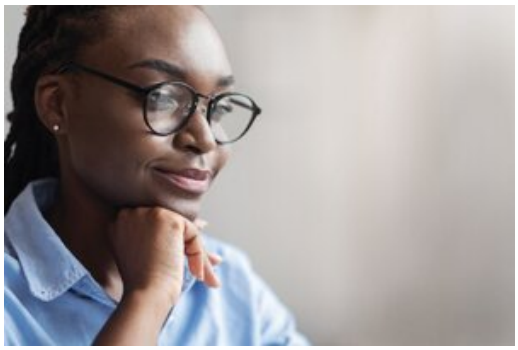

The New Supervision

Are We Meeting the Needs of Today's Therapists?

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Long gone are the days when "virtuoso therapists known simply for their virtuosity," toured campuses, giving bombastic lectures and one-off supervision consultations, says Terry Real, who trained as a social worker at Smith College in the late '60s and is now a therapist, author, and founder of the Relational Life Institute. When the field was more personality driven, with larger-than-life pioneers giving live demonstrations onstage, many therapists in training basked in their gravitas. It was the force of their presence, more than any specific technique, that gave the sense that these giants had something to impart. Since then, in higher education, there's been a shift toward empowering students to take ownership of their ideas and work. Across disciplines and fields, this manifests itself in an increased emphasis on giving students a voice early in their learning. Likewise, in psychotherapeutic training, supervisors and trainees are increasingly likely to think of the supervisory relationship as "co-constructed," says Ron Taffel, therapist, author, and board chair of the Institute for Contemporary Psychotherapy.

My conversations with recent trainees underscore that, yes, relationships between clinical mentors and mentees have changed over recent decades. But just how much and in what ways? Naydine Johney, who earned her PsyD from Antioch in 2019, told me that her supervisor, Martha Straus, has been a life-changing presence, in part because "when you walk into a room she's in, it feels like you're entering a home." Straus helped Johney reflect on her decisions and sharpen her clinical skills, and she was a pillar of support and affirmation. "There were times when I was exhausted, and I just needed someone to tell me, 'You can do this! Go home, take a nap, and come back tomorrow.' There were times when I just went to her office and cried, and she allowed for that."

As I asked veteran clinicians, supervisors, and training directors about what's changed in supervision over the course of their careers, therapist Ron Siegel's observation felt apt: "for virtually any assertion you can make in our field, the opposite is also true to some degree." Clinicians all had different opinions on whether programs have adopted a more interdisciplinary approach or trainees are still encouraged to adopt and hone one method. Most clinicians I spoke with acknowledged attempts to address racism, sexism, and other systemic inequities and biases, and I heard mixed reviews on the extent to which the field as a whole is moving beyond interventions designed for straight, white, middle-class clients. Nearly everyone described this era in psychotherapy as "the decade of the individual," defined by a focus on trauma. Many lamented the decline of family therapy and systems thinking, even as larger social issues have been moving closer to the fore.

But despite differing opinions on just about everything training related, veteran clinicians agreed that a defining change in the field has been the relationship between mentors and mentees. When Taffel and his cohort were coming up years ago, psychotherapeutic training and the broader culture were governed by rigid linear hierarchies between authority figures and their disciples. Now, mentors and mentees are just as concerned with establishing what he calls a "nonlinear reciprocity."

Johney, currently a supervisor, including of clinicians who have many more years of clinical experience, said she directly acknowledges her supervisees' additional experience and considers herself a sounding board, rather than someone who's going to step in and tell anyone what to do. She explained, "I strive for reciprocity personally and professionally, especially in a supervisor–supervisee relationship. I'm always asking myself, 'What's happening within these interactions that's reciprocal? Do you feel like the learning experience goes both ways? Do you feel like there's an emotional connection that goes both ways?'"

Everyone told me that mentors are pivotal figures in therapists' lives. The lessons a supervisee needs can't be fully imparted in a classroom: they need to be learned in practice. And what clinicians want out of mentorship—and supervision in particular—has changed since Terry Real watched his virtuosic heroes onstage in a packed auditorium.

> *“The words 'two-minute silence' on a transcript do little to convey the emotion in the room when a usually talkative client stops forming words.”*

To varying degrees, training programs and supervisors have adapted to newer clinicians’ needs. In many programs, supervision has always been, and continues to be, prioritized. At the nonprofit Institute for Contemporary Psychotherapy, as well as many centers with a similar ethos and model, Taffel said, “Weekly supervision between veteran clinicians continues as an absolutely essential part of the experience, foundational to our trainees, clients, and mission as a center of learning.” And at the same time, because there are few uniform standards for supervision, for many new clinicians, reliable, in-depth mentorship is harder to come by than it was back when clinicians took for granted that mentors could, and perhaps should, be intimidating.

Is Anyone Watching?

As I started talking to clinicians about how they’d cut their teeth, I wondered whether supervision has changed enough to keep pace with developments in the field. To be effective, a supervisor needs to have many of the same talents and skills as a good therapist—but to use them differently. I wanted to know how veteran and newer clinicians define that edge between therapist and supervisor, and whether the basics of that unique relationship have remained the same since the years when the bombastic lecturers held the stage.

Veteran clinicians told me, with varying degrees of consternation, that trainees and new clinicians tend to have fewer opportunities for supervision—especially live supervision—than in previous decades. That may seem at odds with what’s happening on paper, especially to students acutely aware that they’re required to log thousands of hours of supervised work before they’re accredited. Because an uneven patchwork of requirements for training and supervision varies among states, degrees, and programs, it’s difficult to generalize about how much supervision, and what quality, mental health professionals have received before being licensed.

Traditionally, live supervision requirements have been fulfilled through training programs or internship supervisors, and in many programs they’ve slipped away. Mary Jo Barrett, a longtime therapist and clinical supervisor who codirects the

Center for Contextual Change, summarized what I heard from several veteran clinicians: “Clinical skills have to be learned on your feet. How else would you learn them? But somebody has to observe you and give you feedback.”

Barrett said it’s critical that mentees observe their mentors in practice, and it’s dysfunctional that new clinicians are increasingly sent to work with people on their difficult psychological issues without any supervisor ever seeing firsthand how they interact with a client. We’re all subjective witnesses; no matter how honest we’re trying to be, our report of an interaction with another person is never going to be the full picture.

The idea that people are earning degrees without anyone watching them talk with clients is staggering, and not only to long-timers. “The thing that I was surprised to find in my program is that no one ever has to see you with a client, ever. There was no screen, no one-way mirror; you didn’t have to record yourself with clients,” said Talia Litman, who said she otherwise loved her MFT program at Mercy College in New York State. Her supervisor chose to do joint sessions with her, but that was rare among supervisors at Mercy, Litman said. She sought out her own supervision and mentors, including one who now watches recordings of her online sessions, because she specifically wanted that kind of guidance. Litman thinks live observation should be mandated in training. “You can continue to read or go to training,” she said, “but unless you’re actually doing it and being observed, you’re just learning it on your own with no one continuing to develop you on a practical level.”

For many veterans of the field, live supervision was a cornerstone of their development as therapists. Terry Real, a couples therapist, recalls interviewing a family with a team of supervisors watching from an adjoining observation room. In the therapy room, the kids were scrambling around, loud, uncontained. Real knew he’d lost control and didn’t know how to get it back. The lights dimmed in the therapy room and went up in the observation room, and his supervisors shifted the mics.

“The team talked about me and the family in front of us. They said what they liked about each of us, and the family just settled right down,” Real remembered. “It was very exciting stuff.” That experience was invaluable, he tells me. “Showing your work through a one-way mirror meant you learned not to take yourself dead seriously. You learned to get over the shame of not making the perfect move every time you

uttered a word. You learned to let go of a certain preciousness." And, in doing so, Real said, you learned to "be the same person you are when you cross your office as you are when you cross your living room."

If a supervisor can't observe live sessions, audio or video recordings can certainly provide a better window into a clinician's attunement and decisions than a supervisee's report of what happened. The words *two-minute silence* on a transcript, for example, do little to convey the emotion in the room when a usually talkative client stops forming words. "The kinds of silence vary and change all the time," Naydine Johney told me. "There's a difference between a client crying for two seconds, and the clinician saying, 'It's okay,' and a clinician waiting for 20 seconds for the client to express themselves before reassuring them." As a supervisor, she gives a different note depending on the kind of silence that has passed between the supervisee and the client.

The Business of Supervision

The stakes for quality supervision are high for clinicians' confidence and career trajectories, but also, of course, for clients' well-being. It's difficult to imagine how struggling new clinicians can find their footing without a discerning clinician seeing their struggles live and providing tailored feedback. And yet, live supervision is increasingly considered more a bonus than a staple.

"Live supervision is dying out," said Marlene Watson, Director of Training at the Ackerman Institute for the Family. Ackerman still provides intensive training in family therapy, including four hours of live supervision per week in the Live Clinical program, during which trainees work with families behind a one-way wall (or online platforms during the pandemic), and four hours of live or video supervision for trainees in an externship. Ackerman and several other institutes are outliers for continuing to provide that level of live, in-depth training. Watson explained that the center can maintain its in-depth training program because it's buoyed by charitable funding, not only fees from a business model.

In contrast, as universities across the country have moved to a more corporate model, their administrations have tended to view intensive training programs as costs that won't return financial dividends, several clinicians told me. Meanwhile, under pressure to generate revenue, many graduate programs have begun accepting more candidates without expanding their faculties. While plenty of schools and internships do provide in-depth supervision, there are no standards, and what trainees are provided varies widely depending on their school and degree.

Mary Jo Barrett distilled what's happened to supervision: "Like so many things in our world right now, it's dictated by profit." Live supervision requires one or more experienced faculty members to devote numerous hours concentrating on a single student, and whether students learn to attune to their clients' emotional needs will never affect the university's cash flow. Watson sums it up: "It's costly to provide that kind of training, and many universities don't want to invest that kind of money. Quite a number of PhD and family therapy programs closed because of these kinds of issues."

Changes in supervision models also reflect developments in the clinical understanding of the supervisory relationship, Taffel told me. "Especially as we become more relational and attachment-informed, supervision is considered an evolving process. The relationship is alive with unaddressed issues in the treatment —inevitable empathic gaps, reenactments of a client's history, the therapist's so-called unprofessional feelings, and our implicit biases. These can't help but manifest themselves in supervision and are a valued component of learning," he said. With direct input from a supervisor, all therapists can "build muscle memories that strengthen their own unique identities as therapists."

New clinicians I spoke with had extremely different accounts of their supervision experiences during internship, depending on where they were placed. Jennifer Leslie told me that during the second year of her doctoral program, she'd interned at a busy community agency, where instead of the mandated hour, her supervisor would talk with her for 10 minutes here and there, and Leslie eventually had to get the school involved to advocate for real supervision. The following year, she made sure to seek out a placement at an agency where she'd receive more thorough supervision. Especially for therapists working in underfunded community clinics where there are endless demands on clinicians' time, there's nothing surprising about this story, but it underlines how inconsistent trainees' experiences with mentorship can be.

Even the search for supervision or consultation after launching a private practice can be challenging, given how taxed everyone is for time. One fully licensed clinician who recently started in private practice told me she doesn't have a consulting clinician, although she meets with a peer group periodically. When she's unsure, she crowdsources advice by searching keywords in therapist Facebook groups.

"There were times when I was exhausted, and I needed someone to tell me, 'Go home, take a nap, and come back tomorrow.'"

PHOTO © ISTOCK/FATCAMERA

While she said the strategy has helped her find a range of ideas she couldn't have gathered from a lone supervisor, I personally find the notion that I'd go to a therapist with a difficult personal issue and she'd look for treatment ideas from strangers on Facebook downright alarming. But as one therapist asked me after ranting about diminished supervision: "Am I just old and bitter?" After all, this clinician is being resourceful, searching for guidance while working on her own, in a profession that she said she's found isolating. And given that this particular therapist had in-depth, live supervision during school, it's safe to assume that veteran clinicians have signed off on her good judgment. I keep coming back to what Barrett said: "If you think about our profession, people sit in a room by themselves with clients and nobody knows what the hell's going on in there. It's really wild, right?"

What Makes for Great Supervision?

Nonetheless, many clinicians—veteran and newer—talked about learning from seeing that their supervisors mess up sometimes, too. Litman, who sought out intensive supervision, was invited to observe her supervisor's live couples sessions. She learned concrete skills, like how to open the session with affirmations, modulate her tone of voice, and pace and structure a conversation, but what really stuck with her was the time when her supervisor couldn't deescalate a couple's argument. "She lost complete control of a session. It was a disaster, and somebody left. I was like, 'Wow.' That was really reassuring." That was a lesson she could've fully absorbed only by being there in the room.

In this way, most of the best lessons from supervisors seem ineffable. Liz Rogers, who earned her PsyD from Antioch in 2019, echoed what I heard from many clinicians when she said that "the top quality, even more than incredible knowledge about a technique or intervention, is the relational quality, the ability to cultivate a sense of confidence in the supervisee's thinking and judgment." That relational quality is "an anchor every week," Rogers said. Being held in unconditional positive regard allows supervisees to develop their own way of being with and attuning to clients. When that's not there, the relationship can corrode a new clinician's self-esteem in ways that affect more than their immediate interactions with clients. As Johney described, when you have a supervisor who undermines you, "You never quite become comfortable with any decision you make. The self-doubt follows you around. You become a different person because of how much you're doubting yourself."

As a supervisor listening to new clinicians narrate their struggles with a client, it's challenging to convey that positive regard and trust without leaping in and trying to fix the situation. Supervisors need to focus on their supervisees' needs, not the immediate needs of the individual or family in therapy, and that can be counterintuitive for longtime therapists accustomed to zeroing in on clients. "That took a lot of work," Barrett said, of learning to be a supervisor. "Because my instinct was *how can I help the family*? My instinct was to bypass the therapist and say, 'Do this, do this, do this.'"

Barrett was trained in supervision, which she said is a skill wholly different from providing therapy, and she learned that she needed to focus on maintaining a "balance between being curious and directive." She concentrates on asking supervisees open-ended questions about what's going on and how it's affecting them, rather than following her temptation to interrupt and give directive advice right away. She makes agreements with supervisees about how they wanted to be supervised.

Some newer clinicians told me they were starved for direct advice, while others told me they appreciated that their supervisors and mentors acted more like conversation partners or guides. Leslie said, "What stands out to me most is when supervisors really try to understand, and help me to understand, why I'm doing what I'm doing." She's appreciated when supervisors "really give me the space to name my intentionality" rather than simply noting "someone's working with you consistently, you must be doing your job."

For Leslie and others, it was helpful that sometimes supervision mirrored therapy, in that supervisors encouraged in-depth reflection and some personal disclosure. “The best supervisors I’ve had are the ones who I felt were the most authentic,” she said. “I could bring in my countertransference. I could name the ugly, messy, sticky parts of my work and know it wouldn’t be used against me; my vulnerability would be celebrated and embraced to make me a better clinician.”

Conversely, John Hughes, who graduated with a master’s in counseling in 2017 while changing careers in his 30s, told me he’d always hoped supervision would be more direct and advice driven than it was. He felt that supervisors wanted to have more therapy-like conversations about his personal experience and reactions. “I’ve had supervisors who I’ve loved and am still in very close contact with. I remember telling one of them, ‘I already know about how stressful it is. And I don’t need the support: I need you to tell me what to do.’”

That request, Hughes said, might come across as dismissive or impatient to a supervisor trained during an era when green therapists routinely processed their own issues with mentors at length, but Hughes said he’s grown up in a culture steeped in psychotherapeutic concepts and has already done that personal work on his own. For his cohort, he said, “when we show up for supervision, we need skills. We need interventions.”

Virtuosity is a luxury his generation can’t afford, Hughes said. While older directors of training programs may chafe at younger clinicians seeking quick techniques as silver bullets, many of those clinicians see those techniques as necessities created by numerous structural problems well outside their control. Building a roster of clients committed to ongoing, intensive psychotherapy would be ideal, Hughes said, but added that his colleagues are trying to maintain careers in a world where more clients are looking for tangible help and have only enough coverage for a limited number of sessions—and where therapists are competing with ever more sophisticated, low-cost therapy apps.

Hughes said, “I think we need to make sure we’re preparing ourselves for that new reality. We should be saying, ‘Okay, we know the clinical relationship is so important. How do we adapt that for this new time when everybody only gets 12 sessions?” The field is by and large led by veterans who’ve spent less, if any, of their time and emotional energy foregrounding those constraints when plotting their careers and developing their clinical styles—which means new clinicians can’t necessarily call upon veteran supervisors to give them proactive advice grounded in experience.

In the United States at least, supervisors who came of age in earlier decades have a sharply different existential frame of mind from that of many younger clinicians, who are keenly aware not only of financial constraints within the mental health field, but also that few people of their generation will be able to afford retirement, and climate change–driven catastrophes will affect them for the rest of their lives. “I have yet to meet someone over 60 who can tolerate that,” Hughes said, so he thinks younger clinicians need to come up with ways to support each other in peer groups, to help each other and the field come to grips with the new existential terms of finding meaning in life.

Another realm where a fundamental lack of understanding can harm the supervisor–supervisee relationship—and even harm the supervisee—is race. An example is an experience one Black clinician, who didn’t want to be named, told me she’d had with a white male supervisor. “There was something he wasn’t getting” during their conversations about her work with a Black family. The supervisor described his perspective as “more objective” than hers, and he wasn’t able to appreciate the cultural gaps between the family and the health and education systems they were navigating. It was difficult for the new clinician that her supervisor missed what she was saying around race and culture.

She ultimately sought advice from a white colleague, who eventually accompanied her to a meeting with the white supervisor and reinforced the Black clinician’s ideas. Only then did the supervisor acknowledge her perspective. This story, and the fact that this new clinician had to weigh whether she could use her name in this article without being perceived as “angry,” shows how far we are from racial equity within the field.

Naydine Johney, who is also Black, advocates for supervisors, and therapists in general, to trade in the concept of *cultural competency* for *cultural humility*, in which another culture or worldview isn’t something to master. Instead, *cultural humility* asks all of us to constantly develop our capacity to reflect on and be accountable for changing power dynamics.

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A beginner’s humility, in general, can be an asset a supervisee brings to the supervisory experience, as well as to the relationship with clients. As Litman told me, her lack of experience and knee-jerk certainty as a trainee meant she made fewer clinical assumptions before delving into various interventions. In fact, given her genuine curiosity, she was able to make headway with a client that a supervisor

had immediately diagnosed with borderline personality disorder, as well as with many couples that her supervisors had speculated were lost causes. Litman believes that clinicians in training, not yet wearied or reflexively diagnostic, “can probably bring just a little bit more hope.”

And, of course, at their best, supervisors themselves are hard at work instilling hope in their trainees and carrying forward their own hope for the field. Taffel told me that supervisors at most nonprofit institutions essentially donate their time because they’re so committed to the mission of expanding access to skilled psychotherapists. They deeply understand that along with inspired teaching, “supervision is, and always will be, the relational heartbeat of clinical training.”

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