addition, it is unclear whether the responses of these supervisors were examples of these supervisory techniques. An exploration of the possible difference between supervisory techniques and more generalized supervisory responses might yield insight into supervisory training requirements as well as into issues of technique.

Other valuable studies might investigate the differences between required and privately contracted supervision and experiences with assigned versus chosen supervisors. Another might explore the different functions and potentially different supervisory methods of supervision required at the different stages in the clinical social worker's career. An investigation of the perspective of social work schools, clinical training programs, and agencies on differences in their understanding and response to psychologically impaired supervisees would provide more material for study. This could include studying policies and procedures for response and rates of occurrence of events which invoke these regulations. Similarly, differing state licensing requirements for social workers and for social work supervisors could be compared with numbers and the nature of ethics reports and other indications of efficacy.

All such studies would all provide information to determine the ideal structure in which to train clinical social workers and clinical social work supervisors. This might

include required treatment for students and additional required coursework, supervision, and licensure for supervisors. With a better understanding of the effectiveness of various training requirements, leaders in the clinical social work field could then examine the feasibility of implementing such new requirements.

# APPENDIX A

## INDIVIDUAL CONSENT FOR PARTICIPATION IN RESEARCH

I, _____, acting for myself agree to take part in the research entitled: The Modulation of Supervisory Technique with Psychologically Impaired Supervisees. This work will be carried out by Leah Harp, LCSW, under the supervision of Barbara Berger, PhD. This work is conducted under the auspices of the Institute for Clinical Social Work, 200 N. Michigan Avenue, Suite 407, Chicago IL, 60601, (312) 726-8480.

**Purpose**

The purpose of this study is for dissertation completion.

**Procedures used in the study and the duration**

Participants will be interviewed for approximately one hour. A follow-up interview may be conducted if additional material is generated by the subjects or if the researcher would like to clarify material. A demographic survey and a semi-structured interview will be conducted. The participants' responses will be audio-taped. No payment will be offered to the participants.

**Benefits**

The main benefit of this study is a greater understanding of the use of supervision in clinical social work. No benefits will accrue directly to the participants in this study. They may benefit if they use this time to explore their thoughts on the subject. In addition they may appreciate their role in contributing to the body of knowledge on the whole. This study seeks to understand more about the process by which supervisors respond to psychologically impaired supervisees.

**Costs**

There are no costs associated with participation.

**Possible risks/side effects**

No risks are predicted. However, some participants may find talking about this topic troubling if it evokes difficult memories of their work as a supervisee or a supervisor. If this is the case, the researcher will suggest that the subject contact their current or former therapist, supervisor, colleague, or dean for a referral for psychotherapy.

**Criteria for Participation**

Subjects must meet the following criteria:

1. In clinical practice for ten or more years
2. Licensed at the highest level available in the state
3. Supervising for five or more years

4. Participation in a psychoanalytic or intensive psychodynamic personal psychotherapeutic treatment
5. Involvement in furthering the field, i.e., teaching, membership in professional organizations, committees, writing for professional journals, study groups, etc.
6. Practitioner of depth psychotherapy
7. Identification as a clinical social worker.

**Privacy/confidentiality**

Data for research will be maintained in a secure location, i.e., locked file cabinet, for 5 years after graduation and then will be destroyed. The statistical and coded data will be maintained indefinitely.

**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 may contact Leah Harp, LCSW, at (312) 243-0969, or Barbara Berger, PhD, at (312) 346-7757. If I have any questions about my rights as a research subject, I may call Dan Rosenfeld, M.A., Chair of the Institutional Review Board, ICSW, 200 N. Michigan Avenue, Suite 407, Chicago, IL, 60601, (312) 726-8480.

**Signatures**

I have read this consent form and I agree to take part in this study as it is explained in this consent form. I certify that I meet the criteria for participation.

_____ _____
Signature of Participant Date

I certify that I have explained the research to _____ 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 Date

# APPENDIX B

## DEMOGRAPHIC SURVEY AND SEMI-STRUCTURED INTERVIEWS

A. Demographic Information

1. What is your age?
2. What is your sex/gender?
3. What is the highest degree you have earned and in what field?
4. What is the setting of your personal and professional life (i.e., urban/suburban/rural)?
5. How many years in practice?
6. How many years supervising?
7. Who have you supervised (e.g., BSW/MSW/PhD students, practicing social workers)?
8. In what setting(s) does the supervision take place (i.e., agency (on-going, LCSW hours), psychoanalytic training supervision, institute consultation, private practice)?
9. How would you characterize your personal treatment experience?
10. Could you describe your theoretical/treatment orientation?
11. What is your participation in training programs, your affiliation with institutes or organizations, teaching activities, membership in professional organizations, committees, writing for professional journals, study groups, etc.?
12. Are you currently seeking supervision/consultation?
13. Have you had supervisory training? If so, what was it?

B. Semi-Structured Interview

1. Subject as supervisor:
    a. How do you decide how to work best with a supervisee?
    b. Tell me about the most difficult supervisee.
    c. How did the problem present itself?
    d. Did you modulate your technique? How did it work?
    e. What was your process in developing your technique?
    f. Do you ever recommend treatment? Discuss.
    g. Define and discuss the teach vs. treat conundrum.
    h. Define and discuss the concept of “impaired supervisee.”
2. Subject as supervisee:
    a. Tell me about your experiences as a supervisee.
    b. Did your supervisor every change their technique with you when you were going through a stressful time, a difficult countertransference experience, a particularly rough patch of your own treatment?
    c. If you had multiple supervisors, did they utilize different technique and if so how do you understand that?
3. Subject as professional:
    a. How did you learn supervision?
    b. How should supervision be taught? How do you teach supervision?
4. Any other thoughts?
5. Any comments on this process?
6. Could you recommend others for the study?

# APPENDIX C

## SURVEY OF OFFERINGS ON SUPERVISION FROM CLINICAL MSW/PHD/DSW PROGRAMS[3]

[3] As of August, 2004.

Loyola University

Loyola does not offer courses on supervision. There is a doctoral level course on teaching that does provide information on supervision. Both the master and doctoral level's have component on organizational, programmatic supervision. They do not offer Continuing Education Unit (CEU) courses on supervision. New field instructors are offered a six hour training course for which there is no charge and no CEU's offered. Returning field instructors are invited to presentations by faculty and PhD students that are two hours in length and held twice a semester. These are free of charge and CEU's are available.

Smith College School for Social Work

Smith offers no MSW level courses on supervision but does offer a doctoral level course. Beginning in the Summer of 2005, Smith offers a new certification program in advanced clinical supervision for supervisors with three or more years of experience. This is composed of sixty hours of classroom learning plus a year long practicum. They developed this partially in response to developments in Social Work Law. Many states now require supervisors who provide advanced licensure supervision to have a special certification. In Texas, this requires a 40 hour training.

Smith offers, but due to geographic factors, does not require a one day workshop on supervision. Their annual continuing education week also offers training on supervision. Occasionally Smith will provide supervision training to their supervisors in the field, i.e., in California.

Tulane University

Tulane offers no courses on supervision on the master's or doctoral level. In the past, they have offered elective courses. For the 2003-04 season, they did not offer any continuing education programs nor internet courses on supervision.

Tulane required a half-day training for new field instructors. They require their returning field instructors to attend a no-charge day long workshop, for which they received CEU's. Some supervisors do not attend. They are looking for grant money for in-depth trainings. They are concerned about supervisors retiring and want to assure appropriate training for new supervisors.

University of Maryland

The University of Maryland offered one elective course in the 2004-2005 year on supervision. It reviewed the history of supervision, the different tasks of supervision, different supervisory techniques, issues that may arise in different settings.

The University offers an orientation to new field instructors. In addition, they offer five, half day training sessions over the academic year. They free of charge and provide CEU's. However, they distinguish field instruction from supervision and the focus of the trainings are on field instruction issues, i.e., evaluation of student performance of the field, discussing differences, disabilities, process recordings, learning contracts. In addition, they attempt to provide CEU opportunities to social workers on supervisory topics they will find useful, management, ethics and supervision, the supervisor/supervisee relationship.

New York University

NYU offers no courses on supervision on the master's or doctoral level. Field instructors are required to take a course which meets for two hours once a week for 13 weeks.

Columbia University

Students (approximately 100) who major in Advanced Generalist Practice (AGP&P) in their second year take a course in Supervision. Supervision is also an elective in the second year which at least another 25 students take. So, about 25% of the graduating class each year has taken coursework in Supervision. Columbia's doctoral program is administrative and thus provides coursework on administrative supervision. Columbia requires a no-cost, 12 session Seminar in Field Instruction (SIFI) for all first time field instructors. The seminar, each session of which is two hours, looks at the teaching function inherent in good supervision and trains the field instructors in the adult learning information necessary to be a good supervisor. In addition, there are Advanced SIFI's of six sessions each in Clinical, AGP&P, Policy and Social Administration supervision.

# APPENDIX D

## REQUIREMENTS FOR SUPERVISORS TO BE SUBJECTS

1. Ten or more years of practice
2. Licensed at the highest level available in their state
3. Five or more years of supervising
4. Psychoanalytic or intensive psychodynamic personal psychotherapeutic treatment
5. Involvement in furthering the field, i.e., teaching, membership in professional organizations, committees, writing for professional journals, study groups, etc.
6. Practitioner of depth psychotherapy

# APPENDIX E

## A PRIORI THEMES

1. Deciding how to work best with a particular supervisee
2. Difficult Supervisory situations
3. Definition of psychologically impaired supervisees
4. Responses to psychologically impaired supervisees
5. Method of developing response
6. Recommending treatment
7. Difference between supervision and psychotherapy
8. Supervisor's experiences as a supervisee
9. How supervisor learned how to supervise
10. How supervision should be taught
11. Process of interview
12. People entering the field due to unresolved issues
13. Need for treatment as part of training
14. Inherent difficulties in being a supervisee
15. Inherent challenges presented by the supervisory relationship itself
16. Role of the supervisor
17. Lack of training in supervision
18. Co-constructed nature of supervisory relationship

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