

Where to Turn for Help: Responses to Inadequate Clinical Supervision

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ABSTRACT. This article addresses issues pertaining to the experience of trainees who encounter deficient supervision. The pertinent literature concerning insufficient supervision is reviewed, and a case example is described in which deficient supervision resulted in tragic consequences. Ethical considerations and implications are discussed, and recommendations are offered to trainees who find themselves working in clinical contexts in which supervision is lacking. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2002 by The Haworth Press, Inc. All rights reserved.]*

KEYWORDS. Supervision, therapists-in-training, ethics, inadequate supervision

Effective psychotherapy supervisors not only provide education and support for psychology trainees, but also facilitate the delivery of clinical services and ensure adherence to standards of practice. When clinical supervision is inadequate or unavailable, beginning therapists may feel alone and insecure in their professional activities. In this paper, I review the pertinent literature concerning insufficient psychotherapy supervision and describe a case example from my work at a psychiatric hospital that

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The Clinical Supervisor, Vol. 21(1) 2002
<http://www.haworthpressinc.com/store/product.asp?sku=J001>
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involved such a deficiency. As a counselor on an adult inpatient psychiatric unit, I experienced several personal and professional challenges in my attempts to clarify my role and obtain guidance. In order to elucidate these challenges, I discuss the ways I responded to an ineffective supervisory style while managing a suicidal client.

FACTORS AFFECTING QUALITY CLINICAL SUPERVISION

Over the last two decades, educators have paid greater attention to the importance of clinical supervision in training psychotherapists (Halgin & Murphy, 1995). While several authors have explored the types of behaviors, processes, and styles that characterize effective supervision (Carifio & Hess, 1987; Henderson, Cawyer, & Watkins, 1999; Shanfield, Hetherly, & Matthews, 2001; Shanfield, Matthews, & Hetherly, 1993; Watkins, 1995), there is little literature on the responses of therapists and counselors working within clinical environments where there is inadequate oversight. Consequently, a scholarly discussion of deficient supervision is best articulated by consulting what experts have written regarding the characteristics of good supervision.

While there is no single method or approach that captures the essence of good supervision, Carifio and Hess (1987) surveyed the supervision literature and identified numerous traits and skills characteristic of effective trainers. Specifically, ideal supervisors possess the depth of knowledge and practical expertise necessary for training clinicians. Moreover, they establish clear goals and demonstrate “respect, empathy, genuineness, concreteness, and self-disclosure in [their] dealings with supervisees” (p. 245).

Shanfield, Mohl, Matthews, and Hetherly (1992) analyzed videotaped sessions of supervision and found that excellent teachers of psychotherapy empathize with trainees, respond to the concerns presented in supervision, and provide interpretive comments. In a subsequent study, the authors identified specific behaviors and strategies of high functioning supervisors by conducting a qualitative analysis of transcripts derived from weekly supervision sessions (Shanfield, Matthews, & Hetherly, 1993). They concluded that effective supervisors permit trainees to express freely the challenges and dilemmas they encounter in therapy, affirm and deepen trainees’ interpretations of client problems, and offer recommendations relevant to trainees’ concerns with minimal use of technical language. Noting the importance of these skills, Shanfield et al. (1993) argued that

the good supervisor closely follows the concerns of trainees, while also helping them to develop a deeper understanding of the clinical material they present. Finally, the researchers corroborated these findings in a recent study in which former trainees rated their videotaped psychotherapy supervision sessions, demonstrating that excellent supervisors discuss and provide guidance for the difficult clinical interactions and personal concerns of trainees (Shanfield, Hetherly, & Matthews, 2001).

In addition to describing the characteristics and behaviors of supervisors, several researchers have examined trainees' perceptions of supervisor quality. For instance, Henderson, Cawyer, and Watkins (1999) compared the perceptions of psychology graduate students and their supervisors regarding effective practicum supervision. In their qualitative study, the authors interviewed ten student trainees and five supervisors in order to determine which factors in clinical supervision the participants considered most important. Students viewed the effectiveness of supervision to be a function of the supervisor's general level of knowledge and clinical experience, capacity to facilitate learning, and ability to offer constructive evaluation of trainee performance. Additionally, students identified relationship factors such as trust, approachability, respect, and attentiveness as important supervisor characteristics. While the supervisors in the study noted similar relationship factors, they also emphasized the importance of attending to student development, ethics, and adaptability.

According to Watkins (1997), a leader in psychotherapy supervision research, investigators have directed little attention to the development and consequences of ineffective supervisory styles. Employing the Supervisory Complexity Model to discuss these issues, the author posited that the developmental stage, personality, training, experience, and environmental support of supervisors contribute to the establishment and maintenance of poor supervisory behaviors. He suggested that beginning supervisors, in addition to new therapists, need consistent supervision that facilitates professional growth through open and supportive feedback and prevents the formation of ineffective practices.

Although much less has been written about the characteristics of poor or insufficient supervision, a few researchers have employed self-report measures to study this phenomenon. Allen, Szollos, and Williams (1986) surveyed 142 doctoral students and concluded that poor supervisory experiences "are more easily characterizable by what they fail to provide than by what actually occurs" (p. 95). For example, supervision may break down when trainers lack the ability to give clear and direct feedback, establish an open atmosphere for discussing mistakes, or offer encouragement for risk taking. While the absence of these skills negatively impacts

trainee development, the authors also noted that sexist, authoritarian, or demeaning behaviors significantly compromise the supervisory relationship. Additionally, the investigators found that bad supervisors tend to be avoidant, critical, and preoccupied in their communication.

In a similar investigation, Kennard, Stewart, and Gluck (1987) examined the factors that contribute to positive and negative experiences in psychotherapy supervision by surveying clinical psychology trainees and their supervisors. Trainees rated psychotherapy supervision negatively when assigned to supervisors whom they viewed as providing little support, instruction, and interpretation. However, congruence in theoretical orientation and behavioral style related to trainees' positive experiences in supervision. The authors suggested that greater attention needs to be directed toward didactic interactions and the relational "match" between supervisors and trainees.

Many supervisors view supervision as an opportunity to model appropriate behaviors and teach ethical standards to clinicians (Vasquez, 1992; Walker & Clark, 1999). However, when supervisors do not adhere to ethical guidelines and principles, the supervisory alliance weakens considerably or even disintegrates (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). In response to such violations of the supervisory relationship, trainees may avoid seeking assistance and recourse due to the power differential they experience (Jacobs, 1991; Tyler & Tyler, 1997). Confronted with an ethical challenge or with an ineffective supervisory style, trainees may ask themselves questions about how to respond or where to turn for help.

CASE DESCRIPTION

In this section, I present a case example from my personal experience that highlights ethical and treatment challenges. Specifically, I describe the ways I perceived and responded to a clinical environment that lacked sufficient supervision. I also explain the process by which I discovered the importance of establishing a network of colleagues for support and remaining self-aware in difficult professional situations.

The first inpatient unit in which I worked provided short-term respite for adults in crisis due to various mental health problems including suicidal ideation, psychosis, or substance abuse. As a new clinician, my primary responsibilities were to facilitate group counseling, evaluate patient stabilization, and ensure patient safety. Upon my hire, I was informed that I would have the opportunity to participate in weekly super-

vision meetings with the unit coordinator. Considering that this practicum was my first clinical experience, the possibility for supervision excited me as I looked forward to learning practical strategies for working with diverse clinical populations. More importantly, though, I hoped that supervision would be a safe environment in which to discuss the questions and concerns I experienced during difficult interactions with the patients. Unfortunately, pressures from staff shortages and financial constraints prohibited weekly meetings with my supervisor; after a few months of employment, supervision consisted of unscheduled, brief “check-ins” approximately every two weeks. Resonating with the conclusions of Allen, Szollos, and Williams (1986), my initial supervisory experiences were defined more by what they lacked than by what they provided.

The effects of absent supervision were most pronounced for me while working with a suicidal client, whom I will refer to as “Roger.” Roger was a 25-year-old Caucasian man who was admitted to the unit for severe depression and suicidality. During his intake session, the client reported a significant substance abuse history, stating that he had been drinking heavily since the age of 12. The severity of his alcoholic behavior progressed to the point that his wife ultimately decided to leave him. While describing the marital separation, Roger stated that he felt “alone and useless” and that he did not fault his wife for terminating their relationship because he was “such a loser.”

As Roger told me his story, I found myself becoming increasingly nervous and consumed with self-doubt. As he spoke, Roger’s comments seemed awkward and scripted. Appearing listless and despondent, he made minimal eye contact and offered vague commitments for remaining safe. I felt ineffective and unprepared. How should I establish a therapeutic alliance with Roger? In what ways might problems with alcohol be complicating his depression? Given his troubling history, might there be special considerations for ensuring his safety?

In response to these questions, I initially turned to my supervisor for assistance and feedback. When I approached him, however, he was unavailable to address my concerns, and he offered no specific recommendations. Although he generally affirmed my work on the unit, I still felt unsure of myself. During this time of need, I quickly learned that my supervisor was not the only resource for support. Rather, I began to rely on the other staff of the inpatient unit, who included a multidisciplinary team of psychiatrists, psychologists, social workers, and nurses. In order to obtain advice for managing my intervention with Roger, I spoke with an experienced psychiatric nurse. She allayed my fears and confusion by acknowledging that Roger was a difficult client and suggesting that I try to “remain pa-

tient” with him. Moreover, she affirmed my clinical skills by noting similar dilemmas that I had encountered and handled well on the unit. Her comments were more reassuring than those of my supervisor who had observed me only rarely. From that point forward, the nurses’ station served as a safe venue for me to find guidance.

Over the next several weeks, Roger and I had lengthy discussions about his life during our one-to-one and group counseling sessions. Despite efforts by the other staff members and myself to provide encouragement and hope for Roger, he ultimately committed suicide on the unit. Sometime around two o’clock one morning, he hung himself with his bed sheet. While I was not present at the time of the incident, my coworkers and I felt a collective responsibility for Roger’s death. What had gone wrong? Could his suicide have been reasonably prevented? Roger was on periodic safety checks during the time when he hung himself. How could we have kept him safe? How could we prevent another suicide?

Immediately following the incident, the working environment on the unit changed markedly. In order to establish that the customary policies and procedures had been followed, the institutional administrators and supervisors spoke with all staff members. Daily meetings and interviews replaced the previously absent supervisory style. Unfortunately, this review of procedures did not reveal the lack of clinical supervision prior to the suicide nor were any supervisors held accountable. Instead, questions of legal liability became the primary focus of concern. While the administrators ultimately concluded that the staff had taken appropriate measures to ensure Roger’s safety, I again felt isolated and confused on the unit. Facilitating several group sessions a day, I was responsible for helping the other patients understand and cope with Roger’s death. During this time, I was confronted with the challenge of having to integrate the loss of Roger within a professional context of extreme scrutiny and oversight.

With the exception of one staff debriefing session immediately following Roger’s death, the institutional administration provided no structured mechanism for supporting staff members after the tragic event. Consequently, my personal response was again to consult with my colleagues. I turned to another clinician whom I respected and in whom I had much confidence. After revealing my concerns to her, she warmly responded by sharing similar feelings of self-doubt as well as frustration with the deficient supervisory atmosphere. Over time, the clinicians on the unit found informal ways to support one another through this crisis. I felt reassured and again discovered the need for professional feedback that is empathic, clear, and honest.

REFLECTIONS, CONCLUSIONS, AND RECOMMENDATIONS

In retrospect, I have often asked myself why I did not respond at the time to the ethical considerations and implications associated with this inadequate supervision. I wondered what were my responsibilities to report a potentially unsafe clinical environment. In struggling with these questions, I realized that my harsh retrospective criticism was somewhat unfair to myself. As Jacobs (1991) noted, "Because students are emotionally vulnerable in the context of their supervision, they are in a poor position to advocate for themselves should the boundaries of that relationship break down" (p. 133). Like many trainees, I had in fact identified my need for supervision and directly sought such assistance from my supervisor. However, I had no frame of reference within which to compare this first clinical experience, and I was intimidated by the power differential.

My work on the inpatient psychiatric unit was tremendously formative in my development as a therapist and a potential clinical supervisor. Within this context, I had the opportunity to encounter multiple forms of mental illness and learn effective treatment strategies for helping individuals in crisis. More importantly, though, I learned about the vital importance of consulting with coworkers and establishing a network of colleagues in direct care work. As primary sources of support and guidance when supervision is ineffective, such relationships serve to validate and affirm a trainee's clinical judgement.

After reviewing the relevant literature, and with confirmation from my own clinical experience, I now understand that the role of the psychotherapy supervisor is not only to educate and respond to trainees' concerns, but also to facilitate client change (Holloway & Neufeldt, 1995) and minimize risks to client safety (Walker & Clark, 1999). In order to ensure that supervision is appropriate, supervisors and trainees need to delineate clearly their mutual rights and responsibilities. Tyler and Tyler (1997) proposed a "bill of rights" for supervisees, in which they outlined the parameters of the supervisory process and designate standards for creating an equitable relationship and quality training. More specifically, the authors asserted that supervisees should have the right to "choose among potential supervisors," expect "complete confidentiality with regard to their own disclosure," and offer "feedback to supervisors concerning the efficacy of supervision" (p. 88).

Similarly, some authors recommend the use of written contracts in supervision, especially given the current litigious environment of mental health care. Osborn and Davis (1996) suggested ways to develop a super-

vision contract, and they argued for the specification of goals and expectations, promotion of professional collaboration, reinforcement of ethical standards, and documentation of services. Such an instrument “serves to remind supervisors of their ethical and legal responsibilities to both the supervisee and his or her clients and thus . . . holds supervisors more accountable for their professional behavior” (p. 131).

While attempts to codify the relationship between supervisors and trainees may improve the adequacy of supervision over time, many beginning therapists will continue to find themselves inadequately supervised. As in my experience, these clinicians will likely turn to their colleagues to obtain support and advice under such circumstances. However, it is incumbent upon experienced clinicians to advocate systemic improvements in supervision and to be alert for unethical or inappropriate oversight of trainees.

REFERENCES

- Allen, G. J., Szollos, S. J., & Williams, B. E. (1986). Doctoral students' comparative evaluations of best and worst psychotherapy supervision. *Professional Psychology: Research and Practice, 17*(2), 91-99.
- Carifio, M. S., & Hess, A. K. (1987). Who is the ideal supervisor? *Professional Psychology: Research and Practice, 18*(3), 244-250.
- Halgin, R. P., & Murphy, R. A. (1995). Issues in the training of psychotherapists, In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice*. (pp. 434-455). New York, NY: Oxford University Press.
- Henderson, C. E., Cawyer, C. S., & Watkins, C. E. (1999). A comparison of student and supervisor perceptions of effective practicum supervision. *The Clinical Supervisor, 18*(1), 47-74.
- Holloway, E. L., & Neufeldt, S. A. (1995). Supervision: Its contributions to treatment efficacy. *Journal of Consulting and Clinical Psychology, 63*(2), 207-213.
- Jacobs, C. (1991). Violations of the supervisory relationship: An ethical and educational blind spot. *Social Work, 36*(2), 30-135.
- Kennard, B. D., Stewart, M. S., & Gluck, M. R. (1987). The supervision relationship: Variables contributing to positive versus negative experiences. *Professional Psychology: Research and Practice, 18*(2), 172-175.
- Ladany, N., Lehrman-Waterman, D. L., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist, 27*(3), 443-475.
- Osborn, C. J., & Davis, T. E. (1996). The supervision contract: Making it perfectly clear. *The Clinical Supervisor, 14*(2), 121-134.
- Shanfield, S. B., Hetherly, V., & Matthews, K. L. (2001). Excellent supervision: The residents' perspective. *Journal of Psychotherapy Practice & Research, 10*(1), 23-27.

- Shanfield, S. B., Matthews, K. L., & Hetherly, V. (1993). What do excellent psychotherapy supervisors do? *American Journal of Psychiatry*, *150*(7), 1081-1084.
- Shanfield, S. B., Mohl, P. C., Matthews, K. L., & Hetherly, V. (1992). Quantitative assessment of the behavior of psychotherapy supervisors. *American Journal of Psychiatry*, *149*, 352-357.
- Tyler, J. M., & Tyler, C. L. (1997). Ethics in supervision: Managing supervisee rights and supervisor responsibilities, In *The hatherleigh guide to ethics in therapy*. (pp. 75-95). New York, NY: Hatherleigh Press.
- Vasquez, M. J. T. (1992). Psychologist as clinical supervisor: Promoting ethical practice. *Professional Psychology: Research and Practice*, *23*(3), 196-202.
- Walker, R., & Clark, J. (1999). Heading off boundary problems: Clinical supervision as risk management. *Psychiatric Services*, *50*(11), 1435-1439.
- Watkins, C. E. (1995). Psychotherapy supervision in the 1990s: Some observations and reflections. *American Journal of Psychotherapy*, *49*, 568-581.
- Watkins, C. E. (1997). The ineffective psychotherapy supervisor: Some reflections about bad behaviors, poor process, and offensive outcomes. *The Clinical Supervisor*, *16*(1), 163-180.